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Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care

Malcolm J. Harkins III

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BE CAREFUL WHAT YOU ASK FOR: THE REPEAL OF THE BOREN AMENDMENT AND CONTINUING FEDERAL RESPONSIBILITY TO ASSURE THAT STATE MEDICAID PROGRAMS PAY FOR COST EFFECTIVE QUALITY NURSING FACILITY CARE

MALCOLM J. HARKINS III, J.D.

INTRODUCTION

In 1980 Congress, at the behest of the states, passed the Boren Amendment ("Boren") to the Medicaid Act. The Boren Amendment transferred to the states the primary authority and responsibility, previously exercised by the Secretary of the Department of Health and Human Services (the "Secretary"), for determining and assuring that Medicaid payment rates complied with the substantive standards of the Medicaid Act. The Boren Amendment obligated the states to pay for nursing home services — and later inpatient hospital services — at rates which the states found were reasonable and adequate to meet the costs incurred by efficiently and economically operated hospitals and nursing homes to provide care and treatment in compliance with federal and state quality of care standards.

Largely at the instigation of the states, the Boren Amendment was repealed by the 1997 Balanced Budget Act. The National Governors Association ("NGA") argued that the Boren Amendment needlessly

constrained state direction and imposed excessive fiscal demands. As the repeal was moving through Congress, several states considered cutting Medicaid payment rates.[1]

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1. The Medicaid program, which is jointly financed by the federal government and participating states, provides health insurance coverage for forty million persons, about twelve percent of the population of the United States. The majority of Medicaid beneficiaries are low income parents and their children. Medicaid provides health insurance coverage for twenty percent of all children in the United States and is the single largest purchaser of maternity care, paying for one-third of all births in the United States. Although comprising a much smaller percentage of Medicaid beneficiaries, the elderly consume the greatest amount of covered services. Medicaid, for example, is the largest purchaser of nursing home, and other long term care services. Medicaid pays for one-half of all nursing home care and almost forty percent of home and community based care for the elderly.

In 1999 Medicaid funds represented approximately forty percent of all federal funds paid to the states. Similarly, Medicaid spending constituted a large portion of state spending. In 2001, Medicaid spending was almost twenty percent of total state expenditures. Moreover, due to expansion in eligibility and coverage, among other things, Medicaid spending as a percentage of total state expenditures almost doubled in the period between 1987 and 2001. After a period of unprecedented low growth in Medicaid expenditures, due primarily to the robust economy, Medicaid expenditures have begun to increase. Between 1995 and 1997 Medicaid expenditures grew at slightly more than three percent per annum; between 1997 and 1998 the average annual increase in Medicaid expenditures exceeded five percent. More recently, Medicaid expenditures in fiscal year 2000 grew by almost eleven percent per annum and such expenditures are predicted to increase by almost fourteen percent in 2001. *See* 7 BNA: Health Plan & Provider, 1, 1 (Nov. 7, 2001). *See generally Prepared Testimony of Charles A. Bowsher, Comptroller General, United States General Accounting Office, Before the Committee on the Budget, House of Representatives*, FED. NEWS SERVS., Apr. 4, 1995, at 5 (discussing growth in Medicaid program costs and states' efforts to obtain program waivers). In contrast, the overall federal budget grew at less than four percent in the 1990's. *See* GENERAL ACCOUNTING OFFICE, MEDICAID: SPENDING PRESSURES DRIVE STATES TOWARD PROGRAM RETENTION, GAO/HEHS-95-122, at 4 (April 1995) [hereinafter GAO/HEHS-95-122 Report].

Medicaid expenditures have begun to increase at the same time that state revenues have begun to decline. Forty-four states reported actual revenues below forecasted levels as fiscal year 2001 began. A significant number of states also reported expenditures that exceeded budgeted levels. By the beginning of fiscal year 2001, seven states had convened special sessions to address budget shortfalls and a total of twenty-eight states had implemented or considered budget cuts. Unable, or unwilling, to cut eligibility or coverage, states began to seek alternatives means of constraining or reducing expenditures. Among other things, states sought to cap, or reduce, spending for nursing home care. In some instances, efforts were made to substitute home and community based care for nursing home care. In addition, about one-third of the states adopted or proposed freezes or reductions in payments to institutional providers. Thus, while few states actually implemented payment rate reductions at the time of the repeal, many states took steps to do so as the economy slowed and the revenue dropped. These actions were taken despite the fact that an August 2001 study prepared for the American Health Care Association found that Medicaid payments to nursing homes failed to cover the cost of such services in forty-nine of the fifty states. The shortfall between payment rates and the cost of services averaged in excess of nine dollars per patient day of care (ranging from a low of $2.69 per patient day of care in North Carolina to a high of $21.11 per patient day of care in New Jersey).

In this article the background and the legislative history of the Medicaid Act's payment standards, including the Boren Amendment, as well as their application by the Courts are analyzed. The replacement legislation for the Boren Amendment and its legislative history also are examined. Finally, other provisions of the Medicaid Act that provide a basis for providers to challenge the adequacy of Medicaid payments are considered.

The article concludes that the Medicaid Act contains payment criteria that institutional care providers can enforce, notwithstanding repeal of the Boren Amendment. In fact, repeal of the Boren Amendment eliminated special payment criteria and procedures favorable to states and applicable only to payments to institutional providers. Repeal of Boren actually removed limitations on the Secretary's responsibility to assure that states' Medicaid payments to institutional providers complied with the Medicaid Act. As a result, this article argues, the effect of Boren's repeal is to remand the states to the Medicaid Act's general substantive and procedural payment standards, restore the Secretary's duty to review and validate the compliance of the states with the Act's payment standards and to assure affirmatively on an ongoing basis that state Medicaid payment methodologies comply with the Act. Despite the intentions of the states and the Congress that repealed Boren, states no longer have the protections afforded by Boren and providers should be able to enforce the Act's substantive requirements against the states and the Act's procedural requirements against the Secretary. Together, these requirements mandate that the Secretary approve and provide federal funding only for State Medicaid payment methodologies and procedures that assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that Medicaid beneficiaries have the same access to services as the general population.

The information discussed above regarding aggregate Medicaid spending is taken from reports prepared for the Kaiser Commission on Medicaid and the Uninsured. *See* V. Smith & E. Ellis, *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001 and 2002*, Health Management Assoc. (Oct. 2001) [hereinafter *Medicaid Budgets*]; J. Guyer, *Policy Brief: The Role of Medicaid in State Budgets*, Henry J. Kaiser Family Found. (Oct. 2001) [hereinafter *Policy Brief*]. The data regarding the shortfall in Medicaid payments versus the cost of services was extracted from A BRIEFING CHARTBOOK ON SHORTFALLS IN MEDICAID FUNDING FOR NURSING HOME CARE prepared for the American Health Care Association by BDO Seidman, LLP (Aug. 2001).

I. THE MEDICAID PROGRAM

Medicaid is a joint federal-state program that pays for medical services provided to eligible poor and disabled persons.[2] States need not participate in Medicaid.[3] States that choose to participate, however, must administer their Medicaid program in conformance with the Medicaid Act and applicable federal regulations.[4] Although certain services and individuals must be covered by a state Medicaid program, states may choose to provide additional services or cover additional individuals.[5] Participating states receive federal funds to pay part of the cost of providing covered services.[6]

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2. *See* 42 U.S.C. § 1396 (2000), Title XIX of the Social Security Act (formally denominated "Grants to the States for Medical Assistance Programs"). Title XIX was enacted as Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396-1396u (2000)). Medicaid is the largest third-party payor of nursing home care in the United States.

3. *See* 42 U.S.C. § 1396 (2000).

4. *See id.*

5. *See id.*

6. The federal contribution, known as federal financial participation (and formerly referred to as the federal medical assistance percentage), varies from fifty percent to approximately eighty percent of the states' Medicaid expenditures. *See* 42 U.S.C. §§ 1396b(a)(1), 1396(b) (2000). The percentage of a state's Medicaid expenditures eligible for federal matching is determined using a formula that is heavily dependent on a state's per capita income. At the time the formula was adopted, Congress' intention was to provide poor states with more federal funds relative to wealthier states. This sliding scale was intended to provide relative equity in health care services. Relatively wealthier states were presumed to be better able to fund their Medicaid programs from state tax revenues than poorer states. Poorer states were presumed to require greater resources to improve and expand their health care delivery systems and to provide access for unreserved populations.

Since the early 1980's, the federal matching formula, and especially the use of per capita income and the statutory minimum fifty percent matching rate, has been the subject of intense and repeated criticism by the General Accounting Office ("GAO"). *See, e.g.*, UNITED STATES GENERAL ACCOUNTING OFFICE, CHANGING MEDICAID FORMULA CAN IMPROVE DISTRIBUTION OF FUNDS TO STATES, No. GAO/GGD-83-27 at 25 (Mar. 9, 1983); UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAID FORMULA: FAIRNESS COULD BE IMPROVED, No. GAO/T-HRD-91-5 (Dec. 7, 1990); UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAID: ALTERNATIVES FOR IMPROVING THE DISTRIBUTION OF FUNDS, No. GAO/HRD-91-66FS; UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAID: MATCHING FORMULA'S PERFORMANCE AND POTENTIAL MODIFICATIONS, GAO/T-HEHS-92-226; UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAID: METHODS FOR SETTING NURSING HOME RATES SHOULD BE IMPROVED, GAO/HRD-86-26 (May, 1986) [hereinafter GAO/T-HRD-86-26 Report]. Among other things, GAO has noted that per capital income is an inappropriate measure of a state's ability to fund its Medicaid program and, further, that the formula does not take into account the number of persons actually living in poverty in the state. Further, GAO found that the fifty percent minimum federal matching payment in a recent year provided thirty-six states with nearly seven billion federal dollars more than they would have been paid under a proposed "equitable" formula that accounted for state funding resources and the number of low-income residents actually in need of health services. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAID FORMULA: EFFECTS OF PROPOSED FORMULA ON FEDERAL SHARES OF STATE SPENDING, GAO/HEHS-99-29R, at 10 (Feb. 19, 1999) (relying on

Congress delegated the responsibility for overseeing the operation of state Medicaid programs to the United States Department of Health and Human Services ("HHS").[7] Within HHS, the administration of Medicaid is the responsibility of the Centers for Medicare and Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA").[8]

A state that participates in Medicaid must designate a "single state agency" to administer the state's Medicaid program.[9] The single state agency must administer the state's program according to a "State Plan."[10] The State Plan, is a "comprehensive statement" of the state's Medicaid program which must include "assurances that it will be administered in conformity with the specific requirements" of the Social Security Act and HHS regulations.[11]

The State Plan must be submitted to and approved by the Secretary.[12] The Secretary is obliged to approve any State Plan which complies with the requirements of the Medicaid Act.[13] Federal matching funds can be paid to a state only if the Secretary has approved the state's Medicaid Plan.[14]

Nursing home care is a mandatory Medicaid service.[15] The Medicaid Act specifies both the types of care and the services that must be provided by nursing homes that participate in a state Medicaid program.[16] The Act also sets the quality of care standards that must be satisfied by a nursing home that serves Medicaid beneficiaries.[17] The Medicaid Act imposes a high standard on nursing homes: "A skilled nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ."[18] According to the Secretary, this obliga-

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1997 Health Care Financing Administration data to estimate the fiscal effect of a proposed Federal Medical Assistance Percentage change).

7. HHS formerly was known as the Department of Health Education and Welfare. In order to avoid confusion, the Department will be referred to by its current name, HHS, throughout the article.

8. The Health Care Financing Administration recently was renamed the Centers for Medicare and Medicaid Services. Because the majority of statutes, regulations and cases refer to HCFA, that acronym will be used throughout this article.

9. *See* 42 U.S.C. § 1396a(a)(5) (2000).

10. *See id.*; *see also* 45 C.F.R. § 201.3 (2001).

11. 45 C.F.R. § 201.2 (2001).

12. *See* 42 U.S.C. § 1396a(b) (2000).

13. *See id.*

14. *See* 42 U.S.C. § 1396 (2000).

15. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A) (2000).

16. *See id.*

17. *See, e.g.*, 42 U.S.C. §§ 1396r(a)-(d) (2000); *see also* 42 C.F.R. § 483.25 (2001).

18. 42 U.S.C. § 1396r(b)(2) (2000).

tion requires that nursing facilities assure that each facility resident achieves "the highest level of functioning and well-being," and, further, that each resident achieves "optimal improvement," subject only to the resident's right to refuse treatment and the recognized effects of pathology and aging.[19]

Although Medicaid programs are, for the most part, administered by the states, the Medicaid Act imposes specific obligations on the Secretary with respect to implementation of State Plan provisions regarding nursing facilities. The Act provides:

> It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State Plans approved under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote effective and efficient use of public moneys.[20]

This provision does not impose any new obligations on the Secretary. Instead, the provision makes explicit a duty that the courts previously held was implicit in numerous other provisions of the Medicaid Act; the Secretary must assure that Medicaid programs pay only for high quality care mandated by the Act and that nursing home residents actually receive such care.[21]

II. MEDICAID PAYMENT FOR NURSING HOME CARE: THE ACT AND ITS LEGISLATIVE HISTORY

A. Original Payment Standards

In 1966 when the Medicaid Act was adopted, the statute did not contain any substantive standards governing payment for nursing home services.[22] As a result, the states adopted a plethora of payment methodologies based on a variety of factors, some of which had little

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19. HEALTH CARE FINANCING ADMINISTRATION, STATE OPERATIONS MANUAL (SOM): PROVIDER CERTIFICATION ¶ 113, TRANSMITTAL 250 (April 1992) [hereinafter Transmittal 250].

20. 42 U.S.C. § 1396r(f)(1) (2000).

21. *See* Smith v. Heckler, 757 F.2d 583, 590 (10th Cir. 1984).

22. The General Accounting Office noted the Act's lack of specific requirements governing payment for nursing home services:

> Initially, the Medicaid law did not include any specific requirements regarding the methods to be used to pay for nursing home services. States were permitted to develop their own payment methods, subject to the general requirement that payments not exceed reasonable charges consistent with economy, efficiency, and quality of care.

Alabama Nursing Home Ass'n. v. Califano, 465 F. Supp. 1183, 1185 (M.D. Ala. 1979); GAO/T-HRD-86-26 Report, *supra* note 6, at 9. *See also* Park Nursing Ctr., Inc. v. Dep't of Social Servs., 28 B. R. 793, 796-97 (Bankr. E.D. Mich. 1983).

or nothing to do with the actual cost of delivering nursing home care.[23]

After a little more than five years experience with the Medicaid program, Congress determined that the failure to specify substantive payment standards had produced unacceptable results. Some nursing facilities were being overpaid, but others were paid too little. As a result, many nursing homes were unable to deliver the quantity and quality of care needed to meet residents' needs. Indeed, in a number of instances, states confronting budget crises had resolved the crises by refusing to fund the Medicaid program adequately.[24] Consequently, even if the State Plan in theory provided adequate payment, nursing homes sometimes did not receive payment for care — both already delivered and yet to be delivered — at the rate provided by the State Plan and anticipated by the nursing home.[25]

In 1972 Congress amended the Medicaid Act to mandate that states participating in the Medicaid program pay nursing homes on a "reasonable cost related" basis.[26] This standard required that Medi-

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23. One court addressed the variety of payment methodologies used by the states:

> There are wide variations among the States in the manner of financing the cost of nursing home care provided to the needy. In some states the full cost of care is paid. In others, a negotiated rate is developed which may or may not approximate the reasonable cost or reasonable charges for the services provided. Some states, however, depend upon the supplementation of the State's agency's below cost allowances for care with contributions from relatives or the needy individual himself.

Johnson's Prof'l Nursing Home v. Weinberger, 490 F.2d 841, 845 (5th Cir. 1974) (quoting S. REP. No. 744, at 187-88 (1967) *reprinted in* 1967 U.S.C.C.A.N. 3026). Similarly, the General Accounting Office found that:

> States tried a variety of payment methods ranging from the retrospective, reasonable cost reimbursement system used by Medicare to prospective rates based in some instances on state budgets or other factors not directly related to costs associated with providing nursing home care.

GAO/T-HRD-86-26 Report, *supra* note 6, at 9. *See generally* Medicaid Program; Payment for Long-Term Care Facility Servs. and Inpatient Hosp. Servs., 46 Fed. Reg. 47,964 (Sept. 30, 1981) (to be codified at 42 C.F.R. § 447) [hereinafter 1981 Medicaid Program].

24. *See* Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 921 (5th Cir. 2000).

25. GAO reported that:

> The Congress was concerned that some nursing homes were being paid too much, while others were not being paid enough to support the quality of care needed by Medicaid patients.

GAO/T-HRD-86-26 Report *supra* note 6, at 9. *See also* Alabama Nursing Home Ass'n v. Harris, 617 F.2d 388, 392 (5th Cir. 1980) (noting that the state Medicaid program had "a history of financial crises and inadequate funding."); Park Nursing Ctr., Inc. 28 B.R. at 796-97.

26. Social Security Amendments of 1972 § 249(a), Pub. L. No. 92-603, 86 Stat. 1410 (1972)(codified as 42 U.S.C. § 1396(a)(13)(E)). The "reasonable cost related" statutory provision that added a reimbursement standard to the Medicaid Act was, according to

caid payments to providers of nursing home services be predicated on the actual and reasonable costs incurred in treating those patients.[27] Notwithstanding the requirements to base payments on the cost of services, the Act conferred extensive discretion on the states to develop the payment methods and standards that would be used to determine nursing home payments rates.[28] As the court explained in *Alabama Nursing Home Association v. Califano*:

> Congress intended that the state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-funding and rate-setting. The legislative history indicates that the states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula . . . Congress approved the setting reasonable cost related rates on either a prospective or retrospective basis. . . . Congress similarly approved the setting of payment rates on a geographical class, or facility-by-facility basis. . . . Additionally, Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.[29]

Thus, the legislative history of the reasonable cost related provision makes explicit Congress' intention that states have freedom both to define reimbursable costs and to determine the reasonable costs of care, services and equipment.[30]

Congress, to be effective July 1, 1976. The Secretary's implementing regulation, however, did not require the states to be in compliance until January 1, 1978. GAO/T-HRD-86-26 Report, *supra*, note 6, at 9. *See* Alabama Nursing Home Ass'n v. Califano, 433 F. Supp. 1325, 1331 (M.D. Ala. 1977) (holding Secretary's regulation invalid "insofar as it sets an effective date other than July 1, 1976"), *affirmed*, 617 F.2d 385 (5th Cir. 1980).

27. *See* 42 U.S.C. § 1396(a)(13)(E).

28. 1981 Medicaid Program, *supra* note 23, at 47,965. In 1972, Congress amended Title XIX of the Social Security Act to require that state plans provide: "[f]or payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary. . . ." *See* 42 U.S.C. §1396(a)(13)(E).

The amendment was designed to confer flexibility on the states to determine an appropriate payment methodology. *See, e.g.*, Alabama Hosp. Assoc. v. Beasley, 702 F.2d 955, 958 (5th Cir. 1983) (noting that state became "dissatisfied with the Medicare principles it had previously used and developed an alternative [prospective] reimbursement methodology as permitted by the then effective [reasonable cost] code provision. . . .").

29. Alabama Nursing Home Ass'n, 617 F.2d at 392.

30. *See* S. REP. NO. 92-1230, at 287 (1972). *See also* Alabama Nursing Home Ass'n, 617 F.2d at 392.

The states' payment methods had to be reviewed, compliance with the Act had to be verified and each state's methodology had to be approved by the Secretary, however.[31] Both the Secretary and the courts pointed out that Congress conferred Plan approval authority on the Secretary because of concern that, in the past, states had adopted "unrealistically low" rates and had "refus[ed] to recognize as allowable costs some of the real costs of providing the services" imposing on nursing facilities "pressure to cut corners and provide lower quality care."[32] Moreover, the depth of Congress' concern is evidenced by the requirement that the Secretary approve *and* verify both the state's cost-finding methods *and* the state's proposed rate-setting methodology.[33]

In order to obtain the Secretary's approval of a reasonable cost related payment plan the states were required to submit to the Secretary, along with the proposed Plan, a detailed explanation of the proposal.[34] Among other things, the state had to explain to the Secretary the anticipated effect of the state's payment system.[35] The state's explanation had to be supported by "documentation or analysis showing that the plan's methods and standards actually produced a reimbursement rate that fell within the maximum and minimum allowable rates."[36] Moreover, the Secretary was required to conduct an independent study or analysis to ensure that the [state]'s plan complied with the statutory requirement.[37] The Secretary's approval was necessary before the payment methodology became effective.

The Secretary's review focused on verifying the appropriateness of each element in the state's payment methods and standards. The Secretary judged and validated "a State's payment methods and standards from a technical standpoint,"[38] determining whether each component produced adequate payment for the goods and services addressed by that portion of the payment methodology. Each element of the Plan had to be justified on both a stand alone basis and based on its interaction with other payment methods and standards.[39] The Secretary's review examined whether the individual elements of the payment methodology (*e.g.*, nursing salaries, food costs, etc.) were

31. *See* 42 U.S.C. § 1396a(a)(62)(b) (2000).
32. Alabama Nursing Home Ass'n v. Harris, 617 F.2d 388, 393 n.6 (5th Cir. 1980).
33. *See id.*
34. *See* 42 U.S.C. § 1396a(a) (2000).
35. *See id.*
36. Alabama Nursing Home Ass'n, 617 F.2d at 394.
37. *See id.*
38. 1981 Medicaid Program, *supra* note 23, at 47,965.
39. *See id.*

reasonably cost related, and then determined whether the aggregate payment rate was reasonably cost related. The Secretary could not approve a plan based on "the application of . . . [an] institutional assumption" that a plan with certain characteristics should satisfy the statutory standard.[40] Secretarial approval "represent[ed] a comprehensive judgment that [the Plan] elements, and their interaction, result in payments that are consistent with the requirements in [the Act] and the regulations that implement it."[41]

The states complained that the reasonable cost related regulations were complex and that it was difficult to demonstrate compliance to the Secretary's satisfaction. The states argued that, in order to secure federal approval, most state Medicaid programs simply adopted Medicare's retrospective cost based reimbursement principles. The states also argued that use of Medicare principles was inherently inflationary because such principles contained no incentives for efficient performance.[42]

B. The States Get What They Asked For: The Boren Amendment Is Adopted

In 1980, Congress amended the Medicaid Act and changed the Act's payment criteria for skilled nursing facilities.[43] This legislation, now repealed, was known as the Boren Amendment.[44] The Boren Amendment provided in pertinent part as follows:

> [A] State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded . . . through the use of rates (determined in accordance with the 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 and to assure

40. Alabama Nursing Home Ass'n, 617 F.2d at 394.

41. 1981 Medicaid Program, *supra* note 23, at 47,965.

42. *See, e.g.*, 42 C.F.R. § 447.276(c) (2001) (Medicare methodology automatically approved); 1981 Medicaid Program, *supra* note 23, at 47,966. *See also* GAO/T-HRD-86-26 Report, *supra* note 6, at 10 (states complained that reasonable cost related standard was too restrictive and inflexible).

43. The Act was amended one year later to extend the Boren Amendment's provisions to hospital reimbursement. *See* 42 U.S.C. § 1396a (1982).

44. Named for retired Sen. David H. Boren, D-Okla., who championed it.

> 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 . . . .[45]

Boren made two major changes in the payment standards imposed by federal law. One change revised the process used by the states and the Secretary to develop, review and approve the payment provisions of state Medicaid plans. The second change altered the substantive payment standards imposed by the Medicaid Act.

First, prior to Boren, the Secretary was responsible for determining whether the State Plan satisfied federal standards.[46] Boren, however, stripped that authority from the Secretary and transferred it to the states.[47] As a result, after 1980, the states were responsible for determining — *i.e.*, making a finding — that their Medicaid payment Plans satisfied federal standards.[48] Boren provided that the Secretary was obliged to fund state Medicaid Plans based solely "on the [state's] assurances which attest to the fact that the State's findings do indeed indicate that the payment rates are reasonable . . . ."[49] The Secretary could not look behind the state's assurances or examine the state's finding unless it was patent on the face of the Plan that the assurance was false.[50] In fact, the Secretary did not receive or review the State's

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45. 42 U.S.C. § 1396a(a)(13)(A) (1981).

46. *See* 42 U.S.C. § 1396a(b) (2000).

47. *See* 42 U.S.C. § 1396a(a)(13)(A) (1981).

48. *See* Amisub (PSL), Inc. v. Colorado Dep't of Social Servs., 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 495 U.S. 935 (1990); Alabama Hosp. Assoc. v. Beasley, 702 F.2d 955, 958 (5th Cir. 1983); Indiana Ass'n of Homes for the Aging, Inc. v. Office of Medicaid Policy, 1995 U.S. App. LEXIS 16163 at *4 (7th Cir. 1995); Illinois Hosp. Ass'n v. Edgar, 765 F. Supp. 1343, 1345 (N.D.Ill. 1991).

49. Final Rule, Payment for Long Term Care Facility Services and Inpatient Hospital Services, 48 Fed. Reg. 56,046, 56,051 (Dec. 19, 1983) [hereinafter 1983 Medicaid Program].

50. *See, e.g.*, Erie County Geriatric Ctr. v. Sullivan, 952 F.2d 71 (3d Cir. 1991) (illustrating the extreme limitation imposed on the Secretary's State Plan approval authority after Boren). *Erie County* is the only reported decision holding that a State Plan was invalid because the Secretary's approval was unwarranted. In fact, *Erie County* may be the only Boren case in which the Secretary's approval was the principal issue, rather than the State's Plan development process. *See also* GAO/T-HRD-86-26 Report, *supra* note 6, at 10 (Secretary did not review technical merit of studies and analyses supporting state's finding). *Cf.* Alabama Hosp. Assoc., 702 F.2d at 962 (suggesting that, because the plan's "general structure" was upheld, the district court could "choose not to suspend operation of the plan altogether" even though the plan did not include specific components required by the Medicaid Act). *Compare* Alabama Nursing Home Ass'n v. Califano, 465 F. Supp. 1183, 1186 (M.D. Ala. 1979) (upholding Secretary's plan approval even though "there is no valid statistical basis" for the rates in the state plan), *reversed* 617 F.2d 388 (5th Cir. 1980) (holding that Boren's predecessor required the Secretary to establish criteria defining efficiently

findings or the data on which the findings were based.[51] The relative unimportance of the Secretary under Boren is illustrated by the fact that the state's payment system could be implemented even prior to the time that it was submitted to, or approved by, the Secretary.[52] The Secretary's review process was so perfunctory that the courts generally refused to defer to the Secretary's approval of a state's payment Plan.[53]

Second, prior to Boren, federal law required that each component of the state's payment methods and standards result in reasonable cost related payment. Boren, however, shifted the focus of the substantive inquiry from elements of the payment methodology to the reasonableness and adequacy of the aggregate payment rate. Thus, the state was authorized to use virtually any type of payment methodology so long as the state concluded that the aggregate payment rate was reasonable and adequate, as defined by the Act. Moreover, the Boren Amendment only required payment of the costs that "must be incurred by efficiently and economically" operated nursing homes.[54] Further, under Boren, the reasonableness and adequacy of the payment rate was tested by determining whether the state paid the reasonable and allowable costs of delivering services incurred by substantial percentages of nursing facilities in the state.[55] The possi-

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and economically operated and to verify, based on documentation and analysis, that payment rate satisfied statute).

51. *See* Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990). *See also* GAO/T-HRD-86-26 Report, *supra* note 6, at 10 (The Secretary "does not require submission of studies or analyses supporting the 'finding' and provides no guidance on what constitutes an acceptable basis for a 'finding.'"); Independent Acceptance Co. v. California, 204 F.3d 1247, 1252 (9th Cir. 1999); Connecticut Hosp. Ass'n v. O'Neill, 793 F. Supp. 47, 51 (D.Ct. 1992) (State "is not required to submit these findings to the HCFA, but the findings are subject to judicial scrutiny.").

52. *See* 42 C.F.R. § 430.20 (2001).

53. *See, e.g., Erie County*, 952 F.2d at 71; Independent Nursing Home v. Simmons, 732 F. Supp. 684, 687-88 (S.D. Miss 1990) (characterizing the Secretary's review as "cursory" because the Agency has no obligation to, and does not, "'examine [the state's] assurances for accuracy or truthfulness or for anything,'" quoting Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891, 898 (E.D. Va. 1985)).

54. *See* 42 U.S.C. § 1396a(a)(13)(A) (2000); *see generally* 1981 Medicaid Program, *supra* note 23, at 47,965.

55. *See infra* note 123 and cases collected there using percentage of facilities' paid cost of service to determine whether rates fell within a "zone of reasonableness."

A second approach sometimes used focused on the percentage of providers' total costs of service paid by Medicaid statement, rather than the percentage of providers paid the full cost of service. The flaws in this approach was addressed by the Third Circuit:

> While aggregate [cost] coverage is telling, it is not dispositive. Among other things . . ., further analysis might provide evidence as to whether a large percentage of the unreimbursed costs must be incurred by efficiently and economically operated facilities. If this is true, evidence of aggregate cost cover . . . would not

bility that an individual nursing facility might not be paid the full costs of serving Medicaid beneficiaries, or that individual items of cost might not be fully reimbursed, was irrelevant.[56]

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suffice to show compliance with the federal requirement that the rates be reasonable and adequate.

New Jersey Hosp. Ass'n v. Waldman, 1995 U.S. App. LEXIS 37153 at *11 (3d Cir. 1995). In short, the statute defined reasonable and adequate rates by whether payments covered the costs incurred by efficiently and economically operated providers, not by the percentage of total costs of care reimbursed statewide.

56. The magnitude of the change wrought by the Boren Amendment is evident from comparisons of cases decided under the reasonable cost related standard and cases decided after Boren. For example, in *Alabama Nursing Home Ass'n* the Fifth Circuit held that the Secretary had an obligation "to ensure that the [state's] payment methodology would in fact result in reasonable cost related reimbursement." 617 F.2d 388, 392 (5th Cir. 1980). Further, the Court held that the Secretary had illegally failed to establish specific criteria or standards defining the meaning of crucial statutory and regulatory terms. Specifically, the state had failed to define an efficiently and economically operated facility and also failed to formulate criteria to judge the reasonableness of the classes used in the reimbursement methodology. The Secretary failed to verify that the payment methodology, in fact, resulted in reasonable cost related payment. In contrast, several courts, post Boren, held that neither the states nor the Secretary had an obligation to define or to identify efficient and economical facilities. *Compare* Illinois Health Care Ass'n v. Bradley, 983 F.2d 1460, 1464 (7th Cir. 1993), Alabama Hosp. Assoc. v. Beasley, 702 F.2d 955, 958 (5th Cir. 1983) (holding that, under Boren, it was unnecessary for court to decide whether Secretary, or the state, was obliged to define statutory terms before approving State Plan); Memorial Hosp., Inc. v. Childers, 1995 WL 504806 at *5 (W.D.Ky. 1995) *and* 1983 Medicaid Program, *supra* note 49, at 56,049 *with* Amisub (PSL), Inc. v. Colorado Dep't of Social Servs., 879 F.2d 789, 796 (10th Cir. 1989), *cert. denied*, 495 U.S. 935 (1990). After Boren, the Secretary, with the support of the judiciary, disclaimed authority to verify the state's findings or even to verify that the state had in fact, made the required finding. To the contrary, the Secretary argued that, if the state assured that the required finding was made, the Secretary was required to approve the State Plan. *See, e.g.*, Erie County Geriatric Ctr. v. Sullivan, 952 F.2d 71, 78 (3d Cir. 1991); 48 FED. REG. 56,046, 56,052 (1983) ("federal review . . . not directed toward validating a state's payment methods and standards . . .").

So complete was the deference accorded the states with respect to both cost finding and rate calculation that many believed the Secretary had abdicated his responsibility to assure compliance with the Medicaid Act. For example, after studying the Medicaid program, the General Accounting Office stated:

> [E]xisting HCFA guidance and monitoring have been inadequate to ensure proper accountability and compliance with the requirements in the statute and regulations that all nursing homes receive reasonable and adequate reimbursement.
>
> [W]e recommend . . . that HHS, to maintain proper accountability, determine whether states have established criteria to define [the statutory standards] and develop payment methods and standards based on studies or analyses supporting the reasonableness and adequacy of the resulting rates.
>
> As emphasized in the conference report on the Omnibus Reconciliation Act of 1980, the Secretary of HHS retains final authority to review the rates and disapprove them if they do not meet the requirements of the statute . . . HCFA's acceptance of a state's assurance based on whether a 'finding' has been made does not . . . provide an adequate basis for determining (as HHS acknowledges HCFA is responsible for doing) whether the state has complied with the requirements in the statute and regulations.

1. The Legislative History of the Boren Amendment

The legislative history of the Boren Amendment identifies two related problems that the Amendment was intended to address. The Senate Finance Committee Report argues that complex federal payment requirements in conjunction with an exhaustive federal evaluation and approval process denied the states the administrative and fiscal discretion to design their Medicaid programs.[57] The states, it was argued, simply deferred to HCFA, and avoided the cumbersome review process by adopting the automatically approvable Medicare payment principles.[58] As a practical matter, states, it was argued, could not establish payment systems on, for example, a prospective basis or tie payments to what care should cost versus what care did cost.[59]

The Senate Report emphasizes that, under the Boren Amendment, states are free to establish rates on a statewide or other geographic basis, or on an institution by institution basis, and without reference to Medicare principles. The 1981 Senate Report — which was given special emphasis by the Secretary in developing regulations to implement Boren[60] — also stated that the Committee expected the Secretary to keep regulatory and other preconditions to Plan approval to the minimum necessary to assure proper accountability. Indeed, the Report stated explicitly that a state's assurance of compliance with federal standards would normally be conclusive.[61]

Paradoxically, although Boren transferred responsibility for determining whether the state's Medicaid Plan complied with federal law from the Secretary to the states, neither Boren nor the legislative history defined any of the key terms of the legislation.[62] In regulations implementing the statute, the Secretary also declined to provide

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See GAO/T-HRD-86-26 Report, *supra* note 6, at 31-32. The Secretary rejected GAO's recommendations. *See id.* at 30-31. Similarly, courts routinely held that the states were not required to submit documentation supporting their findings and that the Secretary was under no obligation to conduct any analysis of the state's assurance that its payment rates met the Boren Amendment's standards. *See, e.g., Connecticut Hosp. Assoc'n*, 793 F. Supp. at 51.

57. *See* S. REP. NO. 92-1230, at 288 (1972).

58. *See id.*

59. *See id. But see* Alabama Hosp. Assoc. v. Beasley, 702 F.2d 955, 959 (5th Cir. 1983) (noting that state replaced Medicare payment methodology with a prospective payment system that was reviewed and approved by the Secretary under the reasonable cost standard); Park Nursing Ctr., Inc. v. Dep't of Social Servs., 28 B.R.793, 801-02 (E.D. Mich. 1983) (same).

60. *See* 1981 Medicaid Program, *supra* note 23, at 47,968.

61. *See* S. REP. NO. 97-139, at 478 (1981).

62. *See* 1983 Medicaid Program, *supra* note 49, at 56,049.

federal definitions. The Secretary asserted that such definitions "would unnecessarily intrude upon the legislatively mandated flexibility provided to States . . . ."[63] The Secretary even declined to require each state to provide its own definition of an "efficiently and economically" operated facility.[64] Thus, discretion to define key terms in the federal statute, such as "reasonable," "adequate," or "efficiently and economically operated facility" was left to the states along with the discretion to determine whether their Plans satisfied those definitions.

The legislative history also makes clear that the broad discretion transferred to the states was not unlimited. The 1980 Conference Committee Report stated that the conferees "intended that a State not develop rates . . . solely on the basis of budgetary appropriations."[65] The Senate Report also states that Boren was "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care."[66] For this reason, the Boren Amendment mandates that reimbursement rates be sufficient to enable nursing facilities to "provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . ."[67]

Congress' effort to assure that Medicaid payment rates were reasonable and adequate to provide the quality of care mandated by the Act was not isolated or fleeting. Seven years later additional amendments to Boren further tied the adequacy of payment rates to the nursing homes' ability to deliver quality care.[68] The Omnibus Reconciliation Act of 1987 modified Boren to require that payment rates "take into account . . . the costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident . . . ."[69]

This requirement — expressly defining payment rates in terms of nursing facilities' ability to deliver quality care — was a novel and innovative approach to Medicaid rate setting and was, perhaps, the most important aspect of Boren. Prior to adoption of the Boren Amendment, the reasonableness and adequacy of Medicaid payment was de-

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63. *Id.*

64. "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." *Id.*

65. S. REP. No. 97-139, at 478 (1981).

66. *Id.*

67. 42 U.S.C. § 1396a(a)(13)(A) (2000).

68. *See id.*

69. *Id. See also* Children's Hosp. of Philadelphia v. Dep't of Pub. Welfare, 568 F. Supp. 1001, 1009-10 (E.D.Pa. 1983) ("Beginning in fiscal 1982 there will be an annual percentage reduction in the federal funds a state will receive for Medicaid reimbursement . . . .").

fined, almost exclusively in economic terms, *i.e.*, by comparing Medicaid payment to the cost actually incurred to provide services. The fact that health care was involved was irrelevant. The standards used to determine economic and efficient operation were predicated on financial analysis and could have been applied to a public utility or virtually any business. Boren, however, required states to make a finding and to assure the Secretary that payments were sufficient to allow providers to comply with state and federal quality of care standards.[70] Thus, the Boren Amendment tested the reasonableness and adequacy of payment rates in terms of nursing homes' ability to comply with federal and state quality of care standards.

Congress plainly sought to preclude states from continuing to balance Medicaid budgets on the backs of beneficiaries.[71] Linking payment rates to quality care and regulatory enforcement standards was simple common sense, but it was also motivated by concern that the care scandals caused by arbitrary, budget driven Medicaid cuts in the 1960's and 1970's not be repeated.

Superficially, the legislative history can be read to indicate that passage of the Boren Amendment reflected the culmination of the states' efforts to escape from burdensome and tedious federal oversight of their Medicaid spending decisions.[72] Although the states surely desired to avoid federal interference with their spending decisions, it would be a gross mistake to view Boren as the culmination of a principled effort to vindicate state sovereignty.

Boren was, in its inception and implementation, an effort to reduce federal and state expenditures. The legislative history of Boren, for example, begins with a Senate Finance Committee Report titled "Spending Reductions: Recommendations of the Committee on Finance Required by the Reconciliation Process."[73] Thus, shortly after

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70. *See* 42 U.S.C. § 1396a(a)(13)(A) (2000).

71. Prior to Boren, the States often had attempted to tie Medicaid payment rates to state appropriations. After adoption of the reasonable cost related standard, such attempts were generally unsuccessful. *See, e.g.*, Alabama Nursing Home Ass'n. v. Califano, 433 F. Supp. 1325, 1329 (M.D. Ala. 1977) (State legislature's failure to appropriate sufficient funds does not excuse compliance with Medicaid Act). After Boren, states continued to attempt to balance their budgets by cutting Medicaid payments. *See, e.g.*, Illinois Hosp. Ass'n v. Dep't of Pub. Aid, 576 F. Supp. 300, 361 (ND. Ill. 1983); Lapeer County Med. Care Facility v. Michigan, No. 1:91-CV-333, 1992 WL 220917, at *2 (W.D. Mich. 1992).

72. *See, e.g.*, Alabama Hosp. Assoc. v. Beasley, 702 F.2d 955, 959 n.9 (5th Cir. 1983) (noting that in adopting Boren, Congress recognized "the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.").

73. *See* H.R Con. Res. 307, 96th Cong. § 3(a)(115) (1981).

Boren was adopted, the Fifth Circuit held that a State Plan payment methodology approved under the repealed reasonable cost standard — which the court characterized as requiring higher provider payments than Boren — *ipso facto* complied with the Boren Amendment. The Court stated:

> HHS approved the plan under the "reasonable cost" standard contained in the former code provision, a standard which is more generous from the [plaintiff hospitals'] perspective. Congress, in replacing the reasonable cost standard with one based on considerations of efficiency and economy, intended to give the states flexibility to lower reimbursement levels below those required by the reasonable cost standard. Because the new "efficient cost" standard is designed to lower the threshold of permissible reimbursement rates, rates properly approved under the reasonable cost standard will satisfy the new efficient cost standard. In fact [the plaintiff hospitals] offer no plausible reason why the [Secretary], after approving the plan under the more restrictive reasonable cost standard, might reach a different result under a suitable defined efficient cost standard.[74]

Further, within one year Boren was followed by a package of Medicaid amendments that included significant cuts in federal contributions to state Medicaid programs.[75] Congress planned to cut federal outlays for Medicaid by more than 900 million dollars in fiscal year 1982.[76] The new law also provided for a scaled reduction of federal payments to states in later years with cuts in Medicaid payments of an additional two percent in 1983 and one percent in 1984.[77] Federal money constituted between fifty and eighty-three percent of the Medicaid funding for any state. Obviously, Congress knew the planned cuts would have a significant impact.[78]

Congress mollified the states' opposition to cuts in federal funding by guaranteeing the states the near unilateral discretion to set Medicaid payment rates. In fact, Congress mandated the cuts in federal funding, but prohibited HHS from implementing the cuts until the Secretary promulgated regulations implementing Boren.

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74. Alabama Hosp. Assoc., 702 F.2d at 958-59 (5th Cir. 1983). *See also* Children's Hosp. of Philadelphia, 568 F. Supp. at 1010 (holding that Boren "beyond question . . . authorized the states to implement . . . cost containment scheme.").

75. *See* H.R. REP. No. 158, at 279 (1981); *and* S. REP. No. 139, at 477 (1981).

76. *See id.*

77. *See id.*

78. *See id.*

There was undoubtedly some truth to the contention that the Secretary's review process was cumbersome and inhibited creative rate setting. Yet, it is hard to credit the states' argument for more discretion and for the opportunity to innovate as complete. The real problem at the heart of the state's demand for change was that, after ten years of arbitrary rate setting, the states found intolerable the mandate in Boren's predecessor that payment methods bear a real, verifiable reasonable relationship to the cost of care. The states simply could not tolerate federal oversight that demanded that States demonstrate that their Medicaid payment methodologies actually comply with federal law.[79] The states supported Boren primarily because they believed that the amendment gave them discretion to cut payments without any federal oversight to confirm that their assurances of compliance with federal law were grounded in objective, verifiable facts and not on speculation.

The states' view — in which the Secretary concurred — that Boren conferred almost unlimited discretion to formulate their own Medicaid payment methodologies based however tightly or loosely on whatever criteria the states deemed appropriate is reflected in a report issued approximately five years after Boren's adoption by the General Accounting Office. Five years after Boren was adopted, GAO studied the states' Medicaid programs to determine how effective the states had been in establishing prospective payment systems that provide nursing homes an incentive to reduce costs without adversely affecting quality of care.[80] GAO reported that it had "identified weaknesses in each phase of the rate-setting process. These weaknesses meant that HCFA lacked adequate assurances that the states' reimbursement rates were reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing homes."[81]

Although GAO found that all aspects of the states' rate setting processes were flawed, a single basic flaw pervaded the process — the Secretary had not established any guidelines identifying reimbursable costs and the states likewise had not adopted "well-defined criteria defining allowable and unallowable costs."[82] Moreover, in many instances, GAO found that the states had conducted no studies or

79. During this same time frame, Congress amended the Medicaid Act and other Social Security Act programs to substantially expand the scope of covered benefits and the class of individuals eligible for such benefits. The combination of decreasing federal revenues and expanding benefits and coverage mandates put enormous pressure on state budgets.

80. *See* GAO/T-HRD-86-26 Report, *supra* note 6, at 2.

81. *Id.*

82. *Id.* at 14.

analyses to ensure that their reimbursement systems paid reasonable rates.[83] Consequently, neither the Secretary nor the states knew "whether reimbursement rates [were] adequate to assure Medicaid beneficiaries access to quality nursing home care."[84]

For example, noting that accurate base-cost data are essential in setting payment rates, GAO nonetheless found that the base year costs (responsible for eighty to ninety percent of payment rates) that the states used to set payment rates were not based on audited data.[85] Further, while GAO stated that "it is important that states have well-defined written criteria defining allowable and unallowable costs," the states had left the critical decisions whether and to what extent costs were allowable to the discretion of auditors.[86] GAO also noted that payment methodologies used by the states assigned nursing homes to groups, but the states had not undertaken any studies or analyses of the assignment criteria to ensure that the groupings reflected legitimate differences in the cost of care.[87] GAO concluded that "[t]his resulted in reimbursement rates that may not be adequate to insure quality care in some economically and efficiently run nursing homes, while giving other nursing homes in the subgroup unreasonable profits."[88] GAO also found that the inflation index used by more than one-half of the states to adjust base period costs forward twelve to eighteen months to the rate year did not "accurately reflect[ ] the increased costs experienced by nursing homes."[89] As GAO stated, "[s]election of an appropriate index is important . . . because 50 to 60 percent of increased expenditures is due to inflation."[90] Finally, GAO noted that, in 1981 Medicaid budget shortfalls had caused two of the states studied to reduce "reimbursement[ ] . . . rates below what the state[s] had previously determined were needed for an efficiently and economically operated nursing home to provide quality care."[91] Not-

83. *See id.*

84. *Id.* at 3.

85. *See id.*

86. *See* GAO/T-HRD-86-26 Report, *supra* note 6, at 14. In fact, noting that neither the federal regulation nor the Secretary's Medicaid manual provided guidance regarding appropriate allowable cost criteria, GAO noted that more than one-half the states studied continued to utilize Medicare principles. This despite the fact the states fought for Boren to free their programs from Medicare's principles!

87. *See id.* at 2.

88. *Id.*

89. *Id.* at 24. To illustrate the minimal supervision exercised by the Secretary, GAO pointed out that, in one instance, the Secretary had approved a State Plan that limited rate increases to a specified percentage, but that a federal district court found that the rate cap was arbitrary and unrelated to actual cost of care. *Id.* at 32.

90. *Id.*

91. *Id.* at 26.

ing that Boren's legislative history explicitly stated that the amendment did not permit "states to develop rates solely on the basis of budgetary appropriations" GAO reported that, "[i]n both cases, [the Secretary] accepted the states' findings and assurances that their rates were reasonable and adequate."[92]

Stripped to their essence, GAO's findings demonstrate that, soon after Boren was adopted, many states were exercising discretion to set Medicaid payment rates as they wished, were doing so without any basis to believe that rate setting criteria, including the inflation index, appropriately defined reasonable and legitimate allowable costs and with so little federal oversight that the Secretary had no "basis for determining . . . whether the state has complied with the requirements in the statute and regulations."[93] GAO's conclusion that the Secretary had freed the states, and that the states had exercised their new freedom, to set rates arbitrarily and without regard to the statutory criteria would be echoed repeatedly by the courts.

2. The Boren Amendment in the Courts

The irony of Boren was that one objective of the Amendment was to decrease federal oversight of state payment Plans, but, in reality, federal oversight was transferred from the executive to the judiciary. To be sure, judicial intervention was not routine and the courts applied a far more lenient standard of review than the Secretary previously had. Nonetheless, as states exercised their new authority to self-validate their Medicaid payment Plans, providers increasingly turned to the courts to fill the void created when Congress stripped the Secretary of authority to evaluate state compliance with the Medicaid Act's payment standards.[94]

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92. *See* GAO/T-HRD-86-26 Report, *supra* note 6, at 32.

93. *Id.*

94. Although the states would assert that the Boren Amendment subjected them to increased Medicaid payment litigation, GAO relatively early on both predicted the litigation and put the blame squarely on the states. GAO, based on its analysis of state Medicaid nursing home reimbursement methodologies in the years immediately after Boren was adopted, noted that the refusal of the Secretary and the states to adopt "well-defined written criteria defining allowable and unallowable costs," *Id.* at 14, made litigation inevitable. GAO concluded that "as a result" of the failure to adopt such written criteria, "whether and to what extent . . . costs were allowable for reimbursement purposes was left to the judgment of the auditor and subject to litigation." *Id.*

In addition, even before Congress enacted the Boren Amendment, the courts were routinely hearing private suits brought by providers directly under the Medicaid Act, challenging the adequacy of reimbursement. *See* Edgewater Nursing Ctr., Inc. v. Miller, 678 F.2d 716 (7th Cir. 1982) (suit directly under 42 U.S.C. § 1396a(a)(13)(E), requiring payment on "reasonable cost-related basis"); Forbes Health Sys. v. Harris, 661 F.2d 282 (3d Cir. 1981) (same); Alabama Nursing Home Ass'n v. Harris, 617 F.2d 385 (5th Cir. 1980)

a. Enforcement of the Boren Amendment by the Courts: The Supreme Court Speaks

Prior to 1990, lawsuits were filed in at least twenty-two states alleging that state Medicaid reimbursement rates violated Boren. All of the appellate courts which addressed the issue found that the Boren Amendment conferred judicially enforceable rights on healthcare providers.[95] With limited exception, these courts found that the Civil Rights Act, 42 U.S.C. § 1983, conferred on providers an express right of action to enforce Boren. Notwithstanding the nearly unanimous opinions of the appellate courts, states continued to argue that providers had no right to invoke judicial oversight of the state's compliance with federal law.

In *Wilder v. Virginia Hospital Association*,[96] the Supreme Court resolved the question. The Supreme Court determined that Boren conferred independent procedural and substantive rights on providers.[97] The Court held that section 1983 created an express cause of action to enforce both the procedural and substantive rights conferred by the Boren Amendment.[98]

(same); California Hosp. Ass'n v. Obledo, 602 F.2d 1357 (9th Cir. 1979) (direct suit under 42 U.S.C. § 1396a(a)(13)(E) "reasonable cost" standard); Massachusetts Gen. Hosp. v. Weiner, 569 F.2d 1156 (1st Cir. 1978) (same); 42 U.S.C. § 1396a(a)(30) (2001). When Congress enacted the Boren Amendment payment standard, it did not eliminate the providers' recognized standing to sue directly under the Medicaid Act on grounds that Medicaid payment violated the prevailing standard.

95. *See* Robert A. Bitterman, *Civil Rights-Medicaid Law-Healthcare Providers Acquire a Federal Right under the Boren Amendment to Reasonable Medicaid Reimbursement Rates and May Enforce Their Right Under 42 U.S.C. Section 1983*, 69 U. DET. MERCY L. REV. 659 (1992). *See, e.g.*, Oregon Ass'n of Homes for the Aging, Inc. v. Oregon, 884 F. Supp. 382 (D. Ore. 1994).

96. 496 U.S. 498 (1990).

97. *See id.* The Court was unanimous in holding that the Boren Amendment conferred on providers an enforceable right to have payment rates established using the procedures specified in the statute. *See Wilder*, 496 U.S. at 527. The Court split five to four on whether Boren created a substantive right to reasonable and adequate Medicaid payment rates. *See id.* at 527-28.

98. *Wilder* was not the first time that the enforceability of the Boren Amendment was before the Supreme Court. In 1987 the Supreme Court granted certiorari to resolve the question in *Coos Bay Care Ctr. v. Oregon*, 803 F.2d 1060 (9th Cir. 1986). However, that case became moot prior to argument and was dismissed. States continued to press the argument that providers had no cause of action to enforce Boren. Four years later the Supreme Court again granted certiorari in *Wilder* to decide the question.

Note, however, that several courts also had held that a cause of action could be implied under Boren. *See, e.g.*, California Hosp. Ass'n v. Schweiker, 559 F. Supp. 110 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983); Folden v. Washington State Dep't of Soc. & Health Servs., Medicare & Medicaid Guide (CCH) ¶ 28,238 at 21,307, *aff'd* 1992 U.S. App. LEXIS 32, at *311 (9th Cir. 1992); *see also* Coos Bay Ctr. v. Oregon Dep't of Human Res., 803 F.2d 1060, 1063 (9th Cir. 1986), *cert. granted*, 481 U.S. 1036 (1987), *vacated*, 484 U.S. 806 (1987).

The *Wilder* Court noted that the Amendment required that the state's Plan "provide for payment . . . according to rates [that] the state finds are reasonable and adequate and to make assurances to that effect." The Court stated: "The Boren Amendment to the [Medicaid] Act creates a right, enforceable in a private cause of action pursuant to section 1983, to have the State adopt rates that it finds are reasonable and adequate to meet the costs of an efficient and economical health care provider."[99]

Because the statute required a state "in the making of its findings to judge the reasonableness of its rates against the objective benchmark of an 'efficiently and economically' operated facility providing care in compliance with federal and state standards," the Court held that the statute provided a yardstick by which trial courts could measure a state's compliance with federal law.[100] The Court determined that the language of the Boren Amendment was "cast in mandatory rather than precatory terms" and "succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge.'"[101] According to the Court, evaluation of the state's compliance with Boren's standards was "well within the competence of the judiciary."[102] Finally, the Court held that "if a State errs in finding that its rates are reasonable and adequate . . . , then a provider is entitled to have the court invalidate the current state plan and order the state to promulgate a new plan that complies with the Act."[103]

The *Wilder* court also held that the statute created an enforceable substantive right to a minimum level of payment.[104] The Court held that it would be meaningless "for Congress to require a state to make findings without requiring those findings to be correct."[105] The Court determined that both the plain language and legislative history of the statute clearly demonstrated that "by requiring a state to find that its rates were reasonable and adequate, the statute also imposed the concomitant obligation to adopt reasonable and adequate rates."[106]

Finally, the Court held that Congress had not foreclosed judicial enforcement of the Boren Amendment. The Court determined that the plain language of the Medicaid Act did not expressly preclude a private remedy under section 1983. The Court further held that a

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99. *Wilder*, 496 U.S. at 524.
100. *Id.* at 519.
101. *Id.* at 498.
102. Wilder v. Virginia Hospital Association, 496 U.S. 498, 499 (1990).
103. *Id.* at 520, n.18.
104. *See id.*
105. *Id.*
106. *Id.* at 515.

federal cause of action was not implicitly precluded because the Medicaid Act contained no comprehensive administrative remedial scheme.[107]

b. The Boren Amendment in the Inferior Federal Courts

Virtually all of the Boren cases brought against states alleged both a procedural violation (*i.e.*, that the state had not made the required finding) as well as a claim that the payment rate was not substantively reasonable and adequate. The rulings in these cases, however, almost always turned on whether the state had made an appropriate finding that its payment rates complied with substantive federal payment standards.[108]

After adoption of the Boren Amendment, the states tended to give themselves the benefit of the doubt when determining whether their State Plans complied with federal payment standards. Indeed, in many instances, the states took Congress' admonition that the Secretary keep regulatory and other requirements to a minimum to mean that Boren's proscriptions were mere formalities. Thus, as GAO found, the post Boren years saw states, often in response to state budget pressures, attempt to manipulate nursing home payment methodologies to reduce rates without any serious or objective attempt to determine whether the resultant payment rates were "reasonable and adequate," or whether the costs of "economically and efficiently operated" facilities were paid. In fact, many states appeared to believe that the procedural component of Boren could be satisfied simply by reciting that the required action had been taken or by doing a perfunctory analysis of a limited or gerry-rigged data set. The courts, however, read the findings requirement to require far more.

The courts held, for example, that the procedural component of Boren required that the state engage in "a bona fide finding process

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107. Chief Justice Rehnquist, joined by Justices O'Connor, Scalia, and Kennedy, dissented in *Wilder*. Even the dissent recognized that providers had a right to force states to adhere to the rate setting process (*i.e.* the findings and assurance requirements) prescribed in the statute. *See id.* at 527. However, the dissenters argued that allowing providers to seek court-imposed rates would subvert the statutory process and thereby undermine Congress' intent in passing Boren. Thus, the dissent refused to find any substantive right for providers under Boren. *See id.* at 528.

108. *See, e.g.*, Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 801-04 (5th Cir. 1993); Illinois Health Care Ass'n, 983 F.2d at 1464-65; Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 529-31 (8th Cir. 1993); Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1313-16 (2d Cir. 1991); Temple Univ. v. White, 941 F.2d 201, 207-10 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992); Colorado Health Care Ass'n v. Colorado Dep't of Soc. Servs., 842 F.2d 1158, 1165-66 (10th Cir. 1988); Mississippi Hosp. Ass'n v. Heckler, 701 F.2d 511, 516-17 (5th Cir. 1983).

and [make] assurances to the Secretary based on those findings."[109] A state could create its own findings process as long as the required finding was made "on the basis of some reasonably principled analysis."[110] The courts held that the annual findings must be based on "the result[s] of careful and objective studies of cost data,"[111] and "empirical analysis [ ] [that] measure[s] the effects of the payment program."[112] These annual studies must include "quantified data and descriptive analysis . . . [of] the relevant factors . . . [sufficient to demonstrate that the agency] made a good faith examination of the impact" of its ratesetting decisions.[113] Mere "conceptual policy decisions" do not constitute findings.[114]

The courts did not always consistently interpret the requirement to use a bona fide findings process. For example, some courts held that the finding could be made by establishing standards that a hypothetical efficiently and economically operated facility must satisfy, but that the state did not need to identify specific facilities that met those standards.[115] In contrast, other courts invalidated state reimbursement methodologies because states failed to identify specific facilities that were efficiently and economically operated.[116] The courts' somewhat different articulation of the finding requirement sometimes obscured a fundamental point on which all courts agreed. The basic

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109. Amisub (PSL), Inc. v. Colorado Dep't of Social Servs., 879 F.2d 789, 797 (10th Cir. 1989), *cert. denied*, 495 U.S. 935 (1990); *see also* John M. Burman, *Judicial Review of Medicaid Hospital and Nursing Home Reimbursement Methodologies under the Boren Amendment*, 3 ANNALS HEALTH L. 55, 79 (1994).

110. Folden v. Washington State Dep't of Soc. & Health Servs., 981 F.2d 1054, 1057 (9th Cir. 1992); Multicare Med. Ctr. v. Washington, 768 F. Supp. 1349, 1393 (W.D. Wash. 1991). *Accord* Temple Univ. Hosp. v. White, 729 F. Supp. 1093 (E.D. Pa. 1990), *aff'd*, 941 F.2d 201 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992); *Amisub (PSL)*, 879 F.2d at 796-97; Oklahoma Nursing Home Ass'n, Medicare & Medicaid Guide (CCH) ¶ 40,949 at 33,980-81; Missouri Health Care Ass'n v. Stangler, 765 F. Supp. 1413, 1415 (W.D. Mo. 1991); Washington Hosp. Ass'n v. Washington, Medicare & Medicaid Guide (CCH) ¶ 36,352 at 14,345 (W.D. Wash. 1987); California Hosp. Ass'n v. Schweiker, 559 F. Supp. 110, 117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983)

111. *Mississippi Hosp. Ass'n*, 701 F.2d at 517.

112. *Temple Univ.*, 941 F.2d at 210.

113. *Colorado Health Care Ass'n*, 842 F.2d at 1168; *see* Orthopaedic Hosp. v. Kizer, Medicare & Medicaid Guide (CCH) ¶ 40,853 at 33,216, 33,218-19 (C.D. Cal. 1992).

114. West Virginia Univ. Hosp., Inc. v. Casey, 885 F.2d 11, 30 (3d Cir. 1989), *cert. denied*, 496 U.S. 936 (1990); Memorial Hosp., Inc. v. Childers, 1995 WL 504806 at *5 (W.D. Ky. 1995) ("Informed or reasoned judgment . . . does not meet the standard set by the Boren Amendment.").

115. *See, e.g.*, Dep't of Health & Soc. Servs. v. Alaska State Hosp. & Nursing Home Ass'n, 856 P.2d 755, 761 (Alaska 1993). *See also* Illinois Health Care Ass'n v. Bradley, 983 F.2d 1460, 1467 (7th Cir. 1993).

116. *See, e.g.*, Amisub (PSL), Inc. v. Colorado Dep't of Social Servs., 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 495 U.S. 935 (1990).

obligation imposed by the Act is that "[t]he state must make findings which establish a nexus between the costs of operating efficient and economical nursing facilities and the . . . reimbursement rates."[117]

Resolution of alleged procedural violations of the Boren Amendment generally disposed of a provider's entire case for two reasons. First, failure to make the required finding and assurance resulted in invalidation of the state's payment methodology without regard to whether payments actually were reasonable and adequate.[118] Second, as the *Wilder* court noted, the courts generally agreed that, if a state has complied with the procedural requirements imposed by the Amendment and regulations, a federal court would employ a deferential standard of review to evaluate whether the rates complied with the substantive requirements of the Amendment.[119]

However courts articulated the test, use of a deferential standard of review placed an almost insurmountable burden on plaintiffs attacking the adequacy of payment rates. In such a case, a provider alleging a substantive Boren violation had to prove that, in the aggregate and on a state-wide basis, the rates that the state paid failed to reimburse a large portion of providers for the cost of delivering care in compliance with care standards.[120] The reasonableness and adequacy of Medicaid payments to individual nursing homes, no mat-

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117. Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991). *See also* Illinois Health Care Ass'n v. Bradley, 776 F. Supp. 411, 418-19 (N.D. Ill. 1991), *affirmed*, 983 F.2d 1460 (7th Cir. 1993).

118. *See* Wilder v. Virginia Hospital Association, 496 U.S. 498, 520 n.18 (1990); Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 801-04 (5th Cir. 1993); Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 529-31 (8th Cir. 1993); Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1313-16 (2d Cir. 1991); Temple Univ. v. White, 941 F.2d 201, 207-10 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992); Colorado Health Care Ass'n v. Colorado Dep't of Soc. Servs., 842 F.2d 1158, 1165-66 (10th Cir. 1988); Mississippi Hosp. Ass'n v. Heckler, 701 F.2d 511, 516-17 (5th Cir. 1983).

119. *See Wilder*, 496 U.S. at 520 n. 18; *Abbeville Gen. Hosp.*, 3 F.3d at 804. *See also Temple Univ.*, 941 F.2d at 209-10; *Amisub (PSL)*, 879 F.2d at 801; *West Virginia Univ. Hosp.*, 885 F.2d at 24, *cert. granted*, 494 U.S. 1003 (1990), *and later proceeding*, 898 F.2d 357 (3d Cir. 1990), *cert. denied*, 496 U.S. 936 (1990), *aff'd*, 499 U.S. 83 (1991); Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1294 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Mississippi Hosp. Ass'n*, 701 F.2d at 516; Kansas Health Care Ass'n v. Kansas Dep't of Soc. & Rehab. Servs., 822 F. Supp. 687, 690 (D. Kan. 1993); Dep't of Health & Soc. Servs. v. Alaska State Hosp. & Nursing Home Ass'n, 856 P.2d 755 (Alaska 1993). *Cf. Pinnacle*, 928 F.2d at 1313; *Illinois Health Care Ass'n*, 983 F.2d at 1463 (courts advert to arbitrary and capricious standards of review where some findings exist but find Medicaid plans invalid solely due to inadequacy of findings).

120. *See Colorado Health Care Ass'n*, 842 F.2d at 1167; *Amisub (PSL)*, 879 F.2d at 797; Thomas v. Johnston, 557 F. Supp. 879, 914-15 (W.D. Tex. 1983); Memorial Hosp., Inc. v. Childers, 1995 WL 504806 at *6 (W.D. Ky. 1995) (Court "should focus upon the overall reimbursement plan and its objectives" and view "straight provisions . . . in the overall context of more generous ones.").

ter how efficiently and economically operated, were irrelevant under Boren.[121] Moreover, there was no bright line that distinguished a reasonable and adequate rate from one that was unreasonable.[122] Instead, the provider had to prove that the state's payment rates fell outside of a "zone of reasonableness."[123] The breadth of the zone of

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121. Bethesda Found. of Nebraska v. Dep't of Health Care Pol'y, 902 P.2d 863 (Colo. 1995) is a particularly extreme example of the principle discussed in the text. Plaintiff, *Bethesda Foundation*, appealed its Medicaid payment through the administrative process. The administrative law judge found, and the court did not disagree, that "plaintiff's overall operation of the nursing home was efficient and economical." *Id.* at 866. According to the ALJ, the Colorado Medicaid system was not designed to account for or adequately pay the reasonable costs of services provided to such patients. *Id.* The court held that:

> Underlying the position adopted by the ALJ and the district court is the premise that, under Medicaid, it is inefficiently or economically operated. That premise has been rejected on numerous occasions to . . . . It is the overall payment for all nursing facilities in a particular classification that is evaluated for statutory compliance for establishing reimbursement compensation rather than the adequacy of payment for any one component or single facility.

Id. (citations omitted). Notwithstanding the court's assertion to the contrary, the Boren Amendment explicitly states that medicaid rates must pay the costs incurred by an efficiently and economically operated facility. Further, the Amendment's implementing regulations confirm that an administrative exception process, such as that discussed in *Bethesda*, must be available to assure that costs incurred by economically and efficiently operated facilities would be paid, even if the state's general reimbursement principles would not routinely do so. *See* 48 FED. REG. 56046, 56050, 56052 (Dec. 18, 1983). *Cf. Amisub* (PSL), 879 F.2d at 747 (requiring state to identify efficiently and economically operated providers and to pay costs of service incurred by such providers); Children's Memorial Hosp. v. Dep't of Pub. Aid, 562 F. Supp. 165, 173 (N.D.Ill. 1983) (application of payment methodology based on average patient population to hospital with unique mix and intensity of service is unrelated to efficiency and economy); Memorial Hosp., Inc. v. Childers, 1995 WL 504806 at *11 (W.D. Ky. 1995) ("The Court believes that the Administrative Appeals process is a legitimate and workable procedure for considering individual inequities."). Nevertheless, *Bethesda Foundation* is indicative of the extent of deference sometimes accorded Medicaid agencies when the substantive validity of a payment rate was questioned.

122. *See Colorado Health Care Ass'n*, 842 F.2d at 1169; 1983 Medicaid Program, *supra* note 49, at 56,049.

123. Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 803 (5th Cir. 1993); Lett v. Magnant, 965 F.2d 251 (7th Cir. 1992), *citing* West Virginia Univ. Hosp., Inc. v. Casey, 885 F.2d 11, 26 (3d Cir. 1989), *aff'd on other grounds*, 111 S. Ct. 1138 (1991). Wisconsin Hosp. Ass'n v. Revitz, 820 F.2d 863, 864 (7th Cir. 1988); Hillhaven Corp. v. Wisconsin Dep't of Health and Social Servs., 733 F.2d 1224 (7th Cir. 1984).

In practice, the "zone of reasonableness" sometimes was defined by a surrogate that demonstrates the extensive margin of error allowed the states. The surrogate focused on the percentage of all nursing homes paid less than their costs. For example, if a substantial portion of nursing homes — generally more than fifty percent — did not receive rates covering their *actual* costs, both HCFA and the courts were likely to find a violation of the Boren Amendment. *See* Health Care Ass'n of Michigan v. Babcock, Medicare & Medicaid Guide (CCH) ¶ 39,182 at 26,105-06 (W.D. Mich. 1991). In theory, the fifty percent rule of thumb reflected the common sense judgment that it is highly unlikely that more than one-half the state's nursing homes were uneconomical or inefficient. Thus, HCFA refused to approve state plans that failed to reimburse more than fifty percent of a state's providers for the actual costs of delivering Medicaid services. *See, e.g.*, Health Care Financing Admin-

reasonableness, the difficulty of establishing an aggregate, statewide shortfall and the presumption of regularity attached to agency decisions virtually precluded proof of a substantive violation.

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istration Notice of Hearing, 55 Fed. Reg. 1518, 1519 (Jan. 16, 1990) (notice of hearing concerning disapproval of Colorado state plan's reimbursement methodology); Health Care Financing Administration Notice of Hearing, 55 Fed. Reg. 7034 (Feb. 28, 1990) (Louisiana state plan disapproved even though sixty percent were paid costs); Health Care Financing Administration Notice of Hearing, 55 Fed. Reg. 46,873 (Nov. 7, 1990) (Missouri plan amendment disapproved because substantial number of providers would not recover full actual cost). *Cf. Thomas*, 557 F. Supp. at 914-15 (Boren Amendment violated because sixty percent were not reimbursed their costs); Oklahoma Hosp. Ass'n v. Oklahoma Dep't of Human Servs., Medicare & Medicaid Guide (CCH) ¶ 33, 057 at 10,249-50 (W.D. Okla. 1983) (substantial likelihood of violation where forty percent of providers were not being reimbursed their costs); *Colorado Health Care Ass'n*, 842 F.2d at 1169 (no violation where reimbursement ceiling at ninetieth percentile of costs); *Mississippi Hosp. Ass'n, Inc.*, 701 F.2d at 517-18 (no violation where reimbursement at eightieth percentile of costs).

There is no statute or regulation that provides that compliance with the Boren Amendment may be evaluated by comparing the percentage of providers paid their costs against the percentage not paid their costs. Use of a comparative percentage test to evaluate compliance with Boren was never [explicitly] established or endorsed by HCFA. There is nothing in the legislative history of Boren suggesting that a Medicaid program satisfies the Act's payment requirements if some percentage of providers are paid the cost of delivering care. There is no study, analysis or investigation that validates the proposition that payment of the costs of service incurred by a specified percentage of providers assures payment of the costs incurred by economically and efficiently operated providers. Yet many, perhaps most, judicial and administrative decisions base their determination of a state's compliance with the Act on whether some percentage of facilities — usually fifty percent or more — recover the cost of providing Medicaid services.

In contrast, courts rebuffed attempts to justify payment rates adopted under the reasonable cost related standard by pointing to the percentage of providers paid the cost of service. For example, in *Alabama Nursing Home Ass'n*, the court noted that "Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items," but found that the Secretary had failed "to perform [her] statutory and regulatory duties" where a Medicaid plan was approved because it paid the cost of service incurred by sixty percent of providers. The court held that the Secretary "never attempted to verify that the sixtieth percentile ceiling would, in fact, result in reasonable cost related reimbursement," never required the state to submit "documentation or analysis showing that the plan's . . . reimbursement rate fell within the maximum and minimum allowable rates" and never conducted "an independent study or analysis to ensure that the [state's] plan complied with the statutory requirement." 617 F.2d at 394 (*footnote omitted*). Instead, the court held that the Secretary had approved the plan based solely on "the application of the agency's institutional assumption that any plan that reimburses at or above the projected billing rate of the median facility in a class meets the regulatory minimum reimbursement rate. The application of such an assumption does not satisfy the requirements of § 1396a(a)(13)(E)." *Id.*

The discretion granted the states after Boren was so broad that courts never questioned the comparison of the percentage of providers paid their costs versus those not paid and no court ever demanded that a state Medicaid agency validate its decision to reimburse specific percentiles of cost through studies and analysis, as the Fifth Circuit had demanded the Secretary do. To the contrary, after Boren, the states were permitted to do exactly what the Secretary had been denied permission to do, *i.e.*, justify Medicaid payment rates by "institutional assumption."

III. THE REPEAL OF THE BOREN AMENDMENT

The *Wilder* decision effectively ended the states' hope that their Medicaid rate setting decisions would be insulated from oversight. In fact, despite the *Wilder* court's sharp disagreement over the existence of a substantive right to reasonable and adequate payment, there was unanimity that Boren conferred an enforceable right to have payment rates determined using a bona fide findings process.[124] *Wilder* put the states on notice that the discretion conferred by Boren was not unlimited. Further, *Wilder* put the states on notice that the courts would assure that payment rates were adopted on an objective, principled basis.

Ironically, however, *Wilder's* holding that providers could enforce Boren in the courts also ultimately led to the Amendment's repeal. The decision in *Wilder* came at a time when Congress was increasing financial pressure on the states by expanding benefits that state welfare programs were required to offer and by lowering the thresholds for eligibility.[125] At the same time, health care costs for institutional as well as other types of care were increasing rapidly due to inflation, the advent of new technology and, especially in nursing homes, increases in the intensity of service required to satisfy patient needs as well as heightened regulatory scrutiny.[126]

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124. *See* Wilder v. Virginia Hosp. Assoc., 496 U.S. 498, 498 (1990).

125. In the years immediately prior to 1990, "Congress expanded Medicaid coverage by mandating that states serve certain low-income groups and provide certain services. GAO/HEHS 95-122 Report, *supra* note 1, at 27. The number of persons served by Medicaid continued to increase at about eleven percent per year through the early 1990's, but Medicaid costs increased even faster, at more than fifteen percent per year. *Id.* at 26-35. These federal mandates required that state Medicaid programs cover "additional low-income pregnant women, children and Medicare beneficiaries." The mandates also required that Medicaid provide coverage for families no longer eligible for benefits under certain welfare programs, for severely impaired individuals under sixty-five years of age and for chronically ill or disabled individuals. *Id.* at 27-28. It was estimated that the mandates added about six million individuals to the Medicaid rolls nationwide, between 1990 and 1992. The number of persons covered by Medicaid continued to increase in the next years at about eleven percent per year. *Id.* at 26. However, Medicaid costs increased even faster, at about fifteen percent per year. This increase is explained, in part, by the facts that, although the poor, elderly and disabled accounted for only one-fourth of Medicaid beneficiaries, such individuals incurred about sixty-six percent of Medicaid expenditures. *Id.* at 19.

126. From 1975 to 1985, the number of long-term care Medicaid recipients rose slightly — from 1.4 million to 1.5 million, while the programs's total funding nearly quadrupled, from 4.7 billion to 16.3 billion dollars in the same decade. According to HCFA figures, there were 1.7 billion long-term care Medicaid recipients in 1993, but the federal bill for long-term care totaled 34.2 billion dollars. At the same time, long term care's portion of the budget has been increasing. In 1970 long term care made up twenty-five percent of the national Medicaid budget. In 1995, long term care constituted more than one-third of Medicaid spending. Similarly, in 1970, 7.4 percent of the United States' income (GDP)

Changes in the way that nursing home care was delivered illustrate one of the reasons that the cost of care increased. At just about the same time that *Wilder* was decided, Congress, by statute, changed the standard of care required of nursing homes.[127] By statute Congress dictated that "[a] nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ."[128] The statute also effectively elevated the patient's mental and psychosocial needs to a status co-equal with medical and nursing needs. Moreover, enforcement of the new standards focused on the quality of care provided to each resident, not the care delivered generally by the facility and, further, employed a "zero tolerance" philosophy.[129] Both the Secretary and Congress recognized that the new requirement would be costly and required that the states increase Medicaid payments to cover the increased cost of care.[130]

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was devoted to health care. In 1995, health care constituted fourteen percent of GDP. *See A Policy Inst. of the Gerontological Soc'y of America*, THE PUBLIC POLICY AND AGING REPORT, NATIONAL ACADEMY ON AGING, (Nov. 1995), *available at* http://gsa.iog.wayne.edu/NAA/ppl.html. *See also* GAO/HEHS 95-122 at 33. *See also* GAO/HEHS 95-122 Report, *supra* note 1, at 33.

127. *See* 42 U.S.C. § 1396r(b) (2000).

128. 42 U.S.C. § 1396r(b)(2) (2000). HCFA's Interpretive Guidelines, which govern certification inspections of facilities under federal law, define "highest practicable" as

> the highest level of functioning and well-being possible, limited only by the . . . individual's presenting functional status and potential for improvement or reduced rate of functional decline . . . . The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and normal aging process.

Transmittal 250, *supra* note 19. HCFA's Interpretive Guidelines identify only two limitations on each facility's obligation, under the highest practicable standard, to obtain "optimal" resident improvement or lack of deterioration: (1) a resident's right to refuse treatment; and (2) recognized pathology and the normal aging process. *Id.*

129. The new enforcement philosophy included a variety of new "remedies" for noncompliance including civil money penalties of up to $10,000 per day. *See* 42 U.S.C. § 1396t (2000); 42 C.F.R. § 488.430 (2001).

130. *See, e.g.*, H.R. REP. NO. 100-391(I) (1987). Commenting on the OBRA 1987 reforms, the House Budget Committee noted that Medicaid State Plan amendments must "assure that state payment rates *actually take into account the costs of complying with the new requirements.*" *Id.* at 464 (emphasis supplied). The Committee continued:

> *Quality care is not free. A number of these requirements will entail additional costs of operation for nursing facilities participating in Medicaid.* The Committee amendment would therefore require that, with respect to complying facilities, state Medicaid payment rates take into account the costs of complying with the requirements relating to provision of services, residents' rights, and administration.
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> *The committee amendment would mandate significant additional requirements* for many State Medicaid nursing home programs. It is the intent of the Committee *that the States'* Medicaid programs provide for an adjustment (in their Medicaid plan) and

The cost of nursing home care was escalating at precisely the same time that states were obliged to fund a variety of new and expanded welfare programs.[131] Faced with a choice between increasing state taxes to fund the new federal mandates or reallocating existing dollars, many states chose to decrease state funding of long term care.[132] Encouraged by *Wilder* and compelled by this combination of

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make payments *commensurate to the cost incurred* by the providers in implementing the new requirements .

Id. at 463-64 (emphasis added).

The House Energy and Commerce Committee estimated that additional state and federal Medicaid expenditures attributable to nursing home reforms would approximate one billion dollars in fiscal years 1988-90, with roughly 447 million dollars representing federal expenditures. *Id.* at 542-43. The House Ways and Means Committee noted that the reforms would increase overall Medicare program outlays by seventy-five million dollars for the same period. *Id.* at 1655. These estimates also took into account that many OBRA 1987 requirements were being phased in during and after this period.

The 1990 modification of § 1396a(a)(13)(A) was yet an additional step by Congress to assure that states provide adequate reimbursement for facility compliance with reform provisions, as Congress had envisioned in 1987. Entitled "assurance of appropriate payment amounts," the 1990 Amendment was characterized by the House Budget Committee as follows:

> *Assurance of appropriate payment amounts.* — As this Committee recognized in the report to accompany the House Budget Committee's 1987 Budget Reconciliation Amendments, quality nursing home care is not without cost . . . . The Committee anticipated then — as it does today — that a number of the reforms contained within OBRA 1987 will entail additional costs of operation for nursing facilities participating in Medicaid.
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> In order to assure that Medicaid State payment rates allow for these additional costs, OBRA 1987 requires that, for those Medicaid nursing facilities in compliance with the law, such rates must take into account the costs of meeting the statute's requirements relating to the provision of services, residents' rights, and administration. To ensure that State Medicaid payments actually take these costs into consideration, OBRA 1987 also requires that each State submit to the Secretary (by April 1 of each fiscal year), a State Plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services furnished on or after October 1, 1990. . . .
>
> The Committee bill clarifies that State Medicaid plan amendments must include a detailed description of the State methodology used in determining the appropriate adjustment in the payment amounts for nursing facility services. In addition, the bill specifies that these costs include the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

H.R. REP. No. 101-881, at 120 (1990). HCFA, for its part, has been less than vigilant in policing the states' adherence to these financial requirements. *See* American Health Care Ass'n v. Bowen, 1991 WL 154456 (D.C. Cir. 1991); Erie County Geriatric Ctr. v. Sullivan, 952 F.2d 71, 78 (3d Cir. 1991); *Belshe*, 103 F.3d 1491 (9th Cir. 1997); GAO/T-HRD-86-26 Report, *supra* note 6, at 29-33.

131. *See supra* note 125.

132. The long term care component of the state Medicaid budget was as obvious a target for reallocation or cutting as it was attractive because it was one of the largest components of the state budget. Many states made plain their intention to cut Medicaid spending with or without Congressional action. *See* Patricia Riley, *Long Term Care: The Silent Target of*

decreasing funding and increasing costs, many hospitals and nursing homes resorted to the courts to resolve Medicaid payment disputes. Increasingly, the courts were being asked to fill the role previously held by the Secretary — *i.e.*, to validate the states' assurance that it had adopted Medicaid payment standards using the required findings process and in compliance with the substantive payment standards established by federal law.

The forum in which the states fought the battle over the right to set Medicaid payment rates without federal oversight shifted from the judiciary to the legislature. The states began to develop and pursue a legislative agenda that characterized Boren's guarantee of reasonable and adequate payment as an example of the type of federal mandate that resulted in unwarranted and excessive state expenditures. In the mid 1990's the states' pleas for relief from Boren's mandates began to fall on receptive ears as Congress searched for ways to cut federal spending, balance the federal budget and disentangle the federal government from local political and spending decisions.

Repeal of Boren was championed by the National Governors Association (NGA). NGA's bipartisan effort was led by Governor Bob Miller, a Democrat from Nevada, and by then Governor, and now Secretary of Health and Human Services, Tommy Thompson, a Republican from Wisconsin. NGA argued that Boren kept Medicaid payment rates artificially high by denying the states fiscal discretion to control costs and by preventing the states from taking advantage of open-market competition.[133] In a policy statement issued in [February 1996] for example, NGA, in addition to urging that "the Boren Amendment and other Boren-like statutory provisions must be repealed," argued that "[s]tates must have maximum flexibility in the design and implementation of cost-effective systems of care."[134] According to the NGA, [s]tates must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan."[135] NGA not only argued that the courts ought not be able to enforce the Medi-

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the Federal and State Budget Debate, Pub. Pol'y and Aging Report, NAT'L ACADEMY ON AGING 9, (Nov. 24, 1997), *available at* http://gsa.iog.wayne.eud/NAA/ppl.html [hereinafter *Silent Target*]. The Medicaid program, as a whole, constituted nineteen percent of all state spending. Medicaid spending ranked second only to elementary and secondary education as the largest state budget item. *See id.* Moreover, fifty-nine percent of Medicaid dollars were spent on long term care for the elderly and disabled. *See id.*

133. *See* Alice Ann Love, *Nursing Home Medicaid Cuts Ok'd,* AP ONLINE, (Aug. 15, 1997).

134. Memorandum from American Health Care Association to AHCA State Affiliate Executives 1 (Feb. 7, 1996) (on file with author).

135. *Id.*

caid Act's requirements at the behest of providers, the governors also sought to "streamline" the plan amendment and approval process and "to assure that federal intervention occurs only when a state fails to comply substantially with federal statutes or its own plan."[136] Instead of acknowledging the widespread care problems that Congress had found attributable to inadequate Medicaid payment for nursing facility services when the states last exercised similar discretion to set payment rates free of secretarial and judicial oversight, NGA proposed to define such problems out of existence. Specifically, while the governors advocated maintenance of the quality of care standards added to the Medicaid Act by OBRA '87, NGA urged that the states be given "flexibility to determine enforcement strategies for nursing home standards."[137] On February 4, 1997, the NGA unanimously adopted The Governors' Agenda for the 105th Congress. Most importantly, the NGA urged the repeal of the Boren Amendment, and sought greater state flexibility in establishing managed care networks and controlling Medicaid eligibility standards and benefits by repealing Medicaid waiver requirements.[138]

The states' claims that they were denied discretion to administer their Medicaid programs by the Act generally and by the Boren Amendment, specifically, were largely illusory. Section 249, the reasonable cost related reimbursement provision, specifically guaranteed the states discretion to develop their own payment methodologies. Boren went further and permitted the states to develop and to validate their payment methodologies. Further, the states even were authorized to define the terms of federal law that would be used to test the adequacy of Medicaid payments. Moreover, a state's determination that it had complied with federal law, if based on reasoned analysis of objective data normally established conclusively the state's right to hundreds of millions of federal dollars.

The broad discretion to determine Medicaid payments to institutional providers actually possessed by the states was noted by numerous commentators. For example, it has been pointed out that the legislation extending the Boren Amendment to hospital reimbursement was "grounded in Regan's New Federalism" and "provided new and expansive discretion to the states" that enabled the states "to un-

136. *Id.*

137. *Id.*

138. *See* AMERICAN POLITICAL NETWORK, INC., *Health Line,* August 15, 1997; Center on Budget and Policy Priorities, *Medicaid and Child Health Provisions of the Bipartisan Budget Agreement,* (May 28, 1997) *available at* http://www.cbpp.org/mcaidbud.htm [hereinafter CBPP Paper].

dertake unique and narrowly tailored approaches to their health care problems."[139] Similarly, the Congressional Budget Office rejected the states' claims that the Medicaid program unduly constrained their discretion, opining that the states have "a great deal of flexibility" under current law.[140] The Report notes that the states "set reimbursement rates to providers and have broad discretion over the amount, duration, and scope of the services provided. That flexibility fosters a great deal of variation among state programs." CBO summarized its conclusions: "Medicaid spending levels are determined primarily by state choices, not by federal requirements . . . ."[141]

Although some states moved almost immediately following repeal of Boren to cut nursing home payments,[142] the states overstated the fiscal impact of the repeal of the Boren Amendment. The National Governors' Association estimated that cuts in nursing home payments alone would amount to six to eight billion dollars over four to five years.[143] This amount represented almost one-half the total Medicaid savings sought by congressional leaders.[144] However, during the debate on repeal, the Congressional Budget Office determined that the Governors' estimate was a gross exaggeration because the states currently exercised "broad discretion" and "flexibility" that was already implicitly incorporated in federal spending projections. Consequently, according to the Congressional Budget Office, the Governors' proposal would lead to 2.9 billion dollars in federal Medicaid savings — less than one-half the amount projected by the NGA.[145]

In addition, to the extent that statutory limits or state discretion actually constrained the states, such limits were routinely set aside. The federal government was waiving Medicaid Act requirements and permitting states to adopt novel and creative financial mechanisms at an unprecedented pace. In fact, the Clinton Administration approved

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139. Jocelyn M. Johnston, *The Medicaid Mandates of the 1980s: An Intergovernmental Perspective*, PUB. BUDGETING & FINANCE, Spring 1997, at 1, 3-34.

140. *See* CBPP Paper, *supra* note 138.

141. *Id.*

142. *See Homes Assail Repeal of Their Shield Against Cuts*, ST. LOUIS POST-DISPATCH, Aug. 16, 1997, at 24. [hereinafter *Homes Assail Repeal*]. Kentucky, for example, proposed a twenty-eight million dollar cut in aggregate nursing home payments. The cut was estimated to mean a seven dollar reduction in per patient per diem payment rates.

143. *See Homes Assail Repeal*, *supra* note 142; *see also* CBPP Paper, *supra* note 138.

144. *See id.*

145. CBO's estimate was even lower — 1.2 billion dollars over the period from 1998-2002. About forty percent of the savings would come from payments to hospitals and sixty percent from payments to nursing homes. *See id.* CBO also estimated that five billion federal dollars could be saved over seven years by repealing the Boren Amendment. *See Silent Target*, *supra* note 132.

so many waivers that the Secretary was accused of effecting a de facto amendment of the Act.[146]

To the extent that the states' discretion had been restricted by the so called federal mandates adopted during the 1980's, those restrictions limited the states' discretion to define eligibility and covered services, not to specify reimbursement rates.[147] In reality, the states' objection to Boren was the same objection that had been at the heart of the states' opposition to Boren's predecessor — the statute permitted the states' compliance with federal law to be reviewed and verified by an independent third party, *i.e.*, by the courts, thereby stifling the states ability to set Medicaid payment rates without reasoned, objective analysis of the costs of providing care. Moreover, the states objected to Boren because in many instances, the courts held that the state had adopted their Medicaid payment methodologies without satisfying even the minimal demands made by Boren. The states' persistent refusal to comply with Boren resulted in a dismal record in the courts, leading the General Accounting Office, in 1995, to conclude:

> Provider suits brought under the Boren Amendment, 42 U.S.C. § 1396a(13), have been a major factor pressuring states to increase payment rates . . . . Particularly in recent

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146. *See* Janet Lewis Greene, *Community Health Centers Say Medicaid Waivers Allow Too Much Managed Care*, 7 MANAGED CARE L. OUTLOOK 6, (July 19, 1994).

147. *See generally* Jocelyn M. Johnston, *The Medicaid Mandates of the 1980's: An Intergovernmental Perspective*, PUB. BUDGETING & FINANCE, Spring 1997, at 3-34. [hereinafter Johnston]. Some even have argued that "[d]espite some of the rhetoric about federal mandates, states have voluntarily decided to provide most, if not all, the optional benefits covered under Medicaid." Robert B. Friedland, *Medicare, Medicaid, and the Budget*, 7 PUB. POL'Y AND AGING REP. OF THE NAT'L AACD. ON AGING 1 (Nov. 1995), *available at* http://gsa.iog.wayne.edu/NAA/pp1.html.

The irony behind this fact ought not go unnoticed. Prior to the 1980's, the states had discretion to determine individual eligibility standards for coverage and the medical services that would be provided to Program beneficiaries. The appeal to limit state discretion by mandating eligibility standards and covered services came from the states. As has been noted:

> By the middle of the 1980s, a number of state leaders, most from the southeastern U.S., had become increasingly concerned about the deterioration of health care services for poor women and children. This concern led directly to a series of federal Medicaid legislative efforts designed to enhance coverage of poor women and children, and to further reduce the extent to which states differed in their treatment of poor women and children.
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> The decade of Medicaid mandates began with OBRA 1981, which reduced federal Medicaid matching rates for the states for three years and reduced AFDC eligibility thresholds across the states. OBRA-shaped by the early Reagan administration embraced the "New Federalism" ideals of enhanced state autonomy.

Id. By the end of the decade, the Governors had reversed course entirely and now blamed the mandates for most of the state's fiscal ills. *See generally id.*

> years, states have been dogged by provider lawsuits forcing them to better justify or raise their Medicaid payment rates to hospitals and nursing homes.[148]

Stated differently, the states sought repeal of Boren because they wanted the authority to spend more than two hundred billion federal Medicaid dollars without a concomitant obligation to adhere to any federal standards when doing so.

Not surprisingly, the states never mentioned the fiscal crises and quality of care debacles that had occurred the last time that the statute afforded the states discretion to set payment rates without oversight. The impact on the quality of care was, however, a primary concern for those responsible for delivering the care and for nursing home residents.[149] The call for reduction in Medicaid payment rates abated as tax revenue grew along with the economy and many states experienced budget surpluses in the 1990's.

When the economy turned downward and slipped into recession, tax revenues likewise declined and many states have either made budget cuts or announced plans to do so.[150] After the terrorist attacks of September 11, 2001, the deterioration in the fiscal conditions has accelerated and, as unemployment rises, tax revenues have declined while the Medicaid rolls began to swell, further increasing pressure on already burdened state budgets.[151] The prominence in state budgets of Medicaid (on average twenty percent of total state spending), especially the long term care component, made Medicaid programs, generally, and long term care specifically, obvious targets for state spending reductions.

Thus, in late 2001, state Medicaid directors and budget officials in twenty states reported gubernatorial directions to reduce current

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148. GAO/HEHS 95-122 Report, *supra* note 1, at 53.

149. The impact on quality will not be obvious immediately. As has been noted:

> Over time though, undercutting Medicaid will inevitably translate into a lower quality of care for Title XIX patients. Providers do have the option to refuse Medicaid patients and for those who have an alternative patient base, opting out of the program could result from over-eager rate-cutting. For those who stay in, the need to "cost shift" to other patient's billing will no doubt intensify as Medicaid rates fall way below the cost of care. For state taxpayers whose insurance costs go up due to cost-shifting, the benefit of state Medicaid cuts will be illusory. These negative trends though will take time to surface as countervailing political forces. In the meantime, the critics and complainers of Boren will have their day to dance on its grave.

Joseph D. Courtney, *The Boren Amendment R.I.P.*, CONN. L. TRIB., Sept. 22, 1997. *See also Homes Assail Repeal, supra* note 142, at 24; Terese Hudson, *Medicaid: Will the Public Program Neglect the Poor to Pay for the Elderly?*, HOSP. AND HEALTH NETWORKS, May 20, 1995, at 28.

150. *See Policy Brief, supra* note 1, at 1-2.

151. *See id.*

(fiscal year 2002) year Medicaid spending below the level authorized by the legislature.[152] Further, the vast majority of states began seeking "ways to address Medicaid spending issues without cutting back on eligibility or benefits for beneficiaries." Against this background it is not surprising that, by late 2001, "[a]bout one-third of the States adopted or proposed freezes or actual reductions in provider payments."[153]

A. The Replacement Legislation

The Balanced Budget Act of 1997 repealed the Boren Amendment in its entirety.[154] The Act replaced Boren with a requirement that states use a public process to set rates.[155] Ostensibly, the public process provides the opportunity for participation by health care providers and by Medicaid beneficiaries. The language of the new statute is as follows:

> (13) provide —
> (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which —
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
> (iii) final rates, the methodologies underlying the establishment of such rates, and justification for such final rates are published, and
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs.[156]

Where Boren had required states to find and assure that payment rates were reasonable and adequate to permit providers to satisfy quality of care standards, the new legislation only requires the federal gov-

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152. *See id.* at 5.

153. Medicaid Budgets, *supra* note 1, at 29.

154. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4712(c), 111 Stat. 509 (1997).

155. *See* 42 U.S.C. § 1396a(a)(13) (2000).

156. *See id.*

ernment to study the "effect on access to, and the quality of, services provided to beneficiaries" of the rate setting methods used by the states.[157] The results of the study are to be reported to Congress within four years.[158]

In short, Boren was replaced by a statute that contained no substantive payment standard and one that did not even require that the state consider the impact of its rate setting decisions on the ability to deliver quality care or to comply with state and federal care standards. Moreover, the replacement statute did not provide even the limited administrative oversight encompassed in Boren's assurance requirement. As a result, the statute appears to authorize the states to spend billions of federal dollars without any federal administrative oversight.[159]

Indeed, the purpose to preclude federal oversight is evident in the legislative history. Discussing the proposed Boren repeal, the Budget Reconciliation Recommendations of the Committee on Finance[160] notes that "in several states, providers and provider organizations challenged state policies in federal courts alleging that the state's procedures for reimbursement violated requirements of the Boren amendments."[161] The Recommendations continued: "following a Supreme Court decision [*Wilder*] that the amendments created enforceable rights for providers, a number of courts found that state systems failed to meet the test of 'reasonableness' and some states had to increase payments to these providers."[162] Thus, the House Report

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157. *See* Medicaid Budgets, *supra* note 1, at 29.

158. *See id.*

159. The full extent of the unfettered discretion Congress believed that it was conferring on the state is evident in the dialogue in the Congressional Record. After a proposal to reinstate the Boren Amendment was defeated, a compromise amendment was offered. The compromise would have "simply require[d] that the states provide assurance to the Secretary that the rates will be actuarially sufficient to ensure adequate care." 143 CONG. REC. S6301-02, *S6305 (1997) (statement of Sen. Wellstone). Even this standard was rejected in the name of state flexibility. *See id.*

160. *See Budget Reconciliation Recommendations of the Committee on Finance*, 105th Cong. 95 (1997).

161. *Id.*

162. Legislators blamed the escalation in payments to nursing homes on the courts. For example, Senator William Roth, one of the most vocal opponents of Boren, contended:

> The Boren amendment, for example, has been used to actually bid the price of nursing home care up higher. Between 1980 and 1985, Medicaid payments for nursing home care increased by an average of 7.8 percent annually. In 1989, payments had increased by 8.8 percent from the previous year. But after a key Supreme Court decision on the Boren amendment in 1990, Medicaid payments for nursing home care increased by 17 percent in 1991.

141 CONG. REC. S18693 (1995). *See also* 143 CONG. REC. S7738 (1997) (statement of Sen. Abraham). The argument, of course, ignores: (1) other influences on costs; and (2) the

accompanying the new legislation sought to permit continued oversight by the Courts. The Report states that it was the "Committee's intention that, following enactment of this Act, neither this nor any other provision of section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive."[163] The state of nursing home care during the first ten years of the Medicaid program when states had the same discretionary authority that they sought again with the repeal of the Boren Amendment was largely ignored.

In contrast, the minority felt that Boren's "reasonable and adequate" payment standard was crucial to ensuring that there be no return to the conditions that existed before the 1987 nursing home reforms. Rep. John Dingell (D-MI), for example, warned that repealing the Boren Amendment would mean a return to "warehousing" the elderly, and "disgraceful" nursing conditions which previously existed.[164]

Fortunately, for all concerned, the economic expansion the United States enjoyed through the 1990's blunted the immediate fiscal impact of the repeal.

IV. POSSIBLE STATUTORY CLAIMS AFTER THE REPEAL OF THE BOREN AMENDMENT

At the time that repeal of the Boren Amendment was moving through Congress there was widespread belief that passage of the repeal would leave nursing facilities without a statutory basis on which to predicate claims for adequate payment. This belief ignored the text and history of the Medicaid Act.

The Boren Amendment and its predecessors had provided special payment standards and plan approval procedures for State Plan

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fact that, with perhaps an isolated exception, no federal court ever ordered a state to increase Medicaid payment rates. Others pointed out that despite the increase in payment rates, Medicaid had constrained further increases because, on the average, Medicaid already paid less than the cost of services. Robert B. Friedland, *Medicare, Medicaid, and the Budget*, 7 PUB. POL'Y AND AGING REP. OF THE NAT'L ACADEMY ON AGING 1 (Nov. 1995), *available at* http://gsa.iog.wayne.edu/NAA/ppl.html; 145 CONG. REC. S6163-74 (1997) (statement of Sen. Milkulski) (Maryland Medicaid paid nursing homes on average of 78 dollars per day, but care cost an average of 112 dollars per day).

163. H.R. REP. NO. 105-149 (1997). *See also* Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 919 n.12 (5th Cir. 2000) (Congress sought to preclude lawsuits contesting adequacy of Medicaid payment.)

164. *See Medicine & Health*, Vol. 51, No. 24, June 16, 1997. *See also* 143 CONG. REC. S6,163-74 (1997) (statement of Sen. Milkulski); 142 CONG. REC. H4,569, 4,574, 4,586 (1997); 143 CONG. REC. E1361 (June 27, 1997) (statement of Rep. Coyne); 143 CONG. REC. H2968-69 (May 20, 1997) (statement of Rep. Cardin).

provisions specifying the states' Medicaid payment methodology and standards for hospital and nursing home care. However, the Amendment never was the exclusive statutory basis for a payment claim. The statute contains a variety of provisions that long have provided a basis for challenging inadequate Medicaid payment rates. In fact, the NGA position paper regarding Medicaid reform explicitly acknowledges that other provisions of the Act have been held to establish enforceable reimbursement standards.[165] Arguably, repeal of the Boren Amendment's special rules remands State Plan provisions specifying provider payment methodologies to the same substantive and procedural requirements the Act applies to all other State Plan provisions. Thus, the Medicaid Act without the Boren Amendment arguably provides several bases on which providers might predicate claims for appropriate and adequate reimbursement.

A. Repeal of the Boren Amendment Subjects the Provider Payment Provisions of State Medicaid Plans to the Substantive and Procedural Requirements Applicable to All Other Plan Provisions

The Medicaid Act imposes on the Secretary an obligation to review and approve state Medicaid Plans. Section 1901 provides, in pertinent part, "[the sums made available under this section shall be used for making payments to states which have submitted, and had approved by the Secretary, State Plans for medical assistance."[166] Section 1902 provides that the Secretary may approve a State Plan if, but only if, he determines that the "plan . . . fulfills the conditions specified in the Act."[167]

The conditions that the State Plan must satisfy in order to obtain the Secretary's approval and qualify for federal funding are set out in the statute.[168] The Plan provisions that must be approved by the Secretary fall into three general categories: (1) provisions regarding administration of the Plan; (2) provisions regarding the scope and quality of services delivered by providers and suppliers; and (3) provision regarding payments.

Section 1902(a)(4)(A), for example, provides that a State Plan must "provide . . . such methods of administration . . . as are found by the Secretary to be necessary for the proper and efficient operation of

165. Nat'l Governors' Assoc., NGA Pol'y Index page: EC-7 Long-Term Care, *available at* http://www.nga.org/Pubs/Policies/EC/ec08.asp.

166. 42 U.S.C. § 1396 (2000).

167. 42 U.S.C. § 1396a(b) (2000).

168. *See* 42 U.S.C. § 1396(a)(a) (2000).

the plan . . . ."[169] In addition, the Act requires that the State Plan include "descriptions of . . . [the standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance of are high quality."[170] Further, the Act provides the State Plan must "provide such safeguards as may be necessary to assure that . . . such care and services will be provided, in a matter consistent with simplicity of administration and the best interest of the recipients . . . ."[171]

The nature and scope of the state's obligation to pay for services continues to be explicitly defined in the Act. The Act provides that a State Plan for medical assistance must:

> provide such methods and procedures relating to . . . the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .[172]

Thus, section 1902 (a)(30)(A) provides that the State Plan must satisfy five specific requirements regarding payment for services: (1) the State Plan must provide payment methods and procedures; (2) the methods and procedures must be adequate to assure that payments are consistent with efficiency; (3) the methods and procedures must assure that payments are consistent with economy; (4) the methods and procedures must assure that payments are consistent with quality of care; and (5) the methods and procedures must assure that payments are sufficient to enlist sufficient providers so that care and services are available to program beneficiaries to the same extent that they are available to the general population.[173]

Section 1902(a)(62) provides that the Secretary can approve a State Plan only if the Plan "fulfills the conditions specified" in the

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169. 42 U.S.C. § 1396a(a)(4) (2000).

170. 42 U.S.C. § 1396a(a)(22)(D) (2000).

171. 42 U.S.C. § 1396a(a)(19) (2000).

172. 42 U.S.C. § 1396a(a)(30)(A) (2000).

173. The Act also provides, in addition to the language replacing the Boren Amendment, that payment rates cannot be developed or established in secret. The Act specifies that the State Plan must provide "for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this title." 42 U.S.C. § 1396a(a)(29) (2000).

Act.[174] Thus, the Secretary can approve a State Plan only if he determines that the payment "methods and procedures" in the Plan "*assure* that payments are consistent with efficiency, economy, . . . quality of care" and equality of access to health care.[175]

The responsibility of the Secretary is not limited to rubber stamping a State Plan that mouths the correct words. Instead, the Act requires that the Secretary make a qualitative judgment about the effectiveness of State Plan provisions governing care in and payment for nursing home services. Section 1919(f) will assure achievement of the specified goals. The Act's requirement that the Plan "assure payments consistently with efficiency economy, quality of care" and equal access effectively prescribes the nature and depth of the Plan evaluation required of the Secretary. Because Congress dictated that a State Plan "fulfills the conditions specified in [section 1902(a)]" only if it "assures" payments consistent with specified goals, the Secretary cannot rest approval of a Plan on opinion, educated guesses, speculation, probabilities or theories. Instead, the mandate that the payments "assure" consistency with specific objectives makes clear that the Secretary may approve a Plan only if there is a high degree of certainty that the payments satisfy the statutory criteria. The degree of certainty required to support approval of a Plan cannot be achieved unless the Secretary conducts a bona fide, substantive and thorough empirical analysis and rests his determination on the relevant factors and objective data identifying the relationship between payments made pursuant to the State Plan and the statutory objects of economy, efficiency, quality of care and equal access in the given state.

B. The Repeal of the Boren Amendment Did Not Confer Unfettered Discretion on States to Develop and Implement Medicaid Payment Methodologies

Opponents of the Boren Amendment who believed that the repeal would leave the states with almost unfettered discretion to set payment rates failed to recognize that the Act contained other provisions governing the calculation, and amount, of Medicaid payment.[176] Indeed, analysis of the Act and its legislative history demonstrates that

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174. *See* 42 U.S.C. § 1396a(a)(62) ("The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section . . . .").

175. 42 U.S.C. § 1396(a)(30(A) (2000) (emphasis added).

176. *See* American Med. Ass'n v. Mathews, 429 F. Supp. 1179, 1194-95 (N.D. Ill. 1977). Moreover, some courts have held that Boren Amendment standards continue to govern Medicaid payment until the state promulgates rules or regulations, or adopts legislation, replacing the State Plan adopted and implemented under Boren. *See* Florida Ass'n of Rehabilitation Facilities, Inc. v. Florida, 1999 WL 304633 at *4 (S.D. Fla. 1999).

repeal of the Boren Amendment actually eliminated state rate setting discretion in a number of important areas. In fact, the repeal arguably broadened the degree of federal oversight required of State Plan provisions governing reimbursement of institutional providers.

First, the repeal did not eliminate the basic Medicaid payment standard governing payment to all types of providers and suppliers.[177] Indeed, the NGA itself acknowledged that section 1902(a)(30) prescribed rate setting criteria and, in NGA's view, had caused the states the same problems as the Boren Amendment.[178]

Second, the Boren Amendment limited the extent of the Secretary's review of State Plan provisions regarding institutional payments because the special rules formerly set forth in Boren, conferring discretion on the states and limiting the Secretary's oversight, no longer apply. Institutional rate setting should be governed by the same rules applicable to all other providers. In the past, for example, unless the state's claims were obviously untrue, the Secretary was required by Boren to accept the state's assurance that its payment Plan complied with federal law. Now, however, section 1902(a)(30) no longer requires federal deference to the states' decisions.

Third, the Boren Amendment focused not on the appropriateness of the state's payment methods and procedures, but on the adequacy of aggregate payment rates. Section 1902(a)(30) explicitly requires that the Secretary approve a State Plan if the state's methods and procedures assure payment consistent with efficiency, economy, quality of care and equal access. Thus, the State Plan approval process should now focus on the payment "methods and procedures" and on whether they "assure" payment consistent with the statutory objective. In the past, when the Secretary has been obliged to review the state's payment "methods and standards," the Secretary has perceived a duty to "judge [ ] and validate [ ] a state's payment methods and standards from a technical standpoint,"[179] to "assess [ ] the appropriateness of each element of the state's payment system,"[180] and to approve the

177. *See* DeGregorio v. O'Bannon, 500 F. Supp. 541, 549 (E.D. Pa. 1980) (equal access provision sets minimum payment standard); Opelika Nursing Home, Inc. v. Richardson, 356 F. Supp. 1338, 1343 (M.D. Ala. 1973) (section 1902(a)(30) applies to payments to all providers of Medicaid services); Dowling v. Davis, 840 F. Supp. 731, 734 (E.D. Cal. 1992) (section 1902(a)(30) governs the amount and calculation of payment); *Mathews*, 429 F. Supp at 1194-95 (section 1902(a)(30), added to Act in 1967, is the basic reimbursement standard for medical care and services under Medicaid).

178. *See supra* note 165.

179. *See* Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 48 Fed. Reg. 56,046, 56,052 (Dec. 19, 1988) (codified at 42 C.F.R. § 447).

180. *See* 1981 Medicaid Program, *supra* note 23, at 47,965.

Plan only if "these elements and their interaction result[ed] in payments that are consistent [with the statute regulations]."[181]

HCFA, however, appears to have adopted a laissez-faire approach consistent with NGA's view. For example, the federal agency has advised the State Medicaid Directors that:

> The intent of section 4711[the Boren Amendment's replacement] is to provide states with maximum possible flexibility, as well as to minimize HCFA's role in reviewing inpatient hospital and long-term care state plan amendments involving payment rate changes. HCFA would consider the state to be in compliance with [the Boren replacement] provision if it elected to use a general administrative process similar to the Federal Administrative Procedures Act that satisfies the requirements for a public process in developing and inviting comment in section 4711. This will allow states the flexibility to follow current state public procedures.[182]

HCFA's position ignores its prior interpretation of similar language as well as the mandate of section 1902(a)(30)(A) to approve only State Plans containing payment methods and procedures "assur[ing] that payments are consistent with efficiency, economy, and quality of care" and equal access. HCFA's position also ignores long-standing precedent. Courts interpreting section 1902(a)(30) as well as other provisions of the Act have held that the states cannot determine that State Plan provisions provide the assurance required by the Act unless objective cost and quality data are known and analyzed.[183] Rate setting by chance, or based on an assumption that the Act's criteria have been satisfied, is not permitted by the Act.[184]

Viewed in the context of the rest of the Medicaid Act, repeal of the Boren Amendment ultimately may limit state discretion. For example, Boren authorized the states to define the meaning of key statutory terms (*e.g.*, efficient and economic) and permitted each state "to

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181. *Id.*

182. Letter from Sally K. Richardson, Director, *Center for Medicaid and State Operations, HCFA* to State Medicaid Directors (Dec. 15, 1997) (copy on file with author) [hereinafter Richardson Letter].

183. *See* Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496-98 (9th Cir. 1997) (cannot know that rates are consistent with economy, efficiency, quality of care without identifying and considering the cost of services); Arkansas Med. Soc'y v. Reynolds, 819 F. Supp. 816 (E.D. Ark. 1993), *affirmed* 6 F.3d 519, 529-31 (8th Cir. 1993). *See also* Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991); Illinois Health Care Ass'n v. Bradley, 983 F.2d 1460, 1464-65 (7th Cir. 1993); Amisub (PSI), Inc. v. Colorado Dep't of Soc. Servs., 879 F.2d 789 (10th Cir. 1989). *But see* Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 923-24 (5th Cir. 2000).

184. *Cf.* Alabama Nursing Home Ass'n v. Harris, 617 F.2d 385, 392-94 (5th Cir. 1980).

make its own finding that the state plan complied with federal law."[185] The current statute does not delegate such authority to the states. This is the case for two reasons.

First, using language remarkably similar to the Boren Amendment, section 1902(a)(30)(A) requires that the Secretary approve the State Plan only if the Plan's payment methods and procedures "assure" that payments meet certain standards.[186] The Secretary's failure to conduct an objective and principled analysis of the Plan's compliance with the Act's standards arguably would violate the Plan approval mandate of section 1902 and also constitute a failure to fulfill the "duty and responsibility" imposed on the Secretary by other provisions of the Act.[187] Thus, the Secretary, rather than the state, arguably is once again charged with the responsibility of validating a Plan's compliance with federal law.

Second, although some may argue that section 1902(a)(30) is vague, where the Act imposes a duty to review and approve a State Plan, the courts have held that the Secretary is obliged to define the key terms used in the Act's applicable payment provisions.[188] Should the Secretary fail to supply definitions, terms such as "efficiency" and "economy" have been defined by practice and, as *Wilder* noted, enforced by the courts for many years.[189] Moreover, in important respects, the Act provides its own definitions.[190] Terms such as "care," "services," and "best interest of the recipients" are defined by reference to other provisions of the Act that detail the types and quality of services that must be provided by nursing homes. For example, 42 U.S.C. § 1396r, requires that, "nursing facilities provide services and activities that attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care."[191] Notwithstanding its failure to recognize the payment implications of section 1902(a)(30), HCFA has acknowledged that the repeal of Boren did not undercut the obligations imposed on the states by the Act to assure quality long term care: "The

185. 42 U.S.C. § 1396a(13) (1994).

186. *See* 42 U.S.C. § 1396a(a)(30)(A) (1994).

187. 42 U.S.C. § 1396r(f)(1) (2000), for example, specifies that: It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State Plans approved under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote effective and efficient use of public monies. *Id.*

188. *See* Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 507 (1990).

189. *See id.*

190. *See, e.g.*, 42 U.S.C. § 1396r(b)(2) (2000).

191. *Id.*

repeal of the Boren amendment has not relieved states of the responsibility of promoting quality of care for their beneficiaries served in nursing homes."[192]

In sum, overlooked in the rush to repeal Boren, was the fact that the Amendment had transferred authority to validate a State Plan's compliance with federal requirements from the Secretary to the states. Also ignored in the rush to repeal was the fact that Boren also gave the states broad discretion and flexibility to define key standards that established the scope of the state's obligation. Focusing only on the fact that the Boren Amendment had been the basis for state liability, opponents of the Amendment did not recognize that repeal would reinstate aspects of the federal-state relationship as it existed before 1980. The Medicaid Act makes clear that the Secretary, exercising the authority conferred by section 1902 (a) (30), can approve a State Plan only if he determines that a State Plan's methods and procedures assure payments consistent with economy, efficiency, quality of care and equal access. Thus, the Act now defines the responsibilities of the Secretary in terms that the states may find hauntingly similar to the obligation imposed by the Act prior to Boren.

Admittedly, the legislative history of the Boren repeal states that the Committee contemplated that the Act would not support a cause of action to challenge the adequacy under federal law of a state's Medicaid payment rates. Unfortunately for the states, the Committee's language is years too late and far to little to prevent enforcement of section 1902(a)(30).

C. *The Medicaid Act Contains Enforceable Payment Standards Even After the Repeal of the Boren Amendment*

1. *Section 1902(A)(30) Provided Enforceable Payment Standards Before the Adoption of the Boren Amendment*

When originally adopted, the Medicaid Act contained two provisions governing the amount of payments to providers. The Act contained a generic payment standard, applicable to all providers, 42 U.S.C. section 1396a(a)(30).[193] Section 1902a(30), at the time it was first adopted, mandated that the Secretary should approve State Plans which:

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192. Richardson Letter, *supra* note 182.

193. DeGregorio v. O'Bannon, 500 F. Supp. 541, 546-47 (E.D. Pa. 1980); American Med. Ass'n v. Mathews, 429 F. Supp. 1179, 1194-95 (N.D. Ill. 1977); Thomas v. Johnston, 557 F. Supp. 879, 883-84 (W.D. Tex. 1983); Opelika Nursing Home v. Richardson, 356 F. Supp. 1338, 1343 (M.D. Ala. 1973).

> Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.[194]

The second payment standard contained in the Medicaid Act required that State Plans provide for payment of the reasonable costs incurred by hospitals to provide in-patient services to Medicaid patients.[195]

Courts generally read the two payment provisions together and presumed that the provisions specific to hospital reimbursement imposed an obligation on the state in addition to the obligation imposed by section 1902(a)(30). The state was required to develop a State Plan including payment methods and standards that complied with both the reasonable cost payment standard and to assure that such payments were no more than the reasonable charges paid by Medicare for similar services.[196] Compliance with both provisions was mandated because, as originally adopted, the inpatient hospital provision established the statutory minimum and section 1902(a)(30) established a ceiling, limiting Medicaid payments to a provider's Medicare reasonable charges for similar services. Payments to non-hospital providers, on the other hand, were subject only to the reasonable charge limit imposed by section 1902(a)(30).

Initially, almost all providers who sued under section 1902(a)(30)(A) were denied relief.[197] Although providers argued that section 1902(a)(30)(A) established minimum payment standards, most courts viewed the section as authority for the Secretary to impose upper limits on provider payments.

Despite the differing interpretations of section 1902(a)(30)(A), there was no question about the enforceability of the section. For example, in the early years after the Medicaid Act was adopted, most courts held that determination of the amount of payment due for Medicaid covered nursing home services was committed to the state's discretion, subject only to the limitation that payments could not ex-

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194. 42 U.S.C. § 1396(a)(30) (2000).

195. *See* Briarcliff Haven, Inc. v. Dep't of Human Res., 403 F. Supp. 1355, 1362-63 (N.D. Ga. 1975); Lee v. Laitinen, 448 P.2d 154, 156 (Mont. 1968).

196. *See* 42 U.S.C. § 1396(a)(30) (2000); *DeGregorio*, 500 F. Supp. at 549-50.

197. *See, e.g., Briarcliff Haven*, 403 F. Supp. at 1362-63.

ceed the reasonable charges paid by the Medicare program for the same services.[198]

One court, for example, held that the Act specified no minimum payment for skilled nursing home services, only a maximum payment amount, *i.e.*, the Medicare reasonable charges.[199] The Court further ruled that, under the Act, reimbursement determinations by the state might include all or only part of a nursing home's costs of delivering services. However, the court held that section 1902(a)(30) conferred no right to a minimum payment but only a right to a payment that did not exceed reasonable charges.[200]

In the first years after the Act was adopted, many nursing homes sued under section 1902(a)(30) challenging the Secretary's effort to equate reasonable charges and reasonable costs.[201] The courts unanimously upheld the Secretary's authority to do so.[202] Payment on the basis of Medicare reasonable costs as defined at the time was considered generous, especially in light of the failure at that time of many states' Medicaid programs to pay the cost of care. Among other things, payment on a reasonable cost basis would have included payment of a return on equity and an allowance on debt.[203] One case pointed out that the experience of the local nursing homes indicated that payment on a reasonable cost basis was likely to produce more revenue than payment on a charge basis.[204] No court, however, even suggested that section 1902(a)(30) was not judicially enforceable.

The perception that section 1902(a)(30) was only an upper limit on payments reflects the fact that the courts, the Department of Health and Human Services, and State Medicaid agencies appear, in many instances, to have pursued an ad hoc, rather than a systemic

198. *See* American Nursing Home Ass'n v. Cost of Living Council, 372 F. Supp. 517 (D.D.C. 1973), *rev'd*, 497 F.2d 909 (Temp. Emer. Ct. App. 1974); American Nursing Home Ass'n v. Cost of Living Council, 368 F. Supp. 490, 493-94 (D.D.C. 1973), *rev'd*, 497 F.2d 909 (Temp. Emer. Ct. App. 1974); *Opelika Nursing Home*, 448 F.2d at 660-61; *Briarcliff Haven*, 403 F. Supp at 1362-63; Johnson's Prof'l Nursing Home v. Weinberger, 490 F.2d 841, 843 (5th Cir. 1974).

199. *See Briarcliff Haven*, 403 F. Supp. at 1362-63.

200. *See id.*; *Opelika Nursing Home*, 323 F. Supp. at 1210-11.

201. *See, e.g., Johnson's Prof'l Nursing Home*, 490 F.2d at 843; *Opelika Nursing Home*, 448 F.2d at 660-61; *Opelika Nursing Home*, 323 F. Supp. at 1210-11. *Cf.* Carbon Hill Health Care, Inc. v. Beasley, 528 F. Supp. 421, 423 (M.D. Ala. 1981) (holding that section required states to promulgate regulations to insure allowable costs incurred in manner consistent with Medicaid Act).

202. *See supra* note 201.

203. *See, e.g.*, 42 C.F.R. § 405.429 (2001); *Opelika Nursing Home*, 448 F.2d at 660-61; Opelika Nursing Home, 323 F. Supp. at 1210-11.

204. *See Opelika Nursing Home*, 356 F. Supp. at 1343-45.

approach to rate-setting.[205] For example, despite the fact that section 1902(a)(30) originally required that State Plans provide methods and procedures that assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care, it appears that, in the early years, no effort was made to compel states to have a basis to believe that the statutory objectives were met prior to implementing the State Plan provisions.[206] As one court pointed out, prior to the early 1990s, no court had held that a state Medicaid agency had an obligation to make a finding that its rates satisfied the statute before the State Plan was put in place.[207] Even more remarkable, there does not seem to be a single reported decision in which a plaintiff asked a court to require a state to determine in advance of implementation that its State Plan satisfied the statute. To the contrary, it seems that the accepted procedure in the early years was that a state would implement its rate-setting methodology and providers or recipients would sue for injunctive relief if there was actual harm. Yet, there was agreement that the Act provided a cause of action to challenge an allegedly illegal payment rate.[208]

Section 1902(a)(30) also was enforced in actions brought to compel the Secretary to comply with the Act.[209] Some courts held that the provision reflected Congress' expectation that the Secretary of the Department of Health and Human Services would establish standards and definitions governing the interpretation of section 1902(a)(30).[210] In *Opelika Nursing Home, Inc. v. Richardson*, for example, the Court held that section 1902(a)(30) was singularly lacking in specificity and, therefore, administrative interpretation of the statute was a necessity.[211] Similarly, in *American Medical Association v. Mathews*, the Northern District of Illinois held that: "[b]ecause Medicaid is a federal-state cooperative program and state methods and procedures must be approved by the Secretary to assure conformity with federal law, it is reasonable to infer that Congress vested responsibility in the Secretary to give meaning to the language."[212]

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205. *See* Lee v. Laitinen, 448 P.2d 154, 156 (Mont. 1968).

206. *See* American Med. Ass'n v. Mathews, 429 F. Supp. 1179, 1194-95 (N.D. Ill. 1977); Dowling v. Davis, 840 F. Supp. 731, 734 (N.D. Cal. 1992).

207. *See id.*

208. *See id.*

209. *See Opelika Nursing Home*, 356 F. Supp. at 1343-45.

210. *See id.*

211. *See id.*

212. *Mathews*, 429 F. Supp. at 1194-95.

The Secretary exercised the authority conferred by the Act to define some of the terms of section 1902(a)(30).[213] Specifically, although the statute limited Medicaid payment rates to Medicare reasonable charges, the Secretary first recommended, then later required, that Medicaid payments not exceed the Medicare reasonable *cost* level.[214] Moreover, despite the fact that section 1902(a)(30) — unlike the provisions governing inpatient hospital reimbursement — did not incorporate the reasonable cost payment standard, the Secretary adopted informal guidelines suggesting that the reasonable cost reimbursement standards ought to be applied to payments to non-hospital providers. For example, HHS' Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs, set forth the Department's interpretation.[215] The Manual provided:

> For institutions, other than hospitals, the fee structure will focus on payment on a reasonable cost basis determined according to commonly used accounting methods on a per diem or relationship of cost to charges basis. For comparable facilities, payment equivalent to reasonable costs under Part A of Title XVIII is recommended.[216]

Many courts acknowledged that a major purpose of section 1902(a)(30) and its implementing regulations was to make services available to the Medicaid beneficiaries.[217] Yet, the early decisions generally ignored the possibility that the statute imposed an independent obligation (*i.e.*, with respect to minimum payment levels) beyond the reasonable charge limitation.[218] Instead, courts asserted that the "consistent with" clause was a further limitation on reasonable charges and, in fact, provided the basis for the Secretary's authority to limit reasonable charges to reasonable costs.[219]

A few early decisions interpreting section 1902(a)(30) did suggest, however, that there were some minimum Medicaid payment

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213. *See* American Nursing Home Ass'n v. Cost of Living Council, 497 F.2d 909, 911-12 (Temp. Emer. Ct. App. 1974).

214. *See id.* (emphasis added).

215. *See id.*

216. PUBLIC ASSISTANCE ADMINISTRATION, HANDBOOK SUPPLEMENT D, § D-5340. *See also* Lee v. Laitinen, 448 P.2d 154, 156 (Mont. 1968).

217. *See* Johnson's Prof'l Nursing Home v. Weinberger, 490 F.2d 841, 844-45 (5th Cir. 1974); Opelika Nursing Home v. Richardson, 356 F. Supp. 1338, 1393-95 (M.D. Ala. 1973).

218. *See* Briarcliff Haven v. Dep't Human Res. of Georgia, 403 F. Supp. 1355, 1362-63 (N.D. Ga. 1975); American Nursing Home Ass'n v. Cost of Living Council, 372 F. Supp. 517, 521-22 (D.D.C. 1974); American Nursing Home Ass'n v. Cost of Living Council, 368 F. Supp. 490, 493-94 (D.D.C. 1973).

219. *See Johnson's Prof'l Nursing Home*, 490 F.2d at 844-45; *Opelika Nursing Home*, 448 F.2d at 660-61; *Opelika Nursing Home*, 323 F. Supp. at 1210.

standards.[220] These courts appeared to focus, not on the statutory language of section 1902(a)(30), but on the implementing regulations and Manual provisions.[221] The Manual, and later the regulations, required that payments be sufficient to assure Medicaid beneficiaries access to medical services to the same extent as the general population.[222]

One of the earliest cases applying the Medicaid Act's payment provisions held that the equal access requirement dictated that both the quantity and the quality of services available to Medicaid beneficiaries must be the same as the quantity and quality of services available to the general population. In one case, the Montana Supreme Court held:

> [I]t is apparent that the clear legal duty imposed upon the Welfare Board is not in terms of a specific rate of payment, but in the form of an objective to be attained; namely, to make nursing home care available to recipients to at least the same extent as to the general population. Petitioners arrive at the same concept of the duty imposed, but on the basis of federal law requirements as to standards of service. Whether phrased in terms of quality or quantity, the duty imposed is the same, to make available to Title XIX recipients at least that which is available to others.[223]

The Montana court's decision defining access in terms of the quality of services as well as the quantity, however, stands alone.[224]

Two other decisions found that section 1902(a)(30)'s implementing regulations required a minimum payment level sufficient to provide a defined quantity of service.[225] Remarkably, these two decisions hold that:

> A state which elects to participate in the Medicaid program is required to provide eligible recipients with assistance in five general categories of medical treatment. [citations omitted]. Unless rates are set for each of the required services at a level

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220. *See, e.g.*, Lee v. Laitinen, 448 P.2d 154, 156 (Mont. 1968).

221. *See id.*

222. *See id.*

223. *See id.*

224. These courts, however, held that limitations on access due to insufficient funding were permissible because providing fewer services for an entire year was better than full access for part of a year and no access for the remainder. *See Lee*, 448 P.2d at 156. The court never addressed the alternative that the state fully find its obligations under the federal statute. *See id.*

225. *See* Dowling v. Davis, 840 F. Supp. 731, 734 (N.D. Cal. 1992); DeGregorio v. O'Bannon, 500 F. Supp. 541, 549 (E.D. Pa. 1980).

> which will offer a sufficient number of providers the opportunity to receive payments which will exceed their marginal costs for servicing Medicaid recipients (and to be induced thereby to enlist in the program), it would be possible for states to evade the Federal requirement of providing all five categories of services, by setting unreasonably low rates for certain disfavored services . . . . But the "equal access" regulation tests directly the adequacy of a rate in furthering the goals of the Medicaid Act, by evaluating the rate's performance in making medical services available to eligible individuals.[226]

In sum, section 1902(a)(30) was routinely enforced by the courts beginning in the first few years after the Medicaid Act was adopted. Although courts generally did not view the section as a minimum payment standard, courts routinely held that the section defined the Secretary's power and duties with respect to sate plan provisions governing Medicaid provider payment.

2. *The Evolution of a Minimum Payment Standard and the Metamorphosis of Section 1902(a)(30)(A) from a Ceiling into a Floor*

A little more than five years after the Medicaid Act was adopted, there was widespread agreement that the consequence of conferring near limitless rate setting discretion on the states was that, as a whole, the nursing home component of the Medicaid health care delivery system was a chaotic mess. Various commentators pointed out that the payment methods adopted by the states varied greatly.[227] Some states used cost-finding and payment methodologies designed to pay the full cost of services.[228] Other states paid a negotiated rate which may or may not have approximated the cost of delivering care.[229] Still other states used a flat rate or another payment methodology that was unrelated to the actual cost of care.[230] Such payment systems provided no incentives for efficient delivery of care.[231]

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226. *DeGregorio*, 500 F. Supp. at 549-50.

227. *See, e.g.*, Johnson's Prof'l Nursing Home v. Weinberger, 490 F.2d 841, 844-45 (5th Cir. 1974).

228. *See Johnson's Prof'l Nursing Home*, 490 F.2d at 844-45; Murphy Nursing Home, Inc. v. Rate Setting Comm'n, 364 Mass. 454, 462-63, 468-69 (1973).

229. *See Johnson's Prof'l Nursing Home*, 490 F.2d at 844-45.

230. *See* Minnesota Ass'n of Health Care Facilities, Inc. v. Dep't of Pub. Welfare, 602 F.2d 150, 153-54 (8th Cir. 1979).

231. *See id.*

There was a widely held perception among lawmakers that most states set payment rates arbitrarily.[232] Further, there also was a broad consensus that payments rates generally were too low to support quality care.[233] Following an investigation prompted by a spate of care scandals, Congress determined that some providers were paid too little while others were paid too much.[234] Further, Congress concluded that, as a general rule, state Medicaid payment methodologies failed to bring about quality care, and failed to promote the efficient and economic provision of services.[235] In the early and mid-1970's, Congress reacted by making several changes in the way that Medicaid paid for nursing home care. In the process, section 1902(a)(30) was transformed from a payment rate ceiling into a minimum payment standard.

First, on October 30, 1972, Congress amended the Medicaid Act to add specific criteria governing payment to nursing homes.[236] Effective July 1, 1976, the statute required: "[p]ayment of the skilled nursing facility, and intermediate care facility services provided under the plan on a reasonable cost-related basis as determined in accordance with methods and standards which shall be developed by the state on the basis of cost-finding methods approved and verified by the Secretary."[237]

Although the "reasonable cost related" standard contained in section 249 contemplated that the States would continue to exercise discretion and flexibility in designing Medicaid payment systems to fit local needs,[238] the new statute, in contrast to its predecessor, precluded arbitrary rate setting by requiring that the cost-finding methods be related to the cost of care and be "approved and verified by the Secretary." Thus, Congress now imposed on HHS the obligation to analyze and verify whether the state's payment methods and standards satisfied the Medicaid Act.[239] The Fifth Circuit held that section 249 required the Secretary to:

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232. *See* American Nursing Home Ass'n v. Cost of Living Council, 372 F. Supp. 517, 521-22 (D.D.C. 1974).

233. *See id.* (*quoting* Sen. Harrison Williams).

234. *See* Thomas v. Johnston, 557 F. Supp. 879, 883-84 (W.D. Tex. 1983); *American Nursing Home Ass'n*, 372 F. Supp. at 521-22.

235. *See Minnesota Ass'n of Health Care Facilities*, 602 F.2d at 153-54.

236. *See American Nursing Home Ass'n*, 372 F. Supp. at 521-22; American Nursing Home Ass'n v. Cost of Living Council, 497 F.2d 909, 911-12; Opelika Nursing Home v. Richardson, 356 F. Supp. 1338, 1393-95 (M.D. Ala. 1973). *Thomas*, 557 F. Supp. at 883-84.

237. 42 U.S.C. § 1396a(a)(30) (2000).

238. *See* Alabama Nursing Home Ass'n v. Harris, 617 F.2d 385, 391-92 (5th Cir. 1980).

239. *See id.* at 392-93.

> (1) establish standards and criteria by which the State and Federal officials could determine the meaning of crucial statutory terms; and
> (2) actually verify, through documentation obtained from the state or by independent study conducted by the Secretary, that payments under the State Plan actually met the statutory standard.[240]

Further, the Court held that HHS could not approve a State Plan by relying upon an unverified institutional assumption that payment at the sixtieth percentile incurred by the class satisfied the statute.[241]

Second, Congress directed HHS to eliminate the common practice of permitting the resident (and his or her relatives or friends) to supplement the Medicaid rate by making additional payments to the provider. Medicaid programs in several states were based on the expectation that inadequate Medicaid payments would be supplemented with additional private payments. Because Medicaid payments now were required to be "reasonably cost related," rate supplementation was considered unnecessary.

Consequently, the Secretary by regulation provided that supplementation would be phased out beginning July 1, 1971.[242] According to the regulation, the State could permit supplementation for a limited time after July 1, 1971, only if it certified that Medicaid payments were less than the reasonable cost of nursing home care.[243] As a result, the Medicaid payment became the exclusive source of provider payment for Medicaid services provided by nursing homes.

Third, at about the same time that Congress adopted section 249 and eliminated supplementation, HHS codified the equal access requirement in the Code of Federal Regulations.[244] In 1978, the Medicaid Act was amended to include the essential text of the regulation.[245] The purpose and effect of codification of the equal access provision in the Code of Federal Regulations, and later in section 1902(a)(30),[246] was to draw attention to the requirement and to estab-

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240. *Id.* at 394.

241. *See id.*

242. *See* Johnson's Prof'l Nursing Home v. Weinberger, 490 F.2d 841, 844-45 (5th Cir. 1974); *Opelika Nursing Home*, 448 F.2d at 660-61.

243. *See Johnson's Prof'l Nursing Home*, 490 F.2d at 844-45.

244. *See* DeGregorio v. O'Bannon, 500 F. Supp. 541, 549 (E.D. Pa. 1980). The substance of the new regulation originally had appeared in 1966 in HHS's Handbook of Public Assistance Administration, Supplement D, § D-5320.1.

245. *See* 43 Fed. Reg. 45176.

246. The equal access provision was added to the statute effective December 19, 1989, by Pub. L. No. 101-239 § 6402(a).

lish an objective, enforceable, minimum Medicaid payment standard.[247]

Finally, in 1981 Congress eliminated the reasonable charge limitation from section 1902(a)(30). As amended the statute required that the State Medicaid Plan: "provide such methods and procedures relating to . . . the payment for care and services available under the plan . . . as may be necessary to assure that payments are consistent with efficiency, economy, and quality of care."[248]

According to the legislative history, the intent of the amendment was straight forward — the repeal "remove[d] Medicare reasonable charge levels as a ceiling on Medicaid payments."[249] The change, which was almost unnoticed for many years, would have a substantial impact on Medicaid reimbursement.[250]

When the reasonable charge limitation was deleted, the significance of the phrase "consistent with economy, efficiency and quality of care" changed dramatically. Efficiency, economy and quality of care no longer modified the reasonable charge limitation. Instead, the "consistent with" requirement now mandated that the State Plan's payment methods and procedures must be consistent with economy, efficiency and quality of care.

Moreover, any doubt that section 1902(a)(30) established an enforceable minimum payment standard was eliminated when the section was further amended in 1989. Although the Secretary's regulations implementing section 1902(a)(30)(A) long had contained a requirement that Medicaid beneficiaries have access to services equal to that of the general population, Congress believed that the equal access requirement was given insufficient attention.[251] Consequently, Congress amended section 1902(a)(30) to incorporate the

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247. *See* Arkansas Med. Soc'y, Inc. v. Reynolds, 834 F. Supp. 1097, 1099 (E.D. Ark. 1992); Lee v. Laitinen, 448 P.2d 154, 156 (Mont. 1968); Dowling v. Davis, 840 F. Supp. 731 (E.D. Cal. 1992); *DeGregorio*, 500 F. Supp. at 549; Clark v. Kaizer, 758 F. Supp. 572 (E.D. Cal. 1990) (dental); King v. Sullivan, 776 F. Supp. 645 (D. R.I. 1991) (general).

248. 42 U.S.C. § 1396a(a)(30)(A) (2000).

249. Omnibus Budget Reconciliation Act of 1981, *Report of the Committee on the Budget*, H.R. REP. NO. 97-158, at 312 (1981).

250. The significance of the change was obscured by the fact that in 1981 the Boren Amendment's rate setting standards had been extended to state plan provisions governing payment for inpatient hospital services. *See id.* State plan provisions regarding payments to nursing homes had been subjected to Boren in 1980, the prior year. As a result, the Secretary reviewed and approved state plan provisions governing institutional payment pursuant to a special set of rules distinct from the generally applicable plan approval process. Thus, although section 1902(a)(30)(A) was not limited by its terms to noninstitutional providers, the impact of the repeal of the reasonable charge limitation was viewed primarily in terms of its impact on payments to physicians. *Id.* at 312-13.

251. *See Arkansas Med. Soc'y*, 6 F.3d at 526.

requirement directly in the statute. The amendment expanded the existing minimum requirement that payments be consistent with efficiency, economy and quality of care to also require that payments be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population."[252] As a number of courts have held, the equal access requirement was added to section 1902(a)(30) to expand the state's minimum payment obligation and to encourage enforcement.[253]

The legislative changes, especially the adoption of section 249's reasonable cost related payment requirement and the amendment of section 1902(a)(30) marked a sea change. After years of state discretion and scandals, Congress had had enough. The statutory and regulatory amendments established definitive payment limits, denying states unlimited discretion to establish Medicaid payments methodologies.[254] The changes were designed to assure that there was a verifiable and reasonable relationship between payments to nursing homes and the objectives of the Medicaid Act before the State received federal matching funds. Thus, in one of the first actions enforcing the equal access requirement, as set forth in the regulations, HHS in an amicus brief took the position — and the court agreed — that the equal access provision and the reasonable cost related payment standard were complementary minimum requirements for Medicaid payments.[255]

3. Courts Have Enforced Section 1902(a)(30) On Behalf of Various Providers and Suppliers

The Act's guarantee of payment consistent with economy, efficiency, quality of care and equal access set forth in section 1902(a)(30) plainly can be enforced in an action brought under 42 U.S.C. § 1983. Section 1902(a)(30) has been enforced in numerous federal and state court cases.[256] Indeed, one court recently has re-

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252. 42 U.S.C. § 1396a(a)(30(A) (2000).

253. *See id. See also* Methodist Hosps., Inc. v. Family and Soc. Servs. Admin., 860 F. Supp. 1309, 1331-32 (N.D. Ind. 1994); Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen, 866 F. Supp. 1444, 1451-52 (D. Mass. 1994). *See also* H.R. REP. No. 101-247, at 389-90 (1989). The 1989 amendment was prompted by concern that Medicaid beneficiaries had inadequate access to obstetrical services. However, section 1902(a)(30)(A) — and the equal access provision — always had applied and continued to apply to all covered services. *See, e.g., Bullen*, 866 F. Supp. at 1454.

254. *See* Alabama Nursing Home Ass'n v. Harris, 617 F.2d 385, 392-93 (5th Cir. 1980).

255. *See* DeGregorio v. O'Bannon, 500 F. Supp. 541, 549 (E.D. Pa. 1980).

256. *See, e.g.*, Visiting Nurse Ass'n of North Shore, Inc. v. Bullen, 866 F. Supp. 1444, 1452 (D. Mass. 1994).

jected summarily an argument that section 1902(a)(30) was not enforceable, noting that the courts nearly unanimously hold that the provision is enforceable.[257] In fact, section 1902(a)(30) routinely is enforced not just by the courts, but by HHS' Departmental Appeals Board as well.[258]

Section 1902(a)(30) provided a basis for Medicaid reimbursement litigation for twenty years before *Wilder* was decided, *i.e.*, almost from the inception of the Medicaid Program. More recently, courts have found that section 1902(a)(30) is similar to the Boren Amendment in function and that key terms in section 1902(a)(30) and the Boren Amendment substantially overlap.[259] As a result, when the courts have applied the traditional principles discussed in *Wilder* and its progeny, it has been held that section 1902(a)(30) can be enforced through an action brought pursuant to section 1983.[260] Yet, enforceability of section 1902(a)(30) ultimately is not dependent on the viability of the *Wilder* decision. When traditional principles governing determination of the enforceability of federal statutes pursuant to section 1983 are applied to section 1902 (a)(30)(A), the section plainly qualifies for private enforcement.

For example, the courts have held that, because section 1902(a)(30) governs provider payment rates, providers plainly are among the intended beneficiaries of the provision.[261] In addition, courts have emphasized that section 1902(a)(30) is written in terms of legislative command and does not merely state a Congressional preference.[262] Specifically, section 1902(a)(30) provides that a State Plan "must" include payment methodologies and procedures that are con-

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257. *See id.*

258. *See In re* Colorado State Plan Amendment No. 88-11, Health Care Financing Administration Remand Order (ADMR June 23, 1995); *In re* Colorado Dep't of Soc. Servs., No. 90-155-1272 (DAB Aug. 19,1991).

259. *See* Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 524-25 (8th Cir. 1993); Arkansas Med. Soc'y, Inc. v. Reynolds, 816 F. Supp. 819, 822-23 (E.D. Ark 1993).

260. *See Arkansas Med. Soc'y, Inc.*, 819 F. Supp. at 1448.

261. *See* Methodist Hosps., Inc. v. Family and Soc. Servs. Admin., 860 F. Supp. 1309, 1330-32 (N.D. Ind. 1994); *Visiting Nurse Ass'n*, 866 F. Supp at 1451-52; Arkansas Med. Soc'y, 6 F.3d at 526; Illinois Hosp. Ass'n v. Edgar, 765 F. Supp. 1343, 1348-49 (N.D. Ill. 1991). *Cf.* Children's Memorial Hosp. v. Dep't of Pub. Aid, 562 F. Supp. 165, 167 n.1 (N.D. Ill. 1983) (hospital has standing to enforce section 1902(a)(30)). *But see* Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 927-29 (5th Cir. 2000) (holding that section 1902(a)(30) can be enforced by Medicaid beneficiaries, but not by providers); Pennsylvania Pharmacists Assoc. v. Houston, No. 00-1898, 2002 WL 389273 (3d Cir. Mar. 13, 2002) (reversing Rite Aid of Pennsylvania, Inc. v. Houston, 171 F.3d 842, 850 n.7 (3d Cir. 1999) and holding that beneficiaries may enforce section 1902(a)(30(A), but providers may not).

262. *See Arkansas Med. Soc'y, Inc.*, 819 F. Supp. at 821-22 (E.D. Ark. 1993).

sistent with efficiency, economy, quality of care and equal access.[263] Further, the courts have held that, although the statute reserves discretion and flexibility to the states to craft their own payment Plans, the terms of the statute are well understood and sufficiently definite for judicial enforcement.[264] Several courts have held, for example, that the Boren Amendment was more nebulous than section 1902(a)(30).[265] These courts pointed out that, unlike the Boren Amendment, section 1902(a)(30) actually provides a measuring rod that gives objective meaning to its terms,[266] and that the terms of section 1902(a)(30) are defined by other provisions of the Medicaid Act, by regulations, and by common usage.[267] Finally, the courts have held that the context and background of section 1902(a)(30) did not evidence any Congressional intent dispelling the strong presumption that the statute was enforceable.[268]

Examination of the legislative history vanquishes any doubt about the enforceability of section 1902(a)(3). In fact, the courts have held that the legislative history of section 1902(a)(30) affirmatively demonstrates that Congress intended that the provision be enforceable privately through an action brought based on section 1983.[269] Unlike the Boren Amendment, section 1902(a)(30) was modified and expanded in 1989 against a backdrop of routine and notorious provider enforcement, through section 1983, of the Medicaid Act payment provisions.[270] Thus, one court has stated:

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263. *See Arkansas Dep't of Human Servs.*, No. 90-119, (DAB Aug. 22, 1991); *Arkansas Med. Soc'y, Inc.*, 819 F. Supp. at 821-22. *See also* Minnesota Home Care Ass'n v. Gomez, 108 F.3d 917, 918 (8th Cir. 1997) ("The Medicaid Act mandates consideration of the equal access factors of efficiency, economy, quality of care and access to services in the process of setting or changing payment rates . . .").

264. *See Arkansas Med. Soc'y*, 6 F.3d at 527.

265. *See id.*

266. *See id.* at 527-28.

267. *See id.*

268. *See id.*

269. *See* Visiting Nurse Ass'n of North Shore, Inc. v. Bullen, 866 F. Supp. 1444, 1448 (D. Mass. 1994).

270. Of course, repeal of the Boren Amendment included language that stated that the committee intended that no other provision of the Medicaid Act should serve as a basis for institutional reimbursement litigation. Although such a statement of the Committee's intent might be persuasive in some other context, such commentary should be too little and too late to preclude enforcement of § 1902(a)(30). The Supreme Court repeatedly has rejected similar attempts to smuggle subsequent commentary into an existing statute. *See* Pennsylvania Med. Soc'y v. Snider, 29 F.3d 886 (3d Cir. 1994). "'[E]ven when a subsequent House Committee has commented upon an earlier statute, the interpretation carries little weight with the courts.'" *Id.* at 898-99 (citing New York City Health of Hosps. Corp. v. Perales, 954 F.2d 854, 861 (2d Cir. 1992)).

> When the Equal Access language of § 30(a) was adopted in 1989 Congress was not acting on a tabula rasa. There was a history of § 1983 enforcement of the Medicaid statute by providers and beneficiaries of which Congress was presumed to be aware. Given this tradition, congressional intent and language must be especially clear to support the conclusion that the Congress intended to treat the provisions applicable to these providers differently than it had other beneficiaries under the Act.[271]

Moreover, Congress added the equal access provision to section 1902(a)(30) precisely because the requirement, when it was embodied only in the regulation, was perceived as receiving inadequate enforcement.[272]

For many years, the Medicaid Act contained two distinct procedures governing approval of State Plan provisions: (1) a special set of rules applicable only to State Plan provisions governing payments to institutional providers; and (2) a separate set of rules governing Secretarial approval of State Plan provisions governing payments to noninstitutional providers.[273] The Boren Amendment, for example, set forth specific standards governing the amount of payment due institutional providers, supplied unique procedures governing development of such payment plans and established standards governing Secretarial review and approval of State Plan provisions regarding institutional reimbursement.[274] Section 1902(a)(30), in contrast, was viewed as the statutory standard governing Medicaid payment for outpatient services, physician services and other noninstitutional services. It is, however, clear that section 1902(a)(30) governs payment to institutional providers and that it can be enforced in an action brought by such providers. Indeed, section 1902(a)(30) establishes the general standards that govern payments for all types of covered services under the Medicaid Act.

The contention that section 1902(a)(30) is limited to noninstitutional providers is contradicted by the history of the section and by the case law interpreting section 1902(a)(30). For almost thirty years courts have characterized section 1902(a)(30) as the basic payment

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271. *Visiting Nurse Ass'n of North Shore, Inc.*, 866 F. Supp. at 1451; *see also Arkansas Med. Soc'y*, 6 F.3d at 526; *Methodist Hosps.*, 860 F. Supp. at 1331-32.

272. *See, e.g., Arkansas Med. Soc'y*, 6 F.3d at 526; H.R. REP. NO. 101-247, at 2,115-16 (1989).

273. *See Arkansas Med. Soc'y*, 6 F.3d at 522 n.2.

274. *See* 42 U.S.C. § 1396a(a)(13)(A) (1981).

standard governing all Medicaid payment for services.[275] Section 1902(a)(30) has been enforced at the behest of institutional providers[276] and recipients[277] as well as noninstitutional providers. In fact, the general provisions of HCFA's regulations governing State Plan payment provisions (*i.e.* the regulations establishing standards governing all Medicaid payments) state that the regulations are based in part on Section 1902(a)(30).

Second, section 1902(a)(30) is broadly phrased and there is no limitation to State Plan provisions that establish methods and procedures for payment of noninstitutional providers. There is no obvious basis for reading such an unexpressed legislative intent. In fact, finding an implicit Congressional intent to deny institutional providers payment rights that the statute confers upon noninstitutional providers not only does violence to the plain language of the statute, it also makes no sense. Institutional providers and their patients have no lesser need for payment methods and standards consistent with the efficiency, economy, quality of care and equal access than do noninstitutional providers and their patients. Assuring noninstitutional providers a defined level of payments creates arbitrary distinctions unrelated to the goals of the Medicaid Act, including the goals made explicit by section 1902(a)(30).[278]

Finally, after repeal of the Boren Amendment, section 1902(a)(30) provides the only explicit standards governing State Plan provisions regarding payments for Medicaid covered services. Notwithstanding the rhetorical excess of the repeal's sponsors, it would defy common sense — as well as the language of the statute — to believe that Congress intended to authorize states to spend billions of dollars in federal matching funds for hospitals and nursing home care, but did not provide any standards governing the amount of such expenditures. The statute expressly provides that in order to qualify for federal funding, a State Plan "must assure" that payments are consistent with defined goals. Further, as HHS instructed the Medicaid

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275. *See Visiting Nurse Ass'n*, 866 F. Supp. at 1454; DeGregorio v. O'Bannon, 500 F. Supp. 541, 546-47 (E.D. Pa. 1980).

276. *See* Seneca Nursing Home v. Kansas State Bd. of Soc. Welfare, 490 F.2d 1324, 1328-29 (10th Cir. 1974); Minnesota Ass'n of Health Care Facilities, Inc. v. Dep't of Pub. Welfare, 602 F.2d 150, 153-54 (8th Cir. 1979); Arkansas Med. Soc'y v. Reynolds, 834 F. Supp. 1097, 1100-01 (E.D. Ark. 1992).

277. *See* Arkansas Med. Soc'y, Inc. v. Reynolds, 819 F. Supp. 816 (E.D. Ark. 1993); Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993); *Seneca Nursing Home*, 490 F.2d at 1328-29; *Arkansas Med. Soc'y*, 834 F. Supp. at 1100-01.

278. *Cf.* Hillhaven Corp. v. Revitz, 733 F. Supp. 1224, 1225 (D. Wisc. 1984); Methodist Hosps., Inc. v. Family and Soc. Servs. Admin., 860 F. Supp. 1309, 1330-32 (N.D. Ind. 1994).

Directors, the repeal of the Boren Amendment did not relieve the states of their obligation to assure quality care as defined in the Act.[279]

The proposition that the states have unfettered discretion not only to spend billions of federal dollars but also to establish the standards governing the expenditure of federal money allegedly delegated by Congress raises Constitutional considerations.[280] Congress may delegate broad discretion to the states to design their Medicaid programs.[281] Congress should not be allowed, however, to delegate to the states unlimited authority to determine how federal money will be spent.

Courts enforcing section 1902(a)(30) almost uniformly read the statute to "establish[ ] an unambiguous statutory obligation for states participating in the Medicaid program to establish a procedurally sound rate setting methodology which considers the relevant factors of efficiency, economy, quality of care and equal access."[282] Courts generally find that section 1902(a)(30) imposes a procedural obligation on the states with respect to the manner in which the payment provisions of State Plans are developed despite the fact that the provision contains no requirement similar to the "findings" requirement imposed by the Boren Amendment.[283] The obligation to develop a payment methodology based on a procedurally sound, principled analysis is, however, consistent with section 1902(a)(30)'s command that the Plan's methods and procedures must "assure" payments consistent with efficiency, economy, quality and equal access.

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279. *See* Richardson Letter, *supra* note 182.

280. The Non-Delegation Clause of the Constitution requires that Congress not delegate its lawmaking function. U.S. CONST., art. 1, § 1; Loving v. United States, 517 U.S. 748, 758 (1996). While the Supreme Court has consistently recognized that the Congress "simply cannot do its job absent an ability to delegate power under broad general directives," it also has made clear that Congress may not, absent a demonstrable basis, delegate unfettered discretion to executive agencies. Mistretta v. United States, 488 U.S. 361, 372 (1989). Under the "intelligible principle" test, Congress must clearly delineate "the general policy, the public agency which is to apply [the general policy], and the boundaries of this delegated authority" in order to transfer constitutionally. *Id.* at 372-73. Here, one could reasonably argue that the Secretary's non-uniform and seemingly unbounded delegation of the discretion to spend billions of federal dollars as well as to establish the standards governing those expenditures fails to satisfy the "intelligible principle" test and, therefore, violates the delegation doctrine.

281. *See* Beal v. Doe, 432 U.S. 438, 443 (1977).

282. *Arkansas Med. Soc'y*, 819 F. Supp. at 821-22.

283. *See* Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1029-30 (7th. Cir. 1996); Illinois Hosp. Ass'n v. Edgar, 765 F. Supp. 1343, 1348-49 (N.D. Ill. 1991) (holding that section 1902(a)(30) complements the Boren Amendment).

In *Arkansas Medical Society*, for example, the court held that the payment provisions of the State Medicaid Plan had to be justified by data and analysis prior to implementation. The court said:

> The state must consider, on the basis of some reasonably principled analysis, the substantive requirements of 42 U.S.C. § 1396a(a)(30)(A) in setting its payment rates. The state's payment rates are not proper if the methods and procedures it utilizes in formulating its rates, rather than being bona fide and objective, are merely an exercise to make the best case to support the state's rates, and the state considers only factors favorable to its position while failing to consider the relevant factors.[284]

The Ninth Circuit recently has come to a similar conclusion.[285] In *Orthopaedic Hospital v. Belshe* the Court of Appeals held that, in setting Medicaid payment rates, the "[state] must rely on responsible cost studies, its own or others," that provide reliable data as a basis for its rate setting.[286] Similarly, in *Visiting Nurse Association v. Bullen*,[287] the court held:

> The issue is not whether the rate set by the defendants will in fact have a particular result, failure of equal access, forcing these providers out of the market place with replacements. Rather the issue is whether the rates set by the defendants conform to particular criteria — whether they took the equal access issue and other statutory standards in consideration.[288]

HHS has taken a similar position. In *In re Colorado State Plan Amendment No. 88-11*, the Departmental Appeals Board upheld the Secretary's refusal to approve a plan amendment.[289] The Board, applying section 1902(a)(30), held that the state's payment methods and standards had to be justified by data demonstrating linkage to the

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284. *Arkansas Med. Soc'y*, 819 F. Supp. at 823 (citations omitted).

285. *See* Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997).

286. *See id.* The Ninth Circuit ruling is consistent with HCFA's position that the regulations contemplate that payment provisions adopted pursuant to § 1902(a)(30) will be predicated on objective contemporaneous data. *See also Illinois Hosp. Ass'n*, 765 F. Supp. at 1349 (hospitals have section 1983 cause of action to challenge, under 42 U.S.C. § 1396a(a)(30)(A), state's failure to develop payment methods and procedures for outpatient procedures based on empirical studies).

287. 866 F. Supp. 1444 (D. Mass. 1994), *rev'd on other grounds*, 93 F.3d 997 (1st Cir. 1996).

288. *Id.*

289. *See In re* Colorado State Plan Amendment No. 88-11, Health Care Financing Administration Remand Order (ADMR June 23, 1995).

statutory criteria.[290] Moreover, the Board held that the regulations implementing section 1902(a)(30) contemplated that the state would determine proper payment rates in a reasonable manner and that its determination would be documented contemporaneously, not years later.[291]

Whatever means are used to develop the data, at a bare minimum, section 1902(a)(30) commands that the state consider efficiency, economy, quality of care and equality of access.[292] Recently, for example, one court held that the obligation imposed by section 1902(a)(30) could not be satisfied unless the state first determined what it costs an efficient [provider] economically to provide quality care.[293] In *Orthopaedic Hospital v. Belshe*, the Ninth Circuit also held that the State Plan violated section 1902(a)(30) and ordered that:

> Upon remand the department should undertake responsible cost studies that will provide reliable data as to the hospitals' costs in providing outpatient services to the end that it determines the cost to an efficient hospital economically providing quality care. The state must then set rates that have some reasonable relations to such costs . . . .[294]

According to the court, unless such an analysis is done and a baseline is established, neither the state nor the Secretary would have a basis to know whether the methods and standards assured payment consistent with efficiency, economy, quality or equality of access.[295] The Ninth Circuit specifically noted that while payments must bear some "reasonable relationship" to costs, payment of less than reasonable costs might be permissible in some circumstances.[296] However, the state had the burden of justifying a "rate that substantially deviates from such determined cost."[297]

In developing payment provisions under section 1902(a)(30) for State Medicaid Plans and considering economy, efficiency, quality of care and equal access, as mandated by the statute, the states are not bound to utilize a specific or rigid formula.[298] To the contrary, the courts emphasize that section 1902(a)(30) confers considerable dis-

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290. *See id.*
291. *See id.*
292. *See* Arkansas Med. Soc'y, Inc. v. Reynolds, 819 F. Supp. 816, 816 (E.D. Ark. 1993); Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 519 (8th Cir. 1993).
293. *See* Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1498-99 (9th Cir. 1997).
294. *Id.* at 1500.
295. *See id.*
296. *See id.* at 1498-99.
297. *Id.* at 1500.
298. *See id.* at 1498-99.

cretion and flexibility on the states to design payment systems using procedures that suit their own circumstances.[299] In fact, courts have even held that section 1902(a)(30) leaves the states free to consider factors in addition to those enumerated in the statute. For example, courts have held that states are free to consider health planning goals. Thus, courts have stated that states are free to build incentives into their State Plans to encourage or discourage certain types of behavior or provider operations.[300]

On the other hand, rate setting solely based on budgetary considerations violates section 1902(a)(30).[301] As one court held, "[b]y tying payment rates solely to state budgetary needs, [the state] has totally ignored the federal mandate that rates must be adequate to assure Medicaid beneficiaries reasonable access to hospital services of adequate quality."[302] Similarly, rates may not be set based solely on comparison of rates paid by other states.[303] Moreover, as was the case under the Boren Amendment, "in reviewing the state's Medicaid plan, if a court concludes that the state has failed in its obligation to consider the requirements of the Medicaid Act, the court may invalidate the state action without reviewing substantive compliance."[304]

Other courts have disagreed, holding that section 1902(a)(30) does not require that State Plan provisions be justified theoretically in advance of implementation. The Seventh Circuit, for example, has distinguished section 1902(a)(30) from the Boren Amendment. According to the Court, unlike the Boren Amendment, section 1902(a)(30) requires a state "to produce a result, not to employ any

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299. *See* Elizabeth Blackwell Health Ctr. for Women v. Knoll, 61 F.3d 170, 178 (3d Cir. 1995). Some courts have stated that § 1902(a)(30) confers even more discretion and flexibility than the Boren Amendment. *Belshe*, 103 F.3d at 1498-99; Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 527-28 (8th Cir. 1993). Thus, although most courts appear to contemplate that states will develop rate setting systems based upon an investigation and study of pertinent data, one court has held that information about the statutorily mandated factors can be obtained informally. Minnesota Homecare Ass'n, Inc. v. Gomez, 108 F.3d 917, 918 (8th Cir. 1997).

300. *See Belshe*, 103 F.3d at 1498-99; Rite Aid of Pennsylvania, Inc. v. O'Houstoun, 1999 WL 164349 at *8 (3d Cir. 1999).

301. *See Arkansas Med. Soc'y*, 6 F.3d at 530-31; Kansas Hosp. Ass'n v. Whiteman, 835 F. Supp. 1556, 1571 (D. Kan. 1993); Arkansas Med. Soc'y, Inc. v. Reynolds, 816 F. Supp. 819, 823 (E.D. Ark 1993); Illinois Hosp. Ass'n v. Dep't of Pub. Aid, 576 F. Supp. 360, 371-72 (N.D. Ill. 1983). *But see* Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 922-23 (5th Cir. 2000).

302. Illinois Hosp. Ass'n v. Dep't of Public Aid, 576 F. Supp. 360, 368 n.9 (N.D. Ill. 1983).

303. *See Arkansas Med. Soc'y*, 6 F.3d at 530-31.

304. *Arkansas Med. Soc'y*, 819 F. Supp. at 824-25. *See also Belshe*, 103 F.3d 1491 (9th Cir. 1997).

particular methodology for getting there."[305] Although this position has been rejected implicitly by the Eighth Circuit[306] and the Ninth Circuit[307] and by other courts, a number of early decisions interpreting section 1902(a)(30) rest on similar reasoning.

The position of the Seventh Circuit and the earlier decisions contravene the intent of the Medicaid Act. In essence, the Seventh Circuit ruling permits a state to utilize a "hit or miss" approach in which a substantive result that is contrary to the statute is permissible so long as the state reacts and modifies the Plan. As a general proposition, it is inconceivable that Congress intended to permit the states to wager the health, safety and welfare of Medicaid beneficiaries on a game of chance.

Indeed, section 1902(a)(30)(A) expressly precludes "hit or miss" rate setting.[308] The statute, like the Boren Amendment, requires that the State Plans' methods and standards "assure" payments consistent with the Act's goals of efficiency, economy, quality of care and equal access to quality care.[309] Unlike Boren, the Secretary, not the state, must verify the assurance *prior* to approving a State Plan for federal funding.[310] It would make little sense to cast the requirements for State Plan approval in terms of a guarantee and then permit the state to relegate achievement of the Act's goals to chance.[311]

The only way the State can assure that the Plan complies with section 1902(a)(30) is to develop the Plan based on objective data and analysis. Without such data and analysis, the Secretary has no basis to determine whether the Plan assures compliance with the statute and,

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305. *Methodist Hosp.*, 91 F.3d at 1029-30. *See also Evergreen Presbyterian Ministries, Inc.*, 235 F.3d at 933 n.33 (5th Cir. 2000) (state failed to conduct any studies of the impact of the rate reduction on providers; court does not decide necessity of studies but notes "that studies while helpful, are not required by the language of section 1902(a)(30)(A)."); Rite Aid of Pennsylvania, Inc. v. O'Houstoun, 1999 WL 164349 at *6-7 (3d Cir. 1999) (arguing that section 1902(a)(30) requires a result not a process; but also holding that state cannot act arbitrarily and upholding payment methodology based on eleven month investigation). *Cf.* New Jersey Hosp. Ass'n v. Waldman, 1995 U.S. App. LEXIS 37153 at *5 (3d Cir. 1995) (section 1902(a)(30) is substantive requirement; court reviews procedure and impact of rate change jointly).

306. *See* Minnesota Homecare Ass'n, Inc. v. Gomez, 108 F.3d 917, 918 (8th Cir. 1997).

307. *See Belshe*, 103 F.3d 1491 (9th Cir. 1997).

308. *See* 42 U.S.C. § 1396a(a)(30)(A) (1994).

309. *See id.*

310. *See id.*

311. *See* Lapeer County Med. Care Facility, No. 1:91-CV-333, 1992 WL 220917, at *9 (objective findings necessary to support state's assurance of compliance with Medicaid Act must be completed prior to implementation to assure that achievement of Act's goals is not impeded).

therefore, no basis to approve the Plan.[312] Further, the majority of courts — and HHS — reject the Seventh Circuit's position. The prevailing rule is that the data and analysis required to justify payment methods and standards under section 1902(a)(30) must be developed contemporaneously with the adoption of the payment provisions.[313]

For example, HHS' Departmental Appeals Board, in an action to enforce section 1902(a)(30), held that the state was required to have contemporaneous documentation to support the State Plan payment provisions.[314] The Board held, "[the documentation to be provided to HCFA upon request is supposed to be documentation about data, calculations, and computations used in making a state's findings."[315] Similarly, in *Arkansas Medical Society* the Eighth Circuit held that "in determining whether DHS has complied with the equal access provision, the court considers DHS's actions prior to the rate reductions."[316] In other instances, courts likewise have held that the burden is on the state to develop and maintain contemporaneous documentation demonstrating that it developed its rate setting methodology based upon the statutorily mandated factors.[317]

As was the case with the Boren Amendment, section 1902(a)(30) claims appear, for the most part, to be resolved based upon whether the state developed the payment Plan properly. However, even if a Plan is developed in a procedurally proper manner, the payment provisions still must actually achieve the substantive statutory goals of assuring consistency with efficiency, economy, quality of care and equality of access.[318] In *Visiting Nurse Association v. Bullen*, for example, the First Circuit held that even though a Plan had been properly

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312. *Cf.* Erie County Geriatric Ctr. v. Sullivan, 952 F.2d 71 (3d Cir. 1991); *Belshe*, 103 F.3d 1491 (9th Cir. 1997).

313. *See* Pennsylvania Dep't of Pub. Welfare, DAB No. 1557 (1996).

314. *See id.*

315. *Id. See also* North Carolina Dep't of Human Resources, DAB No. 1025 (1989) ("After-the-fact assumptions, based on a study which came about only after the federal agency has discerned a problem, are wholly inadequate."); *and* Arkansas Dep't of Human Resources, DAB No. 1273 (1991) (stating HCFA's position that regulations contemplated an effort by the state to determine this amount in some reasonable manner which could be documented).

316. Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 527-28 (8th Cir. 1993).

317. *See* Pennsylvania Dep't of Pub. Welfare, DAB No. 1557 (1996).

318. *See* Minnesota Homecare Ass'n, Inc. v. Gomez, 108 F.3d 917, 918 (8th Cir. 1997); Arkansas Med. Soc'y v. Reynolds, 819 F. Supp. 816, 822-23 (E.D. Ark. 1993); Elizabeth Blackwell Health Ctr. for Women v. Knoll, 61 F.3d 170 (3d Cir. 1995); Kansas Hosp. Ass'n v. Whiteman, 835 F. Supp. 1556, 1571 (D. Kan. 1993); *Arkansas Med. Soc'y*, 6 F.3d at 530-31.

developed, the District Court had wrongly refused to consider the substantive validity of the Plan.[319] The court stated:

> Since we have concluded that the state was in full procedural compliance, plaintiffs must now adduce evidence that (1) the methods and procedures adopted by the state were inadequate to insure "equal access" or (2) the bottom-line reimbursement figures derived under that methodology were too low to retain health care providers in the Massachusetts Medicaid Program.[320]

The court went on to hold that HCFA's approval of a Plan provision was not dispositive.[321] Instead, according to the court, HCFA's approval was entitled to some deference, but was not "automatically conclusive at the summary judgement stage."[322]

Because there are a limited number of decisions addressing substantive compliance under section 1902(a)(30), there are few guideposts regarding the evidence or standards that apply when a plaintiff seeks to demonstrate a substantive violation. It appears, however, that, as was the case under the Boren Amendment, a court will analyze a state's compliance by examining aggregate data and not based upon analysis of the Plan's impact on individual providers.[323] One court, for example, has held that determination of compliance with section 1902(a)(30) is based upon statewide statistics regarding average reimbursement rates and provider participation.[324] Yet another court has held that proof of a substantive (or procedural) violation of section 1902(a)(30) is available from a wide variety of sources including the state, from public hearings, from proposed Plan changes and from published state regulations.[325]

Significantly, however, some courts have held that a State Plan's methods and standards must assure payments that are consistent with economy, efficiency, quality of care and equal access without regard to whether other regulations also obligate a provider to deliver care con-

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319. *See* Visiting Nurse Ass'n of North Shore, Inc. v. Bullen, 93 F.3d 997, 1011 (1st Cir. 1996).

320. *Id.*

321. *See id.*

322. *Id.*

323. *See* Visiting Nurse Ass'n v. Bullen, 866 F. Supp. 1444, 1452-53 (D. Mass. 1994), *rev'd on other grounds*, 93 F.3d 997.

324. *See* Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 527-28 (8th Cir. 1993).

325. *See* Visiting Nurse Ass'n of North Shore, Inc. v. Bullen, 93 F.3d 997, 1005 (1st Cir. 1996).

sistent with such standards.[326] For example, in *Orthopaedic Hospital v. Belshe*, the state attempted to defend its State Plan by arguing that a direct link between the payment provisions and quality of care was unnecessary because quality was assured by other regulations, including the Medicare certification regulations.[327] The Ninth Circuit however rejected the argument:

> The Department argues that the payments do not independently have to support quality care because quality care is assured by other regulations. Essentially, the Department's position is that it doesn't have to pay the costs of quality care because hospitals are contractually obligated to provide quality care once they agree to take Medicaid patients, and because hospitals' licensing requirements require them to provide quality care. We disagree. The Department, itself, must satisfy the requirement that the payment themselves be consistent with quality care.[328]

Similarly, other courts have held that a failure to relate payments to even one of the factors mandated by section 1902(a)(30) violates the statute.[329] The state has an obligation to set payments consistent with quality care that is independent of the hospital's obligation to comply with licensure and certification standards. Although the meaning of equal access and quality care may be defined by reference to other statutes and regulations, such statutes and regulations do not supplant the obligation to pay for care at the level mandated by the statute.

The Boren Amendment conferred authority on the states to define key statutory terms governing compliance with federal law and to determine whether their State Plans complied with those standards. If the state provided a facially valid assurance to the Secretary that it had complied with federal law the Secretary essentially was bound to approve the payment provisions of the State Plan and to provide matching federal funds. As a result, challenges to Medicaid payment plans based on the Boren Amendment almost always were brought primarily or exclusively against the state. The appropriateness of the Secretary's decision approving the State Plans' payment provisions played little, if any, role in the court's determination of the validity of the

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326. See Orthopaedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997). *But see* DeGregorio v. O'Bannon, 500 F. Supp. 541, 541 (E.D. Pa. 1980).

327. *See Belshe*, 103 F.3d at 1496-98.

328. *Belshe*, 103 F.3d at 1497.

329. *See* Ohio Hosp. Ass'n v. Ohio Dep't of Human Servs., 579 N.E.2d 695, 699 (Ohio 1991).

State Plan.[330] There is only one reported case in which the Secretary's approval of a State Medicaid Plan's payment provisions was a principal focus of the plaintiff's challenge.[331] In that case, the court held that the Secretary's decision to approve the State Plan was invalid because the state's assurance that it had made a finding of compliance with federal law obviously was facially invalid.[332]

Repeal of the Boren Amendment eliminated the special substantive and procedural plan approval rules applicable to State Plan provisions governing institutional reimbursement. The Act now subjects State Plan provisions regarding institutional payment to the same process applicable to all other State Plan provisions. The obligations imposed by the Act with regard to State Plan approval currently fall at least as heavily upon the Secretary as upon the states.

Although enforcement of section 1902(a)(30) to date has focused, as it did under the Boren Amendment, on state compliance with the Act, it seems likely that the validity of the Secretary's approval of State Plan payment provisions also will become a focus of judicial inquiry. Section 1902(a)(30) reallocates between the Secretary and the states the obligations imposed by the Act with respect to the development and approval of State Medicaid Plan payment methodologies. The Act imposes on the states the obligations to adopt a State Plan that satisfies the standards set forth in section 1902(a)(30), in the first instance, if the state wishes to obtain federal matching funds. In addition, however, the Act, in section 1902(a)(30) also specifically requires the Secretary to determine that the State Plan satisfies the statutory standards in order for the state to obtain federal matching funds. In contrast to the limited role assigned to the Secretary by the Boren Amendment, the Act now places the obligation to determine whether the Plan complies with federal law exclusively and squarely on the Secretary.

Because the Secretary now has the obligation under the Act, entirely independent of the state, to approve only State Plan provisions that satisfy the requirements of section 1902(a)(30), the appropriateness of the Secretary's decision to approve a State Plan is likely to be challenged by providers and scrutinized by the courts. Undoubtedly,

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330. In fact, noting that the Secretary's review and approval was largely perfunctory courts often invalidated state payment plans even though the Secretary had approved the plan. Indeed, the general rule was that the Secretary's approval of a state Medicaid payment plan was not even entitled to judicial deference.

331. *See* Erie County Geriatric Ctr. v. Sullivan, 952 F.2d 71, 71 (3d Cir. 1991)

332. *See id.*

the Secretary will argue that the decision to approve a State Plan is entitled to deference.[333]

Whether deference is accorded to the Secretary's decision or not, the reality is that the Secretary's decision to approve a State Plan is now, in contrast to the situations under the Boren Amendment, a critical decision in the process of implementing institutional payment methodologies. Consequently, the Secretary's decision undoubtedly will be subject to more frequent challenges by providers and to more searching judicial scrutiny.

Further, the Secretary will no longer be able to defend the decision to approve a State Plan's payment provisions based upon the assertion that HHS lacks authority to examine the state's rate setting decisions or the validity of the assumptions underlying the Plans payment methodology. Instead, the Secretary will be required at a minimum to demonstrate that the State Plan approval rested on evidence that provided a reasonable basis to believe that a Plan's methods and procedures assured payments consistent with efficiency, economy, quality of care and equality of access. In the past, the courts have regularly rejected the attempts to justify State Plan payment methodologies based upon unsupported institutional assumptions, inadequate or unprincipled analysis and inadequate data. Indeed, because state Medicaid programs likely will be unable or unwilling to rescind new benefit programs introduced in the 1990's or to toughen eligibility, it is reasonable to anticipate that state Medicaid programs will attempt large cuts in provider reimbursement. Moreover, HHS, itself, through the Departmental Appeals Board, has interpreted section 1902(a)(3)(A) objective studies and data assembled at the time the Plan was proposed. In sum, because of the Secretary's independent authority and the critical role that the Secretary's approval decision now plays, it is reasonable to anticipate that courts, at a minimum, will require the Secretary to independently justify approval of the State Plan's payment provisions with substantial evidence on the record as a whole demonstrating that the methods and standards assure payment consistent with each of the factors set forth in section 1902(a)(30).

V. CONCLUSION

Over the thirty-five years since the adoption of the Medicaid Act Congress repeatedly has increased the authority of the states to determine the basis on which institutional providers will be reimbursed for care and services rendered to program beneficiaries. The autonomy

333. *See* Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984).

granted the states has come at a price, however. Specifically, states historically have reacted to budgetary pressures and shortfalls by reducing Medicaid funding, one of the largest, if not the largest, line items in the states' budgets. There is, however, no free lunch and institutional providers have been forced to make care choices based on the shortfall in necessary or anticipated Medicaid payments. Both the quantity and the quality of care may be impacted and, ultimately, the states' citizenry pay the price in the form of reduced services or treatment. Indeed, the history of the Medicaid Act is characterized by cycles in which state control over institutional payment rates is increased followed shortly by increasing allegations that care, especially nursing home care, is inadequate.

There is no indication that this historic tendency has abated since the repeal of the Boren Amendment. Instead, the real impact of the repeal of the Boren Amendment was obscured and deferred by the years of economic expansion and budget surpluses that followed the repeal. The states had no incentive to reduce Medicaid eligibility, benefits or payments in such times. Not only were many state budgets blessed with significant surpluses, the low unemployment rate meant that the number of persons qualifying for Medicaid coverage was reduced. In such circumstances, rather than contracting their Medicaid programs, many states began to expand their programs, loosening eligibility requirements, expanding available benefits and increasing provider payments.

As the economy slowed, however, states once again began to consider slashing Medicaid spending and payments for institutional care, however, especially long term care, which was an obvious target because it comprised such a large percentage of the Medicaid budget. Indeed, because state Medicaid programs likely will be unable or unwilling to rescind new benefit programs introduced in the 1990s or to toughen eligibility, it is reasonable to anticipate that state Medicaid programs will attempt large cuts in provider reimbursement.[334]

The repeal of the Boren Amendment has encouraged Medicaid officials — albeit incorrectly — to believe that federal law places no fetters on their discretion. Yet, the obvious consequence of reducing

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334. *See generally* Medicaid Budgets, *supra* note 1; Robert Pear, *States Face Hard Choices on Medicaid Cuts*, N. Y. TIMES, Jan. 14, 2002, at 1. *See also* Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 921 (5th Cir. 2000) (rate change justified by state's need to address budget deficit); Tallahassee Memorial Reg'l Med. Ctr. v. Cook, 109 F.3d 693, 704 (11th Cir. 1997) (state Medicaid agency's rate cuts shift burden of program's shortfall to providers); Florida Ass'n of Rehabilitation Facilities, Inc. v. Florida, 1999 WL 304638 at *5 (S.D. Fla. 1999).

funding in this fashion is to invite litigation. When institutional providers are no longer able to comply with minimum standards and lack any other realistic options, it is reasonable to expect that they will bring lawsuits, as they have in the past, seeking to compel principled rate setting and to obtain rates sufficient to provide quality care.

Despite the repeal of the Boren Amendment, the Medicaid Act continues to contain payment criteria that institutional care providers can enforce. The repeal of the Boren Amendment eliminated special payment criteria and State Plan approval procedures favorable to states and applicable only to payments to institutional providers. As a result, states no longer have the benefit of Boren's limitations and providers may enforce the Act's basic payment requirements.

Section 1902(a)(30) contains enforceable payment standards that predate even Boren. Under that section, the Secretary is required to provide federal funding only for State Plans that include payment methodologies and procedures that assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that Medicaid beneficiaries have the same access to services as the general population. Unlike the situation under Boren, compliance with section 1902 should depend at least as much on the substantive impact of the state's Medicaid payments as on the procedures used to develop the payment standards.