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Judicial Review of Medicaid Hospital and Nursing Home Reimbursement Methodologies Under the Boren Amendment

John M. Burman*

INTRODUCTION

Medicaid is the largest third-party payer of nursing home care in the United States, and one of the largest payers of inpatient hospital services. Medicaid expenditures for nursing home and hospital services are stampeding out of control, spurred on by a decade of increasing federal mandates and decreasing federal financial support. States' attempts to rein in Medicaid expenditures are regularly thwarted by court decisions that find states in violation of the Boren Amendment. The Boren Amendment is an obscure and virtually indecipherable piece of legislation, which was intended to give states the discretion to develop novel and creative methods of reimbursing providers of nursing home and inpatient hospital services, thereby promoting efficiency and cost-containment. Instead, the Boren Amendment has turned into a litigation nightmare, with courts often taking an aggressive role in evaluating the merits of Medicaid reimbursement methodologies.

This article offers an overview of the Medicaid program, in general, and Medicaid reimbursement of nursing home and inpatient hospital services, in particular. It surveys the carnage of a decade of Boren Amendment litigation and analyzes the appropriateness of judicial review of Medicaid reimbursement methodologies. It concludes by proposing standards for review-

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ing courts to follow when called upon to evaluate Boren Amendment challenges.

I. STATUTORY BACKGROUND

Medicaid is a joint federal-state program intended to pay the cost of necessary medical services provided to certain persons who are unable to pay for such services. It was originally enacted as Title XIX of the Social Security Act. While simple in concept, Medicaid has been accurately described as "a morass of bureaucratic complexity." States need not participate in Medicaid. However, those that choose to participate must administer the program in conformance with the Social Security Act and applicable federal regulations. In return, the state is eligible to receive federal funds to pay part of the cost of providing covered services.

Congress has delegated the responsibility for administering Medicaid to the United States Department of Health and Human Services (HHS). Within HHS, the administration of Medicaid is the responsibility of the Health Care Financing Administration (HCFA).

A state that participates in Medicaid must appoint a "single state agency" to administer the state's Medicaid program. That agency must administer the state's program according to a "state plan" submitted to and approved by HCFA. The state plan, which is a "comprehensive statement" of the state's program, must include "assurances that it will be administered in conformance with the specific requirements" of the Social Security Act and HHS regulations.

The Social Security Act and HHS regulations require participating states to provide certain health care services to certain

5. The federal contribution, known as the federal medical assistance percentage, varies from fifty percent to eighty percent of the states' Medicaid expenditures, depending on a particular state's average per capita income. 42 U.S.C. §§ 1396b(a)(1), 1396d(b) (1988 & Supp. III 1991).
6. See 42 U.S.C § 1396 (authorizing the state to receive funds only after a plan has been submitted to, and approved by, the Secretary of HHS).
7. 3 Medicare & Medicaid Guide (CCH) ¶ 13,170 (Nov. 12, 1992).
groups of individuals, and to pay for those services according to certain general standards. Within this federal statutory and regulatory framework, states have considerable discretion in administering their Medicaid programs. States may choose to provide additional services or cover additional individuals. They may also select the methods and standards for reimbursing providers of health care services. Each state and territory that participates in Medicaid has chosen to structure its program differently. Accordingly, there are fifty-four distinct Medicaid programs. 11

Unlike Medicare, with which it is often confused, Medicaid is a welfare program. 12 Eligibility is restricted to persons who meet stringent income and asset limitations and who possess certain characteristics. Medicaid is potentially available to two groups: the "categorically needy" and the "medically needy." Coverage of the former group is mandatory. 13 Coverage of the latter group is within the state's discretion. 14

Categorically needy persons are those who fall within a defined category and meet certain income and asset guidelines. There are two such categories: 1) minor children of single parents, and the parent with whom they reside, and pregnant women; and 2) persons who are over age sixty-five, blind, or disabled. Persons in the first category must also meet the eligibility guidelines for Aid to Families with Dependent Children (AFDC) 15 or be able to meet them when their children are born.

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Persons in the second category must meet the eligibility guidelines for Supplemental Security Income (SSI).\textsuperscript{16} AFDC and SSI are “income maintenance” programs that provide cash subsidies for living expenses. Medicaid coverage for AFDC and SSI recipients is automatic.\textsuperscript{17}

The medically needy are those persons who fall within the categorical requirements for AFDC or SSI, but are ineligible for cash assistance because their assets or income exceed the eligibility limits.\textsuperscript{18} They are eligible for Medicaid to cover their medical expenses if two requirements are met: 1) the state in which they reside has elected to cover the medically needy, and 2) their income and assets are insufficient to pay for necessary medical care.\textsuperscript{19} A state that elects to cover the medically needy must establish reasonable income and resource limitations to determine eligibility for participation in the program.\textsuperscript{20}

II. Hospital Services

Inpatient\textsuperscript{21} and outpatient\textsuperscript{22} hospital services are mandatory Medicaid services.\textsuperscript{23} Participating states must reimburse hospitals that provide such services to Medicaid recipients. A hospital that wishes to receive Medicaid funds for providing such services must meet certain criteria, such as state licensure and certification, and must enroll with the single state agency as a provider.

States have substantial discretion in determining the methods and standards for reimbursing hospitals that provide care to Medicaid recipients. The primary restriction is the Boren Amendment, which applies to reimbursement for inpatient hos.


\textsuperscript{20} 42 C.F.R. §§ 435.812(a), 435.841(a) (1992).

\textsuperscript{21} “Inpatient hospital services” are those services “ordinarily furnished in a hospital for the care and treatment of inpatients.” 42 C.F.R. § 440.10(a)(1) (1992).

\textsuperscript{22} “Outpatient hospital services” are “preventive, diagnostic, therapeutic, rehabilitative, or palliative services . . . that are furnished to outpatients.” 42 C.F.R. § 440.20(a)(1) (1992).

pital services only. 24 States must determine their rates in accordance with certain methods and standards they develop. These rates must be

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 and to assure that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate quality. 25

The states must assure the Secretary of HHS that their rates comply with this requirement. In addition, the rates must "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." 26

III. NURSING FACILITY SERVICES

Nursing home care is also a mandatory Medicaid service. 27 Participating states must reimburse nursing facilities that provide services to Medicaid recipients. A nursing facility that wishes to receive Medicaid funds for providing such services must meet certain criteria, such as state licensure and certification. They must also enroll with the state's Medicaid agency as a provider. 28

States have substantial discretion in determining the methods and standards for reimbursing nursing facilities that provide care to Medicaid recipients, the primary restriction being the Boren Amendment. Just as with hospital services, states must use rates determined according to certain methods and standards they develop. These methods and standards must "take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each [recipient]) of complying with


26. Id. The so-called "disproportionate share" provision was enacted to provide additional Medicaid funds to large, urban hospitals, which provide large amounts of care to Medicaid recipients.


These rates are subject to the same "reasonable and adequate" standard described for hospital services above.30

IV. THE BOREN AMENDMENT

The "reasonable and adequate" standard31 for reimbursing hospitals and nursing facilities32 is often referred to as the "Boren Amendment" standard. The Boren Amendment was enacted as part of the Omnibus Budget Reconciliation Act of 1980.33 Congress passed the amendment to provide the states with more freedom in developing and implementing reimbursement methodologies that would promote an efficient and economical delivery of hospital and nursing facility services.34

The Boren Amendment's "reasonable and adequate" standard is an aggregate one. That is, the state's total Medicaid reimbursement for nursing home and/or hospital reimbursement must be reasonable and adequate to meet the costs that would be incurred if all the facilities in the state operated economically and efficiently.35 It does not create a right for an individual facility to receive a specific rate. Accordingly, the state is not required to reimburse a facility for the costs it actually incurs, or even the costs it reasonably incurs.36 Therefore, a state does not violate the Boren Amendment if its methodology does not re-

30. Id.
31. The requirement that states make assurances to HHS is the procedural component of the standard, while the substantive component defines those costs that must be met.
33. Originally, the Boren Amendment applied only to reimbursement of nursing facilities. Pub. L. No. 96-499, § 962(a), 94 Stat. 2650. It was amended to apply to hospitals and to require that state reimbursement methodologies take into consideration hospitals that provide services to a disproportionate number of low income patients. Pub. L. No. 97-35, § 2173, 95 Stat. 357,808 (codified as amended at 42 U.S.C. § 1396a(a)(13)(A) (1988)). As amended, the Boren Amendment is an astonishingly bad piece of legislative drafting; it consists of 1 sentence, with over 340 words, 21 commas, 9 parentheticals, 1 semicolon, and references to 5 other statutory provisions.
result in reimbursement to an efficiently and economically operated facility for its actual costs, as long as the methodology passes the aggregate test. 37

Congress enacted the amendment to enable states to move away from "the inflationary nature of . . . cost reimbursement." 38 To facilitate innovation and flexibility, Congress eliminated stifling and expensive federal oversight by transferring primary responsibility for developing hospital and nursing home rates from HCFA to the states. 40 Boren limits HCFA's role to reviewing the reasonableness of the state's assurances that its methodology meets the reasonable and adequate standard, rather than reviewing the state's finding that the methodologies meet the standard. 41 Unfortunately, some courts are reinstating HCFA's oversight role by holding that HCFA must look behind the state assurances to the findings themselves. 42 HCFA's "stifling and expensive federal oversight" has been replaced by stifling and expensive Boren litigation.

Under Boren, there is, at least theoretically, a range of "reasonable" methods and standards, giving states "substantial discretion" in choosing a methodology for reimbursing hospitals or nursing facilities, subject to HCFA approval. 44 Unfortunately, HCFA has failed to promulgate regulations defining any of the significant terms contained in the Boren Amendment, leaving a "definitional abyss, [which] has spawned considerable litigation." 45 The states have been left to divine what "standards and methods" will result in rates that are "reasonable and adequate" to meet the costs that "must be incurred" by an "efficiently and economically operated" hospital or nursing facility.

State Medicaid reimbursement methodologies must also include a rate appeals mechanism. 46 The appeals process must allow providers to "submit additional evidence and receive prompt administrative review . . . [of] such issues as the agency

37. Lett, 965 F.2d at 256.
40. See id. at 516.
41. See id. at 507.
42. See, e.g., Erie County Geriatric Ctr. v. Sullivan, 952 F.2d 71, 81-82 (3d Cir. 1991).
43. See Wilder, 496 U.S. at 519.
44. Id.
45. Lett, 965 F.2d at 253.
determines appropriate . . . . "47 Most states limit the issues on
review by precluding a challenge to the reimbursement method-
ology itself.48 Accordingly, the administrative appeals mecha-
nism allows a facility to request a change in its rate(s) because
the state agency incorrectly computed the facility’s rate(s). It is
a challenge to the application of the reimbursement methodol-
ogy to the particular facility, not a challenge to the reimburse-
ment methodology itself. By contrast, a Boren Amendment
challenge attacks the reimbursement methodology as resulting
in rates that are not adequate to meet the costs that must be
incurred by efficiently and economically operated facilities.

Despite the discretion vested in the states by the Boren
Amendment, providers have been very successful in challenging
state reimbursement methodologies on the grounds that they vi-
olate the Boren Amendment. Individual providers, groups of
providers, and provider associations have all sued states under
Boren.49 HCFA’s previous stifling oversight has been replaced
by expensive and erratic judicial review.

V. SCOPE OF BOREN AMENDMENT LITIGATION

A. Provider Remedies Under Boren

An early issue in Boren Amendment litigation was what rem-
edy or remedies were available to providers that wished to chal-
lenge state Medicaid reimbursement methodologies. The
preferred method of seeking redress has been a § 198350 action,
for which federal courts have jurisdiction. After nearly a decade
of litigation, the issue was finally resolved in Wilder v. Virginia
Hospital Ass’n.51 Writing for the majority in a five-to-four deci-
sion, Justice Brennan found that the Boren Amendment created
a substantive federal right enforceable by health care providers

47. Id.
49. Recipients are also becoming involved in Boren challenges. See, e.g., Bon-
nyman, Deciding Who Swims with the Sharks: Boren Amendment Litigation,

51. 496 U.S. 498 (1990). The Supreme Court recently declined an invitation to
reconsider its decision in Wilder. Abbeville General Hosp. v. Ramsey, 3 F.3d 797 (5th
Cir. 1993), cert. den., 114 S. Ct. 1542 (1994). The Court also denied certiorari in an-
other Boren Amendment case that raised issues of state courts’ deference to federal
courts. Indiana State Board of Public Welfare v. Tioga Pines Living Ctr., Inc., 622
through a § 1983 action. Providers have a right to "reasonable and adequate rates," not simply a right to findings and assurances by a state that its methodology will result in such rates. Defining and measuring the extent of that right is a critical issue in Boren litigation.

Although § 1983 provides a remedy against states, it does not provide a remedy against HCFA. The Social Security Act does not create a private right of action against HCFA. However, providers seeking review of the Secretary's approval of a state reimbursement plan have successfully sought judicial review under the federal Administrative Procedures Act.

B. The Pervasiveness of Boren Litigation

Every state government lives under the cloud of Boren Amendment litigation, even if it has never been a defendant in a lawsuit. Reported cases reveal provider challenges in at least thirty states of state methodologies for reimbursing nursing facilities and hospitals. In those states where providers have not filed lawsuits, it is safe to assume that providers and provider organizations have used and will continue to use the threat of Boren Amendment challenges to negotiate more favorable reimbursement methodologies. Such litigation is enormously costly, and with the outcome often difficult to predict, it is a formidable threat.

While providers have enjoyed significant success in challenging states for procedural violations of the Boren Amendment, they have had less success in challenging states for noncompli-

52. 496 U.S. at 523. Wilder also held that providers need not exhaust administrative remedies before bringing a § 1983 action. Id.

53. Id. at 524.


55. Id. In Wilder, the Supreme Court declined to address the appropriateness of judicial review under the APA. 496 U.S. at 514 n.12.

56. As of July 1, 1994, there were more than one hundred reported opinions, including appellate opinions, involving Boren Amendment challenges to states' reimbursement methodologies for nursing facilities, including ICFs/MR, and hospitals.

57. In the author's experience as a consultant to the Wyoming Department of Health, every provider and provider association that is unhappy with Medicaid reimbursement routinely raises the specter of a Boren Amendment challenge, regardless of the relative merits of such a claim.
VI. Appropriate Use of Judicial Review

The first issue that should arise in a lawsuit founded in the Boren Amendment is whether judicial review is appropriate. If the challenge is procedural, judicial review is likely to be appropriate. However, if the challenge is substantive, several additional factors set forth below must be considered before the court enters the arena of institutional health care reimbursement.

A. Procedural Challenges

Boren Amendment litigation challenging the procedural aspect has focused on two issues: 1) the definition of an "efficient and economically operated" facility, and 2) the procedure a state must follow in "finding" that its methodology results in rates that meet the "reasonable and adequate" standard. If the challenge is directed at the state's alleged failure to define an efficiently and economically operated facility or the state's alleged failure to make findings to support its assurances to HCFA, judicial review is generally appropriate where the plaintiff successfully carries the burden of coming forward with "credible evidence" to rebut the presumption that the state has made proper findings.59

58. As of January 1, 1994, courts had found procedural deficiencies sufficient to invalidate states' reimbursement methodologies in thirty-one of the forty-nine reported cases that raised such issues; in contrast, providers have succeeded in seven of the twenty-seven reported cases that involved substantive Boren challenges.


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B. Substantive Challenges

Before deciding whether to consider substantive challenges pursuant to § 1983 or to defer judicial review, courts should consider three factors: 1) the nature of institutional health care reimbursement, 2) the relief available under the state’s administrative appeals process, and 3) the scope of the challenge and the relief sought by the plaintiff. Consideration of these factors should lead the court to defer judicial review under the doctrines of primary jurisdiction or abstention in some cases, to dismiss the challenge in other cases, and to proceed with judicial review in the remaining cases.

1. Institutional health care reimbursement

Institutional health care reimbursement is remarkably complex and imprecise. Whether the standard is “reasonable cost” or Boren’s more flexible “reasonable and adequate” rates, articulating the standard is little more than stating a general philosophy — it is meaningless until converted into workable definitions and formulae. The terms “reasonable” and “cost” are inherently and deliberately vague, as are “adequate” and “efficiently and economically operated facility.”

Most nursing home reimbursement methodologies are prospective. Facilities receive a per diem rate for each recipient, based on the facility’s historical costs. That is, the facility’s costs in a prior fiscal period and a predicted inflation factor are used to project a rate for the future.\footnote{Prospective rates may be subject to a cap, often based on some percentile of all facilities’ costs.} If the facility provides services for less than the prospective rate, it pockets the difference. If it spends more to furnish services than Medicaid pays, it must absorb the loss. While computation of such a rate sounds relatively simple, it is not.\footnote{The complexity of prospective payment methodologies for nursing home care is graphically illustrated by the court’s opinion in New Jersey Ass’n. of Health Care Facilities v. Gibbs, 838 F. Supp. 881, 896 (D.N.J. 1993), aff’d, 14 F.3d 48 (3d Cir. 1993). In denying a preliminary injunction, the court wrote over 200 paragraphs relating to findings of fact. Id.}

To begin with, the state’s methodology must define at least three kinds of costs: 1) actual costs, 2) allowable costs, and 3) reimbursable costs (costs that Medicaid will pay). Taken together, these definitions identify which costs incurred by a facility during the prior period will be used to project the facility’s...
Medicaid rate in a future period. Defining these terms is neither obvious nor simple. Neither Boren nor HCFA defines costs in any way, leaving this task to the states.

There are several potential and legitimate definitions of each type of cost. In simple terms, "actual costs" are all the expenses incurred by a facility during a specific period of time, whether or not they relate to patient care. It is inflationary and inappropriate, however, to reimburse a facility for all its costs; the facility has no incentive to become efficient or economical. Accordingly, the state must decide which actual costs are "allowable" under the state's methodology.

"Allowable costs" are expenses that relate to patient care, such as salaries for nurses and nurse aides. Other costs, such as excessive compensation to nursing home management, are generally not allowable. Determining allowable costs is a lengthy process, involving an audit of every penny spent by a facility. Even under the most detailed reimbursement methodology, there is considerable room for disagreement over whether an expenditure was "allowable" and thus may be used as a basis for projecting a future rate. Obviously, an agency's decision not to allow certain costs can profoundly affect a provider's rate.

After determining which costs are "allowable," the state must decide which allowable costs are "reimbursable." For example, although salaries for nurses are an allowable cost because nursing services relate directly to patient care, there are other issues to consider. For example, there is no compelling reason for the state to pay for more nursing care than Medicaid recipients require, or to reimburse a facility for paying salaries that exceed the market price. Accordingly, state Medicaid programs often limit the number of reimbursable nursing hours and salaries.

Generally, a provider may raise issues involving the state's determination of allowable costs in an administrative proceeding. Since providers' actual costs and allowable costs vary widely, even among similar facilities, the determination must necessarily

62. The issue of "costs" is complex. There are at least four different methods of computing costs, each of which is significantly different. See Anderson & Hall, supra note 1, at 221.

63. Issues such as depreciation make the definition of cost troublesome. One court held that depreciating a facility that is increasing in value is not an actual cost to the facility. Folden v. Washington State Dep't of Social & Health Servs., 744 F. Supp. 1507, 1516 (W.D. Wash. 1990).

64. The Boren Amendment does not require states to reimburse allowable costs, only the costs that "must be incurred." See 42 U.S.C. § 1396a(a)(13)(A) (1988).
be individualized. Only at the conclusion of the administrative process will the provider, or the state, know the provider’s final rate.65

Hospital reimbursement is often considerably more complex. Hospitals provide many more types of services and procedures than do nursing homes, and their costs vary widely. As a result, most states have some sort of prospective reimbursement methodology that pays hospitals based on the nature and intensity of the services furnished. But, as with any form of prospective reimbursement, the rate must have a basis. That basis is often the “allowable costs” incurred by the hospital in some fiscal period. Again, the agency’s determination of “cost” and “allowable costs” often leads to substantial disagreement, as does the agency’s definition of “reimbursable cost.” As with nursing home rate appeals, the resolution of hospital rate disputes can significantly alter that rate.

The inherent complexity of reimbursement methodologies can result in a provider’s rate(s) changing through the administrative process, even when the appeals process does not permit the provider to challenge the reimbursement methodology itself.66 For example, an agency’s ultimate decision to allow a facility to include an additional type of cost in computing its allowable historical costs can significantly alter the facility’s rate(s). Even in a state that has limited the issues that may be raised on appeal, a provider must be permitted to present additional evidence as part of its request for a recalculation of its rate. The process will generally include a review of whether the agency’s decision to allow a particular facility’s cost is appropriate under the state’s methodology. That is an issue that should be resolved through an administrative process, not through a Boren lawsuit.

65. An appeals process is of limited value in a state that uses a flat rate, such as Oklahoma. See for example, Oklahoma Nursing Home Ass’n v. Demps, 816 F. Supp. 688 (W.D. Okla. 1992), where the court found the state’s flat rate for nursing homes procedurally invalid because the state’s assurances were not supported by adequate findings. Flat rates are not inherently impermissible; the question is whether the state’s findings support its assurances.

66. Reimbursement methodologies may also take into consideration the quality of care provided in a given facility and/or the level of care furnished by the facility. A methodology that considers such factors adds an additional layer of complexity and makes an aggregate evaluation under Boren problematic. Costs that do not relate to either quality of care or level of care are not costs that must be incurred.
2. Relief available through the administrative appeals process

States' administrative appeals processes vary widely. The appropriateness of judicial review depends in part on whether the provider suing the state may obtain the relief it seeks through the administrative appeals process. Even when the state does not allow a challenge to the methodology itself, which is the norm, the provider may be able to succeed.

The provider's ability to obtain relief also depends in part on the state's reimbursement methodology. Some methodologies include absolute caps, which always subject the provider's rate to some limit. Others contain only presumptive limits, which allow a provider to receive more than the limit if it can prove that it is efficiently and economically operated and has incurred costs beyond its control. If the state's methodology does not contain absolute caps, judicial review is generally inappropriate since the facility has the potential to obtain the relief it seeks without judicial intervention. Even where caps are absolute, however, the inherent complexity of institutional health care reimbursement should cause courts to be reluctant to enter the fray.

3. Scope of the provider challenge and relief sought

Boren suits may be filed under § 1983 by an individual provider, a group of providers, or an association of providers. Plaintiffs may seek a higher rate for a specific facility or facilities or a declaration that the state's entire methodology is illegal. When deciding whether to consider the challenge, the court ought to look at the nature of the relief sought as a determining factor.

If the plaintiff in a Boren suit seeks a higher rate for a specific facility or group of facilities, judicial review is inappropriate. The reason is twofold. First, the appeals process must, by defini-


69. Since the system's failure to pay higher rates may be caused by the providers' failure to appeal and carry their burden, not by the state's failure to comply with Boren, it will be difficult for a provider to show that the methodology, in the aggregate, is illegal.
tion, permit the provider to present additional evidence and to obtain prompt review of the provider's rate calculation. As discussed above, that right is inherently more significant than it may first appear because of the nature and complexity of institutional health care reimbursement.

Second, the Boren Amendment creates aggregate rights, not rights for individual providers; therefore, judicial review is appropriate only if the plaintiff seeks a determination that the state's entire methodology, in the aggregate, violates Boren, not if the plaintiff merely seeks additional money for itself. If the plaintiff seeks individual relief, judicial review should not simply be deferred; instead the provider's challenge should be dismissed.

4. Bases for deferral

Administrative agencies, not courts, are equipped to evaluate a provider's request for an increase in its rate. Accordingly, if a provider is seeking additional compensation, courts should defer judicial review under one of two doctrines: primary jurisdiction or abstention. Deferring judicial review allows providers and states to attempt to resolve complex issues of institutional health care reimbursement, recognizes the imprecise nature and complexity of reimbursement methodologies, and reserves judicial review for systemwide challenges. 70

At least one court has relied upon the doctrine of primary jurisdiction 71 as a reason for deferring judicial review of a § 1983 action. 72 While acknowledging the provider's right to bring such an action, the court deferred to the state's administrative agency because the agency had the "specialized knowledge" needed to review the provider's request. 73

70. Although exhaustion of administrative remedies is not a prerequisite to a § 1983 action, a facility's failure to exhaust administrative remedies may preclude a subsequent judicial challenge to that rate on non-Boren grounds. See American Healthcare Ctr. v. North Dakota Dep't of Human Servs., [1994-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 42,214 (N.D. 1994) (doctrine of res judicata precluded facility's action against state for breach of its Medicaid provider agreement because the facility did not appeal its rate through the administrative appeals process).

71. Under the doctrine of primary jurisdiction, it is appropriate to defer judicial review to an administrative agency with the experience and expertise to review such matters. Capitol Hill Hosp. v. District of Columbia, 769 F. Supp. 16, 17 (D.D.C. 1991).

72. Id.

73. Id.
Deferring to the primary jurisdiction of a state agency is particularly appropriate when the provider files a § 1983 action in state court. State courts should not interfere with the orderly resolution of Medicaid reimbursement disputes if the provider can obtain the relief it seeks through the administrative process. Courts are "not designed to be an alternative body" for resolving administrative disputes.\textsuperscript{74}

Federal courts may abstain from exercising jurisdiction when judicial review on an issue of state law would disrupt the state's attempt "to establish a coherent state policy in an area of significant local concern."\textsuperscript{75} Known as "Burford" abstention, deferring judicial review in such a situation is proper when a decision by a federal court would disrupt state administrative proceedings.

Burford abstention is often ideally suited to Boren litigation. Most Boren suits are filed in federal court. All involve providers dissatisfied with their reimbursement rates. All involve reimbursement methodologies that are subject to an administrative appeals process, which federal judicial review would disrupt. All involve institutional health care reimbursement, a matter of substantial public concern. Some involve a systemwide challenge to the reimbursement methodology while others involve a specific facility or group of facilities. While the scope of state appeals processes varies, most institutional reimbursement methodologies are sufficiently complex that virtually any provider's rate(s) may be substantially changed as a result of the process. Accordingly, whether abstention is appropriate depends on the nature and scope of the relief the provider seeks, not whether the action is asserted under § 1983.\textsuperscript{76}

Burford abstention is appropriate in Boren litigation when the provider bringing the action does not challenge the state's reimbursement methodology in the aggregate, but seeks, instead, higher rates for an individual facility or group of facilities.\textsuperscript{77} In such a case, the administrative appeals process is

\textsuperscript{74} Id.


\textsuperscript{76} In \textit{Wilder v. Virginia Hosp. Ass'n}, the Supreme Court rejected the argument that the existence of state administrative procedures should foreclose resort to § 1983. 496 U.S. 498 (1990). That holding does not, however, preclude Burford abstention where appropriate. \textit{See} Heartland Hosp., 792 F. Supp. at 671.

\textsuperscript{77} \textit{See}, e.g., St. Michael Hosp. v. Thompson, 725 F. Supp. 1038, 1045 (W.D. Wis. 1989).
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designed to provide a forum in which the provider may assert an entitlement to higher rates for an individual facility under the state's reimbursement methodology.

Abstention is appropriate even if the rate the provider seeks exceeds the maximum rate allowable under the reimbursement methodology. A Boren challenge cannot be based on the experience of a specific facility, no matter how adverse; it must address the reimbursement methodology in the aggregate. In a facility-specific case, the failure to abstain results in an unwarranted interference in administrative processes designed to resolve complex institutional reimbursement disputes, and sets the stage for judicial second-guessing of state agency policy decisions.

Abstention may even be appropriate where the administrative appeals process does not allow for a challenge to the reimbursement methodology itself. The claim the provider wants to assert, that the reimbursement methodology is illegal, may generally be raised through resort to judicial review of the administrative decision. In such an appeal, of course, the issue remains whether the reimbursement methodology is, in the aggregate, deficient.

Abstention is inappropriate only where the relief sought is systemwide and cannot be achieved through the administrative appeals process. Given the complexity of institutional health care reimbursement, however, whether a Boren challenge involves a systemwide challenge, or is merely a rate appeal masquerading as a § 1983 action, may not be readily apparent.

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78. See, e.g., Forest Health Systems v. Missouri Dep't of Social Servs., 1994 WL 120301, p.*4 (Mo. App. 1994), reh. denied (the experience of any one facility "proves nothing").

79. Id. (although the state administrative appeals process did not allow a provider to challenge the reimbursement methodology, the availability of judicial review of administrative decisions provides a forum for a challenge to an agency decision); but see Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehabilitative Servs., 822 F. Supp. 687, 689 (D. Kan. 1993) (court refused to abstain where the provider association challenged the methodology itself and the administrative appeals process prohibited such a challenge).

VII. PROPER ANALYSIS FOR COURTS

If, after considering the issues above, a court finds judicial review of a Boren case appropriate, the manner in which the case is resolved should vary depending on whether the challenge is procedural or substantive.

A. Procedural Issues

1. Standard of review

Boren's procedural requirements are satisfied if the state engaged in "a bona fide finding process and made assurances to HCFA based on those findings." The state may create its own finding process, as long as it considers, "on the basis of some reasonably principled analysis," whether its reimbursement rates meet the reasonable and adequate standard. Judicial review of a state's compliance with Boren's requirements is de novo. However, the only question before the court is whether the state conducted a "reasonably principled analysis." The court may substitute its judgment only if the state made a "clear error of judgment."

2. Burden of proof

There is a presumption that states engage in a bona fide findings process before submitting assurances to HCFA that their reimbursement methodologies comply with Boren. Therefore, a provider challenging the state's process under Boren must produce credible evidence to rebut that presumption.
3. Efficiently and economically operated facilities

The costs that an “efficiently and economically operated facility” must incur create the “benchmark” against which reimbursement methodologies are to be measured. Therefore, the definition of an “efficiently and economically operated facility” is a critical Boren issue; different definitions naturally lead to dramatically different reimbursement rates.

A primary procedural issue in Boren suits is whether a state must identify specific facilities that are efficiently and economically operated, and use those facilities’ costs as a benchmark for Boren compliance, or whether a state may establish a benchmark by implicitly defining such facilities through its methodology. An early and influential decision appeared to adopt the former view. However, subsequent decisions have overwhelmingly adopted the latter, and better, view.

One of the most frequently cited Boren decisions is AMISUB (PSL), Inc. v. State of Colorado Department of Social Services. In that case, the Tenth Circuit upheld a decision invalidating Colorado’s inpatient hospital reimbursement methodology for failing to comply with Boren’s procedural requirements. In particular, the State had failed to identify specific facilities that were efficiently and economically operated. The court held that the State’s findings must “identify and determine 1) efficiently and economically operated hospitals; 2) the costs that must be incurred by such hospitals; and 3) payment rates which are reasonable and adequate to meet the reasonable costs of the state’s efficiently and economically operated hospitals.” Providers have interpreted this language to mean that a state must identify specific facilities that are efficiently and economically operated and use the costs that they must incur as the Boren bench-

87. Abbeville, 3 F.3d at 805.
88. Nebraska Health Care Ass’n v. Dunnig, 575 F. Supp. 176, 178-79 (D. Neb. 1983). HCFA, as is its wont, has refused to provide regulatory guidance, resulting in a plethora of needless litigation, resulting in a variety of different and often conflicting decisions. HCFA’s failure to define Boren’s terms has cost states millions of dollars in attempts to comply with its “amorphous terms.” Multicare, 768 F. Supp. at 1390. Further, HCFA has even refused, at times, to actively support states embroiled in Boren litigation, even when HCFA has approved the state’s methodology. See, e.g., Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1315 (2d Cir. 1991) (court’s finding that state violated Boren “buttressed by the fact that HCFA has stood mute during this appeal,” even though HCFA had approved the reimbursement methodology at issue).
89. 879 F.2d 789 (10th Cir. 1989).
90. Id. at 796.
This analysis is neither consistent with the intent of Boren nor dictated by the language of the decision.

The Seventh Circuit Court of Appeals articulated the other view: a state’s methodology may be a “relative rather than an absolute concept.” That is, a state’s methodology may implicitly define a benchmark facility by establishing standards that a hypothetical efficiently and economically operated facility must meet without identifying specific facilities that meet those standards. Those facilities that meet the methodology’s standards are, by implication, efficiently and economically operated. This view is supported by the letter and spirit of Boren, but does not imply that the state need not go through its findings process.

It is possible, of course, that no actual facilities in the state will have the precise characteristics of the hypothetical benchmark. While courts tend to focus on the number or percentage of facilities that meet the benchmark, that focus is misplaced. The absence of specific facilities that meet the hypothetical standard does not mean that the methodology violates Boren. It may only mean that the industry in a state is inefficient and uneconomical, not that the state’s methodology is necessarily deficient.

The Boren Amendment does not expressly require a state to identify specific facilities as efficiently and economically operated. The Amendment requires states to pay the costs that facilities that are efficiently and economically operated must incur. Such facilities may be real or hypothetical.

91. See, e.g., Muticare Medical Ctr. v. Washington, 768 F. Supp. 1349, 1391-92 (W.D. Wash. 1991) (rejecting the providers’ argument that AMISUB requires states to identify specific facilities as efficiently and economically operated).
92. Illinois Health Care Ass’n v. Bradley, 983 F.2d 1460, 1467 (7th Cir. 1993).
93. Id. at 1467; see also Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 805 (5th Cir. 1993).
94. It is common sense to assume that lower cost facilities tend to be more efficient and economic than higher cost facilities if both facilities provide a comparable level and quality of care. New Jersey Ass’n of Health Care Facilities v. Gibbs, 838 F. Supp. 881, 895 (D.N.J. 1993).
96. It is not unreasonable to assume that most, if not all, facilities in a given state are inefficient. They have, often for decades, been reimbursed pursuant to a cost-based system, meaning that they received payment for most costs incurred, even if those costs were unreasonable or inappropriate. Without an incentive to become efficient or economical, there is no compelling reason to believe they are. Under Boren, a state may properly “determine that all of its facilities could further cut costs and increase their efficiency.” Id. (emphasis omitted).
As noted above, Congress enacted the Boren Amendment to provide the states with more freedom to develop and implement alternative reimbursement methodologies. Therefore, when developing its methodology, a state ought to be allowed to establish an efficiently and economically operated “benchmark” in any way it chooses. Whether that benchmark is defined explicitly or implicitly is irrelevant. The issue is whether there is a “nexus” between facilities’ reasonable costs and the state’s reimbursement rate, not whether the benchmark was determined in a certain manner. Courts ought to limit the scope of their review to that question and disregard the issue of whether the state identified specific facilities as efficiently and economically operated.

4. A state’s findings must be based on an objective analysis of the rates that result from its methodology

Providers often challenge the process the state followed in making findings, alleging that the state did not engage in a bona fide findings process. The factual basis for a state’s assurances that its rates satisfy Boren must result from findings based on an objective analysis of the rates that result from the state’s reimbursement methodology. A state that does not conduct such an analysis has no basis to assure HCFA of its compliance. Assurances based on assumptions or speculation, rather than on findings from an appropriate analysis, are necessarily defective, and properly serve as the basis for Boren Amendment litigation. However, in preparing its findings, a state may use any “reasonably principled” method of analysis.

Given the Boren Amendment’s relatively simple procedural requirements, it appears remarkable that many states have had one or more reimbursement methodologies enjoined for procedural noncompliance, often because they failed to make adequate findings. The explanation is simple, and has little to do with the Boren Amendment. Instead, it has to do with Medicaid funding.

The combination of the last decade’s health care inflation and federal mandates caused state Medicaid budgets to careen out of control. States struggling to balance budgets cannot ignore

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97. Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 805 (5th Cir. 1993); Illinois Heath Care Ass’n v. Bradley, 983 F.2d 1460, 1465 (7th Cir. 1993); Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1314 (2d Cir. 1991).
98. Abbeville, 3 F.3d at 804.
rapidly escalating Medicaid expenditures.\footnote{In most states, hospital and nursing facility expenditures constitute the large majority of all Medicaid expenditures.} In addition, the federal share of Medicaid expenditures has declined even though the number of federally mandated Medicaid services has increased. Naturally, state governments have attempted to control the increase in Medicaid expenditures by directing state Medicaid agencies to freeze, reduce, or slow the growth of hospital expenses, nursing facility expenses, or both.\footnote{See, e.g., LaPeer County Medical Care Facility v. Michigan, [1992-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 40,432 (W.D. Mich. Feb. 4, 1992) (describing a legislatively mandated 9.2 percent cut in all state line items); see also Oklahoma Nursing Home Ass’n v. Demps, 816 F. Supp. 688 (W.D. Okla. 1992), appeal dismissed, 9 F.3d 117 (10th Cir. 1993) (state Medicaid agency revised downward its initial recommendation regarding an increase in nursing home rates for fiscal year 1992 based on the state legislature’s appropriation for that year). Not surprisingly, both states were found to be in violation of the Boren Amendment.} This has placed state Medicaid agencies in a catch twenty-two.

Instead of building a reimbursement system from the ground up, by empirically determining what costs an “efficiently and economically operated” facility must incur to provide services that meet applicable federal and state laws, agencies are often forced to work from the top down. The agency must determine how much it can pay providers given the funds it has been appropriated by the state legislature. This phenomenon of inadequate funding has left many states with virtually no hope of complying with the procedural requirements of the Boren Amendment, let alone the substantive ones. States cannot make findings upon which to base their assurances to HCFA because the state reimbursement rates often have less to do with an objective analysis of empirical data than with legislative fiat. Legislative funding is, of course, a political issue beyond the control of most state Medicaid agencies. Unfortunately, it plays directly into the hands of providers bringing a Boren challenge. Ultimately, the state is likely to be ordered to come up with the funds even after spending hundreds of thousands of dollars on the litigation.\footnote{For example, after being enjoined from implementing cuts in nursing home rates because of Boren violations, the State of Michigan agreed to pay an additional thirty million dollars annually to providers. Health Care Ass’n v. Babcock, [1991 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,182 (W.D. Mich. Feb. 28, 1991).}

Courts should not and cannot allow state budgets to dictate reimbursement rates. However, courts should recognize that budgets are a factor, often a significant one, in setting rates. Whether a state changes its rate methodology solely, or even
primarily, because of budgetary reasons is irrelevant as long as the resulting rates meet the Boren standard. What is relevant is whether the state follows the proper procedure in implementing the methodology.

B. Substantive Review

1. Standard of review

States that comply with Boren's procedural requirements have had some success in defending Boren challenges made on substantive grounds because courts should, and sometimes do, defer to the state's judgment in establishing a reimbursement methodology that is approved by HCFA. Assuming procedural compliance, the only question ought to be whether the methodology is arbitrary and capricious. That is, in the aggregate, do the rates that the state pays fall within a "zone of reasonableness"?

2. Burden of proof

If the state successfully shows procedural compliance with Boren, the provider suing the state bears the burden of proving that the state has acted arbitrarily and capriciously. Given the relatively imprecise nature of institutional health care reimbursement, that burden is a heavy one.

3. Aggregate standard

As discussed above, the Boren "reasonable and adequate" standard is an aggregate standard. That is, the state must pay rates that, in the aggregate, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. Although an aggregate computation is necessarily imprecise, these statistics demonstrate more
clearly than most that a state has complied with Boren.\textsuperscript{106} Aggregate figures are imprecise because of the difficulties in measuring the total amount any large system would pay, particularly a system that does not impose absolute caps on facilities' rates.

Despite its imprecision, judicial review should only focus on the aggregate; courts ought not to evaluate whether a particular facility received a certain rate.

A relatively simple two-step process determines whether a state's methodology meets the aggregate standard. The process is inextricably tied to the objective benchmark of the costs that must be incurred by an efficiently and economically operated facility. The first step is to determine whether the state has satisfied the procedural requirement of defining an efficiently and economically operated facility. Assuming that the state complied with the procedural aspect of Boren, the court should accept the state's definition unless the provider meets the burden of showing that the state's definition is arbitrary and capricious. In this area, where no two experts will ever agree, a court will seldom have a basis to find that the agency's definition is not reasonable.\textsuperscript{107} Unless the agency has abused its discretion, the court should not step into the policymaking arena of redefining an efficiently and economically operated facility.\textsuperscript{108}

The second step, assuming that the state's definition of an efficiently and economically operated facility is not arbitrary and capricious, is to make an aggregate calculation; do the state's total expenditures for nursing home care or hospital care equal or exceed the Medicaid costs that all such facilities in the state would incur if they were efficiently and economically operated. If so, the state's methodology satisfies Boren. If not, the state is hoist on its own petard. By its own benchmark, the state has failed to comply with Boren.

Changes in a state's methodology because of budgetary constraints should be measured against the same standard. The question is whether the state's expenditures, including budget


\textsuperscript{107} See, for example, New Jersey Ass'n of Health Care Facilities v. Gibbs, 838 F. Supp. 881 (D.N.J. 1993), in which the court examined at length conflicting expert testimony about nursing home reimbursement. The experts agreed on virtually nothing.

\textsuperscript{108} If the court finds the agency's definition of "efficiently and economically operated" to be arbitrary and capricious, the court should order the agency to redefine the term in accordance with Boren. A court should never substitute its own or the plaintiff's definition; to do so is to usurp the agency's policymaking function.
cuts, meet the aggregate standard, not whether providers are receiving less than they received before. If, as part of the process, the state redefines “efficiently and economically operated,” making new findings and assurances to HCFA, the analysis should be the same: 1) whether the state followed the procedural requirements of Boren, and if so, 2) whether the redesigned methodology passes the aggregate measure.

CONCLUSION

The Boren Amendment represents everything that is wrong with Medicaid; it is based in federalism. The combination of federal mandates, HCFA’s sporadic oversight, reductions in federal funds, and increasingly limited state funds often places states between the rock of federal law and the hard place of state budgetary constraints. However, when the issue is compliance with Boren, the law allows, as should the courts, the rock to roll, at least a bit.

The Boren Amendment is not nearly as clear as courts have suggested. Institutional health care reimbursement is very imprecise. To hold that a state’s necessarily imprecise reimbursement methodology falls short of Boren’s ambiguous standards is wrong. It is equally inappropriate for courts to evaluate specific rates against the Boren benchmark; such issues are properly raised in the administrative appeals process.

Judicial review is appropriate only where 1) the relief sought cannot be obtained through the state administrative appeals process, and 2) the desired relief is system wide, not provider specific. In no case should courts become involved in making policy decisions about how to define an efficiently and economically operated facility or what kind of costs that facility needs to incur. These decisions should be left to the states.