

THE MISTAKES OF MEDICAID: PROVIDER PAYMENT DURING THE PAST DECADE AND LESSONS FOR HEALTH CARE REFORM IN THE 21ST CENTURY

This case is about money and not about quality of care.¹

Indeed, the [medicaid payment] requirement necessarily establishes a tension between Congress's concern for keeping Medicaid costs as low as possible on the one hand and its regard for providing quality care to Medicaid recipients on the other.²

Health care costs are spiralling, as a result of inflation, high-tech advances, the aging population and defensive medical practices.³ State and federal tax revenues for the payment of health care are declining due to an economic recession.⁴ Hospitals, nursing homes, doctors and other health care providers who participate in the medicaid program are caught in the cross fire between increasing costs and decreasing payments.⁵

In 1990, total national health care expenditures reached \$666.2 billion.⁶ Medicaid was the single largest contributor to the rising cost of public health care coverage, growing by 20.7% from 1989 through 1990.⁷ The problem of paying medical providers adequate amounts without bankrupting the payer is a critical issue for both the government-funded health care programs and the health care system as a whole.⁸

After Congress amended the federal medicaid laws and granted states increased authority in 1980 to determine the level of payment

¹ *Folden v. Washington Dep't of Soc. & Health Servs.*, 744 F. Supp. 1507, 1518 (W.D. Wash. 1990), *aff'd*, 981 F.2d 1054 (9th Cir. 1992).

² *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 534 (D. Me. 1992).

³ See Katharine R. Levit et al., *National Health Expenditures, 1990*, HEALTH CARE FINANCING REV., Fall 1991, at 30; Helen C. Lazenby & Suzanne W. Letsch, *National Health Expenditures, 1989*, HEALTH CARE FINANCING REV., Winter 1990, at 4, fig.2; Office of National Cost Estimates, *National Health Expenditures, 1988*, HEALTH CARE FINANCING REV., Summer 1990, at 1, 2.

⁴ See Levit, *supra* note 3, at 29, 30; Sally T. Sonnefeld et al., *Projections of National Health Expenditures Through the Year 2000*, HEALTH CARE FINANCING REV., Fall 1991, at 1.

⁵ See *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 14 (3d Cir. 1989), *cert. granted*, 494 U.S. 1003 (1990).

⁶ Levit, *supra* note 3, at 29.

⁷ *Id.*

⁸ See Sonnefeld, *supra* note 4, at 1.

to medicaid providers, states were faced with two options for controlling medicaid costs: cutting services or cutting expenditures.⁹ After many states cut optional medicaid services, they began developing creative payment systems that began to slow the increases in medicaid expenditures.¹⁰ In response to level, and often declining, reimbursement, many providers and even some medicaid recipients have challenged the adequacy of medicaid payment in federal court.¹¹ Many such plaintiffs have succeeded in convincing federal judges that payment is inadequate, and in invalidating state payment systems.¹²

The result has been increased federal judicial involvement in state medicaid plans, and confusion for the states regarding how to develop a payment system methodology that a state can afford and a court will uphold.¹³ The balance of adequacy and reasonableness is the challenge of the health care system.¹⁴ Increased litigation and judicial involvement in complex health care payment issues are not the answer.¹⁵ Before we undertake reform of our health care system, we must review the problems of the current system and decide what we have learned from our mistakes.¹⁶

This Note addresses some of these fundamental issues in the context of the medicaid provider payment system. Section I describes the medicaid program and the statutory framework governing payment to medicaid providers.¹⁷ Section II discusses the conflicting case law regarding the § 1983 cause of action in medicaid provider payment litigation.¹⁸ Section III discusses the standard of judicial review in

⁹ See HEALTH CARE FACILITIES LAW: CRITICAL ISSUES FOR HOSPITALS, HMOs AND EXTENDED CARE FACILITIES 417 (Anne M. Dellinger ed., 1991).

¹⁰ See generally Robert J. Buchanan et al., *Medicaid Payment Policies for Nursing Home Care: A National Survey*, HEALTH CARE FINANCING REV., Fall 1991, at 56.

¹¹ See, e.g., *Folden v. Washington Dep't of Social & Health Servs.*, 981 F.2d 1054, 1055-56 (9th Cir. 1992) (nursing homes); *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 532 (D. Me. 1992) (recipients); *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 14 (3d Cir. 1989) (hospitals).

¹² See, e.g., *Temple Univ. v. White*, 941 F.2d 201, 220 (3d Cir. 1991), *cert. denied*, *Snider v. Temple Univ.*, 112 S. Ct. 873 (1992); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1318 (2d Cir. 1991); *Casey*, 885 F.2d at 35; *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 801 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990); *Illinois Health Care Ass'n v. Bradley*, 776 F. Supp. 411, 423 (N.D. Ill. 1991), *aff'd*, 983 F.2d 1460 (7th Cir. 1993); *Multicare Medical Ctr. v. Washington*, 768 F. Supp. 1349, 1402 (W.D. Wash. 1991); *Michigan Hosp. Ass'n v. Babcock*, 736 F. Supp. 759, 764 (W.D. Mich. 1990).

¹³ See *infra* notes 52-173 and accompanying text.

¹⁴ See Sonnefeld, *supra* note 4, at 1.

¹⁵ See *infra* notes 174-239 and accompanying text.

¹⁶ See *infra* notes 52-173 and accompanying text.

¹⁷ See *infra* notes 22-51 and accompanying text.

¹⁸ See *infra* notes 52-105 and accompanying text.

medicaid provider payment litigation.¹⁹ Section IV analyzes the problems of judicial enforcement of federal medicaid statutes and judicial review of state medicaid agency actions.²⁰ Section IV also identifies possible solutions to the problems of provider payment, and how these solutions are relevant to the larger reform of the American health care system.²¹

I. STATUTORY FRAMEWORK FOR MEDICAID PROVIDER PAYMENT

Congress enacted medicaid in 1965 to provide medical care to the poor and disabled.²² Unlike medicare, which is a federal program, medicaid is a joint state-federal program, administered at the state level; to receive federal matching funds, participating states must provide a minimum level of services to at least those individuals who are categorically needy.²³ Participating states must provide medicaid to those who receive assistance under the Aid to Families with Dependent Children and the Supplemental Security Income programs.²⁴ Medicaid agencies must submit a detailed state plan that meets the requirements of the federal statute and regulations.²⁵

Prior to 1981, states were required to pay all medicaid providers on the basis of uniform medicare "reasonable charges," which were determined by the Secretary of Health and Human Services ("HHS").²⁶ Recognizing the inherently inflationary nature of these payments, Congress amended the federal medicaid statute in 1980 and 1981 to allow states flexibility and creativity in payment of providers, within general federal guidelines.²⁷ The state plan that each state medicaid agency must file with HHS must include appeal procedures for provider grievances.²⁸ States need not, however, include an opportunity to challenge

¹⁹ See *infra* notes 106–173 and accompanying text.

²⁰ See *infra* notes 174–239 and accompanying text.

²¹ See *infra* notes 240–252 and accompanying text.

²² See 42 U.S.C. § 1396a (1988).

²³ 42 U.S.C. § 1396a(a)(17). States that participate in Medicaid—all states except Arizona—must comply with federal Medicaid requirements. *Smith v. Miller*, 665 F.2d 172, 175 (7th Cir. 1981).

²⁴ 42 U.S.C. §§ 1396a(a)(17) (services), 601 to 615 (AFDC), 1381 to 1383c (SSI) (1988).

²⁵ 42 U.S.C. § 1396a; 42 C.F.R. § 447.201 (1992).

²⁶ See 42 U.S.C. § 1396a(a)(13)(E) (1979) ("reasonable cost related basis"); § 1396a(a)(30)(A) (1979) ("reasonable charges").

²⁷ See Pub. L. No. 95-499 § 962(a), 94 Stat. 2650 (1980) (Boren Amendment); Pub. L. No. 97-35 § 2173, 95 Stat. 808 (1981) (expanding Boren Amendment to apply to hospitals); Pub. L. No. 97-35 § 2174(a), 95 Stat. 809 (1981) (removing "reasonable charges" language from section 30(A)).

²⁸ 42 C.F.R. § 447.253(c) (1990).

the overall medicaid payment policy, and may instead limit appeals to whether the policy has been fairly applied to a specific provider.²⁹

Medicaid payments to acute care hospitals, nursing homes and facilities for the mentally retarded are governed by 42 U.S.C. § 1396a(a)(13)(A), called the "Boren Amendment" because its chief proponent was Senator David L. Boren of Oklahoma.³⁰ This section requires states to pay rates which are reasonable and adequate to meet the costs of efficient and economical providers.³¹ More specifically, the statute requires that the state provide:

[F]or payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates . . . which the State finds and makes assurances satisfactory to the Secretary [of Health and Human Services], are reasonable and adequate to meet the costs of efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality ³²

Regulations issued by HHS require states to prove to the Health Care Financing Administration ("HCFA") that the "Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers."³³ These regulations do not define the terms "reasonable and adequate," "costs" or "economically and efficiently."³⁴ These provisions apply to the reimbursement of long-term care facilities, and only the inpatient portion of costs of hospitals.³⁵ Outpatient costs, a

²⁹ *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 522-23 (1990).

³⁰ See *id.* at 502; 42 U.S.C. § 1396a(a)(13)(A). The term "acute care hospitals" refers to general inpatient hospitals, as opposed to chronic care hospitals that treat long-term conditions. See *Stedman's Medical Dictionary*, 22, 305, 726 (William R. Hensyl ed., 25th ed. 1990).

³¹ 42 U.S.C. § 1396a(a)(13)(A).

³² *Id.*

³³ 42 C.F.R. § 447.253(b)(1)(i) (1992).

³⁴ See 42 C.F.R. § 447.250 to 447.280.

³⁵ 42 C.F.R. § 447.251 (defining "provider" to mean "an institution that furnishes *inpatient* hospital services or an institution that furnishes long-term care facility services" (emphasis added)).

significant portion of hospital costs, are not governed by the Boren Amendment.³⁶

Payment for all care and services available under the state medicaid plan, including hospital outpatient costs, and all other types of medicaid providers not covered under the Boren Amendment, are generally governed by 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").³⁷ Section 30(A) requires that such payment be consistent with economy, efficiency and quality of care.³⁸ A state's medicaid plan must:

[P]rovide 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 ³⁹

HHS regulations "implement" Section 30(A), but do not define the terms "consistent" or "efficiency, economy, and quality of care."⁴⁰

HHS has chosen expressly not to define the terms within these two statutory provisions.⁴¹ The federal agency has left to the states the job of interpreting these provisions when developing payment policies

³⁶ See *id.*; *Orthopaedic Hosp. v. Kizer*, No. 90-4209, slip op. at 11 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing); *New York v. Sullivan*, 894 F.2d 20, 22 (2d Cir. 1990); *New York v. Bowen*, 811 F.2d 776, 779 (2d Cir. 1987); *Michigan Hosp. Ass'n v. Department of Social Servs.*, 555 F. Supp. 675, 677 (E.D. Mich. 1983) (outpatient costs may not be included in rates under Boren Amendment). Hospital outpatient costs are costs for services furnished to patients who are not admitted for inpatient treatment, by an institution that is licensed as a hospital, which are preventive, diagnostic, therapeutic, rehabilitative or palliative. See 42 C.F.R. § 440.20(a) (1992).

³⁷ See 42 U.S.C. § 1396a(a)(30)(A).

³⁸ *Id.*

³⁹ *Id.* This Note does not address cases regarding the provision of Section 30(A) which requires equal access to care. For discussion of access to care under Section 30(A), see, e.g., *Arkansas Medical Soc'y v. Arkansas Dep't of Human Servs.*, 6 F.3d 519, 525-31 (8th Cir. 1993); *Pennsylvania Ass'n of Home Health Agencies v. Snider*, 826 F. Supp. 948, 950-52 (E.D. Pa. 1993); *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 533-34 (D. Me. 1992); *Clark v. Kizer*, 758 F. Supp. 572, 575-79 (E.D. Cal. 1990).

⁴⁰ See 42 C.F.R. § 447.250(b) (stating "Section 447.253(a)(2) implements" Section 30). But see 42 C.F.R. § 447.253(a), which does not have a clause labeled (2). See also 42 C.F.R. § 447.300 (stating "In this subpart, §§ 447.302 through 447.334 and 447.361 implement" Section 30).

⁴¹ 48 Fed. Reg. 56,049 (1983). See also *Folden v. Washington Dep't of Social & Health Servs.*, 744 F. Supp. 1507, 1532 (W.D. Wash. 1990).

for medicaid providers.⁴² As discussed below, federal courts have played a substantial role in interpreting at least the Boren Amendment.⁴³

Among the many other provisions governing provider payment, HHS imposed an overall limit on individual state payments to medicaid providers based on medicare reasonable charges.⁴⁴ An individual state's aggregate payments to its medicaid providers may not exceed the aggregate payment the state would have paid under a medicare reasonable charges calculation.⁴⁵ This provision caps a state's total medicaid provider payment, made after 1981, at the level of medicare reasonable charges—the pre-1981 level of payment.⁴⁶ HHS regulations impose this requirement for payments made under the Boren Amendment and Section 30(A).⁴⁷

In summary, medicaid payment rates for inpatient facilities are governed by the Boren Amendment and HHS regulations which merely repeat the language of the Boren Amendment.⁴⁸ Under this statutory and regulatory scheme states are required to pay providers of inpatient services at rates which are reasonable and adequate to meet the costs of efficiently and economically operated facilities.⁴⁹ In contrast, the medicaid rates for all other types of providers are generally governed by Section 30(A) and companion HHS regulations, which require states to pay rates which are consistent with efficiency, economy and quality of care.⁵⁰ Finally, HHS regulations impose a cap on all state medicaid payment rates, prohibiting overall payments to providers from exceeding medicare reasonable charges.⁵¹

⁴² See 48 Fed. Reg. 56,049.

⁴³ See *infra* notes 49–72 and accompanying text.

⁴⁴ 42 C.F.R. §§ 447.253(b)(2), 447.272, 447.304. “[A]ggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities and ICFs [intermediate care facilities] for the mentally retarded (“ICFs/MR”)), may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.” 42 C.F.R. § 447.272(a). An exception is made for payment to hospitals serving a disproportionate number of low income patients with special needs. 42 C.F.R. § 447.272(c). See also 42 C.F.R. § 447.253(b)(1)(ii)(A) (governing payment to hospitals serving a disproportionately large number of low income patients with special needs).

⁴⁵ See 42 C.F.R. §§ 447.272(a), 447.253(b)(2).

⁴⁶ See 42 C.F.R. §§ 447.272(a), 447.253(b)(2).

⁴⁷ 42 C.F.R. § 447.253(b)(2) (Boren Amendment); 42 C.F.R. §§ 447.304 to 447.362 (Section 30(A)).

⁴⁸ 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. § 447.253(b)(1)(i).

⁴⁹ 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. § 447.253(b)(1)(i).

⁵⁰ 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. §§ 447.300 to .334, 447.361.

⁵¹ 42 C.F.R. § 447.272(a).

II. RECOGNIZING A § 1983 CAUSE OF ACTION FOR MEDICAID PROVIDERS

A. Enforcing the Boren Amendment

In the 1990 case of *Wilder v. Virginia Hospital Association*, the United States Supreme Court held that hospitals could enforce the provisions of the Boren Amendment, the statute governing payment rates for inpatient facility services, under a § 1983 cause of action.⁵² The lower standard of a § 1983 cause of action, as compared with an implied right of action, has prompted increased litigation as a result of the easier access to federal courts.⁵³ The Court's recognition of a

⁵² See *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 524 (1990). Section 1983 provides: Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983 (1988). The Supreme Court has recognized the use of § 1983 as a valid method of enforcing a wide range of statutorily created rights under federal law. See, e.g., *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 113 (1989) (enforcing unions and management rights under Taft-Hartley Act); *Wright v. City of Roanoke Redevelop. & Hous. Auth.*, 479 U.S. 418, 419 (1987) (enforcing tenants' rights under federal housing laws); *Maine v. Thiboutot*, 448 U.S. 1, 4 (1979) (enforcing recipient rights' under Social Security Act).

⁵³ See WALTER GELLHORN ET AL., *ADMINISTRATIVE LAW: CASES AND COMMENTS* 1191-94 (8th ed. 1987) (comparing restrictive view of implied right of action, and far more generous approach under § 1983). See also *Thiboutot*, 448 U.S. at 23 (Powell, J., dissenting) ("No one can predict the extent to which litigation arising from today's decision will harass state and local officials, nor can one foresee the number of new filings in our already overburdened courts.").

Section 1983 does not speak in terms of violations of federal law, but instead refers to "rights, privileges, or immunities." *Golden State*, 493 U.S. at 106. The cause of action does, however, extend to enforcement of rights created by federal law. *Thiboutot*, 448 U.S. at 4. To bring a § 1983 cause of action to enforce a statute, plaintiffs must fulfill a three-part test. See *Wilder*, 496 U.S. at 509; *Dennis v. Higgins*, 498 U.S. 439, 448-49 (1991). First, the plaintiff must be the intended beneficiary of the statute. *Golden State*, 493 U.S. at 112. Second, the statute must impose a binding obligation that is more than a "congressional preference." *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 19 (1981). Third, the statute must not be "too vague and amorphous" such that it is "beyond the competence of the judiciary to enforce." *Golden State*, 493 U.S. at 106 (quoting *Wright*, 479 U.S. at 431-32). Courts may interpret a statute that is not too vague and amorphous by considering the "standards" of the agency. See *Wright*, 479 U.S. at 431-32. Section 1983 creates both a procedural right and a substantive right. *Wilder*, 496 U.S. at 510.

In its recent decision, *Suter v. Artist M.*, the U.S. Supreme Court did not expressly follow the three-part test for a § 1983 action, and instead re-emphasized the *Pennhurst* requirement that the right must be unambiguously conferred by Congress. 112 S. Ct. 1360, 1366 (1992) (holding Adoption Assistance and Child Welfare Act provision requiring "reasonable efforts" was not enforceable under § 1983 cause of action, but instead was only generalized duty of state). While the opinion of the Court cited *Wilder* repeatedly, the dissent concluded that the Court's failure

§ 1983 cause of action for medicaid providers suing under the Boren Amendment has brought about the predicted flood of provider suits.⁵⁴

to use the three-part test in *Wilder* and *Dennis* contravened precedent. See *id.* at 1365-67, 1377 (Blackmun, J., dissenting). Several lower courts have concluded, however, that *Suter* did not overrule *Wilder*, *Wright* or *Golden State*, nor did it replace the analytical framework of these cases. See, e.g., *Arkansas Medical Soc'y*, No. 93-2352, 1993 U.S. App. LEXIS 23106, at *13-16; *Stowell v. Ives*, 972 F.2d 65, 68 (1st Cir. 1992); *Evelyn V. v. Kings County Hosp. Ctr.*, 819 F. Supp. 183, 194 (E.D.N.Y. 1993). Such courts have chosen to synthesize *Suter* and *Wilder* by proceeding with the analytical framework in place, bearing in mind the additional consideration mandated by *Suter*. *Arkansas Medical Soc'y*, No. 93-2352, 1993 U.S. App. LEXIS 23106, at *15. See also *Chan v. City of New York*, 803 F. Supp. 710, 721 (S.D.N.Y. 1992) (stating jurisprudence concerning whether given statute creates right, privilege or immunity under § 1983 is in state of flux), *aff'd*, 1 F.3d 96 (2d Cir. 1993).

The alternate method for plaintiffs attempting to enforce federal statutes is through an implied right of action. See *Touche Ross v. Redington*, 442 U.S. 560, 575-76 (1979); *Cort v. Ash*, 422 U.S. 66, 78 (1975). The plaintiff is required to meet a four-part test to determine "whether Congress intended to create the private remedy asserted" for the violation of statutory rights. See *Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 15-16 (1979). This test reflects a concern for the separation of powers, such that Congress, rather than the courts, controls the availability of remedies for violations of statutes. See *Wilder*, 496 U.S. at 508 n.9. For a recent discussion of providers' implied rights of action to enforce provisions of the Medicaid Act, see *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1352 (N.D. Ill. 1991), holding that providers have no implied right of action to enforce the waiver provision of the Medicaid Act (42 U.S.C. § 1396n). See also *Wood v. Wallace*, 825 F. Supp. 177, 182-83 (S.D. Ohio 1993) (incorporating *Suter* and *Wilder* analysis in review of action to enforce waiver provision).

⁵⁴ See, e.g., Lisa Colasi, Note, *Wilder v. Virginia Hospital Association: Making the Medicaid Reimbursement Rate Challenge a Federal Case*, 12 PACE L. REV. 139, 165 (1992) (predicting increase in provider suits under Boren Amendment as result of *Wilder* decision); C. Lee Cusenbary, Jr., Note, *Under the Boren Amendment, Health Care Providers Have an Enforceable Right, Actionable Under 42 U.S.C. § 1983, to Challenge a State's Reimbursement Plan Under the Medicaid Act*, 22 ST. MARY'S L.J. 519, 540 (1990) (same); Michael D. Daneker, Note, *Medicaid, State Cost-Containment Measures, and Section 1983 Provider Actions Under Wilder v. Virginia Hospital Association*, 45 VAND. L. REV. 487, 489 (1992) (same); Ellen Tracy, Note, *Health Care Providers' Right Under Section 1983 to Enforce the Boren Amendment to the Medicaid Act*, 30 WASHBURN L.J. 578, 587-88 (1991) (same).

The following are merely the reported federal Boren Amendment cases decided after *Wilder* as of Dec. 1993: *Abbeville Gen. Hosp. v. Ramsey*, 3 F.3d 797 (5th Cir. 1993); *Oregon Ass'n of Homes for the Aging, Inc. v. Oregon Dep't of Human Resources*, 5 F.3d 1239 (9th Cir. 1993); *Illinois Health Care Ass'n v. Bradley*, 983 F.2d 1460 (7th Cir. 1993); *Folden v. Washington Dep't of Social & Health Servs.*, 981 F.2d 1054 (9th Cir. 1992); *United Cerebral Palsy Ass'n v. Cuomo*, 966 F.2d 743 (2d Cir. 1992); *Bethphage Lutheran Serv. v. Weicker*, 965 F.2d 1239 (2d Cir. 1992); *Lett v. Magnant*, 965 F.2d 251 (7th Cir. 1992); *Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehab. Servs.*, 958 F.2d 1018 (10th Cir. 1992); *Illinois Council on Long Term Care v. Bradley*, 957 F.2d 305 (7th Cir. 1992); *Yorktown Med. Lab. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Temple Univ. v. White*, 941 F.2d 201 (3d Cir. 1991); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306 (2d Cir. 1991); *Pennsylvania Ass'n of Home Health Agencies v. Snider*, 826 F. Supp. 948 (E.D. Penn. 1993); *Kansas Health Care Ass'n, Inc. v. Kansas Dep't of Social & Rehab. Servs.*, 822 F. Supp. 698 (D. Kan. 1993); *Evelyn V. v. Kings County Hosp. Ctr.*, 819 F. Supp. 183 (E.D.N.Y. 1993); *Oklahoma Nursing Home Ass'n v. Demps*, 816 F. Supp. 688 (W.D. Okla. 1992); *Texas Hosp. Ass'n v. National Heritage Ins. Co.*, 802 F. Supp. 1507 (W.D. Tex. 1992); *Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehab. Servs.*, 794 F. Supp. 356 (D. Kan. 1992); *Connecticut Hosp. Ass'n v. O'Neill*, 793 F. Supp. 47 (D. Conn. 1992); *Hartland Hosp. v. Stangler*, 792 F. Supp. 670 (W.D.

In *Wilder*, the Court concluded that the Boren Amendment was enforceable because it fulfilled the three-part test creating a § 1983 cause of action.⁵⁵ First, the Court concluded that the plaintiffs were the intended beneficiaries of the statute.⁵⁶ Second, the Boren Amendment imposes a binding obligation on states to adopt reasonable and adequate rates.⁵⁷ Third, the Boren Amendment requirement that rates be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities is not too vague and amorphous to be judicially enforceable.⁵⁸ As such, the standard these providers must meet to challenge the Boren Amendment is less strict than the standard for an implied cause of action.⁵⁹

In rejecting the argument that the Boren Amendment is too vague and amorphous to be judicially enforceable, the *Wilder* Court reasoned that the statute and regulations set out factors that a state must consider in adopting its rates.⁶⁰ The Court noted the following factors that states must consider: (1) the unique situation of disproportionate share hospitals, (2) the requirement of adequate nursing home care, and (3) the special situation of hospitals providing inpatient care when long-term care at a nursing home would be sufficient but is unavail-

Mo. 1992); *Massachusetts Fed'n of Nursing Homes v. Commonwealth*, 791 F. Supp. 899 (D. Mass. 1992); *Oklahoma Nursing Home Ass'n v. Demps*, 792 F. Supp. 721 (W.D. Okla. 1992); *United Cerebral Palsy Ass'n v. Cuomo*, 783 F. Supp. 43 (N.D.N.Y. 1992); *Bethphage Lutheran Serv. v. Weicker*, 777 F. Supp. 1093 (D. Conn. 1991); *Rye Psychiatric Hosp. Ctr. v. Surles*, 777 F. Supp. 1142 (S.D.N.Y. 1991); *Illinois Health Care Ass'n v. Bradley*, 776 F. Supp. 411 (N.D. Ill. 1991); *Massachusetts Fed'n of Nursing Homes v. Commonwealth*, 772 F. Supp. 31 (D. Mass. 1991); *Capitol Hill Hosp. v. District of Columbia*, 769 F. Supp. 16 (D. D.C. 1991); *Rye Psychiatric Hosp. Ctr. v. Surles*, 768 F. Supp. 82 (S.D.N.Y. 1991); *Multicare Med. Ctr. v. Washington Dep't of Social & Health Servs.*, 768 F. Supp. 1349 (W.D. Wash. 1991); *Missouri Health Care Ass'n v. Stangler*, 765 F. Supp. 1413 (W.D. Mo. 1991); *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343 (N.D. Ill. 1991); *Lapeer County Med. Care Facility v. Michigan*, 765 F. Supp. 1291 (W.D. Mich. 1991); *Illinois Council on Long Term Care v. Bradley*, 759 F. Supp. 1309 (N.D. Ill. 1991); *Michigan Hosp. Ass'n v. Babcock*, No. 5:89-CV-00070, 1991 U.S. Dist. LEXIS 2058 (W.D. Mich. Feb. 11, 1991); *Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehab. Servs.*, 754 F. Supp. 1502 (D. Kan. 1990); *Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehab. Servs.*, No. 90-4207-S, 1990 U.S. Dist. LEXIS 17854 (D. Kan. Dec. 4, 1990); *Francisco v. Dep't of Human Resources*, No. 89-6244-HO, 1990 U.S. Dist. LEXIS 19766 (D. Or. July 10, 1990).

⁵⁵ *Wilder*, 496 U.S. at 509. For further discussion of the appropriateness of recognizing a § 1983 cause of action, see generally Cass R. Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. CHI. L. REV. 394 (1982).

⁵⁶ *Wilder*, 496 U.S. at 510.

⁵⁷ *Id.* at 512.

⁵⁸ *Id.* at 519.

⁵⁹ See Gellhorn, *supra* note 50, at 1192. For a more detailed discussion of the impact of recognizing a § 1983 cause of action under the Boren Amendment, see generally, Daneke, *supra* note 51; Colasi, *supra* note 51; Tracy, *supra* note 51; Cusenbary, *supra* note 51.

⁶⁰ *Wilder*, 496 U.S. at 519.

able.⁶¹ In addition, the Court stated that efficiently and economically operated facilities that provide care in compliance with federal and state standards, and assure reasonable access to medicaid participants, provide an "objective benchmark" against which states can judge the reasonableness of their rates.⁶² The Court stated that, although the statute gives states substantial discretion in making this judgment, rates must fall within a range of reasonable rates in order to meet the Boren Amendment standard.⁶³ Finally, the Court stated that the Boren Amendment is not too vague and amorphous because, although evaluation of state rates may require some knowledge of the hospital industry, such an inquiry is well within the competence of the judiciary.⁶⁴

As a result of the Court's determination that the Boren Amendment is not too vague and amorphous to be judicially enforced, states face the problem of identifying the unique objective benchmark for the payment of their inpatient hospital and long-term care medicaid providers: what is in fact an efficiently and economically operated inpatient facility.⁶⁵ Two of the three factors the *Wilder* Court suggested as guidance in determining this objective benchmark address exceptions to the typical Boren Amendment provider: disproportionate share hospitals and hospitals substituting for nursing homes.⁶⁶ These "unique" and "special" situations do not determine which of the remaining facilities are objectively efficient and economical.⁶⁷ The Court's third factor is the statutory requirements for adequate care in nursing homes.⁶⁸ This factor does not address hospitals and intermediate care facilities ("ICFs") for the mentally retarded, and, although suggesting criteria for evaluating adequacy, does not identify which nursing homes are efficient or economical.⁶⁹

⁶¹ *Id.* at 519 n.17.

⁶² *Id.* at 519.

⁶³ *Id.* at 519-20.

⁶⁴ *Id.* at 520.

⁶⁵ See *Wilder*, 496 U.S. at 519; 42 U.S.C. § 1396a(a)(13)(A).

⁶⁶ See *Wilder*, 496 U.S. at 519 n.17. 42 U.S.C. § 1396a(a)(13)(A) requires, in relevant part, that states consider:

(1) the unique situation (financial and otherwise) of a hospital that serves a disproportionate number of low income patients . . . and (3) the special situation of hospitals providing inpatient care when long-term care at a nursing home would be sufficient but is unavailable.

Id.

⁶⁷ See *Wilder*, 496 U.S. at 519.

⁶⁸ *Id.* 42 U.S.C. § 1396a(a)(13)(A) requires, in relevant part, that states consider "(2) the statutory requirements for adequate care in a nursing home." *Id.*

⁶⁹ See *id.*

The *Wilder* Court stated that there may be a range within which medicaid rates are reasonable.⁷⁰ The *Wilder* Court noted that rate methodologies based on only the budgetary reduction needs of the state, and methodologies that provide no justification for treating out-of-state hospitals and in-state hospitals differently, fall outside of the range of reasonableness because they have absolutely no relevance to the costs of an efficient hospital.⁷¹ Because the Court did not determine the range for reasonable rates, extensive litigation has ensued over whether particular rates are within the zone of reasonableness.⁷²

The *Wilder* Court determined that the judiciary is competent to evaluate the reasonableness of rates.⁷³ Although the judiciary has debated the appropriate role of judges in technical areas, the consensus has been that judges are competent, and in fact are obligated, to review even very technical issues.⁷⁴ Review of recent cases on the adequacy of payment to medicaid providers makes clear the high level of detail and complexity of the issues involved.⁷⁵ In such cases, judges without particular expertise in the health care system must consider whether complex rate methodologies for the reimbursement of capital costs, wage inflators, diagnosis-related groups ("DRGs"), and many other component costs of providing health care, in fact do meet the costs of efficiently and economically operated facilities.⁷⁶

B. Enforcing Section 30(A)

The Supreme Court has not made a determination that Section 30(A), the federal statute governing payment for outpatient services

⁷⁰ See *id.* at 519-20. HCFA evinced this zone of reasonableness standard as well. 48 Fed. Reg. 56,049 (1983).

⁷¹ See *Wilder*, 496 U.S. at 520 & n.18.

⁷² See, e.g., *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 26 (3d Cir. 1989) (discussing range of acceptable rates); *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1167 (10th Cir. 1988) (same); *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1126, 1133 (7th Cir. 1984) (same). HCFA itself stated that a reasonable and adequate rate is one which falls within a range. See 48 Fed. Reg. 56,049 (1983).

⁷³ See *Wilder*, 496 U.S. at 520.

⁷⁴ See *Ethyl Corp. v. EPA*, 541 F.2d 1, 66-68 (D.C. Cir.) (Bazelon, J., concurring), 68-69 (Leventhal, J., concurring), *cert. denied*, *E.I. Du Pont de Nemours & Co. v. EPA*, 426 U.S. 941 (1976).

⁷⁵ See, e.g., *Temple Univ. v. White*, 941 F.2d 201, 205 (3d Cir. 1991); *Casey*, 885 F.2d at 14; *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 791 (10th Cir. 1989); *Multicare Med. Ctr. v. Washington*, 768 F. Supp. 1349, 1359 (W.D. Wash. 1991); *Folden v. Washington Dep't of Social & Health Servs.*, 744 F. Supp. 1507, 1510 (W.D. Wash. 1990), *aff'd*, 981 F.2d 1054 (9th Cir. 1992).

⁷⁶ See, e.g., *Temple*, 941 F.2d at 205; *Casey*, 885 F.2d at 14; *AMISUB*, 879 F.2d at 791; *Multicare*, 768 F. Supp. at 1359; *Folden*, 744 F. Supp. at 1510.

and most non-acute services, is enforceable under § 1983, as it did in *Wilder* with respect to the Boren Amendment.⁷⁷ Federal district courts currently disagree over whether Section 30(A) is judicially enforceable pursuant to § 1983.⁷⁸ The United States Appeals Court for the Eighth Circuit suggested, in dicta, that it finds the Section 30(A) requirement that rates be consistent with efficiency, economy and quality of care, is enforceable.⁷⁹

In the 1992 case of *Fulkerson v. Maine Department of Human Services*, the United States District Court for the District of Maine determined that the Section 30(A) requirement that rates be consistent with efficiency, economy, and quality of care, was too vague and amorphous to be judicially enforceable.⁸⁰ In *Fulkerson*, a class action was brought by, and on behalf of, Maine medicaid recipients against the state medicaid agency, alleging that rules that required recipients to pay co-payment fees for medical services violated Section 30(A).⁸¹ In contrast with the *Wilder* Court's recognition of an objective benchmark in the efficient and economic facility,⁸² the *Fulkerson* court concluded that an objective determination could not be made as to whether a particular state plan satisfies the efficiency, economy and quality of care requirement in Section 30(A).⁸³ The *Fulkerson* court noted the difficulty in evaluating quality of care by stating that the courts are not qualified for the task of accommodating Congress's competing objec-

⁷⁷ See *Wilder*, 496 U.S. at 509-10 (right to "rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility. . .").

⁷⁸ Compare *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 534 (D. Me. 1992) (efficiency, economy and quality of care under Section 30(A) is not enforceable under § 1983) with *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991) (efficiency, economy and quality of care under Section 30(A) is enforceable under § 1983) and *Orthopaedic Hosp. v. Kizer*, No. 90-4209, slip op. at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

⁷⁹ *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993).

⁸⁰ *Fulkerson*, 802 F. Supp. at 534. The *Fulkerson* court did, however, find enforceable the "equal access provision" in Section 30(A), which requires that rates be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area. *Id.* at 533. The court found that the equal access provision met the three-part test for a § 1983 cause of action: it was clearly intended to benefit the plaintiffs, it imposed a binding obligation on states, and was not too vague and amorphous. See *id.* at 533-34. In finding this provision was not too vague and amorphous, the court cited the availability of statistical data on access, and *Clark v. Kizer*, 758 F. Supp. 572, 575-79 (E.D. Cal. 1990), which enforced the provision in 1990. See *id.* at 534. Unlike the efficiency, economy and quality of care provision of Section 30(A), the court found the equal access provision within the competence of the judiciary to enforce. See *id.* See *supra* note 39 for additional cases discussing the equal access provision.

⁸¹ *Id.* at 531-32.

⁸² *Wilder*, 496 U.S. at 519.

⁸³ *Fulkerson*, 802 F. Supp. at 534.

tives of controlling costs and providing quality care as evinced in Section 30(A).⁸⁴

In contrast with *Fulkerson*, the United States District Court for the Northern District of Illinois has recognized a § 1983 cause of action under Section 30(A), without discussing whether it is too vague and amorphous.⁸⁵ In the 1991 case of *Illinois Hospital Association v. Edgar*, a group of acute care hospitals sued the state medicaid agency for inadequate reimbursement of outpatient hospital services under both the Boren Amendment and Section 30(A).⁸⁶ The *Edgar* court concluded that the plaintiffs could bring a § 1983 cause of action against the state to enforce Section 30(A).⁸⁷ The court cited *Wilder* in its discussion of enforceable rights, but did not address the issue of whether Section 30(A) is too vague and amorphous.⁸⁸ The *Edgar* court considered only whether the plaintiffs were the intended beneficiaries of Section 30(A), and whether the statute imposed a binding obligation on states: two parts of the three-part test used in *Wilder* and *Fulkerson*.⁸⁹

In the 1992 case of *Orthopaedic Hospital v. Kizer*, the United States District Court for the Central District of California similarly held that hospitals have a right under Section 30(A) that is enforceable under § 1983.⁹⁰ The *Orthopaedic Hospital* court compared the language of Section 30(A) with the language of the Boren Amendment, and concluded that both sections were equally obligatory in their wording and neither section was too vague and amorphous to be judicially enforceable.⁹¹ In finding no principled distinction between the two sections, the court noted that both addressed (1) rates for hospital reimbursement, and (2) the criteria of efficiency and quality.⁹²

The only difference the *Orthopaedic Hospital* court found was that the Boren Amendment imposes an additional obligation on the state

⁸⁴ See *id.* at 534-35.

⁸⁵ See *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991).

⁸⁶ *Id.* at 1346 (see Count IV).

⁸⁷ *Id.* at 1349.

⁸⁸ See *id.* at 1348-49.

⁸⁹ *Id.* at 1349; see *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 509 (1990); *Fulkerson*, 802 F. Supp. at 533.

⁹⁰ *Orthopaedic Hosp. v. Kizer*, No. 90-4209, slip op. at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing). See also *Orthopaedic Hosp. v. Kizer*, No. 90-4209, 1992 U.S. Dist. LEXIS 21123, *44-46 (C.D. Cal. Oct. 6, 1992) (finding state rate setting arbitrary and capricious; remanding matter to state agency).

⁹¹ *Orthopaedic Hosp.*, No. 90-4209, slip op. at 6 (order denying summary judgment and requesting further briefing).

⁹² *Id.* at 5.

to make findings.⁹³ The court determined that the terms of Section 30(A) are more vague because the provision refers only to such rates as are "consistent with efficiency, economy, and quality of care," in contrast with the terms of the Boren Amendment, which are capable of "precise computation."⁹⁴ Reasoning that the additional Section 30(A) requirement of equal access is as readily ascertainable, "at least in theory," as the objective benchmark of an efficiently and economically operated facility, the *Orthopaedic Hospital* court concluded that the imprecision of the statute was not a basis for distinguishing between the Boren Amendment and Section 30(A).⁹⁵

In the 1993 case of *Arkansas Medical Society, Inc. v. Reynolds*, the United States Court of Appeals for the Eighth Circuit suggested in dicta that it agreed with the *Orthopaedic Hospital* and *Edgar* courts, and held that the Section 30(A) requirement for consistency with efficiency, economy, and quality of care was enforceable.⁹⁶ In discussing whether another requirement of Section 30(A), the equal access requirement, was enforceable, the court stated that it disagreed with the *Fulkerson* court's conclusion that the efficiency, economy, and quality of care provision was not specific enough to allow enforceability under § 1983.⁹⁷ The *Reynolds* court looked to the *Wilder* opinion, and concluded it was controlling on this point.⁹⁸ The court reasoned that the Boren Amendment language was arguably more nebulous than the Section 30(A) language.⁹⁹ The court made this point, however, when discussing the equal access provision, not the efficiency, economy, and quality of care provision.¹⁰⁰ The Eighth Circuit did expressly disagree, albeit in dicta, with the *Fulkerson* court's reasoning, and agreed with the reasoning of the *Orthopaedic Hospital* and *Edgar* courts.¹⁰¹

In summary, the Supreme Court has conclusively determined that the Boren Amendment, requiring medicaid payments to hospitals and nursing homes to be reasonable and adequate to meet the costs of efficiently and economically operated facilities, is enforceable under

⁹³ *Id.* at 5-6.

⁹⁴ *See id.* at 6.

⁹⁵ *Id.* at 6.

⁹⁶ 6 F.3d 519, 527 (8th Cir. 1993).

⁹⁷ *Id.* Several courts have considered the enforceability of the equal access provision of Section 30(A), a claim typically raised by beneficiaries of state medicaid programs. Courts have generally concluded that the equal access provision is enforceable. *See supra* note 39 for a list of cases interpreting this issue.

⁹⁸ *Reynolds*, 6 F.3d at 527.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

§ 1983.¹⁰² The *Wilder* Court held that the language of the Boren Amendment was not too vague and amorphous to be judicially enforceable because of the factors listed in the statute, and the objective benchmark created by an efficient and economical facility.¹⁰³ The Supreme Court has not considered the enforceability of the Section 30(A) requirement that payments to other providers be consistent with efficiency, economy, and quality of care. Several lower courts have applied the reasoning of *Wilder* to section 30(A) and concluded that both provisions are equally enforceable.¹⁰⁴ At least one federal court, however, has refused to follow *Wilder*, and concluded that the language of Section 30(A) is too vague and amorphous to be judicially enforced.¹⁰⁵

III. THE STANDARD OF REVIEW IN MEDICAID PAYMENT CASES

In its *Wilder* decision, the Supreme Court left unresolved the issue of the proper standard of review for state agency attempts to comply with the Boren Amendment.¹⁰⁶ After recognizing a § 1983 cause of action, and thereby determining that interpretation of the Boren Amendment is within the competence of the judiciary, the next issue is how courts should review state rate-making decisions under the statute.¹⁰⁷ The Court noted in *Wilder* that a right enforceable under § 1983 is not merely a procedural right that rates be accompanied by findings and assurances of reasonableness and adequacy, but also a substantive right to reasonable and adequate rates.¹⁰⁸ Several courts have used some variation of the arbitrary and capricious standard of review in Boren Amendment cases.¹⁰⁹ In *Orthopaedic Hospital*, the court

¹⁰² *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 524 (1990).

¹⁰³ *Id.* at 519.

¹⁰⁴ *Orthopaedic Hosp. v. Kizer*, No. 90-4209 slip op. at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing); *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991). See also *Reynolds*, 6 F.3d at 527 (dicta discussion); *Orthopaedic Hosp. v. Kizer*, No. 90-4209, 1992 U.S. Dist. LEXIS 21123 at *44-46 (C.D. Cal. Oct. 6, 1992) (remanding matter to agency).

¹⁰⁵ *Fulkerson v. Main Dep't of Human Servs.*, 802 F. Supp. 529, 534 (D. Me. 1992).

¹⁰⁶ *Wilder*, 496 U.S. at 520 n.18 ("We express no opinion as to which of the [Boren Amendment] cases contains the correct articulation of the appropriate standard of review.").

¹⁰⁷ See *id.*; *Orthopaedic Hospital*, No. 90-4209, slip op. at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

¹⁰⁸ *Wilder*, 496 U.S. at 510.

¹⁰⁹ See, e.g., *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 800-01 (10th Cir. 1989) (finding payment rate for inpatient hospitals arbitrary and capricious because state based decision on only budgetary factors); *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 24, 35 (3d Cir. 1989) (finding payment rate for out-of-state hospitals arbitrary and capricious because state failed to consider adequately all relevant factors); *Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891, 897

employed an arbitrary and capricious standard in reviewing state medicaid agency compliance with Section 30(A).¹¹⁰

In the leading case of *Citizens to Preserve Overton Park v. Volpe*, the United States Supreme Court stated that a reviewing court must decide whether the actions of an agency are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law.¹¹¹ The arbitrary and capricious standard is applied to non-adjudicatory agency actions subject to the Administrative Procedure Act ("APA"), and is also applied to non-adjudicatory agency action which is not specifically subject to the APA.¹¹² This standard of review is a narrow one, in which a court may not substitute its judgment for that of the agency.¹¹³ Although the judiciary is the final authority on issues of statutory construction, a reviewing court may overturn an agency's action only if the agency's interpretation of the law was impermissible.¹¹⁴ An agency's interpretation of the law is impermissible if it would frustrate Congress's goals.¹¹⁵

Further, the reviewing court must determine whether the agency decision was based on a consideration of the relevant factors.¹¹⁶ If an agency failed to consider relevant factors, its decision must be set aside.¹¹⁷ Adequate consideration of relevant factors requires that an agency provide a rational connection between the facts found and the choice made.¹¹⁸ When a statute directs an agency to consider certain

(E.D. Va. 1985) (applying arbitrary and capricious standard of review to payment rate); *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983) (finding payment rate for inpatient hospitals arbitrary and capricious because state failed to consider all relevant factors); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983) (applying relevant factors test to inpatient hospital payment rate); *Thomas v. Johnston*, 557 F. Supp. 879, 901, 910 (W.D. Tex. 1983) (invalidating payment rate because state failed to consider all relevant factors).

¹¹⁰ *Orthopaedic Hospital*, No. 90-4209, slip op. at 8 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing). See also *Louisiana v. United States Dep't of Health & Human Servs.*, 905 F.2d 877, 881 (5th Cir. 1990) (arbitrary and capricious standard of review, citing 5 U.S.C. § 706(2)(A), for pharmaceutical rates issued pursuant to agency regulations), *reh'g denied*, 1990 U.S. App. LEXIS 15147 (5th Cir. Aug. 14, 1990).

¹¹¹ 401 U.S. 402, 416 (1971).

¹¹² *Id.* at 414; 5 U.S.C. § 705(2)(A) (1982).

¹¹³ *Motor Vehicles Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *SEC v. Chenery Corp.*, 332 U.S. 194, 196, *reh'g denied*, 332 U.S. 783 (1947).

¹¹⁴ See *Chevron v. NRDC*, 467 U.S. 837, 843 & n.9 (holding EPA's interpretation of Clean Air Act term was reasonable interpretation, therefore valid), *reh'g denied*, 468 U.S. 1227 (1984).

¹¹⁵ See *Continental Air Lines v. Department of Transp.*, 843 F.2d 1444, 1453 (D.C. Cir. 1988).

¹¹⁶ *Overton Park*, 401 U.S. at 416.

¹¹⁷ See *id.*; *State Farm*, 463 U.S. at 43 (failure to consider alternatives and relevant factors, without explanation, constituted arbitrary and capricious action).

¹¹⁸ See *State Farm*, 463 U.S. at 52 (citing *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962)).

factors in making a particular decision, it may implicitly prohibit the administrator from taking other factors into account.¹¹⁹

The degree of judicial deference to agency interpretation is dependent upon the complexity of the issue and the relative expertise of an agency as compared with the court.¹²⁰ The weight given to an agency's interpretation depends upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements and its persuasiveness.¹²¹

A. *Judicial Review of Boren Amendment Rates*

In *Wilder*, the Court expressly did not decide which of the previous Boren Amendment cases contained a correct articulation of the appropriate standard of review.¹²² The Court did note, however, that when a state has complied with the procedural requirements of the Boren Amendment, a court employs a deferential standard of review to evaluate whether the rates comply with the substantive requirements.¹²³ The Court cited five cases that employed different variations on the arbitrary and capricious standard of review.¹²⁴ After *Wilder*, courts reviewing compliance with the Boren Amendment have generally reviewed state action on the basis of whether it was arbitrary and capricious.¹²⁵ Several

¹¹⁹ See *American Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490, 512 (1981) (prohibiting agency from relying on factor specifically forbidden by statute); *Addison v. Holly Hill Fruit Prods. Co.*, 322 U.S. 607, 618-19 (remanding regulation because it used factor not identified by statute, and failed to use factor required by statute), *reh'g denied*, 323 U.S. 809 (1944).

¹²⁰ *Ford Motor Credit Corp. v. Milhollin*, 444 U.S. 555, 568-69 (1980). See also *Ethyl Corp. v. EPA*, 541 F.2d 1, 67 (D.C. Cir. 1976) (Bazelon, J., concurring) ("substantive review of mathematical and scientific evidence by technically illiterate judges is dangerously unreliable").

¹²¹ *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) (giving significant weight to agency interpretation out of respect for its knowledge and experience, and need for uniform standards).

¹²² *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 520 n.18 (1990).

¹²³ *Id.*

¹²⁴ *Id.* (citing *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 795-801 (10th Cir. 1989) (court not limited to merely an arbitrary and capricious standard of review, but must determine whether plan is procedurally and substantively in compliance with Boren Amendment); *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 23-24 (3rd Cir. 1989) (court will not engage in independent assessment, but will only inquire whether determination was arbitrary and capricious, and whether state complied with access and disproportionate share requirements); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1294-95 (8th Cir. 1985) (court requires objective evidence of effects of proposed rates to determine whether actions were arbitrary and capricious, or to review factual findings, but HHS decision "significantly" aids court), *cert. denied*, 479 U.S. 1063 (1987); *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1234-38 (7th Cir. 1984) (same); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983) (court decides whether law violated; review is limited to deciding whether action is arbitrary and capricious)).

¹²⁵ See, e.g., *Folden v. Washington Dep't of Social & Health Servs.*, 981 F.2d 1054, 1058 (9th Cir. 1992); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991); *Illinois Health*

of these courts have recited the proposition that state actions are presumed valid.¹²⁶ Some courts, however, have employed something less than a deferential standard of review in assessing substantive compliance with the Boren Amendment.¹²⁷

For example, in the 1991 case of *Multicare Medical Center v. Washington*, the United States District Court for the Western District of Washington issued a fifty-three-page decision finding that the state's reimbursement system for inpatient hospital services both procedurally and substantively violated the Boren Amendment.¹²⁸ In a decision that shocked both commentators and state medicaid officials, a federal judge delved into highly technical areas of reimbursement.¹²⁹ The *Multicare* court decided many complex issues, such as that occupancy was a measure of efficiency and economy, but licensed bed occupancy was not a valid indicator;¹³⁰ factors such as urban/rural setting and wage differentials were not required for peer groupings;¹³¹ capping component costs at the median was not reasonable;¹³² freezing capital costs at a prior year's peer group medial was reasonable;¹³³ and use of a particular update factor as a retrospective and prospective inflation factor was not valid.¹³⁴

Several courts, including the *Multicare* court, have agreed on some general requirements for medicaid rate methodologies.¹³⁵ For example, rates must fall within a zone of reasonableness;¹³⁶ a nexus must

Care Ass'n v. Bradley, 776 F. Supp. 411, 417 (N.D. Ill. 1991); *Multicare Medical Ctr. v. Washington*, 768 F. Supp. 1349, 1389 (W.D. Wash. 1991).

¹²⁶ See, e.g., *Folden*, 981 F.2d at 1058; *Bradley*, 776 F. Supp. at 417; *Multicare*, 768 F. Supp. at 1392.

¹²⁷ See *Multicare*, 768 F. Supp. at 1392, 1396 (state not entitled to deference afforded federal agency; state failing to meet procedural requirements carries burden of proof of substantive compliance); *Connecticut Hosp. Ass'n v. O'Neill*, 793 F. Supp. 47, 52 (D. Conn. 1992) (court may properly examine state's findings to determine if they comply with law).

¹²⁸ *Multicare*, 768 F. Supp. at 1402.

¹²⁹ See generally *Multicare*, 768 F. Supp. 1349. For a discussion of state agencies' reactions and their (and their lawyers') concerns regarding the *Multicare* decision and other cases, see generally "Before and After the Lawsuit: Medicaid's Boren Amendment" (Jeff Harris, ed., 1992) (transcript of 12/9-10/91 conference proceedings of the Medicaid Management Institute, American Public Welfare Association).

¹³⁰ See *Multicare*, 768 F. Supp. at 1381.

¹³¹ *Id.* at 1394.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.* at 1394-95.

¹³⁵ See *infra* notes 121-25 and accompanying text.

¹³⁶ See, e.g., *Folden v. Washington Dep't of Social & Health Servs.*, 981 F.2d 1054, 1058 (9th Cir. 1992); *West Virginia Univ. Hosps. v. Casey*, 855 F.2d 11, 26 (3d Cir. 1989); *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1167 (10th Cir. 1988); *Wisconsin*

exist between rates and economical provider's reasonable costs;¹³⁷ only the overall rate must be reasonable, not the individual components that comprise the rate;¹³⁸ the required findings need not be written;¹³⁹ and budgetary constraints alone can never be a sufficient basis for rates.¹⁴⁰ While these areas of agreement may provide some guidance, a highly complex body of common law is developing in an area governed in large measure by statutes and regulations.¹⁴¹

The *Multicare* court identified the conceptual problem of determining what rates meet the costs of efficiently and economically operated facilities when it criticized the potential for circular reasoning by states.¹⁴² The court stated that:

While the identification and determination of economically and efficiently operated hospitals may be implicit in the rate setting methodology, the State cannot base its findings as to the reasonableness and adequacy of its payment rates on the rate setting methodology alone To say that the State's finding that its rates are reasonable and adequate is implicit in the methodology is to say that the rates are reasonable and adequate because they pay the costs that the State has determined it should pay.¹⁴³

States, however, are left with the continuing problem of finding some other reasonably principled basis for proving their rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers; states are also left with the problem of determining what constitutes a nexus, or rational connection, between their findings and their conclusions.¹⁴⁴

In the 1992 case of *Connecticut Hospital Association v. O'Neill*, thirty acute care hospitals challenged Connecticut's rate methodology for

Hosp. Ass'n v. Reivitz, 733 F.2d 1226, 1233 (7th Cir. 1984); *Multicare*, 768 F. Supp. at 1396; Folden v. Washington Dep't of Social & Health Servs., 744 F. Supp. 1507, 1529 (W.D. Wash. 1990).

¹³⁷ See, e.g., *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991); *Casey*, 885 F.2d at 28; *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 800 (10th Cir. 1989); *Colorado Health Care Ass'n*, 842 F.2d at 1167; *Illinois Health Care Ass'n v. Bradley*, 776 F. Supp. 411, 419 (N.D. Ill. 1991); *Multicare*, 768 F. Supp. at 1397.

¹³⁸ See, e.g., *Colorado Health Care Ass'n*, 842 F.2d at 1169; *Multicare*, 768 F. Supp. at 1397.

¹³⁹ See, e.g., *Colorado Health Care Ass'n*, 842 F.2d at 1168; *Multicare*, 768 F. Supp. at 1392; *Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891, 897 (E.D. Va. 1985).

¹⁴⁰ See, e.g., *AMISUB*, 879 F.2d at 801; *Multicare*, 768 F. Supp. at 1393; *Michigan Hosp. Ass'n v. Babcock*, 736 F. Supp. 759, 764 (W.D. Mich. 1990).

¹⁴¹ See *supra* notes 121-25.

¹⁴² See *Multicare*, 768 F. Supp. at 1393.

¹⁴³ *Id.*

¹⁴⁴ See *id.*

inpatient costs.¹⁴⁵ The state had been paying providers the federally imposed "upper limit"¹⁴⁶—what the state would have paid under medicare.¹⁴⁷ The state claimed that, because it was paying at the maximum aggregate amount permitted by federal law, the complaint should be dismissed.¹⁴⁸ The United States District Court for the District of Connecticut disagreed, indicating that it would not accept the argument that the upper limit supersedes the requirements of the Boren Amendment as dispositive of whether the state is in compliance with the Medicaid Act.¹⁴⁹

The Supreme Court left open the issue in *Wilder* of the appropriate standard of review for agency rate decisions under the Boren Amendment.¹⁵⁰ Without this guidance, many courts have chosen to delve into the highly technical areas of rating methodologies, and have refused to defer to agency expertise.¹⁵¹ The result has been a complex, confusing, and often conflicting body of law regarding what constitutes procedural and substantive compliance with the medicaid payment statute.¹⁵²

B. Judicial Review of Section 30(A) Rates

In the 1992 case of *Orthopaedic Hospital v. Kizer*, the United States District Court for the Central District of California held that the state medicaid agency's compliance with Section 30(A) would be reviewed under an arbitrary and capricious standard.¹⁵³ In making this determination, the court relied on both administrative law precedent and Boren Amendment cases.¹⁵⁴ The court stated that to determine whether the rates were valid, the court must determine (1) whether the agency had considered all relevant factors and (2) whether the facts found and relevant factors considered were rationally connected to the rates of payment set.¹⁵⁵

¹⁴⁵ *Connecticut Hosp. Ass'n v. O'Neill*, 793 F. Supp. 47, 48 (D. Conn. 1992).

¹⁴⁶ See *supra* notes 45–48 and accompanying text (discussing upper limit).

¹⁴⁷ See *O'Neill*, 793 F. Supp. at 48, 49.

¹⁴⁸ *Id.* at 48.

¹⁴⁹ See *id.* at 50.

¹⁵⁰ *Wilder*, 496 U.S. at 520 n.18.

¹⁵¹ See, e.g., *Multicare*, 768 F. Supp. at 1402; *O'Neill*, 793 F. Supp. at 48.

¹⁵² See, e.g., *Multicare*, 768 F. Supp. at 1402; *O'Neill*, 793 F. Supp. at 48.

¹⁵³ *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 8 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

¹⁵⁴ *Id.* (citing *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971) and *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 800 (10th Cir. 1989)).

¹⁵⁵ *Orthopaedic Hosp. v. Kizer*, No. 90-4209, U.S. Dist. LEXIS 21123 *10 (C.D. Cal. Oct. 5, 1992) (order granting plaintiffs' motion for summary judgment).

Before determining whether the agency had considered all relevant factors, the court considered what factors were relevant.¹⁵⁶ The court concluded that relevant factors were found in Section 30(A), namely efficiency, economy and quality of care.¹⁵⁷ The court noted that these were not necessarily all of the relevant factors, but did not reach the question of what other factors were relevant.¹⁵⁸

The *Orthopaedic Hospital* court stated that under circumstances in which clear evidence of congressional intent exists, such as in Section 30(A), the court will examine whether an agency considered certain relevant factors that the agency was *not* specifically required to consider.¹⁵⁹ The court acknowledged that such review may appear unfair to the agency, but that such scrutiny might be desirable because it may encourage agencies to consider all relevant factors.¹⁶⁰ The court noted that this scrutiny was consistent with Supreme Court cases.¹⁶¹ The absence of a statutory or regulatory requirement that agencies consider efficiency, economy and quality of care did not preclude the court, it reasoned, from basing its decision on whether the agency considered those factors.¹⁶²

The *Orthopaedic Hospital* court stated that the agency could not rely on state legislative pronouncements suggesting that efficiency, economy and quality of care were deemed "considered" if the agency itself had discretion to set the precise payment rate.¹⁶³ The burden on the state was to provide evidence *both* that (1) in setting the rates, the agency merely implemented a precisely-crafted statutory enactment that did not permit any agency discretion and (2) the legislature had expressly considered efficiency, economy and quality of care upon enactment of the statute.¹⁶⁴ The *Orthopaedic Hospital* court, however, found evidence of neither in the state agency's rates under Section 30(A).¹⁶⁵

¹⁵⁶ See *id.* at *10-15.

¹⁵⁷ *Id.* at *10-22.

¹⁵⁸ *Id.* at *11 n.3.

¹⁵⁹ *Id.* at *16 (emphasis in original).

¹⁶⁰ *Orthopaedic Hosp.*, No. 90-4209, U.S. Dist. LEXIS 21123 at *16 n.8.

¹⁶¹ *Id.* at 16-20 (citing *American Paper Inst. v. American Elec. Power Serv. Corp.*, 461 U.S. 402, 413 (1983) and *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)).

¹⁶² See *id.* at *21.

¹⁶³ *Id.* at *23-25, 28-30.

¹⁶⁴ *Id.* at *30, 34.

¹⁶⁵ *Orthopaedic Hosp.*, No. 90-4209, U.S. Dist. LEXIS 21123 at *30, 34. The court did, however, find that rate *increases* for three specific outpatient services were adequately considered, and therefore not arbitrary and capricious. *Id.* *44. In its reasoning, the court noted that the agency's

Finally, the *Orthopaedic Hospital* court found no rational connection between the relevant factors and the rates because it concluded that the agency did not consider the relevant factors.¹⁶⁶ The court therefore concluded that the agency acted arbitrarily and capriciously in setting general outpatient rates.¹⁶⁷ The court ordered that the matter be remanded to the agency for further consideration consistent with the opinion.¹⁶⁸ At this writing, the plaintiffs have submitted a request for clarification of the judgment, seeking invalidation of the rates.¹⁶⁹

Following the majority of Boren Amendment cases, the court in *Orthopaedic Hospital* refused to defer to the agency's expertise, and instead determined that the agency had acted arbitrarily and capriciously in setting rates under Section 30(A).¹⁷⁰ The court determined that efficiency, economy and quality of care are factors the agency must consider and suggested that the court may require the agency to consider additional factors not mentioned in the statute.¹⁷¹ The *Orthopaedic Hospital* court appears to be the first court to evince a standard of review for agency compliance with Section 30(A)'s efficiency, economy and quality of care requirement.¹⁷² The court failed, however, to invalidate the rates, concluding that the matter should be remanded to the agency for compliance with the court's decision.¹⁷³

IV. SOLUTIONS FOR MEDICAID PROVIDER PAYMENT AND REFORM OF THE HEALTH CARE SYSTEM: CHALLENGES FOR THE 21ST CENTURY

The current trend in medicaid provider payment litigation does not bode well for incremental reform of the health care system. The Supreme Court's *Wilder* decision definitively established a substantial role for the judiciary in the increasingly complex financial relations

statement of reasons specifically addressed the issues of access, quality and adequacy of care and cost effectiveness. See *id.* at *39-42.

¹⁶⁶ *Id.* at *43.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at *45.

¹⁶⁹ See *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 1-2 (C.D. Cal. Dec. 4, 1992) (plaintiffs' notice of motion and motion to alter or amend revised judgment).

¹⁷⁰ *Orthopaedic Hosp.*, No. 90-4209, U.S. Dist. LEXIS 21123 at *43.

¹⁷¹ *Id.* at *16.

¹⁷² *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 8 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing); *Orthopaedic Hospital v. Kizer*, No. 90-4209, U.S. Dist. LEXIS 21123 *10 (C.D. Cal. Oct. 5, 1992) (order granting plaintiffs' motion for summary judgment). But see *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993) (holding agency failed to consider relevant factors in equal access provision and thereby violated Section 30(A)).

¹⁷³ *Orthopaedic Hosp. v. Kizer*, No. 90-4209, U.S. Dist. LEXIS 21123 *45 (C.D. Cal. Oct. 5, 1992).

between states and their medicaid providers.¹⁷⁴ There are several considerations that make the Court's decision that medicaid providers are entitled to a § 1983 cause of action to challenge state compliance with the Boren Amendment unwise and legally suspect.¹⁷⁵

Industry experts were surprised that the Court concluded there was "little doubt" that *providers* are the intended beneficiaries of a federal law designed to govern a public assistance program benefitting the poor and disabled.¹⁷⁶ Also surprising was the Court's determination that federal HCFA approval of an overall rate structure and an appeals process for provider challenge of the individual application of rates does not protect states from invalidation of rates—rates over which states were intended by Congress to have substantial control.¹⁷⁷ Finally, the Court's decision that federal courts could and should determine the subtleties of one of the country's most complex and changing fields precludes rational progress in provider payment systems.¹⁷⁸ In *Wilder*, the Court refused to defer to state and federal expertise in health care financing, even in light of the heretofore clear congressional intent to delegate substantial technical decisionmaking power to the administrative arm of government.¹⁷⁹

A. *The Unenforceability of Section 30(A): Distinctions Between the Boren Amendment and Section 30(A)*

The *Wilder* precedent presents a dilemma for lower courts considering challenges to Section 30(A) rates.¹⁸⁰ Such courts have two op-

¹⁷⁴ See *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 520 (1990) (stating whether rates are reasonable is inquiry well within competence of judiciary).

¹⁷⁵ See generally, e.g., Colasi, *supra* note 51 (criticizing *Wilder* decision); Cusenbary, *supra* note 51 (same); Daneker, *supra* note 51 (same); Tracy, *supra* note 51 (same).

¹⁷⁶ See *Wilder*, 496 U.S. at 510; "Before and After the Lawsuit: Medicaid's Boren Amendment" 7 (Jeff Harris, ed., 1992) (transcript of 12/9–10/91 conference proceedings of Medicaid Management Institute, American Public Welfare Association).

¹⁷⁷ See *Wilder*, 496 U.S. at 522–23 (holding appeal procedures which do not allow providers to challenge *overall* rate methodology are insufficient to protect state from § 1983 cause of action). But see *Multicare Medical Ctr. v. Washington*, 768 F. Supp. 1349, 1401 (W.D. Wash. 1991) (ordering state to devise appeals process which "[allows] hospitals to raise potentially relevant special factors without opening itself up to frivolous appeals" (citations omitted)); *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 31 (3rd Cir. 1989) (federal regulations implementing Boren Amendment reserve to judgment of states the decision whether to allow challenges to validity of methodology at administrative level).

¹⁷⁸ See *Wilder*, 496 U.S. at 520 (reasonableness of rates is within competence of judiciary).

¹⁷⁹ See *id.* at 519–20.

¹⁸⁰ See *id.* at 520. See, e.g., *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 533 (D. Maine 1992); *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 4 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

tions. By analogizing to the *Wilder* Court's decision on the Boren Amendment, a court may reason that interpretation of the even more ambiguous and precatory language of Section 30(A) is within the competence of the judiciary.¹⁸¹ Alternatively, courts, reasoning without much precedent, may allow only one group of providers (hospitals, nursing homes and ICF/MRs) to challenge only a portion of their payment rates (inpatient service rates).¹⁸² Courts faced with this dilemma have, not surprisingly, issued conflicting decisions.¹⁸³

Both the Boren Amendment and Section 30(A) suffer from the same vagueness of terms.¹⁸⁴ The Supreme Court stated that the Boren Amendment offers factors as guidance in determining the objective benchmark of efficiency and economy, and the adequacy of rates.¹⁸⁵ These "factors," however, have little to do with the majority of providers, as they address only providers with unique and special situations.¹⁸⁶ In contrast, Section 30(A) does not offer guiding factors, even for unique and special providers.¹⁸⁷

The *Fulkerson* court appears to have recognized the distinctions between the Boren Amendment and Section 30(A).¹⁸⁸ Although the *Fulkerson* court did not specifically discuss why Section 30(A) and its implementing regulations do not allow for an objective determination when the Boren Amendment does, the statutes offer some insight.¹⁸⁹ The Boren Amendment refers to efficiently and economically operated facilities, in contrast with Section 30(A), which refers to the concepts of efficiency, economy and quality of care.¹⁹⁰

The Boren Amendment also requires that payment to providers meet the costs of facilities.¹⁹¹ In contrast, Section 30(A) requires that payment to providers be consistent with the concepts of efficiency, economy and quality of care.¹⁹² The less concrete requirement for

¹⁸¹ See, e.g., *Orthopaedic Hosp.*, No. 90-4209, at 8 (Oct. 5, 1992) (order granting plaintiffs' motion for summary judgment); see also *Arkansas Medical Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993).

¹⁸² See, e.g., *Fulkerson*, 802 F. Supp. at 533.

¹⁸³ See, e.g., *id.* (finding Section 30(A) too vague and amorphous to be judicially enforceable); *Orthopaedic Hosp.*, No. 90-4209, at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing) (finding Section 30(A) enforceable).

¹⁸⁴ See 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A).

¹⁸⁵ *Wilder*, 496 U.S. at 519.

¹⁸⁶ See *id.* at 519 n.17.

¹⁸⁷ See 42 U.S.C. § 1396a(a)(30)(A).

¹⁸⁸ See *Fulkerson*, 802 F. Supp. at 533-35.

¹⁸⁹ See *id.* at 534; 42 U.S.C. §§ 1396a(a)(30)(A), 1396a(a)(13)(A).

¹⁹⁰ 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A).

¹⁹¹ 42 U.S.C. § 1396a(a)(13)(A).

¹⁹² 42 U.S.C. § 1396a(a)(30)(A).

consistency, rather than reimbursing costs, may be another reason for the *Fulkerson* court's unwillingness to find an objective benchmark in Section 30(A) and its implementing regulations.¹⁹³

Furthermore, Section 30(A) adds an additional requirement of quality, which is not a factor in the Boren Amendment.¹⁹⁴ Considerable debate has occurred regarding what constitutes quality in health care, and how quality can be measured.¹⁹⁵ The *Fulkerson* court noted the difficulty in evaluating quality of care by stating that the courts are not qualified for the task of accommodating Congress's competing objectives in Section 30(A) of controlling costs and providing quality care, a conflict which is arguably not present in the language of the Boren Amendment.¹⁹⁶

Finally, Section 30(A) does not impose a requirement similar to the Boren Amendment which requires states to make findings and assurances regarding the adequacy of rates.¹⁹⁷ Under Section 30(A), a state must merely ensure that its plan includes payment methods and procedures to assure payments are consistent with efficiency, economy and quality of care.¹⁹⁸ The Boren Amendment offers a court the two concrete guides of findings and assurances which address the adequacy of rates, whereas Section 30(A) offers no such information directly addressing whether rates are consistent with its requirements, and instead requires a court to review, generally, the methods and procedures relating to payment.¹⁹⁹

As a practical matter, payment methodologies for reimbursement of the types of providers under the Boren Amendment, such as hospitals and nursing homes, are developed on a group, or peer group, basis, accounting for the differences between types of providers.²⁰⁰ In

¹⁹³ See *Fulkerson*, 802 F. Supp. at 534.

¹⁹⁴ 42 U.S.C. §§ 1396a(a)(30)(A), 1396a(a)(13)(A); but see *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 5 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing) (Boren Amendment includes quality as criterion).

¹⁹⁵ See Avedis Donabedian, *Quality, Cost and Clinical Decisions*, 468 THE ANNALS 196, 199-204 (July 1983) (discussing measurement and promotion of quality care); Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, LAW & CONTEMP. PROBS. 87, 87-94 (Spring 1991) (same).

¹⁹⁶ See *Fulkerson*, 802 F. Supp. at 534-35; but see *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 5 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing) (Boren Amendment includes quality as criterion).

¹⁹⁷ 42 U.S.C. § 1396a(a)(13)(A). See 42 U.S.C. § 1396a(a)(30)(A).

¹⁹⁸ 42 U.S.C. § 1396a(a)(30)(A).

¹⁹⁹ See 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A).

²⁰⁰ See, e.g., *Buchanan*, *supra* note 11, at 60; *AMISUB v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 798 (10th Cir. 1989); *Illinois Health Care Ass'n v. Bradley*, 776 F. Supp. 411, 419 (N.D. Ill. 1991).

contrast, many providers under Section 30(A) are paid at rates that do not necessarily reflect the unique characteristics or costs of providers.²⁰¹ These statutory and practical differences between the Boren Amendment and Section 30(A) may account for the *Fulkerson* court's determination that Section 30(A) requires specialized knowledge of the workings of the health care system, and that such a determination is beyond the competence of the judiciary.²⁰²

Both the *Orthopaedic Hospital* and *Edgar* courts found Section 30(A) enforceable under a § 1983 cause of action.²⁰³ In *Orthopaedic Hospital*, the court followed *Wilder's* three-part test, concluding that the increased vagueness of Section 30(A) was an insufficient basis for distinguishing between the obligations imposed on states by Section 30(A) and the Boren Amendment.²⁰⁴ An explanation of the *Edgar* court's failure to address whether Section 30(A) is too vague and amorphous for judicial enforcement is not readily apparent.²⁰⁵ The Eighth Circuit failed to support its assertion in *Reynolds* that the Boren Amendment is more nebulous than the Section 30(A) provision requiring consistency with efficiency, economy and quality of care, and instead focused on the equal access provision in Section 30(A).²⁰⁶ The *Reynolds* court's statement that the Boren Amendment is more nebulous than Section 30(A), and its rejection of the *Fulkerson* court's reasoning appears to be dicta, at best, and fails to advance the issue.²⁰⁷

²⁰¹ See, e.g., *Louisiana v. United States Dep't of Health & Human Servs.*, 905 F.2d 877, 881 (5th Cir. 1990) (state used Average Wholesale Price from American Druggists' Blue Book for reimbursement of pharmaceutical drugs, which exceeded pharmacists' actual costs and is arguably not the closest estimate for general and current drug prices); *Clark v. Kizer*, 758 F. Supp. 572, 577 (E.D. Cal. 1990) (state utilized maximum reimbursement rates for dental services, which increased at less than half of Dental Consumer Price Index rate of increase, and reimbursed approximately 40% of dental providers' usual rates).

²⁰² See *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 534-35 (D. Me. 1992).

²⁰³ *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing); *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991).

²⁰⁴ See *Orthopaedic Hosp.*, No. 90-4209, at 6 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²⁰⁵ See *Edgar*, 765 F. Supp. at 1349. In an even more confusing analysis, a federal district court in Oklahoma also applied only a two-part test in evaluating whether participating nursing homes could enforce federal medicaid regulations and statutes under § 1983, but went on to refer to, and not impose, the missing vague and amorphous test in later discussion. See *Oklahoma Nursing Home Ass'n v. Demps*, 792 F. Supp. 721, 725, 728 (W.D. Okla. 1992) (citing *Wilder*, 496 U.S. at 509). Whether this case recognizes a § 1983 cause of action for enforcement of Section 30(A) is not immediately apparent. See *id.* at 726-27.

²⁰⁶ See *Arkansas Medical Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993).

²⁰⁷ *Id.*

Nor do the facts of *Edgar*, *Orthopaedic Hospital* and *Fulkerson* warrant different holdings.²⁰⁸ All three cases involved a class of plaintiffs previously identified as the intended beneficiaries of the Medicaid Act.²⁰⁹ In *Edgar* and *Orthopaedic Hospital*, the plaintiffs were acute care hospitals, entitled to seek enforcement of the Boren Amendment.²¹⁰ In *Fulkerson*, the plaintiffs were medicaid recipients, also entitled to seek enforcement of provisions of the Medicaid Act.²¹¹ If the basis for the different holdings in these cases were the class of plaintiffs, such a distinction must be made under the first part of the *Wilder* test: whether the plaintiffs were the intended beneficiaries of the statute.²¹²

The *Edgar* and *Orthopaedic Hospital* courts' unwillingness to make a distinction between a hospital's right to sue over inpatient versus outpatient rates is understandable. Such a distinction appears superficially meaningless and inconsistent.²¹³ The court's superficial and incompletely reasoned decision in *Edgar* enabled it to avoid this dilemma.²¹⁴ The more thoughtfully reasoned opinion in *Orthopaedic Hospital* remains unpublished, but arguably stands as the most comprehensive analysis to date of the relevant provisions of Section 30(A).²¹⁵

Although some differences exist between the respective requirements of the Boren Amendment and Section 30(A),²¹⁶ recognition of a § 1983 cause of action under Section 30(A) for acute care hospitals

²⁰⁸ See *Fulkerson*, 802 F. Supp. at 533; *Edgar*, 765 F. Supp. at 1349; *Orthopaedic Hosp.*, No. 90-4209, at 1-2 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²⁰⁹ See *Fulkerson*, 802 F. Supp. at 533; *Edgar*, 765 F. Supp. at 1349; *Orthopaedic Hosp.*, No. 90-4209, at 3 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²¹⁰ See *Edgar*, 765 F. Supp. at 1344; *Orthopaedic Hosp.*, No. 90-4209, slip op. at 3-4 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²¹¹ See *Fulkerson*, 802 F. Supp. at 531.

²¹² See *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 509 (1990). While the *Fulkerson* court stated that medicaid recipients were the intended beneficiaries of language under Section 30(A) addressing equal access, the court did not determine whether they were the intended beneficiaries of efficiency, economy, and quality of care. See 802 F. Supp. at 533-34. One commentator suggests that medicaid recipients are less appropriate plaintiffs in medicaid rate cases. Henry Paul Monaghan, *Federal Statutory Review under § 1983 and the APA*, 91 COLUM. L. REV. 233, 259 (Mar. 1991). This commentator states that plaintiffs must assert a property-like right to assert that state rates transgressed federal law, and successfully obtain review. *Id.*

²¹³ See *Orthopaedic Hospital*, No. 90-4209, at 5 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²¹⁴ See *Edgar*, 765 F. Supp. at 1348-49.

²¹⁵ See *Orthopaedic Hosp.*, No. 90-4209, at 2-7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²¹⁶ See *supra* notes 158-91 and accompanying text.

but not for beneficiaries is inconsistent.²¹⁷ Recognizing a § 1983 cause of action for hospitals under the Boren Amendment, but not under Section 30(A), also would result in a confusing inconsistency.²¹⁸ Analysis of the language of Section 30(A), however, indicates that this provision is even more nebulous than the language of the Boren Amendment, is too vague and amorphous to be judicially enforceable, and should be considered beyond the competence of the judiciary.²¹⁹ One commentator doubts whether courts, even if it is within their competence, have the institutional capacity to determine what rates are reasonable and adequate.²²⁰ Faced with the United States Supreme Court's decision that judicial interpretation of the Boren Amendment is appropriate, the increase in lower courts' meddling in Section 30(A), and the large body of cases in which federal judges have micro-managed state medicaid agencies, further judicial interpretation of these specific provisions would only add to the confusion. Statutory and regulatory reform is the only promising solution.²²¹

B. *The Proper Standard of Judicial Review of Medicaid Rates*

The Supreme Court's decision not to address what constitutes the appropriate standard of review for the Boren Amendment leaves a substantial issue unresolved.²²² While a cursory review of the cases noted by the Court suggests an almost universal application of the arbitrary and capricious standard of review, closer scrutiny reveals substantial inconsistency in the level of deference by courts to agency expertise and decisionmaking.²²³ The result of the Supreme Court's

²¹⁷ See *Fulkerson v. Maine Dep't of Human Servs.*, 802 F. Supp. 529, 533 (D. Me. 1992); *Edgar*, 765 F. Supp. at 1349.

²¹⁸ See *Orthopaedic Hosp.*, No. 90-4209, at 5 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing).

²¹⁹ *Fulkerson*, 802 F. Supp. at 534-35. But see *Arkansas Medical Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993) (rejecting *Fulkerson* reasoning and arguing Boren Amendment more nebulous than equal access provision in Section 30(A)).

²²⁰ Monaghan, *supra* note 188, at 259 n.160. For further discussion of review of § 1983 claims, as compared with the review under § 702 of the APA, see generally, *id.*

²²¹ One commentator has suggested a statutory amendment to require the Secretary of HHS to "look behind" the findings and assurances of states under the Boren Amendment. See Colasi, *supra* note 51, at 173. Such a measure, however, would fail to address the increasing litigation and interpretation problems of the other provisions of the Medicaid Act. See *id.*

²²² See *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 520 n.18 (1990).

²²³ See *supra* notes 92-151, and accompanying text; see, e.g., *Folden v. Washington Dep't of Social & Health Servs.*, 891 F.2d 1054, 1058 (9th Cir. 1992) (affirming district court decision which employed arbitrary and capricious standard); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991); *Illinois Health Care Ass'n v. Bradley*, 776 F. Supp. 411, 417 (N.D. Ill. 1991); *Multicare Med. Ctr. v. Washington*, 768 F. Supp. 1349, 1389 (W.D. Wash. 1991).

failure to determine the issues on which courts should defer to agencies and the issues on which states must expect to be challenged, and the large and varied body of case law on rate methodologies, have created a complex and confusing setting within which states must try to formulate valid payment policies.²²⁴

Both the *Multicare* and *Connecticut Hospital Association* cases represent inappropriately detailed judicial review.²²⁵ While a court may be able to determine if some rates are clearly unreasonable, the *Multicare* court exceeded its proper role by examining and deciding highly complex and detailed methodological issues.²²⁶ Congress's clear intent to reserve for the states substantial authority in rate-making decisions should be given full effect.²²⁷ Courts would better serve the public and the health care industry by limiting review to whether overall rates are reasonable and adequate.²²⁸ The judiciary should leave the determination of complex rate components to the agencies with expertise, in whom Congress has vested the authority to make such decisions.²²⁹ The provider appeal procedures that states must establish assure providers a forum for resolving disputes because they allow appeal of issues other than the validity of the overall rate.²³⁰

The *Connecticut Hospital Association* decision reflects another form of inappropriate judicial review.²³¹ In refusing to dismiss a case in which the state was paying the maximum amount allowed by federal law, the court showed either that it did not take into consideration the federal requirements imposed on states, or that it believed the judiciary has the authority to remove such requirements.²³² The statutory language indicates Congress's intent to leave a cap on medicaid rates, and courts should uphold such express policy.

The providers in *Orthopaedic Hospital* succeeded in convincing the court that, whatever Congress meant in Section 30(A) by consistency

²²⁴ See generally "Before and After the Lawsuit: Medicaid's Boren Amendment" (Jeff Harris, ed., 1992) (transcript of 12/9-10/91 conference proceedings of the Medicaid Management Institute, American Public Welfare Association).

²²⁵ See *Connecticut Hosp. Ass'n v. O'Neill*, 793 F. Supp. 47, 50 (D. Conn. 1992); *Multicare*, 768 F. Supp. at 1402.

²²⁶ See *Multicare*, 768 F. Supp. at 1402.

²²⁷ See 48 Fed. Reg. 56,046-49 (1983).

²²⁸ See *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1169 (10th Cir. 1988).

²²⁹ See 48 Fed. Reg. 56,049.

²³⁰ See 42 C.F.R. § 447.253(c).

²³¹ See *Connecticut Hosp. Ass'n v. O'Neill*, 793 F. Supp. 47, 50 (D. Conn. 1992).

²³² See *id.*

with efficiency, economy and quality of care, the state outpatient hospital rates did not comply.²³³ By remanding the matter to the state agency, the *Orthopaedic Hospital* court was able to avoid determining what constitutes consistency with efficiency, economy and quality of care, and thereby avoided a detailed decision like that in *Multicare*.²³⁴ The *Orthopaedic Hospital* court's decision to remand the rates to the agency for review, instead of invalidating the payment system, tempered the success of the providers and created confusion regarding whether the rates would remain in effect.²³⁵ The decision, however, was correct because it left to the agency experts the authority to determine which rates would be valid and consistent with the court's opinion.²³⁶

Both the Boren Amendment and Section 30(A) are vague and amorphous, and arguably inappropriate for judicial review.²³⁷ The judiciary's decision to interpret and enforce these provisions prompts the question of the proper standard of review.²³⁸ Instead of deciding the detailed complexities of state medicaid methodologies, courts should limit their review to whether the state's decision was within the scope of the authority granted by Congress, and whether the exercise of such authority in the particular case frustrates Congress's intent.²³⁹

C. *The Need for Substantial Reform*

If reform of the health care system is successful, Congress will supplant both the Boren Amendment and Section 30(A), and their accompanying regulations, with a provider payment system that avoids the current statutory pitfalls and judicial inconsistencies.²⁴⁰ While the best structure for administering a national health care system, or a

²³³ See *Orthopaedic Hosp.*, No. 90-4209, at 35 (C.D. Cal. Oct. 6, 1992) (order granting plaintiffs' motion for summary judgment).

²³⁴ See *id.*; *Multicare Med. Ctr. v. Washington*, 768 F. Supp. 1349, 1402 (W.D. Wash. 1991).

²³⁵ See *Orthopaedic Hosp.*, No. 90-4209, at 1-2 (C.D. Cal. Dec. 4, 1992) (plaintiffs' notice of motion and motion to alter or amend revised judgment).

²³⁶ See *Orthopaedic Hosp.*, No. 90-4209, at 36 (C.D. Cal. Oct. 5, 1992) (order granting plaintiffs' motion for summary judgment).

²³⁷ See 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A).

²³⁸ See *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 520 n.18 (1990) (Boren Amendment enforceable under § 1983 cause of action); *Orthopaedic Hosp.*, No. 90-4209, at 7 (C.D. Cal. June 28, 1991) (order denying summary judgment and requesting further briefing) (Section 30(A) enforceable under § 1983 cause of action).

²³⁹ See *Chevron v. NRDC*, 467 U.S. 837, 843 & n.9 (1984) (court may overturn agency action only if agency's interpretation of the law was impermissible); *Continental Air Lines v. Dep't of Transp.*, 843 F.2d 1444, 1453 (D.C. Cir. 1988) (agency's interpretation of law is impermissible if it would frustrate Congress' goals).

²⁴⁰ See 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A).

reformed system of health care for the poor, disabled and old, is not obvious, the continuation of state responsibility for local administration is appropriate. Regional differences—in providers, costs, consumer needs, technology—are best addressed regionally.²⁴¹ Such state administration would appropriately be subject to federal oversight. Following are four solutions to the provider payment problems of the current medicaid system that should be implemented as part of the reformed health care system.

1. A Less Ambiguous Statutory Delegation of Power

While statutes will always be insufficient to the task of addressing every possible fact situation, a statute improving upon the Boren Amendment and Section 30(A) is certainly attainable. Reliance upon legislative history is not effective; courts willingly noted that Congress had drafted these provisions with the intent of granting substantial authority to states to determine what rates were adequate and reasonable.²⁴² Federal agency inaction has also proven insufficient to assure states flexibility or creative license, as HHS's refusal to more specifically define the terms of the Boren Amendment has not prevented courts from encroaching on the authority of the states.²⁴³

A statute that expressly delegates to the states the authority to determine what rates are reasonable and adequate would provide a

²⁴¹ See 48 Fed. Reg. 56,049 (1983).

²⁴² See, e.g., *Wilder*, 496 U.S. at 505; *Connecticut Hosp. Ass'n v. O'Neill*, 793 F. Supp. 47, 49 (D. Conn. 1992); *Multicare Med. Ctr. v. Washington*, 768 F. Supp. 1349, 1389 (W.D. Wash. 1991); *Illinois Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1345 (N.D. Ill. 1991).

²⁴³ The Federal Register included the following statement:

A suggestion was made that either the regulations or the State plan should define the term "efficiently and economically operated facility." Since the Medicaid program is administered by the State, we believe the States are in a better position to define or determine what is "efficient and economical" for its Medicaid program. More importantly, we believe any Federal attempt to impose specific definitions would unnecessarily intrude upon the legislatively mandated flexibility provided to States under the statute.

We have also decided not to mandate that the State plan specifically provide a definition of an "efficiently and economically operated facility." The reason for this is that the State's methods and standards implicitly act as the State's definition of an efficiently and economically operated facility, and no explicit definition is necessary. Moreover, States are best equipped to determine what is an efficient and economically operated facility for its Medicaid program, and a prescriptive Federal definition would be contrary to State flexibility. The term "efficiently and economically operated facility" is one that has not been precisely defined by the Congress, the Department, or the health care industry.

48 Fed. Reg. 56,049 (1983).

clear guideline for courts, and would be subject to judicial review on an arbitrary and capricious standard.²⁴⁴ Alternatively, a statute could invest in a federal agency the authority to determine whether states' rate methodologies were in compliance with federal guidelines, as opposed to requiring mere "findings and assurances;" review which would then be subject to an arbitrary and capricious standard. By including a clear expression of support for state or regional creativity in payment practices, Congress would ensure that courts uphold less-than-perfect, yet workable payment reform.

2. Requiring Negotiated Rulemaking

A statutory requirement that states include affected providers in the development of payment methodology serves two purposes.²⁴⁵ First, providers have a voice before they are subject to a new system—beyond that of merely being able to submit written comments on proposed regulation—forcing states to address the expressed needs of the provider community and negotiate final agreements with those most affected. Second, by negotiating agreements with providers, states, providers and recipients avoid future litigation over the basic structure of the payment system.²⁴⁶

In addition, states should be required to include recipient representatives in rulemaking, furthering the same purposes as a requirement for provider involvement. Special problems exist, however, as recipients—particularly individuals in need of public assistance—are unable to obtain representation to the same extent as providers, who can hire lawyers and consultants, and form trade associations to further their interests. While the inclusion of interested parties in rate-making would complicate the process, the benefits would be great for all parties involved.

3. Appeals Process

Appeal procedures must remain a central feature of any health care payment system. If instituted in conjunction with negotiated rulemaking, an appeals process for the fundamental structure of the system

²⁴⁴ For the Supreme Court's discussion of the benefits of granting weight to agency decisions through legislative delegations, see *Field v. Clark*, 143 U.S. 649, 693-94 (1892).

²⁴⁵ For a further discussion of negotiated rulemaking, see generally, Note, *Rethinking Regulation: Negotiation as an Alternative to Traditional Rulemaking*, 94 HARV. L. REV. 1871 (1981).

²⁴⁶ For discussion of the success of negotiated rulemaking, see generally, *Procedures for Negotiated Proposed Regulations* (Recommendation 85-51), 50 Fed. Reg. 52,895 (1985).

would not be necessary for those affected provider or recipient populations who have been adequately represented. The constitutional mandate of due process requires that both providers and recipients have access to appeal procedures, and judicial review of such appeals, regarding the actual application of payment methodologies.

Any statute must provide sufficient protection for the interests of providers and recipients of the health care program, balanced against the interests of the states in offering an affordable, comprehensive plan to those in need. Providers and recipients must be assured of recourse to judicial review, and state and federal agencies must be assured protection of their authority and finality in litigation. In any statute, a foreclosure of additional remedies and appeals would provide a measure of finality lacking in current Boren Amendment cases.²⁴⁷

4. Judicial Review and Remand for Review

The intent of Congress in 1981 was to encourage a reduction in government expenditures for health care, encourage state creativity and not impose the medicare standard of payment on states.²⁴⁸ Under the current system, some courts invalidate a new state payment system and thereby subject the state and its providers to a prior payment system, which may be even less appropriate for the current conditions.²⁴⁹ In contrast, administrative law precedent supports judicial review as exercised by the *Orthopaedic Hospital*, in which the court reviews agency action on an arbitrary and capricious standard, and, upon finding it arbitrary, remands the issue to the agency for review.²⁵⁰

Such a judicial-review-and-remand-for-review system would promote the separation of powers in two ways. First, it would impose a check on agency action, curing arbitrary action or abuse of discretion, by subjecting such action to judicial review and remand. Second, it would protect agency administrative powers by reserving for the agencies the appropriate administrative role of issuing legislative regula-

²⁴⁷ See *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 522-23 (1990) (appeal procedures are insufficient to protect state from § 1983 cause of action).

²⁴⁸ See 48 Fed. Reg. 56,046-49 (1983).

²⁴⁹ See, e.g., *Temple Univ. v. White*, 941 F.2d 201, 220 (3d Cir. 1991); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1318 (2d Cir. 1991); *Illinois Health Care Ass'n v. Bradley*, 776 F. Supp. 411, 423 (N.D. Ill. 1991); *Multicare Medical Ctr. v. Washington*, 768 F. Supp. 1349, 1402 (W.D. Wash. 1991); *Babcock*, 736 F. Supp. at 764.

²⁵⁰ See *Orthopaedic Hosp. v. Kizer*, No. 90-4209, at 35 (C.D. Cal. Oct. 6, 1992) (order granting plaintiffs' motion for summary judgment); see, e.g., *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 420-21 (1971).

tions: exercising their expertise regarding complex and technical issues for which they are better qualified than the courts.²⁵¹ Although a winning plaintiff may not obtain immediate relief in the form of invalidated rates, the confusion created by invalidation of a new rate and imposition of a past rate would be avoided. The revised rates an agency ultimately issues likely would be more carefully crafted than one issued by a judge, and could be imposed retroactively. A review-and-remand-for-review system would also offer finality in agency decisions and litigation, within appropriate boundaries. While agencies could continue to fight with courts and plaintiffs over the need for repeated remand, finality would occur when the benefits of making the suggested changes outweigh the cost of relitigation.

V. CONCLUSION

The current medicaid provider payment system suffers from very general statutory and regulatory language, and excessive judicial interpretation.²⁵² The result is a complex and confusing body of law governing provider rates, a body of law that should not be incrementally revised, but instead should be substantially reformed. A reformed health care system should avoid the vague delegation of authority over the determination of rates by expressly delegating authority to federal and state agencies, with reasonable limits on appeals and judicial review. The new system should also require negotiated rulemaking and reasonable appeal procedures to ensure that those beneficiaries and providers who are affected by the rates have a meaningful opportunity to ensure that payment to providers is fair and appropriate. Finally, a reformed health care system should ensure that judicial review is limited to review of rates, and remand to agencies, where a more careful and appropriate decision can be made by agency experts and representatives of recipients and providers.

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²⁵¹ See *Ethyl Corp. v. EPA*, 541 F.2d 1, 66-68 (D.C. Cir. 1976) (Bazelon, J., concurring).

²⁵² See *supra* notes 49-151, and accompanying text.