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Medicaid, State Cost-Containment Measures, and Section 1983 Provider Actions Under "Wilder v. Virginia Hospital Association"

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Medicaid, State Cost-Containment Measures, and Section 1983 Provider Actions Under *Wilder v. Virginia Hospital Association*

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I. INTRODUCTION

After the Civil War, Congress enacted a statutory private right of action to ensure the protection of an individual's federal civil rights.¹ This right of action, now codified at Title 42, Section 1983 of the United States Code, creates liability for anyone who, acting under a state law, program, or policy, infringes on an individual's federal rights.²

1. Ku Klux Klan Act of April 20, 1871, ch. 22 sec. 1, 17 Stat. 13 (1871). That Act was entitled "An Act to Enforce the Provisions of the Fourteenth Amendment of the Constitution of the United States and for Other Purposes." *Id.*

2. 42 U.S.C. § 1983 (1988). 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

Although the authors of Section 1983 intended the statute to serve primarily as a mechanism for the protection of federal constitutional rights,³ the United States Supreme Court has recognized that Section 1983 is a valid tool for enforcing a wide variety of statutorily created federal rights as well.⁴ The Court has developed a three-part test to determine whether a potential plaintiff may bring a Section 1983 action under a given statute.⁵ For a Section 1983 cause of action to lie, a court must ask: (1) whether the statute in question creates binding obligations for the state or local government; (2) whether the plaintiff asserts an interest under the statute that is not too vague and amorphous to enforce; and (3) whether the statute in question was intended to benefit the putative plaintiff.⁶

Recently, in *Wilder v. Virginia Hospital Association*,⁷ the United States Supreme Court held that health care providers receiving reimbursements under state Medicaid programs may bring suits in federal court challenging state reimbursement schemes under Section 1983.⁸ While perhaps unsurprising in light of the Court's decade-long expansion of Section 1983 rights,⁹ the *Wilder* decision does not fit neatly into the Court's prior Section 1983 jurisprudence.¹⁰ *Wilder* also appears to ignore federal legislative attempts to allow states a greater degree of flexibility in developing cost-effective provider reimbursement programs.¹¹

Largely in response to rapidly increasing health care costs and ex-

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.

Id.

3. Senator Edmunds, Chairman of the Senate committee on the Judiciary in 1871, claimed that Congress intended the bill merely to protect individuals' constitutional rights against state infringement. See CONG. GLOBE, 42nd Cong., 1st Sess. 568 (1871), cited in *Monroe v. Pape*, 365 U.S. 167, 171 (1960).

4. See *Maine v. Thiboutot*, 448 U.S. 1 (1979). In *Thiboutot* the Court recognized the right of Social Security recipients to bring a § 1983 action alleging that the state had violated their federal rights under the Social Security Act. *Id.* at 4. Similarly, in *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 419 (1986), the Court allowed tenants in federal housing to bring a § 1983 cause of action to protect their statutory rights. See also *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989) (granting both unions and management § 1983 rights under the Taft Hartley Act).

5. See *Dennis v. Higgins*, 111 S. Ct. 865, 871 (1991) (summarizing the Court's three-part analysis).

6. *Id.*

7. 110 S. Ct. 2510 (1990).

8. *Id.* at 2525.

9. See *infra* part III.A.

10. See *infra* part IV.B.3.

11. See *infra* part II.B.

penditures,¹² in 1980 Congress enacted the Boren Amendment¹³ (the Amendment) to the Medicaid statute.¹⁴ Congress designed the Amendment primarily to give states broad rate-making power and to allow states to develop reimbursement schemes that would encourage provider efficiency.¹⁵ In the years following the adoption of the Amendment, states developed a variety of cost-containment measures in an attempt to cope with rising health care costs, increasing reimbursement expenditures, and shrinking federal contributions to state Medicaid programs.¹⁶

States, however, were not the only entities to feel squeezed by the failure of revenues to offset increased costs. Faced with the prospect of rapidly diminishing profits, health care providers began to challenge state reimbursement schemes in federal court under Section 1983 and the Boren Amendment.¹⁷ Although the lower courts first appeared reluctant to extend a Section 1983 right of action to providers, by the mid-1980s, federal circuit courts had begun to recognize such a right.¹⁸ This line of cases culminated in 1990 with the Supreme Court's decision in *Wilder*.

The *Wilder* decision promises to engender a significant amount of litigation as states, seeking ways to keep Medicaid expenditures to a minimum while ensuring that poorer citizens receive adequate health care, come in conflict with health care providers seeking to maximize reimbursement rates and maintain profitability. By recognizing the Section 1983 provider action, the *Wilder* Court both ensured a greater degree of federal control over state Medicaid reimbursement schemes and encouraged providers to seek federal interference in state determinations of how best to allocate cost increases between health care recipients and providers. Yet, while it is clear that both recipients and providers have an interest in how these costs are allocated, it is not at all clear that Congress intended for providers and the federal courts to play a significant role in the allocation process. To the contrary, the Boren Amendment, with its emphasis on state control and the provision

12. See *infra* part II.

13. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962, 94 Stat. 2599, 2650-51 (1980) (codified as amended at 42 U.S.C. § 1396a(a)(13) (1988)). Congress extended the Boren Amendment in 1981 to cover hospital providers, Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808-09 (1981), and again in 1987 to cover intermediate care facilities for the mentally retarded, Pub. L. No. 100-203, § 4211(h)(2)(A), 101 Stat. 1330, 1330-205 (1987).

14. The statutory requirements for the Medicaid program can be found at 42 U.S.C. §§ 1396-1396s (1988).

15. See *infra* part II.B.

16. See *infra* notes 47-56 and accompanying text.

17. See *infra* part III.B.

18. See *infra* notes 162-167 and accompanying text.

of adequate health services to qualified individuals, indicates that states and recipients should dominate the allocation process.¹⁹

This Note examines the Supreme Court's decision in *Wilder v. Virginia Hospital Association* allowing health care providers to bring substantive Section 1983 claims for reasonable and adequate reimbursement under the Medicaid statute. Part II outlines the Medicaid reimbursement system and the problems of rapidly rising expenditures and costs currently plaguing the Medicaid program. Part II also reviews congressional efforts, through the enactment of the Boren Amendment, to increase state control and flexibility in balancing the interests of health care recipients and providers. Part III addresses the expansion of Section 1983 rights during the 1980s and the development of the Section 1983 provider action in the lower federal courts.

Part IV discusses the *Wilder* decision and its effect on Section 1983 jurisprudence and the increasingly daunting task of providing adequate health care for the poor. Part IV suggests that the substantive Section 1983 right for providers is inappropriate under the Boren Amendment, which delegated all essential Medicaid rate-making power to the states. Part IV also outlines the possible ramifications of *Wilder* against the backdrop of rising medical costs and the continuing pressure on states to enact cost-containment measures. Part IV argues that federal control of Medicaid reimbursement, through the creation of a Section 1983 right for providers, may curtail innovative state attempts to control health care costs. Ironically, failure to control costs may lead to less, rather than more, health care for Medicaid recipients. Finally, Part V suggests that states may be able to use the Eleventh Amendment to limit the impact of Section 1983 provider rights and to limit federal control over state rate-making schemes. This Note concludes that, although *Wilder* may engender a significant number of provider suits, innovative use of Eleventh Amendment doctrine may allow states to enact careful but creative cost-containment measures without wasting time and money in federal court vindicating those programs.

II. BACKGROUND

A. Medicaid and Health Care Costs

The United States instituted the Medicaid program twenty-seven years ago as an attempt to provide the poor with adequate access to health care.²⁰ The roots of the program lie in New Deal notions of an

19. See 42 U.S.C. § 1396a(a)(13). See generally part II.B, *infra*, for a more complete discussion of this point.

20. See S. REP. No. 404, 89th Cong., 1st Sess. 1-3 (1965), reprinted in 1965 U.S.C.C.A.N. 1943-45; see also CANNAS ET AL., AMERICAN HEALTH LAW 168 (1990). Both Medicaid and Medicare basi-

active role for the government in providing fundamental services for citizens.²¹ Medicaid originally targeted four groups of individuals: the elderly, families eligible for Aid to Families with Dependent Children (AFDC) welfare, the blind, and the disabled.²² During the 1980s, however, Congress expanded the categorical eligibility for Medicaid benefits.²³

Today, Medicaid is a joint state and federal program. The federal government does not require state participation, but states that have chosen to provide Medicaid coverage to their citizens must meet federal requirements.²⁴ Individuals who meet federal eligibility requirements for Medicaid also must satisfy state eligibility requirements to receive coverage.²⁵ To qualify, individuals or families generally must fall below certain minimum income and resource levels set by the states.²⁶ States, however, may elect to provide Medicaid coverage to individuals who ordinarily would not meet eligibility requirements if medical catastrophe has forced those individuals to exhaust many of their financial resources.²⁷

Rather than paying eligible persons directly, Medicaid reimburses health care providers for their treatment of eligible individuals.²⁸ Like states, health care providers elect whether to participate in Medicaid. Participating providers generally must accept Medicaid reimbursements as payment in full for their services.²⁹ For a large number of hospitals and nursing homes across the United States, Medicaid payments

cally provide government-funded health insurance. Nonetheless, they are two different programs. Although there is some overlap in the coverage of the two programs, Medicare, which is entirely federally funded, primarily targets the elderly. Medicaid, on the other hand, mainly covers certain categories of people living in poverty.

21. S. REP. No. 404, *supra* note 20, at 1943-45; *see also* 42 U.S.C. § 1396 (1988).

22. 42 U.S.C. § 1396 (1988). In many states, the elderly and the disabled may receive slightly higher per capita benefits than single parent families. *See* Sylvia A. Law, *Women, Work, Welfare and the Preservation of the Patriarchy*, 131 U. PA. L. REV. 1249 (1983).

23. In 1986 Congress amended the law to require states to provide Medicaid coverage for all poor children under the age of nineteen, regardless of whether the family qualified for AFDC. Pub. L. No. 99-272, §§ 9505(b)(2), 9510(a), 100 Stat. 82 (1986) (codified at 42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), 1396d(n)(2) (1988)). In 1988, Congress opened Medicaid eligibility to two-parent families in which one parent has a work history but currently is unemployed. *See* Family Support Act of 1988, Pub. L. No. 100-485, § 303(a), 102 Stat. 2343, 2385-91 (1988) (codified at 42 U.S.C. § 1396r-6 (1988)).

24. 42 U.S.C. § 1396a(a)(17) (1988).

25. *Id.*; *see also* *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981) (outlining the federal regulations for different state approaches to eligibility for categorically needy recipients).

26. 42 U.S.C. § 1396a(a)(17) (1988); *see also* 42 C.F.R. §§ 435.600-04 (1991).

27. *See* 42 U.S.C. § 1396a(10)(c) (1988); *see also* 42 C.F.R. § 435 (1991).

28. 42 U.S.C. § 1396a(a)(13) (1988).

29. 42 U.S.C. § 1396a(i) (1988) permits a state to terminate the certification of some health care facilities to participate in the Medicaid program. *See also* CANNAS ET AL., *supra* note 20, at 167.

represent a substantial percentage of annual income and, thus, are crucial to their financial health.³⁰

The importance of Medicaid reimbursement to health care providers can be understood only when viewed against the backdrop of rapidly rising health care costs and expenditures. Since 1960, national health expenditures have grown faster than the gross national product (GNP),³¹ and, by the late 1980s, health care costs were rising faster than the rate of inflation.³² Between 1988 and 1989, for example, health care expenditures increased eleven percent,³³ and in 1989 national health expenditures totaled 604.1 billion dollars, more than eleven percent of the GNP.³⁴

Government expenditures on health care have risen correspondingly. Medicaid and Medicare combined now represent approximately fourteen percent of the federal budget,³⁵ and during the 1980s the states, on average, allocated almost eleven percent of their annual budgets to health care expenditures.³⁶ In 1988, Medicaid alone financed almost ten percent of all hospital care and approximately forty-four percent of all nursing home care in the United States.³⁷

Economists have identified several causes underlying the rapid increase in health care costs. Contributing factors include general inflation in the economy, industry-specific inflation, technological innovations in medicine that continue to drive up the cost of health care, and the aging of America, which has increased the demand for health care.³⁸ Due to all these factors, health care expenditures in the 1980s represented an increasingly significant portion of both government and individual spending.³⁹

Despite this substantial increase in the nation's health care expenditures, many hospitals are struggling to meet the costs of providing that care.⁴⁰ Changing demand patterns, brought about in part by the growing percentage of elderly Americans in the population, have led to

30. See Kenneth R. Wing, *American Health Policy in the 1980's*, 36 CASE W. RES. L. REV. 608, 641 (1985-86).

31. Office of National Cost Estimates, *National Health Expenditures, 1988*, HEALTH CARE FINANCING REV., Summer 1990, at 1, 2 [hereinafter *National Health Expenditures, 1988*].

32. Helen C. Lazenby & Suzanne W. Letsch, *National Health Expenditures, 1989*, HEALTH CARE FINANCING REV., Winter 1990, at 1 [hereinafter *National Health Expenditures, 1989*].

33. *Id.*

34. *Id.*

35. *Id.* at 9.

36. *National Health Care Expenditures, 1988*, *supra* note 31, at 1.

37. *Id.* at 5, 22.

38. *Id.* at 643-47; see also, *National Health Expenditures, 1989*, *supra* note 32, at 4 fig. 2.

39. See, e.g., Wing *supra* note 30, at 650, 657. Wing predicted that Medicaid will continue to outgrow state revenue and other expenditures.

40. See *infra* notes 51-63 and accompanying text.

an increasing demand for health care services⁴¹ and a concomitant increase in hospital costs.⁴² The elderly use both a greater quantity of medical care and a higher degree of sophisticated and expensive medical care than their younger counterparts.⁴³ Technological innovations continue to change the face of health care.⁴⁴ Procedures such as organ transplants, genetic testing, and certain types of cancer treatment are much more accessible to the public today than they were in the 1970s.⁴⁵ Yet these innovations also have driven up the operating costs of hospitals.⁴⁶

In response to these rising costs, both private insurance companies and government reimbursement programs such as Medicare implemented cost-control measures in the 1980s. Health Maintenance Organizations (HMOs), for example, attempted to control costs by prepaying providers a lump sum for the treatment of all HMO members in an upcoming year.⁴⁷ Medicare also adopted a prepayment scheme creating diagnostically related groups.⁴⁸ Under that scheme providers receive set payments based on the illness of each patient regardless of the length of the patient's stay in the hospital.⁴⁹

After Congress modified Medicaid reimbursement standards in 1980,⁵⁰ states adopted various cost-containment measures for Medicaid

41. See Maxwell J. Mehlman, *Age-Based Rationing and Technological Development*, 33 Sr. Louis U. L.J. 671 (1989) (reacting critically to a proposal to ration life-extending health care for the elderly and to limit the development of new life-extending technologies). The basis of the proposed rationing is the utilitarian view that increasing technological innovation designed to extend the lives of the elderly represents a significant drain on societal resources. *Id.* at 673-74 & n.17.

42. See Wing, *supra* note 30, at 643-46.

43. *National Health Expenditures, 1989*, *supra* note 32, at 8 & table 3.

44. See William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies*, 257 J.A.M.A. 220, 221 (1987) (suggesting that a significant portion of hospital cost increases are the result of technological change). Examples of technological changes over the past two decades include the introduction of the CAT scan, artificial hearts, organ transplants, and a large number of new genetic screening and testing procedures. *Id.* at 222-23.

45. *Id.* at 220-21.

46. See Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778 (1985-86); see also Joint Appendix at 49 (affidavit of Joseph Brecht), *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

47. See Jon Gabel et al., *The Changing World of Group Health Insurance*, HEALTH AFFAIRS, Summer 1988, at 48, 52-54.

48. Under the Medicare reimbursement scheme, illnesses are classified in diagnostically related groups, usually by severity or type. Medicare then limits the costs per day and the number of days of care for which it will reimburse a hospital according to the diagnostically related group into which the patient's illness falls. See *infra* note 308 and accompanying text.

49. 42 C.F.R. § 412 (1991); see also Bruce C. Vladeck, *Medicare Hospital Payment by Diagnosis-Related Groups*, 100 ANNALS INTERNAL MED. 576 (1984).

50. Omnibus Reconciliation Act of 1980, Pub L. No. 96-499, § 962, 94 Stat. 2599, 2650-51 (1980) (codified as amended at 42 U.S.C. § 1396a(a)(13)(A) (1988)). For a discussion of the subsequent extensions of the Boren Amendment, see *supra* note 13.

as well.⁵¹ Some states established provider cost levels that they considered reasonable and adequate for reimbursement. Nebraska, for example, set Medicaid payment levels so that the least expensive sixty-five percent of all Nebraska hospitals received complete reimbursement for their services.⁵² Illinois established a program that tried to control costs by shifting Medicaid patients to less expensive hospitals.⁵³ Other states adopted a variety of cost-control measures including flat rates of reimbursement or rate caps⁵⁴ and rate freezes⁵⁵ in the quest to control Medicaid expenditures.⁵⁶

Thus, both private and public health care programs often reimburse providers for less than the full cost of treating a patient. The Office of National Cost Estimates reported that, in 1987, private hospitals charged patients 204.7 billion dollars but only received 152.6 billion dollars in net revenues.⁵⁷ Similar discrepancies between the Medicaid costs that hospitals incurred and the Medicaid reimbursements they received existed in many states.⁵⁸ In Virginia, for example, the state's attempts to contain health care costs led to the undercompensation of all hospitals by almost thirty million dollars of approved Medicaid costs in 1986.⁵⁹ Although many of these hospitals made up for the discrepancy

51. See Amicus Curiae Brief of Connecticut et al., *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

52. See *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1293-94 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987). The remaining 35% of Nebraska hospitals no longer received full reimbursement under Medicaid for their services. *Id.*

53. See J. Warren Salmon et al., *Reducing Inpatient Hospital Costs: An Attempt at Medicaid Reform in Illinois*, 13 J. HEALTH POL., POL'Y & L. 103 (1988). The Illinois program reimburses hospitals for the number of patient-days of care they provide for Medicaid patients. More expensive hospitals receive payment for fewer patient-days than do less expensive hospitals. Once a hospital uses up its allotted patient days, Medicaid reimburses the hospital only for emergency treatment. The hospital is expected to transfer all other Medicaid patients to different hospitals. *Id.* at 110.

54. See, e.g., *Dunning*, 778 F.2d at 1292-93 (challenging Nebraska's reimbursement policy in which the state fully reimbursed only the 65% of nursing homes with the lowest costs and partially reimbursed all other nursing homes at the 65th percentile level); see also *Colorado Health Care v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1161 (10th Cir. 1988) (noting that Colorado established a 90th percentile rate cap).

55. See, e.g., *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984) (noting that Wisconsin froze reimbursement rates in 1982 and 1983).

56. See, e.g., *Weber Memorial Care Center v. Department of Health*, 751 P.2d 831 (Utah App. 1988); *Golden Five Inc. v. Department of Social Serv.*, 425 N.W.2d 865 (Neb. 1988).

57. *National Health Expenditures, 1988*, *supra* note 31, at 2.

58. For discussions of various state reimbursement schemes that do not completely reimburse providers, see *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2514 n.3 (1990); *Colorado Health Care Ass'n*, 842 F.2d at 1161-64 & n.2; *Wilmac Corp. v. Heckler*, 633 F. Supp. 1000, 1004 (E.D. Pa. 1986); *Quincy City Hosp. v. Rate Setting Comm'n*, 548 N.E.2d 869, 870-71 (Mass. 1990).

59. Joint Appendix at 47 (affidavit of J. John McMahan), *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043). Mr. McMahan claimed that cost-containment programs hurt some Virginia hospitals to such an extent that they elected not to pay hospital association dues

in patient revenues by increasing income from philanthropy, parking, gift shops, and state subsidies, some still felt squeezed between rising costs and cost-control measures.⁶⁰

State and local public hospitals often fared worse than private hospitals. Because public hospitals frequently treat a disproportionate number of low-income patients, these providers usually are less able to compensate for government cost-cutting measures by shifting costs to private patients.⁶¹ In 1987, state and local providers absorbed over thirty percent of all the bad debt in the health care industry.⁶² Although complete figures are not yet available for subsequent years, the frequency with which providers have challenged both Medicaid and Medicare reimbursement rates indicates that providers continue to feel squeezed by these cost-containment measures.⁶³

Moreover, both the federal and state governments feel increasing budgetary pressure to control health expenditures. The federal government has struggled during the 1980s under Gramm-Rudman budget requirements,⁶⁴ and even states that occasionally ran budget surpluses in the late 1980s face a much more ominous task of balancing their budgets in the 1990s.⁶⁵ During the economic recession of 1990 and 1991, many states faced the reality of lower tax revenues, making the job of balancing state budgets even more difficult.⁶⁶

because of financial hardship. *Id.*

60. *National Health Expenditures, 1988, supra* note 31, at 6; *see also* West Virginia Univ. Hosp., Inc. v. Casey, 885 F.2d 11, 14 (3d Cir. 1989) (noting that "[t]his interesting and complex appeal arises from the cross-fire currently trapping many hospitals across our nation between rising operating costs, on the one hand, and federal legislation aimed at the sharp containment of health delivery costs, on the other"); *Johnt Appendix* at 46-47 (affidavit of J. John McMahon), *Wilder* (No. 88-2043).

61. *See* Kenneth E. Thorpe & Charles Brecher, *Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?*, 12 J. HEALTH POL., POL'Y & L. 313 (1987) (finding that the uninsured poor are more likely to receive hospital care if they live in a city with a public hospital); *see also* Judith Feder et al., *Poor People and Poor Hospitals: Implications for Public Policy*, 9 J. HEALTH POL., POL'Y & L. 237 (1984) (suggesting that Medicaid and Medicare cuts significantly hurt the financial well-being of public hospitals).

62. *National Health Expenditures, 1988, supra* note 31, at 8 table 2.

63. *See, e.g.,* Wilmac Corp. v. Bowen, 811 F.2d 809 (3d Cir. 1987); Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291 (8th Cir. 1986), *cert. denied*, 479 U.S. 1063 (1987); Pinnacle Nursing Home v. Axelrod, 719 F. Supp. 1173 (W.D.N.Y. 1989), *vacated in part*, 928 F.2d 1306 (2d Cir. 1991); AGI-Bluff Manor, Inc. v. Reagen, 713 F. Supp. 1535 (W.D. Mo. 1985).

64. For a discussion of the effect of budgetary pressures on the federal funding of health care, *see* Andreas G. Schneider, *Commentary: Legal and Political Pressures on Health Care Cost Containment*, 36 CASE W. RES. L. REV. 693, 699-704 (1985-86).

65. *See* *Troubles Close to Home*, TIME, July 15, 1991, at 22; *Wilson Tries to Do it Right*, TIME, July 15, 1991, at 23; *Weicker Goes His Own Way*, TIME, July 15, 1991, at 24. All of these articles examine the difficulties states have encountered balancing their budgets and note that part of the problem stems from reduced federal funding.

66. *See supra* note 36 and accompanying text; *see also* Robert J. Samuelson, *Debt*, NEWSWEEK, Dec. 31, 1990, at 22.

In summary, although Americans seem willing to allocate increasing amounts of financial resources to health care, rising costs in the health care industry may restrict access for many who can no longer afford complete insurance. For states facing funding limitations, the rising costs of public insurance programs such as Medicaid create a tension between the societal need to assure adequate medical care for the poor and the limited state resources available to fill that need.⁶⁷ It is in this context that both Congress, through the Boren Amendment, and the states, on their own initiative, have recognized an increasing need for flexibility in reimbursement schemes to maintain the vitality of the Medicaid program.

B. *The Boren Amendment*

Before 1980, the federal government mandated that states participating in the Medicaid program reimburse providers for the reasonable cost of services actually provided to Medicaid patients.⁶⁸ The Secretary of Health and Human Services (HHS), rather than the states, set the reasonable cost standard at levels that usually paralleled Medicare reimbursement.⁶⁹ In 1980, however, Congress amended the Medicaid statute to allow states more flexibility in developing reimbursement schemes for nursing homes.⁷⁰ This legislation is known as the Boren Amendment. In 1981, Congress extended the Boren Amendment to cover hospitals.⁷¹

The language of the Amendment clearly indicates that Congress intended to delegate primary rate-making authority to the states.⁷² The Amendment mandates that states develop the methods and standards by which they calculate reimbursement rates and makes states responsible for conducting studies that produce "findings that such rates are

67. As one commentator has observed, "[t]he delivery of health care is, after all, one activity that can be simultaneously described as a system on the brink of crisis and as a strong and growing industry with equal accuracy." See Wing, *supra* note 30, at 612.

68. See 42 U.S.C. § 1396a(a)(13) (1979); see also H.R. REP. No. 158, Vol. 2, 97th Cong., 1st Sess. 279 (1981).

69. See *supra* note 68.

70. Pub. L. No. 96-499 § 962(a), 94 Stat. 2650 (1980).

71. Pub. L. No. 97-35 § 2173, 95 Stat. 808 (1981). The Boren Amendment provides in part: [A] State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded . . . through the use of rates (determined in accordance with the methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. . . .

42 U.S.C. § 1396a(a)(13)(A) (1988).

72. The Amendment mandates that reimbursement rates are to be "determined in accordance with the methods and standards developed by the states." *Id.*

reasonable.”⁷³ Moreover, the Secretary of HHS retains only minimal oversight authority under the Amendment. The Secretary reviews only state assurances of reasonableness, not the reasonableness of rates themselves.⁷⁴ If the Secretary fails to act within ninety days, the state assurances are deemed adequate.⁷⁵ Another factor limiting federal oversight is the lack of any substantive language in the Amendment that would provide criteria for determining which rates are reasonable and adequate for economically and efficiently operated providers.⁷⁶ Thus, although the Amendment binds states to act within certain procedural guidelines and allows the Secretary to reject state assurances on a case-by-case basis, it creates no clear guidelines for what is or is not a legitimate rate.

The legislative history of the Amendment also indicates that Congress intended to give states broad rate-making power. Both the House and the Senate reports on the Amendment clearly demonstrate that Congress recognized the budgetary pressures on the states to enact greater cost-control measures.⁷⁷ The Boren Amendment was part of a package of Medicaid changes that included a potentially significant cut in federal contributions to state Medicaid programs. Congress expected to cut federal outlays for Medicaid by more than 900 million dollars in fiscal year 1982.⁷⁸ The new law also provided for a scaled reduction of federal payments to states in later years.⁷⁹ Congress intended to cut Medicaid payments an additional two percent in 1983 and one percent in 1984.⁸⁰ Because federal money constituted between fifty and eighty-three percent of the Medicaid funding for any state, Congress knew the planned cuts would have a significant impact.⁸¹ In rejecting the reasonable-cost reimbursement standard, the Senate Committee on Finance noted that the standard had been based on principles that were “inherently inflationary.”⁸² Congress anticipated that, under the new legislation, states would adopt cost-containment measures similar to the prospective payment schemes based on diagnostically related groups that Congress was considering for the Medicare program.⁸³

73. *Id.*

74. *Id.*

75. *Id.*; see also 42 C.F.R. § 447.253 (1989).

76. 42 U.S.C. § 1396d (1988). Although this section defines various terms in the Act, the statute does not define the terms reasonable, adequate, economically, or efficiently.

77. See H.R. REP. No. 158, *supra* note 68, at 292; S. Rep. No. 139, 97th Cong., 1st Sess. 477 (1981), reprinted in 1981 U.S.C.C.A.N. 744.

78. H.R. REP. No. 158, *supra* note 68, at 279, 281-82.

79. *Id.*

80. *Id.* at 281-82.

81. *Id.* at 283.

82. *Id.* at 293.

83. *Id.* at 292-95.

Faced with federal cutbacks, states were left with three options for reforming their Medicaid programs. First, states could choose to offset federal cutbacks by increasing revenue locally. This option, however, lost its appeal in the late 1980s as state governments, already overburdened by the Reagan abdication of federal responsibility for domestic needs, faced additional hardships due to a recession and local opposition to increased taxes.⁸⁴ Second, states could respond to federal cutbacks by reducing the scope or duration of certain covered services under Medicaid. This option, however, would reduce access to health care for poorer citizens. Although the Medicaid Act requires states to fund certain care services, other services like dental care, optical care, and prescription drugs are optional.⁸⁵ States that cover these services easily could cut them in light of reduced funding.⁸⁶ Third, states could reduce reimbursement to providers in an attempt to force providers to control the costs of medical care. By reducing reimbursement rates, states would provide hospitals with an incentive to reduce inefficiencies in care. Theoretically, hospitals could eliminate unnecessary medical tests, reduce the length of patient stays, be more selective in their choice of new technologies, and eliminate administrative inefficiency to cut costs.⁸⁷

The Boren Amendment was designed to facilitate this third option. Under the reasonable care standard used before 1980, states set Medicaid reimbursement rates that paralleled Medicare's reasonable cost rates, which were fixed by the Secretary of HHS.⁸⁸ Thus, prior to the enactment of the Boren Amendment, the federal government, not the states, actually controlled reimbursement rates. When federal cutbacks became a reality in the early 1980s, Congress enacted the Boren Amendment to give states some flexibility in developing cost-containment measures. The Amendment allowed states to set Medicaid reimbursement rates. By so doing, Congress recognized that federal control of the rate-setting process, which failed to take adequate account of variations in local economies, was "inherently inflationary."⁸⁹

84. See *supra* note 51.

85. 42 C.F.R. §§ 440.210, 440.220, 440.1-440.180 (1991). Sections 440.1-440.180 define the medical services discussed under the Medicaid regulations. Sections 440.210 and 440.220 indicate which of those services states must provide as minimum Medicaid coverage.

86. See, e.g., *White v. Beal*, 555 F.2d 1146 (3d Cir. 1977) (recognizing that state coverage of optical services must be rationally related to medical need, but that the state can forego coverage of such service altogether).

87. See, e.g., *Wing*, *supra* note 30; *Sloan, Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade*, 61 MILBANK MEM. FUND Q. 195 (1983).

88. See 42 U.S.C. § 1396a(a)(13) (1976 & Supp. III 1979) (providing the reimbursement standard as it read before the Boren Amendment); H.R. REP. NO. 158, *supra* note 68, at 280.

89. See 42 U.S.C. § 1396a(a)(13) (1988); S. REP. NO. 139, *supra* note 77, at 478.

Social choice theory also sheds some light on congressional motivations behind the Boren Amendment.⁹⁰ With the Medicaid legislation of 1981, Congress, in part, may have bowed to intense executive pressure to cut spending on domestic programs. Two groups clearly bore the brunt of such cuts: providers and patients. Because both Medicaid recipients and health care providers have well-organized, powerful lobbying groups,⁹¹ placing these costs exclusively on either group might have aroused significant interest group opposition. The Boren Amendment allowed Congress to avoid any such discreet allocation of these concentrated social costs. Instead, Congress gave states the responsibility of distributing these costs between the providers and patients as the states saw fit.⁹² Ultimately, then, the states took political responsibility for distributing the burdens of the cutback because the federal government wanted to wash its hands of this allocation.

Surrounding sections of the Boren Amendment bear out this interpretation of the reimbursement provisions. In the section directly preceding the reimbursement provisions, Congress explicitly allowed states to place limits on Medicaid recipients' choices of medical treatments as long as those limits were related to cost effectiveness and the recipients still had reasonable access to health care.⁹³ The Boren Amendment simply granted states the same authority to establish reimbursement schemes for providers.

Despite its abdication of control over the rate-setting process, Congress did indicate a preference that state reimbursement schemes work to increase provider efficiency rather than to funnel the cost of reimbursement deficiencies on to consumers or Medicaid patients.⁹⁴ Allowing the latter would destroy any distribution of the burdens of cutbacks between patients and providers, leaving patients to bear the

90. See MICHAEL T. HAYES, *LOBBYISTS AND LEGISLATORS: A THEORY OF THE POLITICAL PROCESS* (1981). Social choice theory analyzes the legislature through a market approach. It views statutes as deals between interest groups and legislators who "sell" statutes to get reelected. Statutes generally are divided into four categories depending on their effects. If a statute will burden small, cohesive groups in society, it has concentrated costs. If a statute burdens most of society, its costs are distributed. Likewise, a statute that benefits small, cohesive groups has concentrated benefits. If a statute benefits all of society, it has distributed benefits. Any statute may combine any of these effects. Because small, cohesive interest groups tend to be better organized and, thus, more politically effective, Congress is least likely to pass statutes with clear concentrated costs. Instead, it may attempt to avoid such a situation by delegation of the problem to some other governmental body.

91. Several of these lobbying groups are well known, including the Gray Panthers, the American Association of Retired People (AARP), the American Medical Association (AMA), and the American Hospital Association (AHA).

92. S. REP. NO. 139, *supra* note 77, at 472-74.

93. 42 U.S.C. § 1396a(a)(13) (1988); *see also* S. REP. NO., 139, *supra* note 77, at 476-77.

94. H.R. REP. NO. 158, *supra* note 68, at 280, 293; S. REP. NO. 139, *supra* note 77, at 478.

entire burden of federal cutbacks.⁹⁵ Nonetheless, the Boren Amendment requires that reimbursement rates enable hospitals to provide adequate and effective care for Medicaid recipients.⁹⁶ This mandate has been implemented by federal regulations that require states to provide reimbursement to providers in an amount which ensures that crucial health care services remain available to Medicaid recipients.⁹⁷

Thus, the only limit on state discretion that emerges from the statute and its legislative history is a concern for continued patient access to quality health care. If the language of the Amendment creates any federal rights, then it appears to confer those rights on Medicaid patients, not providers — patients must receive adequate care. Beyond this constraint, the Boren Amendment leaves reimbursement to the states. In *Wilder v. Virginia Hospital Association*,⁹⁸ however, the Supreme Court reached the opposite conclusion, finding that the Boren Amendment creates substantive Section 1983 rights for health care providers.⁹⁹ Yet, provider notions of how health resources should be allocated may be very different from those of the patients or of society as a whole.

III. SECTION 1983 AND THE BOREN AMENDMENT

A. *The Expansion of Section 1983 Jurisprudence in the 1980s*

When Section 1983 became law during the Reconstruction, the statute served largely as a tool for vindicating civil rights injuries and other constitutional claims.¹⁰⁰ During the 1980s, however, the Supreme Court significantly expanded the use of Section 1983. In *Maine v. Thiboutot*,¹⁰¹ the Court held that the plain language of Section 1983

95. The Senate report on the bill indicates that it was "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care." S. REP. NO. 139, *supra* note 77, at 478.

96. 42 U.S.C. § 1396a(a)(13)(A) (1989). The Amendment states that hospitals must be able "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 . . ." *Id.*

97. 42 C.F.R. § 447.204 (1990).

98. 110 S. Ct. 2510 (1990).

99. *Id.* at 2525.

100. See CONG. GLOBE, 42nd Cong., 1st Sess., app. 60, 80, 83-85, cited in *Monroe v. Pape*, 365 U.S. 167, 171 (1960). Section 1983 was originally part of the Ku Klux Klan Act of April 20, 1871, 17 Stat. 13 (1871). That Act was entitled "An Act to enforce the Provisions of the Fourteenth Amendment of the Constitution of the United States and for other Purposes." Senator Edmunds, Chairman of the Senate Committee on the Judiciary that considered the original bill, noted that the bill "merely carr[ie]d out the principles of the civil rights bill, which has since become a part of the Constitution, [i.e. the Fourteenth Amendment]." CONG. GLOBE, 42d Cong., 1st Sess. at 568, quoted in *Monroe*, 365 U.S. at 171.

101. 448 U.S. 1 (1979).

makes it applicable to all statutorily created federal rights as well as those created by the Constitution.¹⁰² Building on an earlier decision that applied Section 1983 to state officers who had violated a plaintiff's rights,¹⁰³ *Thiboutot* suggested a broad application of Section 1983 to all forms of official violation of federally protected rights¹⁰⁴ and prefaced a decade-long expansion of Section 1983 rights. The road to the expansion of these rights, however, occasionally twisted back on itself as the Court groped for a workable test that would help it determine the appropriate use of Section 1983.

In *Pennhurst v. Halderman*,¹⁰⁵ for example, the Supreme Court considered whether the Patient's Bill of Rights in the Developmentally Disabled Act (DDA)¹⁰⁶ could support an implied private cause of action on behalf of patients. Although the Patient's Bill of Rights stated that patients should receive the least restrictive treatment possible in order to "maximize their development potential,"¹⁰⁷ the Court refused to find an implied private cause of action for patients of mental institutions.¹⁰⁸

Several factors suggested that the patient-plaintiffs in *Pennhurst* had a valid claim. First, the DDA created a joint federal-state program and required states to make assurances to the federal government that the provisions of the Act had been met.¹⁰⁹ Second, Congress gave no indication that it intended administrative remedial schemes to be the exclusive remedy in the Act.¹¹⁰ Third, the patients claimed their rights under statutory language stating that "[p]ersons with developmental

102. *Id.* at 4.

103. *Monell v. New York City Dep't of Social Servs.*, 436 U.S. 658, 700-01 (1978) (stating that "there can be no doubt that [§ 1983] was intended to provide a remedy, to be broadly construed, against all forms of official violation of federally protected rights").

104. *Thiboutot*, 448 U.S. at 4.

105. 451 U.S. 1 (1981). In *Pennhurst*, residents of a state institution for the profoundly retarded brought suit against Pennsylvania under the DDA, claiming that the state program failed to live up to the Patients' Bill of Rights in the DDA. *Id.* at 5-6. Specifically, the plaintiffs alleged that conditions at *Pennhurst* were "unsanitary, inhumane, and dangerous." *Id.* They sought both injunctive and monetary relief and demanded that *Pennhurst* be closed. *Id.*

The *Pennhurst* decision does not explicitly indicate that the Court was considering a § 1983 claim. Nonetheless, *Pennhurst's* analysis has been incorporated into subsequent § 1983 cases. Thus, *Pennhurst* clearly merits discussion here.

106. Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, § 201, 89 Stat. 486, 502 (1975) (current version codified at 42 U.S.C. § 6009 (1988)).

107. See 42 U.S.C. § 6010 (1976 & Supp. III 1979). The Patient's Bill of Rights reads, in pertinent part:

The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

Id. § 6010(2).

108. *Pennhurst*, 451 U.S. at 31-32.

109. *Id.* at 14-15.

110. See 42 U.S.C. § 6005-09, 6061-63 (1976 & Supp. III 1979).

disabilities have a right to appropriate treatment, services, and habilitation for such disabilities."¹¹¹ Thus, the DDA arguably frames the states' obligation to fulfill those rights.¹¹²

The Court, however, rejected the plaintiffs' claim.¹¹³ Because the statute contained mere findings without enforceable mandatory standards,¹¹⁴ it provided insufficient support for the rights and duties the plaintiffs claimed the statute conferred and mandated.¹¹⁵ More significantly, the Court noted, the limited federal funding available under the Act would not defray the costs of implementing the Bill of Rights.¹¹⁶ Thus, the Court concluded that Congress did not intend the statute to create substantive rights.¹¹⁷

Six years after the *Pennhurst* decision, the Court refined the test for determining the existence of a Section 1983 statutory action. In *Wright v. City of Roanoke Redevelopment and Housing Authority*¹¹⁸ the Court held that a Section 1983 cause of action would lie unless Congress specifically foreclosed such action in the statute or the statute did not create enforceable rights, privileges, or immunities.¹¹⁹ A carefully tailored administrative scheme in the statute could provide evidence that a Section 1983 action was foreclosed under the first prong; hortatory rather than mandatory statutory language would indicate the absence of statutory rights under the second prong.¹²⁰

In *Wright* low income tenants alleged that the City of Roanoke had overbilled them for utilities and violated rent ceilings imposed by the Brooke Amendment to the Housing Act of 1937.¹²¹ Like the patients in

111. *Id.* § 6010(1); see also *Pennhurst*, 451 U.S. at 20 (stating that the Patient's Bill of Rights was only intended to encourage, not mandate, provision of these services for the disabled).

112. See 42 U.S.C. § 6010(3) (1976 & Supp. III 1979).

113. *Pennhurst*, 451 U.S. at 31-32.

114. The preamble to the Patient's Bill of Rights notes that "Congress makes the following findings respecting the rights of persons with developmental disabilities." 42 U.S.C. § 6010 (1976 & Supp. III 1979). The implication from this language is that the rights underlying the finding still would exist even if Congress had made no findings. This analysis is inconsistent with *Pennhurst's* conclusion that patients had no rights.

115. *Pennhurst*, 451 U.S. at 19 (noting that the language in the Patient's Bill of Rights provided "too thin a reed to support the rights and obligations read into it").

116. *Id.* at 24. Because enforcing the plaintiffs' claims would have required that states spend significantly more money than they received under the federal program, the Court concluded that Congress could not have intended to give patients enforceable rights. The Court thought no state would be willing to spend millions of dollars to receive only thousands in federal aid. Thus, enforcing patients' rights would drive states out of the DDA program. *Id.*

117. *Id.*

118. 479 U.S. 418 (1987).

119. *Id.* at 423-25.

120. *Id.*

121. *Id.* at 419. The Brooke Amendment, Pub. L. No. 91-152, § 213, 83 Stat. 379, 389 (1969) (codified as amended at 42 U.S.C. § 1437a (1988)), set rent ceilings for families living in public housing on the basis of income.

Pennhurst, the tenants in *Wright* clearly were the intended beneficiaries of the statute,¹²² and some of the statute's legislative history indicated that Congress anticipated private actions in the courts.¹²³ In addition, the Brooke Amendment and subsequent federal regulations created clear, easily definable standards. The Amendment required that tenants pay thirty percent of their monthly adjusted family income as rent.¹²⁴ Accompanying HUD regulations indicated that these rent payments included a "reasonable amount for utilities"¹²⁵ and also set specific guidelines that public housing authorities were to follow in establishing utility allowances.¹²⁶ Thus, the Court found that the Brooke Amendment's requirement that tenants pay only a reasonable amount for utilities was specific enough to create enforceable federal rights because both the statute and ensuing federal regulations established specific criteria by which courts could judge the reasonableness of utility allowances.¹²⁷ The Court also concluded that Congress clearly intended to make tenants the beneficiaries of the Brooke Amendment.¹²⁸

In 1989 the Court continued its trend of recognizing enforceable federal rights under statutes as long as those rights were not too vague or amorphous. In *Golden State Transit Corp. v. City of Los Angeles*¹²⁹ the Court built on its *Pennhurst* and *Wright* decisions to create a two-step process for determining whether Section 1983 rights existed.¹³⁰ First, the Court indicated that a right must exist under the particular statute.¹³¹ It then reaffirmed the *Wright* and *Pennhurst* analysis for determining the existence of that right.¹³² Second, the Court indicated that the plaintiffs must demonstrate that Congress did not expressly

122. *Wright*, 479 U.S. at 424-25.

123. *Id.* at 425 & n.7 (citing *Housing and Community Development Amendments of 1981: Hearings Before the Subcommittee on Housing and Community Development of the House Committee on Banking Finance and Urban Affairs*, 97th Cong., 1st Sess., pt. 1, at 654 (1981). In these hearings a HUD officer testified that the narrow statutory limits on judicial review were "not intended . . . to eliminato any tenant rights." *Id.*

124. 42 U.S.C. § 1437a(a) (1982 & Supp. III 1985).

125. 24 C.F.R. § 860.403 (1982).

126. 24 C.F.R. §§ 966.50-.59 (1986).

127. *See Wright*, 479 U.S. at 431-32.

128. *Id.* at 430. The Court relied on language in the Amendment which set tenants' rents at "no more and no less than 30 percent of their income." *Id.* at 430. It stated that "the intent to benefit tenants is undeniable." *Id.*

129. 493 U.S. 103 (1989).

130. *Id.* at 108-09. In that case, a taxicab franchise sued Los Angeles because the city refused to renew the plaintiff's franchise license until the plaintiff settled a labor dispute. *Id.* at 103-05. The taxicab franchise, in a § 1983 claim, asserted that the city violated its right to be free from state interference under the National Labor Relations Act. *Id.*

131. *Id.* at 105.

132. *Id.* at 106-07.

foreclose a Section 1983 suit.¹³³

Applying this analysis in *Golden State*, the Court concluded that the National Labor Relations Act created enforceable rights for both management and employees and that these rights included an enforceable right to be free from state interference in collective bargaining.¹³⁴ In support of its conclusion, the Court cited language in the Act that conferred rights on employers and employees.¹³⁵ It also relied on the long history of prior case law that suggested that a state had no role to play in labor-management negotiations.¹³⁶

Recently, in *Dennis v. Higgins*,¹³⁷ the Court summarized the test for statutory rights that has emerged from this line of cases.¹³⁸ Plaintiffs have rights enforceable under Section 1983 if they can satisfy three basic criteria. First, plaintiffs must demonstrate that the statute on which they rely creates binding obligations on the states or on local governments.¹³⁹ Second, the interest the plaintiffs assert must not be overly vague or amorphous.¹⁴⁰ Third, Congress must have intended the statute in question to benefit the plaintiffs.¹⁴¹ The Court's decision to confer reimbursement rights on providers under the Boren Amendment, however, does not appear to meet this emerging standard.

B. *The Development of Section 1983 Provider Actions Under the Boren Amendment*

Although most states developed comprehensive administrative procedures for setting and reviewing provider reimbursement rates, during the 1980s a significant number of providers challenged these rates in federal court.¹⁴² These challenges, however, created confusion in the lower courts over the nature of the providers' cause of action.¹⁴³ As a

133. *Id.*

134. *Id.* at 109.

135. *Id.* at 109 n.6. The Court looked to language of the Act that stated: "It is the purpose and policy of this chapter . . . to prescribe the legitimate rights of both employees and employers in their relations affecting commerce . . ." 29 U.S.C. § 141(h) (1988).

136. *Golden State Transit Corp.*, 493 U.S. at 109-11.

137. 111 S. Ct. 865 (1991).

138. *Id.* at 871.

139. *Id.*

140. *Id.*

141. *Id.*

142. See Amicus Curiae Brief of Connecticut et al., *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043) (discussing the comprehensive review procedures of states); see also *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226 (7th Cir. 1984); *Wilmac Corp. v. Heckler*, 633 F. Supp. 1000 (E.D. Pa. 1986); *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 598 F. Supp. 1400 (D. Colo. 1984).

143. See, e.g., *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1163-64 (10th Cir. 1988) (finding that providers could assert the rights of Medicaid recipients); *St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1043-44 (W.D. Wis. 1989) (finding a private right

result, courts hesitated to take aggressive action in these cases.¹⁴⁴

In several early cases, courts avoided the question of whether providers had enforceable rights under the Boren Amendment by finding that providers and recipients of Medicaid had parallel interests under the Medicaid statute.¹⁴⁵ Because reductions in reimbursement rates might have affected the quality and quantity of care that Medicaid recipients were likely to receive, such reductions potentially infringed on the rights of Medicaid recipients. Some courts concluded, therefore, that providers could bring a Section 1983 suit under the Boren Amendment in order to protect the rights of Medicaid recipients.¹⁴⁶

Other courts, however, simply ignored the question of whether the Boren Amendment gave rise to a Section 1983 cause of action for providers. In *Nebraska Health Care Ass'n v. Dunning*,¹⁴⁷ for example, the plaintiffs, operators of medical facilities, challenged Nebraska's Medicaid rates on behalf of both health care providers and recipients.¹⁴⁸ The district court considered the merits of the case without attempting to distinguish between the rights of providers and recipients under the Medicaid statute.¹⁴⁹

Several other courts also expressly rejected the contention that the Boren Amendment itself gave rise to an implied right of action for providers.¹⁵⁰ In rejecting claims of an implied right of action, these

of action under the Boren Amendment but refusing to decide the merits of the case because the Burford abstention doctrine applied); *AGI-Bluff Manor, Inc. v. Reagen*, 713 F. Supp. 1535, 1542 (W.D. Mo. 1989) (finding no § 1983 right of action under the Boren Amendment); *Coalition of Michigan Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451, 452 (1982) (asserting an implied right of action under the Boren Amendment rather than a § 1983 claim).

144. See, e.g., *Folden v. Washington State DSHS*, 744 F. Supp. 1507, 1525 (W.D. Wash. 1990) (dismissing the plaintiffs' § 1983 claims, but finding a cause of action directly under the Boren Amendment and reviewing that claim under an arbitrary and capricious standard); *Friedman v. Perales*, 668 F. Supp. 216, 211, 225 (S.D.N.Y. 1987) (refusing to "rethink or reweigh the political and financial considerations" behind rate setting and concluding that the plaintiffs presented "no triable issue of fact"); cf. *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989) (finding a violation of the Boren Amendment in a § 1983 claim and, thus, striking down Pennsylvania's reimbursement scheme), *cert. denied*, 110 S. Ct. 3213 (1990).

145. See, e.g., *Colorado Health Care Ass'n*, 842 F.2d at 1164 n.5 (declaring that providers and patients have a parallel interest in reimbursement); *Wilmac Corp. v. Bowen*, 811 F.2d 809 (3d Cir. 1987); *Nebraska Health Care Ass'n v. Dunning*, 575 F. Supp. 176 (D. Neb. 1983).

146. See, e.g., *Silver v. Baggiano*, 804 F.2d 1211 (11th Cir. 1986) (expressly reserving the question); *Coos Bay Care Center v. State of Oregon*, 803 F.2d 1060 (9th Cir. 1986), *vacated on other grounds*, 484 U.S. 806 (1987); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987).

147. 578 F. Supp. 543 (D. Neb. 1983).

148. *Id.* at 544.

149. *Id.* at 544-45.

150. See, e.g., *Michigan Hosp. Ass'n v. Department of Social Servs.*, 738 F. Supp. 1080, 1085-86 (W.D. Mich. 1990); *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1427 (N.D. Ill. 1989) (holding that no private cause of action to sue the Secretary of Health and Human Services exists under the Boren Amendment).

courts relied on a four-step analysis established by the Supreme Court in *Cort v. Ash*.¹⁵¹ The *Cort* analysis first required that the plaintiff be a member of the class "for whose especial benefit the statute was enacted."¹⁵² Second, it demanded evidence of a legislative intent to create a right.¹⁵³ Third, *Cort* required that the recognition of a federal right of action be "consistent with the underlying purposes" of the statute in question.¹⁵⁴ Finally, the Court indicated that it would imply the existence of federal rights only in areas not traditionally relegated to state law.¹⁵⁵ Subsequent cases suggest that legislative intent is the most important ingredient of the *Cort* test.¹⁵⁶

Other courts consistently found no evidence of any legislative intent to create a right of action on behalf of providers under the Boren Amendment.¹⁵⁷ These courts could not accept the idea that providers were members of a class for whom Congress designed the law to benefit.¹⁵⁸ The clearest purpose of the Medicaid program was to provide access to medical treatment for the poor, disabled, and elderly, not to reimburse providers.¹⁵⁹

The reluctance of federal district courts to find an independent cause of action for health care providers presented a significant hurdle for those providers seeking federal court review of state rate-setting procedures.¹⁶⁰ This reluctance also suggested a growing inclination to

151. 422 U.S. 66 (1975). Bethlehem Steel published advertisements seeking to mobilize "truth squads" in an effort to defeat Senator George McGovern's 1972 bid for the Presidency. *Id.* at 70. Shareholders brought suit under a federal criminal statute which prohibited corporations from contributing to or spending money in connection with a Presidential campaign. *Id.* at 68. A unanimous Court ruled that the shareholders had no implied private right of action under the statute. *Id.* at 69.

152. *Id.* at 78.

153. *Id.*

154. *Id.*

155. *Id.*

156. See *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385 (1982); *Cannon v. University of Chicago*, 441 U.S. 677, 694-702 (1979).

157. See, e.g., *Michigan Hosp. Ass'n*, 738 F. Supp. at 1083-84; *Suter*, 719 F. Supp. at 1425 (finding no evidence of a congressional intent to create a private right of action against the Secretary of Health and Human Services under the Boren Amendment).

158. See, e.g., *Suter*, 719 F. Supp. at 1419; *AGI-Bluff Manor, Inc. v. Reagan*, 713 F. Supp. 1535, 1545 (W.D. Mo. 1989) (refusing to recognize a property interest entitling providers to procedural due process in rate setting).

159. See *CANNAS ET AL.*, *supra* note 20, at 165-67.

160. Some providers tried to avoid the issue by asserting Due Process or Equal Protection violations. Those claims rarely resulted, however, in the overturning of the state scheme under the Boren Amendment. *Cf. Wisconsin Hospital Ass'n v. Reivitz*, 630 F. Supp. 1015, 1023-25 (E.D. Wis. 1986) (finding that Wisconsin's rate freeze violated the contracts clause of the U.S. Constitution) *aff'd on other grounds*, 820 F.2d 863 (7th Cir. 1987). *Folden v. Washington State DSHS*, 744 F. Supp. 1507, 1526-27 (W.D. Wash. 1990); *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 598 F. Supp. 1400, 1407 (D. Colo. 1984).

leave rate setting to the states.¹⁶¹ As provider challenges to state rate-setting programs continued to proliferate in the 1980s,¹⁶² however, several federal circuit courts reversed this trend and ruled that providers could rely on Section 1983 as a legitimate cause of action.¹⁶³ Because the Boren Amendment conditioned federal funding on state assurances that rates were reasonable and adequate for economically and efficiently operated providers, these courts found that Congress had created enforceable rights for providers under the Boren Amendment.¹⁶⁴ Moreover, these courts suggested that the HHS Secretary's loose and limited review of state assurances was not a comprehensive federal review procedure and, thus, would not foreclose a Section 1983 action.¹⁶⁵ In short, these courts started with a presumption that the statute gave providers rights enforceable under Section 1983 and then looked to the legislative history of the statute for some indication that Congress had intended to foreclose that remedy.¹⁶⁶ Finding no such indication in the legislative history, these courts concluded that providers had rights enforceable under Section 1983.¹⁶⁷

Thus, prior to the *Wilder* decision, a number of circuit courts had already begun to reassert federal control over rate-setting under the Boren Amendment. The circuits' use of Section 1983, coupled with the Supreme Court's expansion of Section 1983 rights in other areas, created the opportunity for the Court to consider providers' claims as stat-

161. See, e.g., *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1159, 1164-66 (10th Cir. 1986) (insisting that states could consider budgetary constraints when setting reimbursement levels and creating a presumption of validity for state actions under the Boren Amendment); *Friedman v. Perales*, 668 F. Supp. 216 (S.D.N.Y. 1987) (stating that the federal courts should not rethink the political and financial considerations that motivated the state's reimbursement decision).

162. Providers began to base their suits on § 1983 as a cause of action in order to get federal court review of state rate-setting decisions. See, e.g., *West Virginia University Hosps., Inc. v. Casey*, 885 F.2d 11, 18-22 (3d Cir. 1989); *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653, 656-60 (4th Cir. 1989); *Coos Bay Care Center v. State of Oregon*, 803 F.2d 1060, 1062-63 (9th Cir. 1986). But see *Colorado Health Care Ass'n*, 842 F.2d at 1163 (linking the providers' rights with patients' rights).

163. See cases cited *supra* note 162.

164. See, e.g., *Casey*, 885 F.2d at 21 (expressing the belief "that Congress's concern with appropriate hospital reimbursement implies an intent to supply hospitals with an indispensable right to enforce state compliance with federal standards that, whether strictly or loosely, govern state reimbursement methodologies").

165. See, e.g., *id.* at 22; *Coos Bay Care Center*, 803 F.2d at 1062.

166. See, e.g., *Casey*, 885 F.2d at 18 (placing the burden on the state to prove congressional intent to foreclose a § 1983 action); *Virginia Hosp. Ass'n*, 868 F.2d at 658 (finding a § 1983 action implied in language and legislative history of the Boren Amendment); *Coos Bay Care Center*, 803 F.2d at 1062 (suggesting that "[a]ccess to a § 1983 remedy should be denied if . . . the language of the statute indicates a congressional intent to foreclose § 1983 enforcement by making alternative remedies available").

167. See *supra* note 162 and accompanying text.

utory rights under the Boren Amendment.

IV. *WILDER v. VIRGINIA HOSPITAL ASSOCIATION*

A. *The Majority Opinion*

In *Wilder v. Virginia Hospital Association*,¹⁶⁸ the Supreme Court determined that health care providers have the right to bring Section 1983 claims in federal court under the Boren Amendment.¹⁶⁹ According to the majority, the Amendment confers both substantive and procedural rights on providers.¹⁷⁰ The majority based its decision primarily on the legislative history of the Amendment and on a presumption that Section 1983 claims can be brought unless the statute does not create enforceable rights or Congress specifically foreclosed Section 1983 claims.¹⁷¹

Because the language of the statute discusses providers, the majority first assumed that providers must be the beneficiaries of the statute.¹⁷² Although they later conceded that Congress designed the Amendment to give states greater flexibility in setting reimbursement rates, the majority never examined the possibility that states and patients, not providers, may have been the intended beneficiaries of the Amendment.¹⁷³ Nor did they consider that the Boren Amendment is simply one part of the laundry list of requirements for state Medicaid plans.¹⁷⁴ Far from focusing exclusively on the states' obligations to providers, the Amendment focuses primarily on the states' responsibilities to the federal government under the Medicaid program. The major-

168. 110 S. Ct. 2510 (1990).

169. *Id.* at 2525. Chief Justice Rehnquist, joined by Justices O'Connor, Scalia, and Kennedy, dissented in *Wilder*. The dissent relied on the text of the Boren Amendment to conclude that providers could not assert § 1983 rights for several reasons. 110 S. Ct. 2510, 2525-27 (Rehnquist, C.J., dissenting). First, the Boren Amendment is part of a laundry list of requirements that state medical assistance plans must meet for states to receive federal funding. See 42 U.S.C. § 1396a(a)(1988). As such, the dissent concluded that the Amendment was addressed to states rather than to providers. 110 S. Ct. at 2526 (Rehnquist, C.J., dissenting). Second, the Amendment already contained a process for rate setting. A state must make findings and then provide assurances to the Secretary of HHS. See 42 U.S.C. § 1396a(a)(13). The dissent recognized that providers might have a right to force states to adhere to this process, but thought that allowing providers to seek court-imposed rates would subvert the statutory process and thereby undermine Congress' intent in passing the Amendment. 110 S. Ct. at 2527 (Rehnquist, C.J., dissenting). Thus, the dissent refused to find any substantive right for providers under the Amendment. *Id.*

170. *Id.* at 2517-23.

171. *Id.* at 2515-17, 2523-25; see also *Wright v. City of Roanoke Redev. & Hous. Auth.*, 479 U.S. 418 (1987) (establishing these criteria for a § 1983 claim).

172. 110 S. Ct. at 2517.

173. *Id.*

174. See 42 U.S.C. § 1396a(a) (1988) (listing all the major elements that a state plan must include to qualify for the federal Medicaid program). The Boren Amendment, 42 U.S.C. § 1396a(a)(13), is merely one of these requirements.

ity also seemed to ignore that the primary beneficiaries of Medicaid are not providers but the eligible poor, elderly, and disabled.¹⁷⁵ Providers alone cannot receive Medicaid; they must treat Medicaid patients to obtain funding. Furthermore, although provider participation in Medicaid is entirely voluntary,¹⁷⁶ providers are not entitled to participate. The providers' decision to rely on Medicaid funding should not in itself be enough to create federal rights.¹⁷⁷

After assuming that providers were the intended beneficiaries of the Boren Amendment, the majority then rejected the argument that the statute was too vague or amorphous to create enforceable federal rights.¹⁷⁸ Instead, the majority found both procedural and substantive rights for providers: providers could force states to make findings and provide assurances to the Secretary of HHS and could challenge the substance of state reimbursement methods.¹⁷⁹ The majority concluded that the statute's use of mandatory rather than precatory language created clear substantive and procedural obligations.¹⁸⁰ Requiring a state to make findings without providing a mechanism to review the correctness of those findings would render the statute "a dead letter."¹⁸¹ Furthermore, the majority argued, because the statute required a state to evaluate "the reasonableness of its rates against the objective benchmark of an 'efficiently and economically' operated facility,"¹⁸² the statute provided courts with a significant yardstick by which to measure reimbursement. Importantly, that yardstick ultimately belonged to the federal government, not to the states.¹⁸³

There are several weaknesses in the majority's line of reasoning. First, most of the litigation arising under the Boren Amendment has focused on what the majority opinion described as "an objective benchmark."¹⁸⁴ The Amendment itself, however, does not even attempt to define economic and efficient hospitals.¹⁸⁵ Instead, the Amendment leaves

175. See 42 U.S.C. § 1396 (1988); see also 42 C.F.R. §§ 435.500-.541 (1991) (outlining the eligibility requirements for Medicaid).

176. Provider participation is voluntary under the Medicaid program. See *supra* note 29 and accompanying text.

177. In *Pennhurst* a state's voluntary decision to participate in a federal program and to receive federal funds did not create statutory rights for disabled persons in the state's care. *Pennhurst State School v. Halderman*, 451 U.S. 1, 11 (1981).

178. *Wilder*, 110 S. Ct. at 2518, 2522-23.

179. *Id.* at 2519-20.

180. *Id.*

181. *Id.* at 2520.

182. *Id.* at 2523.

183. *Id.*

184. *Id.* at 2523.

185. See 42 U.S.C. § 1396a(a)(13) (1988). In fact, the section of the Medicaid act that supplies definitions for key terms in the Act does not provide a definition of these terms. See 42

the task of definition to the states. Yet, if states create the benchmark by which federal rights exist, a state can violate those federal rights only by failing to pay hospitals according to the rates the state had already set — in other words by violating its own benchmark. The plaintiffs did not allege this violation in *Wilder*. Instead, they alleged that the benchmark itself was a violation of federal rights.¹⁸⁶

Second, the majority recognized but failed to accord proper significance to the primary purpose of the Amendment. Congress designed the Amendment to allow states broad flexibility in devising reimbursement plans¹⁸⁷ and cited the need to move away from federal standards of reimbursement as a primary motivation for enacting the Amendment.¹⁸⁸ In fact, Congress viewed the former Medicare reasonable costs standard that the plaintiffs sought in *Wilder* as “inherently inflationary” and unacceptable for cost containment in Medicaid.¹⁸⁹ For these reasons, in the 1970s Congress rejected an experiment that would have opened the federal courts to these claims¹⁹⁰ and instead resorted to state control of Medicaid rates.¹⁹¹

Despite this evidence of congressional intent to the contrary, the majority not only found that providers could bring a Section 1983 claim, but also allowed the providers to seek temporary imposition of alternate Medicare reimbursement standards on the states.¹⁹² Thus, the Court actually created federal standards in order to grant plaintiffs relief under Section 1983. This decision, then, is substantially different and a substantial departure from the Court’s decisions in *Wright*¹⁹³ and *Golden State Transit Corp.*¹⁹⁴ In *Wright* the Court found that tenant rights to limited utility regulations were enforceable under Section 1983

U.S.C. § 1396d (1988).

186. Virginia’s formula for reimbursement used the median costs of care for peer groups of hospitals in 1982 as its base reimbursement level. The state then readjusted that base annually for inflation. The provider-plaintiffs in *Wilder* challenged the methods Virginia used to calculate median 1982 costs, the use of the consumer price index instead of a factor tied to medical costs to adjust for inflation from 1982 to 1986, and the use of an allegedly inadequate medical cost index factor to adjust for inflation after 1986. See *Wilder*, 110 S. Ct. at 2514 n.3.

187. *Wilder*, 110 S. Ct. at 2514 (noting the respondent’s contention that “Virginia’s plan for reimbursement violates the Medicaid Act because the ‘rates are not reasonable and adequate’”).

188. See H.R. REP. NO. 158, *supra* note 68, at 294; S. REP. NO. 139, *supra* note 77, at 742-44.

189. S. REP. NO. 139, *supra* note 77, at 748.

190. Interestingly, in 1975, Congress toyed with the idea of giving the federal judiciary greater control over Medicaid rates by adopting an amendment requiring states to waive Eleventh Amendment protection against suits by providers in federal court. Pub. L. No. 94-182, § 111, 89 Stat. 1051, 1054 (1975), reprinted in 1975 U.S.C.A.N. 2125. That law was repealed the next year. See Pub. L. No. 92-552, 90 Stat. 2540 (1976).

191. See *supra* part II.B.

192. *Wilder*, 110 S. Ct. at 2514.

193. *Wright v. City of Roanoke Redevel. & Hous. Auth.*, 479 U.S. 418 (1987).

194. *Golden State Transit Corp. v. City of Los Angeles*, 110 S. Ct. 444 (1989).

because HUD had promulgated regulations delineating the scope of that right.¹⁹⁵ In *Golden State Transit*, the statute explicitly declared congressional intent to create rights for both employees and employers.¹⁹⁶ In both cases, the Court demonstrated far more concern for existing federal regulations and explicit statutory language than it demonstrated in *Wilder*.

B. *The Ramifications of Wilder*

The *Wilder* decision already has begun to influence provider suits in the lower federal courts.¹⁹⁷ These post-*Wilder* decisions demonstrate that the creation of both procedural and substantive federal rights for providers under the Boren Amendment is likely to have several negative consequences for both the federal and state governments. First, the decision may make the Medicaid program more difficult to administer. Second, it may defeat cost-containment initiatives in the states. Finally, the *Wilder* decision may pave the way for a significant expansion of the scope of Section 1983 rights.

1. Difficulty in Medicaid Administration

Because the *Wilder* decision is likely to encourage new provider suits and to prolong already existing suits, it clearly will complicate the states' task of developing and administering Medicaid reimbursement schemes. In New York, for example, *Wilder* has given nursing homes new ammunition in their five-year old fight with the state over reimbursement rules.¹⁹⁸ As a result, both sides face further long and potentially costly litigation.

The provider suit in *Pinnacle Nursing Home v. Axelrod*¹⁹⁹ arose after the State of New York attempted to adjust its reimbursement rates in 1987.²⁰⁰ Because certain providers felt that the new rates helped nursing homes with high wage costs and hurt those with low wage costs, these providers sued New York officials seeking to prevent the new rates from taking effect.²⁰¹ After extensive litigation in both state and federal courts, a federal district court ruled that the state had

195. *Wright*, 479 U.S. at 430.

196. *Golden State Transit*, 110 S. Ct. at 450.

197. *See, e.g.*, *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306 (2d Cir. 1991); *Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehabilitation Servs.*, 754 F. Supp. 1502 (D. Kan. 1990); *Ohio Academy of Nursing Homes, Inc. v. Berry*, 654 N.E.2d 686 (Ohio 1990). All three cases evaluate state Medicaid rates in light of *Wilder*.

198. *See id.*

199. 928 F.2d 1306 (2d Cir. 1991).

200. *Id.* at 1310-11.

201. *Id.* at 1311.

failed to make adequate findings and had not provided legitimate assurances to the federal government as required by the Boren Amendment.²⁰² Because the state had failed to comply with these procedural requirements, the district court suspended the new reimbursement plan.²⁰³

The district court, however, refused to reach the issue of whether the new rates met the substantive requirement of the Boren Amendment.²⁰⁴ Instead, the court dismissed the providers' claims that the rates were not reasonable and adequate in deference to the discretion granted the states under the Boren Amendment to determine their own Medicaid plans.²⁰⁵

Relying on the *Wilder* decision, the Second Circuit reinstated the providers' substantive claims on appeal and remanded the case for further proceedings.²⁰⁶ This decision has paved the way for a continuing legal battle between providers and the state.²⁰⁷ As a result, New York may not know whether its 1987 plan meets the Boren Amendment requirements until well into the year 1992.

The *Wilder* Court was certainly aware of the delays and uncertainties the decision might create. Forty-five states filed an amicus curiae brief in the *Wilder* case, in part because of their concern about difficult, protracted litigation over rates.²⁰⁸ The states urged the Court not to allow substantive challenges to provider rates under Section 1983. They feared that the Court's recognition of Section 1983 provider claims would create a dual system of review.²⁰⁹ Under the current federal regulations, states already must create a fairly substantial system of review for reimbursement rates.²¹⁰ Not only must states make findings that rates are reasonable and adequate and, at a minimum, submit annual assurances to the Secretary of HHS, but states also must conduct plan approvals, audits, and policy reviews.²¹¹ Current federal regulations also require states to develop appeals procedures for individual providers.²¹²

Most states have developed extensive review procedures.²¹³ Prior to

202. *Id.* at 1311-12.

203. *Id.*

204. *Id.* at 1312.

205. *Id.*

206. *Id.* at 1318.

207. *Id.* at 1308 (remanding the case to the district court with an instruction to reinstate the claims).

208. See Amicus Curiae Brief for Connecticut et al. at v-vi, *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

209. *Id.* at 1.

210. See 42 C.F.R. §§ 447.250, 447.253 (1990).

211. *Id.*

212. 42 C.F.R. § 447.253(c) (1990).

213. See Amicus Curiae Brief for the National Governor's Ass'n and the Nat'l Ass'n of Coun-

the *Wilder* suit, for example, Virginia had developed a several-hundred page state plan outlining Medicaid reimbursement procedures and coverage.²¹⁴ Virginia also had well-defined appeals procedures. Individual providers could appeal reimbursement decisions first to an administrative body and then through two levels of the Virginia court system by right.²¹⁵ Arguably, the Virginia Court of Appeals developed a significant amount of expertise in Medicaid reimbursement because it usually had final authority over these suits.²¹⁶ As a final resort, unsatisfied providers could seek review of the appellate court decision in the Virginia Supreme Court.²¹⁷

Other states have similarly comprehensive review procedures.²¹⁸ State courts also have shown no hesitation to entertain claims of inadequate reimbursement under the Boren Amendment.²¹⁹ Massachusetts courts, for example, struck down state reimbursement rates when the state failed to prove that the rates were reasonable and adequate and also failed to make assurances to the Secretary of HHS.²²⁰ Moreover, the Massachusetts Supreme Court was willing to grant more than injunctive relief to the providers. The court decided that the hospitals challenging the new reimbursement rates were entitled to reimbursement under the previously approved rate as though that rate had remained in effect throughout the entire dispute.²²¹

The *Wilder* decision undermines the effectiveness and comprehensiveness of these state review procedures. It essentially gives providers

ties at 6-8, *Wilder* (No. 88-2043) (stating that creation of substantive § 1983 rights under the Boren Amendment would produce litigation disrupting the federal-state relationship and would expose states to heavy potential liability). See also Amicus Curiae Brief for Connecticut et al. at vii.

214. See Virginia's Petition for Writ of Certiorari at 13, *Wilder* (No. 88-1043).

215. *Id.*

216. See *id.* at 13-14.

217. If Virginia's scheme had any defects, those defects were most obvious in the *Wilder* case. Virginia review procedures did not allow class action challenges like the one brought in *Wilder*. Nor did they allow providers to challenge the entire scheme of reimbursement. See *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653, 661 (4th Cir. 1989). In *Wilder*, the VHA used a class action suit to challenge Virginia's use of the Consumer Price Index in calculating rates state-wide. See *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2514 n.3 (1990). Perhaps this defect, however, merely points out the need for more complete state administrative review procedures. Virginia's existing review framework easily could have handled such a claim.

218. See, e.g., *New England Memorial Hosp. v. Rate Setting Comm'n*, 475 N.E.2d 740, 742-43 (Mass. 1985) (describing Massachusetts' rate-setting procedures); *St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1040-41 (W.D. Wisc. 1989) (outlining Wisconsin's procedures).

219. See, e.g., *Geriatrics, Inc. v. Colorado Dep't of Social Servs.*, 712 P.2d 1035 (Colo. Ct. App. 1985); *Ohio Hosp. Ass'n v. Ohio Dep't of Human Servs.*, No. 88AP-1034, 1990 Ohio App. LEXIS 2587 (Ohio Ct. App. June 21, 1990); *Volk v. Department of Human Resources*, 799 P.2d 658 (Or. Ct. App. 1990).

220. *New England Memorial Hosp.*, 475 N.E.2d at 744-45.

221. *Id.* at 745.

an alternative method of challenging reimbursement rates. Even if providers' challenges have failed under the state's administrative review mechanisms, providers subsequently may challenge the same payment schemes in federal court. Thus, states that have complied with the procedures of the Boren Amendment, made findings, and received approval from the Secretary of HHS nonetheless may be subject to judicial review as well.²²²

Because no concrete criteria or objective reimbursement standards exist under the Amendment, states cannot predict what federal courts will decide are reasonable and adequate rates.²²³ Significant local variations in factors that contribute to hospital costs will increase this uncertainty.²²⁴ Local variations in wages, food costs, utility costs, the amount of uncompensated care, and other operational costs may make rates that are reasonable in one state unreasonable in another.²²⁵ Thus, the inability of states to rely on absolute standards of reasonableness in the determination of reimbursement rates will add to the uncertainty of the federal review.

2. The Inhibition of State Cost-Containment Innovation

Not only does the creation of a dual system of review add substantial uncertainty to a state's reimbursement decisions, it also may inhibit state efforts to develop innovative cost-containment measures.²²⁶ Providers will be less likely to challenge new methods of reimbursement if they vary only slightly from old methods. Thus, a state whose current scheme reimburses fully up to the eightieth percentile may be more likely to cut costs simply by reimbursing up to only the seventy-eighth percentile rather than by trying new and ultimately more efficient

222. See *supra* part IV.A.

223. See *supra* note 185 and accompanying text.

224. See, e.g., *Washington State Nurses Ass'n v. Washington State Hosp. Comm'n*, 773 F.2d 1044 (9th Cir. 1985) (involving a plaintiff who alleged that state rate-setting procedures were not flexible enough to allow hospitals to pay adequate wage increases); see also *Wing, supra* note 30, at 628-35.

225. See Mark S. Freeland et al., *Measuring Hospital Input Price Increases: The Rebased Hospital Market Basket*, HEALTH CARE FINANCING REV., Spring 1991, at 1, 2-3 (discussing how variable input costs are measured in Medicare and how those costs change over time); E. Greer Gay, *The Rural Health Care Markets: Strategies for Survival*, HEALTH SPAN, Feb. 1990, at 11, 11-15 (discussing the unique needs of rural hospitals).

226. Critics of the Illinois scheme have raised two objections to the plan. First, the plan places hospitals in a position of having to make a price versus volume tradeoff. Hospitals can keep their prices high and accept fewer Medicaid patients, or they can lower prices and accept more Medicaid patients. Neither choice, however, is a guaranty that hospitals will increase profitability. Second, the plan may force patients to travel significant distances from their homes to attain care. Because fewer patients are apt to travel to receive health care, the scheme may affect negatively the quality of care for Medicaid patients in Illinois. See *Salmon et al., supra* note 53, at 111, 116.

methods of reimbursement.

Unfortunately, old methods of cost containment may not work in the 1990s. Many of the factors that have contributed to the current financial difficulties in the Medicaid system will likely worsen in the 1990s.²²⁷ Although regulation slowed the rise of medical costs in the 1980s, it did not curtail cost increases. Costs continued to rise faster than general inflation.²²⁸ In the 1990s, costs should continue to rise as the baby boom generation enters its fifties and America, as a whole, grows older. Elderly Americans generally require more medical care than their younger counterparts.²²⁹ In addition, AIDS patients and newborn children with drug addictions are likely to continue demanding a significant amount of medical resources.²³⁰ With mounting federal budget deficits, Congress is unlikely to increase federal funding to ease the Medicaid burden on states.²³¹

In the mid-1980s some states tried innovative measures to contain medical costs. Illinois, for example, established a voucher system that allocated Medicaid patient days to hospitals.²³² By bargaining down their rates, however, providers could receive more patient days than hospitals with higher rates. Only after a hospital reached its patient-day limit was it restricted to treating Medicaid patients in emergency situations.²³³ Other states sought to enroll Medicaid patients in programs of managed care. Under managed care systems, patients chose a particular physician to act as a primary care provider. That physician then controlled the patient's choice of hospitals and other health care providers.²³⁴

The uncertainty of federal review should make states less willing to enact these kinds of innovative cost-containment measures. By enacting such measures, the states almost certainly will face the prospect of defending their Medicaid programs in federal court. Numerous suits would add significant administrative costs to the institution of new pro-

227. See *infra* notes 228-230 and accompanying text.

228. See Jack Hadley & Katherine Swartz, *The Impacts on Hospital Costs Between 1980 and 1984 of Hospital Rate Regulation, Competition, and Changes in Health Insurance Coverage*, 26 INQUIRY 35 (1989).

229. Wing, *supra* note 30, at 643; see also CANNAS ET AL., *supra* note 20, at 123.

230. Dennis Andrulis et al., *The Provision and Financing of Medical Care for AIDS Patients in U.S. Public and Private Teaching Hospitals*, 258 J.A.M.A. 1343 (1987).

231. In fact, Congress has been looking for ways to trim even more fat from the Medicaid budget. See Robert Pear, *U.S. Moves to Curb Medicaid Payments for Many States*, N.Y. TIMES, Sept. 11, 1991, at A1, A16, for an example of the current political climate.

232. See Salmon et al., *supra* note 53, at 103-05.

233. *Id.* at 106-08.

234. See Rand E. Rosenblatt, *Medicaid Primary Care Case Management, the Doctor-Patient Relationship, and the Politics of Privatization*, 36 CASE W. RES. L. REV. 915, 918-19 (1986).

grams.²³⁵ Furthermore, providers who win injunctions under Section 1983 may force states to abandon new, innovative programs and to reimburse providers, at least temporarily, under the older, ineffective programs. And, if courts follow *Wilder* literally, providers may be able to obtain interim reimbursement under more costly Medicare guidelines until the state can adopt new Medicaid schemes.²³⁶ Thus, instead of controlling costs, an innovative program invalidated through a Section 1983 claim actually could increase the costs to the state. Clearly, the possibility of such a result should make states less willing to reduce or limit provider reimbursement rates in an attempt to control costs. Instead, states may continue to use more traditional, but less efficient, less patient-favoring cost-control measures.

The *Wilder* decision also threatens the continuation of already-instituted state programs that expand the minimum coverage required by federal law. Although some federal requirements exist as to the scope of Medicaid coverage, states retain significant freedom in delineating the types of procedures state Medicaid programs will cover. The federal government merely requires participating states to provide certain types of services to "categorically needy" persons.²³⁷ States also can choose to provide services to "medically needy" individuals whose income has been depleted by catastrophic medical expenses.²³⁸ In addition, any state may opt to pay for more than the basic services.²³⁹ Thus, states are free to develop programs that are significantly more comprehensive than the federally required base. Many state programs, for example, currently cover prescription drugs, dental care, nursing home services, rehabilitation, and optical care²⁴⁰ even though federal Medicaid legislation does not demand that states reimburse providers for these services.²⁴¹ States usually also cover nursing home services in intermediate care facilities despite the fact that this optional coverage may represent forty to fifty percent of Medicaid expenses.²⁴²

States that cannot contain Medicaid costs by adjusting provider reimbursement schemes, however, may begin to curtail the scope of their

235. See *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653, 660 n.7 (4th Cir. 1989) (reflecting judicial recognition of this problem).

236. See *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2514-15 (1990).

237. See 42 U.S.C. § 1396a(a)(17) (1988); 42 C.F.R. §§ 435.100-139 (1990) (outlining the scope of Medicaid coverage in great detail); see also *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981) (outlining federal requirements for Medicaid eligibility).

238. 42 C.F.R. §§ 435.300-350.

239. See 42 C.F.R. §§ 435.200-350 (1990) (detailing the types of care that Medicaid must provide and the types of optional care states also may choose to provide).

240. See CANNAS ET AL., *supra* note 20, at 184.

241. See 45 C.F.R. § 244.10(a)(5)(i) (1990).

242. See CANNAS ET AL., *supra* note 20, at 184.

coverage. A state may decide, for example, to eliminate coverage of optical care or to reduce coverage of intermediate facility nursing home care. As a result, post-*Wilder* Medicaid recipients are likely to find health care growing less accessible in the 1990s.²⁴³

3. The Further Expansion of Section 1983 Rights

The *Wilder* decision also has negative ramifications for the federal government. Creating a Section 1983 right under the Boren Amendment forces federal courts to make open-ended adjudicatory decisions about Medicaid reimbursement.²⁴⁴ Courts now must determine the scope of a federal right under language that provides few specific guidelines.²⁴⁵ The Boren Amendment requires only that providers receive rates that are reasonable and adequate for an economically and efficiently operated facility.²⁴⁶ The Amendment does not set guidelines for determining what rates are reasonable, nor does it explain how courts should determine when a hospital is operated economically and efficiently.²⁴⁷ Worse still, these definitions are mired easily in the shifting sands of variable costs. Each hospital faces a unique mix of labor, utility, charitable care, and technology costs.²⁴⁸ Reasonable reimbursement for one hospital may be unreasonable for another. No discrete oasis of reasonable rates exists.

Although *Wilder* involves challenges to state action under Section 1983 rather than challenges to agency action, the state, in many respects, acts as a substitute for a federal agency under the Medicaid program. The state sets the rates, determines some eligibility, and generally administers the Medicaid program.²⁴⁹ Thus, administrative law may provide the best guide for how courts should approach such an open-ended, technical decision.²⁵⁰

In reviewing administrative determinations of questions of law, such as whether a given rate conforms to the Boren Amendment, courts

243. See *White v. Beal*, 555 F.2d 1146 (3d Cir. 1977) (involving Pennsylvania's decision to cover optional eye care).

244. See James A. Henderson, *Expanding the Negligence Concept: Retreat from the Rule of Law*, 51 IND. L.J. 467 (1976) (outlining the dangers of open-ended adjudication in the field of torts).

245. See *supra* part II.B.

246. 42 U.S.C. § 1396a(a)(13)(A) (1989).

247. See *supra* note 76 and accompanying text.

248. See *supra* part II.A.

249. For a discussion of Medicaid, see *supra* part II.A. For a general list of some of the states' responsibilities under the Medicaid program, see 42 U.S.C. § 1396a(a) (1988).

250. At least one court already has indicated that it will judge any challenge to rates under an arbitrary and capricious standard. See *Friedman v. Perales*, 668 F. Supp. 216, 221 (S.D.N.Y. 1987). The district court decided that it would review the rates only under an arbitrary and capricious standard. Under that standard, any rates that fell within a zone of reasonableness would be upheld by the court. *Id.*

usually invoke the *Chevron* test.²⁵¹ Under that test, a court will uphold an agency decision unless the agency has either (1) contravened clear congressional intent or (2) acted in an arbitrary and capricious manner.²⁵² Good faith attempts at rate setting by states clearly would not contravene congressional intent under the Amendment.²⁵³ Thus, courts probably would use the second prong of the *Chevron* test to review state rate setting. The second prong recognizes the congressional delegation of authority to the agency and the development of agency expertise and, thus, is somewhat deferential.²⁵⁴ Under the second prong of the *Chevron* test, an agency merely must provide reasonable explanations for its decision and demonstrate that it considered alternatives.²⁵⁵

The *Chevron* test clearly resembles the standards that states must meet already under the Boren Amendment. States must provide assurances to the Secretary of the HHS that the chosen rates are reasonable and adequate.²⁵⁶ Thus, arguably, a court's review of Medicaid reimbursement rates under *Chevron* should merely duplicate the review of the Secretary of HHS. The court should focus only on the exact same issue that the Secretary decided: whether the state provided adequate assurances. But this review translates into more of a procedural right than a substantive right.²⁵⁷ It may give providers the right to make sure a state follows the procedures of the Boren Amendment, but it does not translate into a right to receive any particular reimbursement.

The *Wilder* decision, however, suggests a more active role for courts in Section 1983 provider cases. The Court allowed the providers to seek court-ordered reimbursement at new rates.²⁵⁸ This relief is inconsistent with the *Chevron* approach. For a court to set reimbursement rates, it must make its own independent evaluation of what the reasonable and adequate standard mandates rather than, as *Chevron* would suggest, simply review the state's determination of that standard.

Moreover, any court that substitutes its own rates for those of the state arguably violates the position of the Supreme Court in *SEC v. Chenery*.²⁵⁹ In *Chenery*, the SEC decided that common-law agency

251. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

252. *Id.* at 842-43.

253. See *supra* part II.B. for a discussion of congressional intent.

254. *Chevron*, 467 U.S. at 843-44.

255. See *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.* 463 U.S. 29, 56-57 (1983).

256. 42 U.S.C. § 1396a(a)(13) (1988).

257. *State Farm*, 463 U.S. at 57 (noting that, in making a decision, an agency "must supply a reasoned analysis").

258. *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510, 2514-15, 2525 (1990).

259. *SEC v. Chenery* 318 U.S. 80, 93-94 (1943) (stating that the SEC's action "must be measured by what the Commissioner did, not by what it might have done").

principles prohibited directors of a corporation from trading stock during the corporation's reorganization.²⁶⁰ The Court found no justification for such a rule in the common law.²⁶¹ Significantly, however, the Court refused to substitute its own rationale for the SEC rule.²⁶² Instead, it remanded the dispute to the SEC for further clarification.²⁶³

Many of the considerations that led to the *Chenery* decision are applicable in the *Wilder* context. Courts have less expertise than state agencies in setting rates, and federal courts, in particular, may be less politically accountable.²⁶⁴ Instead of following the *Chenery* rule, however, *Wilder* seems to condone the plaintiffs' request for court-ordered rates.²⁶⁵ Thus, unlike *Chenery*, the decision invites lower courts to substitute their judgment for that of the states. The Court thereby decreased the ability of states to predict the likelihood that their Medicaid rates will withstand judicial scrutiny. In so doing, it raised a legitimate question as to why states, acting as surrogate federal agencies, do not deserve as much respect as bona fide federal agencies, particularly in an area like Medicaid where the states probably have greater expertise than do courts.²⁶⁶

In addition to allowing federal courts to substitute their own judgment for that of state legislatures and agencies, the *Wilder* decision also seems to broaden the scope of the Section 1983 right available to putative plaintiffs by creating substantial uncertainty at the borders of the Supreme Court's analytical framework for whether a Section 1983 right exists under a particular statute. Although the Supreme Court clearly expanded the scope of Section 1983 rights under federal statutes in the past decade, the Court seemed to have developed a workable three-part test for the existence of that right in the *Pennhurst*,²⁶⁷ *Wright*,²⁶⁸ *Golden State*,²⁶⁹ and *Dennis*²⁷⁰ decisions.²⁷¹ Although this test may ex-

260. *Id.* at 87-88.

261. *Id.* at 89.

262. *Id.* at 93-95.

263. *Id.* at 95.

264. *Id.* at 94-95 (recognizing congressional delegation and agency expertise).

265. *Wilder*, 110 S. Ct. at 2515, 2525.

266. *See St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1043-44 (W.D. Wis. 1989) (invoking the Burford abstention doctrine in recognition of state expertise in this area).

267. *Pennhurst State School v. Halderman*, 451 U.S. 1, 19 (1980) (stating that the right was too vague and amorphous because plaintiffs based their suit on a provision that contained congressional findings and did not create any obligations).

268. *Wright v. City of Roanoke Redev. & Hous. Auth.*, 479 U.S. 418, 419, 430-32 (1987) (stating that a § 1983 cause of action existed unless Congress foreclosed such an action or unless the statute did not create enforceable rights for the plaintiff).

269. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 105-07 (1989) (affirming the two-step analysis in *Pennhurst* and *Wright*).

270. *Dennis v. Higgins*, 111 S. Ct. 865 (1991).

271. The Court summarized the three earlier cases in the three-part test it enunciated in

plain the Supreme Court's decisions in many of its prior Section 1983 cases, it does not explain the *Wilder* decision. Arguably, an attempt by health care providers to assert Section 1983 rights under the Medicaid statute should fail all three parts of the test.

First, the Boren Amendment may not create substantive obligations on the states.²⁷² The obligations the Amendment imposes on the states are largely procedural. The Amendment requires states to make findings and to provide assurances to the federal government that its reimbursement rates are reasonable and adequate for efficient and economically run facilities,²⁷³ but the statute provides no substantive mandate telling states exactly what those rates should be. It does not, for example, require that states reimburse providers X dollars per patient. The Amendment requires only that the states satisfy themselves that the rates are adequate.²⁷⁴

Second, the right that providers assert under the Boren Amendment is quintessentially vague and amorphous.²⁷⁵ Even assuming that providers properly could claim a substantive right to reimbursement, the language of the Amendment suggests that the Court should have found this right too vague to be enforceable under Section 1983.²⁷⁶ The Amendment merely requires reimbursements to be "reasonable and adequate" for an "efficient and economically operated" health care facility.²⁷⁷ But what is an efficient and economically operated facility? Teaching hospitals, rural hospitals, inner-city hospitals, small clinics, and specialized health care facilities may have widely varying systems of operation.²⁷⁸ A hospital that regularly performs organ transplants may have significantly higher per-patient operating costs than a small rural clinic.²⁷⁹ But is one more efficient than the other? To determine

Dennis, 111 S. Ct. at 871; see also *supra* notes 137-141 and accompanying text.

272. See 42 U.S.C. § 1396a(a)(13) (1988) (providing the language of the Boren Amendment). See, for example, the Court's consideration of the Developmental Disability Act in *Pennhurst*, 451 U.S. at 13-15 (concluding that the Patient's Bill of Rights contains no binding obligations); see also Developmentally Disabled Assistance & Bill of Rights Act, Pub. L. No. 94-103, § 201, 89 Stat. 486, 502 (1975) (current version codified at 42 U.S.C. § 6009 (1988)).

273. 42 U.S.C. § 1396a(a)(13).

274. *Id.*

275. See *supra* notes 266-70 and accompanying text.

276. See 42 U.S.C. § 1396a(a)(13).

277. *Id.*

278. See Vladeck, *supra* note 49, at 581-84 (suggesting that these variations may produce significant differences in the cost of treating a particular illness). Presumably, cost variations would still exist regardless of whether Medicaid or Medicare paid for treatment.

279. The costs and difficulties associated with procuring organ transplants have led some commentators to propose rationing this type of care. See George J. Annas, *The Prostitute, the Playboy, and the Poet: Rationing Schemes for Organ Transplants*, 75 AM. J. PUBLIC HEALTH 187 (1985); see also Marc Roberts, *The Economics of Organ Transplants*, 25 JURIMETRICS J. 256 (1985) (discussing the costs of organ transplants in the early 1980s).

efficiency, a court could restrict its comparisons to facilities that had similar patient populations and provided similar services. This method, however, still would fail to take account of an enormous number of other economic variables that affect a hospital's operating costs. Wage costs, for example, are often different in various parts of the country.²⁸⁰ Likewise, utility, food, and waste-disposal costs also may vary from region to region.²⁸¹

Even assuming that a court could accurately account for all these factors by comparing a provider with similar providers in the same geographic locality,²⁸² the court still must determine which providers are efficient and economically operated. Again, the Amendment is devoid of guidelines. Are eighty percent of providers in a given group efficient? Are ninety percent efficient? How should the court decide?

Furthermore, even if a court is able to determine which providers are efficient and economically operated, it still must determine what constitutes reasonable and adequate reimbursement for these providers.²⁸³ Once again, the Boren Amendment provides no guidance for a court endeavoring to solve this puzzle. Is an eighty percent reimbursement reasonable because the hospital easily can offset any losses by charging non-Medicaid patients more? Is a ninety percent reimbursement adequate? Should reimbursement rates be adjusted once a month, once a year, or once every two years? Neither the Boren Amendment nor its legislative history provide any answers to these questions. The Amendment, then, leaves a court with very few signposts in its quest to evaluate reimbursement rates.

The net result is that when a court strikes down a state reimbursement scheme it necessarily substitutes its own policy decisions for the state's policy decisions. Even if, upon striking down a particular reimbursement scheme, the court allows the state to adopt substitute rates, the court still has made a policy decision that the initial reimbursement scheme was unsatisfactory. A court cannot simply enforce a provider's rights under the Boren Amendment; it must create those rights out of vague and amorphous statutory language.

Finally, health care providers asserting Section 1983 rights under

280. In fact, statewide reimbursement limits sometimes have affected hospital wage scales. See *Washington State Nurses Ass'n v. Washington State Hosp. Comm'n*, 773 F.2d 1044 (9th Cir. 1985) (involving plaintiffs who argued that Medicaid reimbursement procedures impinged on their right to negotiate wage increases).

281. For a discussion of variable input costs, how they may change over time, and how Medicare measures them, see Freeland et al., *supra* note 225, at 2-3.

282. This approach would result in using a market basket method similar to Medicare to evaluate the input costs for various types of hospitals in different geographic regions. See *id.* (discussing the variations in input costs for hospitals and the market basket approach in Medicare).

283. See 42 U.S.C. § 1396a(a)(13) (1988).

the Boren Amendment apparently also convinced the *Wilder* Court that they were the intended beneficiaries of the Amendment.²⁸⁴ This result, however, is far from obvious. As the legislative history makes clear, Congress enacted the Amendment to give states greater flexibility in setting reimbursement rates.²⁸⁵ Moreover, the Medicaid statute itself was intended to provide health care for the poor, not to ensure the fiscal well-being of providers.²⁸⁶ Thus, providers, at best, are only tangential beneficiaries of the statutory scheme.

The Supreme Court's decision to confer Section 1983 rights on health care providers, then, seems incongruous with the analytical framework the Court has established for determining the existence of statutory Section 1983 rights.²⁸⁷ Because the *Wilder* decision seems to ignore many of the principles that limit Section 1983 rights, principles that the Court has recognized in other statutory cases,²⁸⁸ it extends an invitation to plaintiffs to press the Court to develop new Section 1983 rights in different contexts under other statutes. It also forces states to seek new avenues of protection from their increasing vulnerability to Section 1983 claims.

V. PRESERVING STATE FREEDOM: THE ELEVENTH AMENDMENT AND JUDICIAL LIMITS ON PROVIDER ACTIONS

Allowing providers to bring substantive Section 1983 claims means that federal courts have reasserted some control over state rate-setting procedures. The more control federal courts assert, however, the more difficult it may become for states, facing the uncertainty of litigation and its potential negative financial consequences, to experiment with innovative cost-control measures. Nevertheless, through the creative use of doctrine limiting federal court jurisdiction, states planning new reimbursement schemes still may be able to limit the damage *Wilder* does to their ability to implement cost-containment measures. By astute planning, states may retain some of the flexibility Congress intended to give them under the Boren Amendment.

A. *Eleventh Amendment Limitations*

Although the language of the Eleventh Amendment specifically bars only suits against a state brought in federal court by citizens of

284. See *supra* notes 266-70 and accompanying text.

285. See *supra* part II.B.

286. See *supra* notes 20-21.

287. *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990).

288. See *supra* part III.A.

another state,²⁸⁹ the Supreme Court has interpreted the amendment as a much more significant preservation of a state's sovereign immunity to federal court jurisdiction.²⁹⁰ The Court long has held that the Eleventh Amendment also prohibits federal jurisdiction over suits by citizens of the defendant state.²⁹¹ This ban applies whether the plaintiff seeks equitable or legal relief.²⁹²

The Supreme Court, however, also has created a broad exception to this sweeping immunity. In *Ex Parte Young*²⁹³ the Court allowed a suit against a state attorney general who continued to enforce a statute that previously had been declared unconstitutional.²⁹⁴ In refusing to find an Eleventh Amendment bar to the suit, the Court stated that when "an unconstitutional state statute is void," actions taken under the auspices of that statute cannot be considered official actions deserving of immunity under the Eleventh Amendment.²⁹⁵ In 1982, the Court extended the *Ex Parte Young* exception to acts of state officials for which the underlying authorization was merely illegal rather than unconstitutional.²⁹⁶

Although *Ex Parte Young* significantly reduced state sovereign immunity under the Eleventh Amendment, the Court has retained some limits on a plaintiff's ability to bring suit against state officials in federal court. Perhaps the most significant limit stems from the Court's ruling in *Edelman v. Jordan*.²⁹⁷ In *Edelman*, the plaintiffs sued Illinois officials who allegedly failed to deliver the plaintiffs' disability assistance checks.²⁹⁸ The plaintiffs sought an injunction requiring the state officials to deliver the checks on time in the future.²⁹⁹ The plaintiffs also requested that the Court order the state to pay damages for all past benefits the plaintiffs had not received.³⁰⁰ Although the Court granted the injunction, it refused to assess damages for the plaintiffs' lost bene-

289. U.S. CONST., amend. XI. The Eleventh Amendment provides: "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State." *Id.*

290. See William A. Fletcher, *A Historical Interpretation of the Eleventh Amendment: A Narrow Construction of an Affirmative Grant of Jurisdiction Rather than a Prohibition Against Jurisdiction*, 35 STANFORD L. REV. 1033 (1983) (providing a helpful overview of the Supreme Court's struggle to interpret the Eleventh Amendment).

291. *Hans v. Louisiana*, 134 U.S. 1 (1890).

292. *Papasan v. Allain*, 478 U.S. 265 (1986).

293. *Ex Parte Young*, 209 U.S. 123 (1908).

294. *Id.* at 143.

295. *Id.* at 159-60.

296. *Cory v. White*, 457 U.S. 85 (1982).

297. 415 U.S. 651 (1974).

298. *Id.* at 653.

299. *Id.*

300. *Id.* at 656.

fits.³⁰¹ Thus, the *Edelman* decision indicated that a plaintiff could seek prospective or injunctive relief without encountering Eleventh Amendment limitations but could not seek retroactive damages or monetary relief against a state without encountering the Eleventh Amendment bar.³⁰²

Since the *Edelman* decision, the Court steadfastly has refused to allow plaintiffs to seek relief against states if that relief addresses compensatory interests.³⁰³ According to the Court, such suits place an unacceptable burden on state treasuries and, therefore, violate principles of federalism.³⁰⁴ Thus, plaintiffs, in general, may seek prospective relief in federal court, but they may not seek retrospective relief against a state.³⁰⁵

B. Limiting Provider Suits

Health care providers, then, generally may seek declaratory or injunctive relief in Section 1983 suits based on the Boren Amendment. They may request, for example, that a federal court order a state to forego implementation of a particular reimbursement scheme. Providers, however, generally may not recover compensatory damages under Section 1983 by alleging that state reimbursement rates in the past were too low. Thus, although a federal court may be willing to strike down a reimbursement scheme, it cannot order the state to pay damages for its failure to compensate providers adequately in the past under existing schemes.

When a court invalidates an old reimbursement scheme, the crucial question, of course, becomes how providers will be compensated in the future. The answer, at least in many cases, has been that providers usually request a return to a prior reimbursement policy — at least until

301. *Id.* at 664.

302. *Id.* at 664-68.

303. *See, e.g., Papasan v. Allain*, 478 U.S. 265, 277 (1986) (stating that the Eleventh Amendment bars retroactive relief against a state); *Green v. Mansour*, 474 U.S. 64, 68 (1985) (same); *Milliken v. Bradley*, 433 U.S. 267, 289-90 (1977) (same).

304. *Papasan*, 478 U.S. at 277.

305. Most providers bringing suit under § 1983 have sought only prospective relief. Usually, the provider will request either an injunction preventing the state from instituting a reimbursement scheme or declaratory relief in which a court declares that the state reimbursement scheme violates the Boren Amendment. *See, e.g., St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1039 (W.D. Wis. 1989) (plaintiffs sought injunctive and declaratory relief); *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1422 (N.D. Ill. 1989) (plaintiffs sought only a declaratory judgment that rates were not appropriate). In *Will v. Michigan Department of State Police*, 491 U.S. 58, 64, 71 n.10 (1989), the Supreme Court found that the state and state officials were not persons when sued for retrospective relief in state court under § 1983. As a result, providers may be able to seek only injunctive and declaratory relief against the state under § 1983 regardless of what forum they choose.

the state can devise a new policy.³⁰⁶ Courts who find flaws in a current reimbursement policy probably are more likely to grant such a request than to devise a new reimbursement scheme on their own.³⁰⁷ Returning to an old scheme allows the court to avoid making the fact based, highly specific, highly technical decisions that the development of a new plan would require. Thus, granting this type of relief eliminates the need for the court to delve into an area of social policy in which it has little expertise. In addition, using an old plan reduces judicial costs. The court does not need to spend its already over-burdened resources devising a new reimbursement scheme when an acceptable, previously-used scheme already exists.

This result suggests that states may maintain greater control of their Medicaid policy and programs through strategic implementation of cost-cutting measures. By implementing an overall reimbursement scheme in several small stages, each of which could stand independently as a reimbursement scheme, the state may be able to preserve at least some of its cost-cutting measures.

Suppose, for example, that a state reimburses hospitals according to the average costs for an average patient with a particular type of illness. The state would classify patients by illness into categories, often called diagnostically related groups, and then would set reimbursement rates for each diagnostically related group. Such rates also might vary according to the type of facility providing the treatment.³⁰⁸

Now suppose the state wanted to reduce its reimbursement rates to providers from eighty percent of the average hospital costs per patient in each diagnostically related group to seventy percent of these average costs. If the state simply adopted the entire reduction in one stage, providers might be tempted to mount a challenge. If the providers won their challenge in federal court, the judge easily could declare a return to the old eighty percent rates. If the state, however, accomplished this change over five years by enacting separate, smaller reduction measures cutting reimbursement two percent each year, the state actually would have enacted five independent reimbursement schemes. Providers thus would be forced to challenge the first reduction to seventy-eight percent

306. See, e.g., *Wilmac Corp. v. Heckler*, 633 F. Supp. 1000 (E.D. Pa. 1986); *Volk v. Department of Human Resources*, 799 P.2d 658, 659 (Or. Ct. App. 1990) (involving plaintiffs requesting installation of previous rates).

307. See *supra* notes 235-36 and accompanying text.

308. The example assumes a state reimburses providers under a system similar to the Medicare system. Thus, the state would determine the length of a typical hospital stay and the relative expenses of an average patient with a particular disease. It might then reimburse the hospital for this average length of stay — also taking into account the average daily costs of similar hospitals. See *supra* note 49 and accompanying text.

to keep rates at eighty percent.³⁰⁹ Otherwise, successful provider challenges to later reductions would leave the judge with the option of reinstating the "old" seventy-eight percent rate. For example, a judge striking down the third-year reduction from seventy-six to seventy-four percent reimbursement still may allow old rates of seventy-six percent or seventy-eight percent to act as a substitute for the seventy-four percent reimbursement scheme. Thus, the state still might achieve at least part of its cost-cutting goal.

Just as importantly, piecemeal cost cutting may help a state build a record of compliance with the Boren Amendment. Under the Amendment, the Secretary of HHS must accept the state's assurances that its rates meet Boren Amendment standards.³¹⁰ If the state makes findings and provides assurances to the Secretary at each stage of the overall reduction plan, the state will build an evidentiary record supporting its position that the compensation scheme meets the requirements of the Boren Amendment. The state then will be able to meet provider challenges with the argument that HHS approved of its incremental scheme numerous times over a period of years. Such a record should increase the likelihood that a federal judge will find that each stage of the state's cost-cutting program complied with the Boren Amendment.

Of course, a provider always could seek to challenge the entire cost-cutting scheme. But, to throw out the entire scheme, a court would have to find that even the smaller incremental changes in reimbursement rates violate the Boren Amendment. Unless a provider can show that such small changes produce dire economic consequences, most courts still appear unwilling to place such severe restrictions on state freedom.³¹¹

Thus, the Eleventh Amendment protection, which limits suits against state officials to suits for prospective relief, establishes a clear limit on the relief available to providers bringing claims under the Boren Amendment. These providers cannot receive retroactive or compensatory relief.³¹² More significantly, when courts use injunctions to strike

309. These small changes also may look more acceptable to courts. If an 80% reimbursement rate was clearly reasonable and adequate under the Boren Amendment, it might be hard for a court to say the 78% was clearly unreasonable. A full 10% reduction to a 70% reimbursement rate, on the other hand, provides a much starker contrast and might tempt a court to find the state in violation of the Boren Amendment.

310. 42 U.S.C. § 1396a(a)(13) (1988).

311. Courts seem reluctant to review small changes in state reimbursement plans. See *Folden v. Washington State DSHS*, 744 F. Supp. 1507, 1525 (W.D. Wash. 1990) (using language deferential to the state and invoking the arbitrary and capricious standard of review); *St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1039, 1045 (W.D. Wis. 1989) (invoking the Burford abstention doctrine); see also *Friedman v. Perales*, 668 F. Supp. 216, 221-22 (S.D.N.Y. 1987) (invoking the arbitrary and capricious standard).

312. See *Edelman v. Jordan*, 415 U.S. 651, 664-68 (1974).

down a particular cost-cutting scheme, they may replace it with an old, acceptable reimbursement program.³¹³ This judicial solution suggests that, if states enact Medicaid reforms in a piecemeal fashion, they may succeed in preserving at least some cost-cutting reforms.

VI. CONCLUSION

Congress easily could remedy the dilemma of uncertainty for states enacting new cost containment programs by passing legislation directing HHS to set clear criteria on the limits of reasonable and adequate reimbursement. Such legislation, however, would defeat the purpose of the Boren Amendment. Setting federal boundaries for reimbursement would reduce the states' ability to enact innovative cost-containment measures that are sensitive to the varying local costs of health care.

The Boren Amendment recognized the needs of states to enact effective cost-containment measures. It followed other amendments to the Medicaid statute that allowed the states more freedom in restricting Medicaid benefits for recipients. In so doing, the Amendment created a balance between the interests of patients and providers by allowing states to distribute cutbacks in the program between providers, who can spread the costs to all patients, and Medicaid patients themselves. State administrative agencies and legislatures, rather than the federal judiciary, are in the best position to control these decisions. In fact, Congress delegated its decision-making power to the states on this issue. Federal courts should respect that delegation rather than embark on attempts to set the societal balance themselves.

Instead, in *Wilder* the Supreme Court allowed providers to assert Section 1983 challenges to reimbursement schemes and, in so doing, created substantive federal statutory rights for providers under the Boren Amendment. Although the Court had previously expanded the use of Section 1983 jurisprudence in other areas, its extension to Medicaid does not fit in neatly with that previous expansion. Moreover, the creation of substantive rights for providers has created an additional burden for states administering financially strapped Medicaid programs. In fact, the increased potential for litigation over rates may make states less likely to enact creative cost-control measures. State planning, however, which recognizes the inherent Eleventh Amendment limitations on the providers' claims may enable states to restrict federal court intrusion on the reimbursement flexibility they received under the Boren Amendment.

In some states, cost containment may significantly threaten the fi-

313. See *supra* note 306 and accompanying text.

nancial well-being of providers. Some providers may go out of business if state containment programs are too severe. But any such threat is the result of a state policy decision to allocate fewer resources to health care. Until Congress chooses to reassert federal control over such decisions, the courts should allow states to continue making these choices. Providers, who generally are politically well-organized, will have significant clout in state capitals. They may protect their interests successfully by lobbying state legislatures and state administrative agencies. States also may provide some review of reimbursement decisions in state court. But ultimately, allocating the costs of Medicaid is a fundamental decision about the distribution of societal wealth and must remain a political decision.

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