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Deciding Who Swims with the Sharks: Boren Amendment Litigation

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I. Introduction

Medicaid coverage for poor Americans seeking health care resembles the last lifeboat for passengers on the Titanic: it is not nearly large enough to accommodate even half of those in need. The fortunate minority receiving coverage face many perils. But for all of its problems, it is the only refuge available for most.

Swamped by inflation rates in health costs that continue to rise twice as fast as tax revenues, every state's Medicaid program is perpetually on the verge of fiscal crisis. Unable to raise taxes quickly enough to keep pace with health costs, state officials are under continuous pressure to cut the program in order to stay within budget. In most states, Medicaid policy involves a zero-sum game among poor patients, the health care industry, and state government. One player gains only at the expense of another. In order to maintain current services, programs must increase taxes, eliminate benefits, cut eligibility, or reduce provider payments. In other words, an ongoing struggle is taking place between the poor and the health care industry to determine who keeps a seat in the Medicaid lifeboat.

The scramble for Medicaid resources has been intensified by recent federal legislation that restricts states' use of provider revenues to fund the nonfederal share of the Medicaid budget. /1/ Institutional providers /2/ have a dangerous new weapon: Boren Amendment litigation to force the states to raise Medicaid payments. At worst, the success of these suits compels financially strapped states to cut eligibility or reduce services to fund rate increases. At best, it gives providers first claim on new resources available to the program, resources that might otherwise go toward reducing infant mortality or improving health care for the poor.

II. The Impact of Wilder

The Boren Amendment itself is not new. Enacted in 1980, it amended the Medicaid statute provisions for reimbursement of hospitals and nursing homes to require that reimbursement be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." /3/
Although a substantial body of case law developed under this provision during the 1980s, Boren Amendment litigation received a boost from the Supreme Court's 1990 decision in Wilder v. Virginia Hospital Association. That decision confirmed the right of hospitals and nursing homes to sue states under 42 U.S.C. Sec. 1983 to obtain judicial enforcement of the Boren Amendment. The timing of Wilder was propitious for nursing homes, since it anticipated by a few months the effective date of federal mandates regarding nursing home reimbursement.

Almost overnight, Medicaid reimbursement litigation became a growth industry. Hospital and nursing home trade associations and their lawyers held scores of seminars on how to sue the states for more money. By April 1992, the American Hospital Association estimated that approximately 18 states had been sued regarding the adequacy of their hospital rates, and 8 of those cases were settled on terms favorable to providers. The American Health Care Association, representing the nursing home industry, estimated that 20 Boren Amendment suits had been filed on behalf of nursing homes since Wilder.

Significantly for legal services' clients, this growth of reimbursement litigation coincided with proposals for Medicaid cutbacks in a majority of states. Inflation would have prompted such proposals in any event, but the threat of Boren Amendment suits exacerbated the pressures and undermined the bargaining position of advocates for the poor. In fact, a recent federal analysis of Medicaid cost trends found that these cases were creating a Medicaid fiscal crisis for the federal government as well.

III. Health Economics: Myth v. Reality

Boren Amendment plaintiffs contend that they are underpaid by Medicaid. That assertion is part of the subtext of a broader refrain of the hospital and nursing home industries. These providers have long voiced a general complaint that from a financial standpoint they are only marginally viable. They cite the occasional hospital closure or nursing home bankruptcy as evidence that the entire industry needs more money in general, and higher Medicaid and Medicare rates in particular. These claims are broadly reported in the news media without further analysis, and are casually accepted by the public and many policymakers.

The financial realities of the health care industry differ from these claims. Both the hospital and nursing home industries are financially healthy, especially in comparison to other sectors of a recession-wrecked economy. Although hospital margins are down slightly from record highs in the mid-1980s, they are still nearly five percent—well above the industry median for the past quarter-century.

Hospitals often attribute their supposed economic woes to the burdens associated with a large volume of indigent care. They typically exaggerate claims regarding care of the poor by stating the value of such services in terms of "charges," or the amount that the patient is billed. This is analogous to the sticker price of a car and bears little or no relation to the actual cost of the services rendered. Charges are discounted to third-party payers, such as insurance companies, Medicare, and Medicaid. Hospitals often distort their true financial picture by claiming that the
difference between charges and what they are paid by Medicare and Medicaid represents "losses" on those programs.

Even when hospitals make comparisons between what they are paid by Medicaid and their "costs," caution is required. Federal Medicare policy requires providers to file elaborate cost reports. Many of the reporting rules and principles applicable to those reports also govern cost reporting for hospitals and nursing homes under state Medicaid programs. /9/ Providers and their accountants are adept at gaming these requirements, and the calculation and allocation of costs are more of an art than a science. As a result, the appearance of technical precision in provider cost reports is often misleading. A study of Medicare cost reports released in June 1991 by the Prospective Payment Assessment Commission documented many inaccuracies and found that providers' actual costs were substantially overstated. /10/

Another question concerns the practice of reimbursing hospitals for "marginal costs" but not for "fully allocated costs." Marginal costs are the actual additional costs that a facility incurs for treating a particular Medicaid patient. Fully allocated costs are the marginal costs plus an array of fixed costs or overhead that is imputed to the individual even though such costs would have been incurred had the patient not been treated. Hospitals complain that they should be--but are not--reimbursed for allocated costs. Yet, even in states with low Medicaid rates, marginal costs are reimbursed, and therefore providers' claims that they are "losing money on each Medicaid patient" are not literally true. On the contrary, in a national hospital market where one-third of the beds are vacant, even Medicaid payments that are slightly above marginal cost benefit the provider by defraying fixed costs.

The financial complaints of the nursing home industry are also overstated. The industry is quick to blame quality of care problems on inadequate Medicaid reimbursement, which accounts for over half of its revenues. /11/ "You can't stay in a cheap motel and buy three meals a day for what Medicaid pays us to provide 24-hour medical care" is a constant contention of nursing home operators. Yet, they continue to scramble for licenses and certificates of need to operate new beds, leading one to wonder why entrepreneurs would be so eager to get a bigger piece of a business that depended upon a money-losing reimbursement system.

The "cheap motel" analogy distorts both Medicaid reimbursement and the financial structure of the long-term care industry. High occupancy rates sustained by artificially constrained bed supply, self-dealing among different corporate entities all owned by the same principals, real estate speculation aided by Medicaid policies on capital reimbursement, and indirect Medicaid payments not reflected in the basic rate all play a role in enabling operators to make profits from a Medicaid rate structure that they claim is grossly inadequate.

It should be noted that providers, especially hospitals, are a diverse lot. Small rural hospitals in depressed areas and large urban hospitals "of last resort" are in financial distress in many parts of the country. Their distress owes less to reimbursement policies than to broader market trends and a generally dysfunctional American health care financing system.

The plight of these atypical providers is often put forward by the rest of the industry as justification for an across-the-board increase in payments to all providers. This is ironic, because the rural hospitals' difficulties are largely attributable to the success of the big,
profitable urban hospitals in siphoning off their patients through inducements to referring physicians and expensive marketing campaigns. These same wealthy providers often "dump" large numbers of indigent patients on beleaguered inner-city public hospitals. /12/

State Medicaid reimbursement policies are varied. The fact that provider claims of inadequate Medicaid reimbursement have merit in some states does not mean that they are valid in others. An American Hospital Association report released in June 1991 expressed the general industry view that Medicaid is a poor payor. But its state-by-state analysis conceded that, even by industry standards, some states’ payments are relatively generous. One cannot generalize about these states. Mississippi, the poorest state in the country with one of the most restrictive eligibility policies, is generous to its hospitals. /13/

IV. The Role of Advocates in Boren Amendment Litigation

In spite of the financial realities, providers are winning Boren Amendment suits. A number of the reasons for their success have implications for legal services advocates.

An important factor is the administrative and legal competence of state defendants. Compliance with Boren Amendment requirements depends more on form than on substance. The amount that Medicaid pays may have less to do with the outcome of a reimbursement suit than whether state administrators supported their policies with the necessary findings and analyses. States must demonstrate to the court that they used the federally specified factors to fashion their reimbursement policies. If done properly, compliance is largely a matter of documentation that states can satisfy without incurring the expense of major rate increases. /14/ Unfortunately, many state administrators do not attend to procedural requirements, leaving their agencies vulnerable to successful litigation.

A disparity in legal resources may also exist between providers and Boren Amendment defendants. Specialized health lawyers, supported by a stable of industry expert witnesses, may overawe state assistant attorneys general who are misled by the arcane terminology of reimbursement into believing that reimbursement is more technically complex than it actually is.

Political considerations may weaken the defendants' resolve to resist the claims of politically influential provider interests. It may be less politically painful for state officials to settle a Boren Amendment suit and shift the resulting fiscal pain to Medicaid recipients than to stand up to hospitals or nursing homes.

Finally, judges have heard the same steady stream of provider poormouthing that has been directed over the years to the public at large. Judges in these cases usually do not have to shed their preconceptions in order to accept the industry plaintiffs' claims.

These factors all point to the need for poor people to be represented in provider reimbursement disputes. Advocates should play several roles:
They should help states prevent the filing of successful Boren Amendment cases by raising Medicaid administrators' awareness of the need to go through the appropriate procedures and make the necessary findings to support the state's reimbursement policies.

Advocates should intervene in Boren Amendment suits, either as parties or as amici curiae, on behalf of Medicaid clients who may be adversely affected by such cases. Their involvement can bring more legal resources to bear on behalf of the defendants and can minimize the chances that a deal will be struck between state politicians and the provider lobby. Perhaps most importantly, advocates can serve as the conscience of the court, reminding the court that the Medicaid program is to be administered "in the best interests of recipients," /15/ and that whatever the financial hardship experienced by some providers, it is nothing compared to the desperate condition of many who must rely on Medicaid to stay alive.

In states where Medicaid reimbursement is inadequate, advocates can help shape the remedy. For example, if hospitals that serve large numbers of poor people are inadequately reimbursed, relief should focus on increased "disproportionate share" subsidies to those facilities, rather than an across-the-board rate increase that also benefits affluent providers. /16/ Nursing home payment increases should be structured to create incentives for quality resident care and discourage discrimination against individuals who need "heavy care."

To the extent that Boren Amendment litigation results in increased financial costs to the state, advocates can help devise new revenue mechanisms that will enable programs to absorb new costs without cutting eligibility or services. There are ways, already employed around the country, effectively to enlarge the Medicaid lifeboat, without throwing out any of its passengers, by maximizing federal Medicaid matching funds. The National Health Law Program serves as a valuable resource, providing technical assistance around such revenue issues. /17/

footnotes


Medicaid recipients' interests in state payment policies vary markedly between institutional and noninstitutional services. In the case of reimbursement for noninstitutional services, advocates
may need to support higher reimbursement in order to achieve adequate provider participation and recipient access to care. See, e.g., Clark v. Kizer, 758 F. Supp. 572 (E.D. Cal. 1990).

3. Pub. L. No. 96-499, Sec. 962(a) (amending 42 U.S.C. Sec. 1396a(a)(13)(A)).


5. The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) contained a broad array of nursing home reforms. Pub. L. No. 100-203, Title IV, Subtitle C. Implementation was phased in over several years, and a number of major provisions took effect October 1, 1990. By that date, states were to have modified their nursing facility reimbursement policies to cover the additional cost to facilities of compliance with the new law. Pub. L. No. 100-203, Sec. 4211(b) (amending 42 U.S.C. Sec. 1396a(a)(13)(A)). This requirement was strengthened by a 1990 amendment requiring that Medicaid payments to nursing homes take into account the costs of "services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each [Medicaid] resident." Omnibus Budget Reconciliation Act of 1990 (OBRA-90), Pub. L. No. 101-508, Sec. 4801(e) (1990).


8. Testimony of Robert D. Reischauer, Director, Congressional Budget Office, before the Subcomm. on Health & Environment, House Comm. on Energy & Commerce (July 10, 1991). Total margins are defined as "the ratio of aggregate total revenues minus aggregate total costs, to aggregate total revenues," or profits as a percentage of total hospital revenues. The industry often cites "operating margins" because they are lower. Total margins are a more accurate measure of industry financial status, since they represent facilities "bottom lines," and not just the revenue generated from patient billings. Even operating margins in 1990 went up slightly to 2.6 percent, an increase from 2.2 percent in 1989. See Judith Nemes, Operating Margins Rose Slightly in '90, MODERN HEALTH CARE, June 24, 1991, at 2. The health care industry trade press and investment advice newsletters paint a better picture of the financial health of the industry, as contrasted with the providers' public statements.

9. See 42 C.F.R. Sec. 447.253(d).


11. Medicaid itself pays about 42 percent of total nursing home expenses, but also determines the additional amounts that recipients contribute to the cost of their own care. See CONGRESSIONAL RESEARCH SERVICE, supra note 2, at 345-357.


15. 42 U.S.C. Sec. 1396a(a)(19).


17. For instance, the Program's spring 1991 issue of Health Advocate contains information on this topic. While these financing methods have been limited by recent federal law, important opportunities for advocacy remain.