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***Wilder v. Virginia Hospital Association:* Making the Medicaid Reimbursement Rate Challenge a Federal Case**

I. Introduction

The United States Supreme Court in *Wilder v. Virginia Hospital Ass'n*¹ has endorsed a system of judicial review of Medicaid² reimbursement rates that ironically may perpetuate a deprivation of health care for the needy. Medicaid reimbursement rates affect the availability of health care services and the overall quality of care provided to the poor.³ Because states respond to federal budget cuts by reducing Medicaid reimbursement rates, health care providers are encouraged to reduce the quality and scope of services they offer.⁴

In 1980, in an effort to alleviate spiraling health care costs associated with the Medicaid program, Congress adopted the Boren Amendment to the Federal Medicaid Act.⁵ The Amend-

1. 110 S. Ct. 2510 (1990).

2. Medicaid is a federally funded, state administered health care reimbursement program that offers benefits to indigent persons who are either disabled, blind, over sixty-five years of age, or members of families with dependent children. Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1, 4 (1983).

3. Mitchell D. Raup, *Medicaid Boycotts by Health Care Providers: A Noerr-Pennington Defense*, 69 IOWA L. REV. 1393, 1413 (1984).

4. See Wing, *supra* note 2, at 85.

5. 42 U.S.C. § 1396a(a)(13)(A) (1982). The Boren Amendment provides:

A state plan for medical assistance must . . . provide . . . for payment . . . of hospital . . . services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State finds and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such state makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital . . .

ment replaced inflationary Medicaid reimbursement practices with provisions premised on a cost-containment methodology.⁶ The revised regulations mandate state reimbursement of Medicaid providers through rates that are "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities."⁷

On June 14, 1990, the *Wilder* Court held that the Boren Amendment created a substantive federal right for health care providers to "reasonable and adequate" reimbursement rates — a right enforceable under 42 U.S.C. § 1983.⁸ Because the Supreme Court recognized that, in addition to the Medicaid patient, the health care provider is an intended beneficiary of the Boren Amendment,⁹ health care facilities have been given the green light to seek federal judicial review of a state's Medicaid reimbursement practices.

However, in an effort to maintain the intended balance between state and federal program administration, the Court has suggested that a "deferential standard of review"¹⁰ of reimbursement rates established under the states' already broad discretion is appropriate.¹¹ Thus, although providers have been granted the section 1983 route to review, judicial "deference" to state discretion, coupled with a restrictive state administrative appeals process and minimal federal oversight, may effectively insulate reimbursement plans from any meaningful, plenary review.¹²

Because health care providers rely substantially on adequate reimbursement revenues for financial viability,¹³ this Note suggests a legislative amendment of the current administrative

and periodic audits by the State of such reports
Id.

6. *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2516 (1990).

7. 42 U.S.C. § 1396a(a)(13)(A) (1989).

8. *Wilder*, 110 S. Ct. at 2525.

9. *Id.* at 2517. Congress enacted the Boren Amendment in 1980, intending the provisions to apply to reimbursement for nursing and intermediate care facilities. Pub. L. No. 96-499, § 962(a), 94 Stat. 2650 (1980). In 1981, the standard was applied to reimbursement of hospitals. Pub. L. No. 97-35, § 2173, 95 Stat. 808 (1981). The regulations have since been applied to intermediate care facilities for the mentally retarded. Pub. L. No. 100-203, § 4211(h)(2)(A), 101 Stat. 1330 (1987). *Wilder*, 110 S. Ct. at 2513-14 n.2.

10. *Wilder*, 110 S. Ct. at 2523 n.18.

11. 48 Fed. Reg. 56,046, 56,047 (1983).

12. See *infra* notes 222-33 and accompanying text.

13. See *infra* notes 19-21 and accompanying text.

review process. This revision would afford providers a more meaningful review of state-implemented reimbursement rates, and facilitate the recovery of funds previously withheld while inadequate reimbursement rates were in effect.

Part II of this Note discusses the federal-state cooperative Medicaid program and the history of the Boren Amendment provisions. The section includes a discussion of the effects of restrictive reimbursement practices on the nation's health care providers, with special attention given to the plight of public facilities which serve a disproportionate number of poor patients.

Part III reviews the available forums in which providers may challenge state violations of the Amendment's reimbursement provisions, focusing on the section 1983 remedy, its history, its application prior to *Wilder*, and its limitations as a form of relief for under-reimbursed health care providers.

Part IV discusses the dispute giving rise to the *Wilder* decision, the procedural history and the majority and dissenting opinions.

Part V analyzes the implications of the *Wilder* decision. The section suggests that the Court has frustrated the general purpose of the Medicaid Act, which is to provide medical care to the poor, by endorsing the use of expensive section 1983 actions to remedy state noncompliance with federal regulations. Because Congress must safeguard the right to the health care that it has created, a legislative amendment of the current statutory scheme is in order.¹⁴ This Note concludes with a proposed alternative legislative scheme.

II. Background

A. *Structure of the Federal-State Cooperative Medicaid Program*

The Medicaid program was established in 1965 as Title XIX of the Social Security Act.¹⁵ The purpose of the Act was to provide medical assistance to a federally designated category of mandatory recipients including indigents who are blind, disabled, over sixty-five years of age, or members of families with

14. See *infra* notes 256-73 and accompanying text.

15. Pub. L. No. 89-97 § 1902(13)(B), 79 Stat. 346 (1965).

dependent children.¹⁶ Under this cooperative federal-state program, the federal government, through the Health Care Financing Administration ("HCFA"), provides the states with grants-in-aid¹⁷ in return for state administration of the program.¹⁸

To cover the costs of providing medical services to the poor, states primarily rely on federal contributions, which range from fifty to eighty-three percent of their actual costs, depending on a state's relative wealth.¹⁹ In addition to this amount, the federal government contributes approximately fifty percent of the state's administrative expenses under the Medicaid program, including the cost of defending section 1983 challenges for alleged violations of the Boren Amendment.²⁰ In 1988, the federal government paid approximately \$1.51 billion in state administrative costs for the Medicaid program.²¹

State participation in the program is described as "voluntary," but once a state decides to participate, its receipt of funds is conditioned on compliance with mandatory federal requirements.²² Federal conditions require that a participating state submit to the Secretary of Health and Human Services ("Secretary") a "state plan" setting forth the nature and scope of its program, and "assurances" that it will be administered in com-

16. 42 U.S.C. § 1396 (1988).

17. Through grant-in-aid programs, the federal government retains substantial control over the aided programs, while state and local governments are responsible for direct program administration or distribution of funds to recipients. Note, *Making Old Federalism Work: Section 1983 and the Rights of Grant-In-Aid Beneficiaries*, 92 YALE L.J. 1001, 1002 (1983) [hereinafter *Old Federalism*].

18. *Id.*

19. 42 C.F.R. § 433.10(b) (1990). For example:

If a state's per capita income is equal to the national average per capita income, the federal share is fifty-five percent. If a state's per capita income exceeds the national average, the federal share is lower, with a statutory minimum of fifty percent. If a state's per capita income is lower than the national average, the federal share is increased, with a statutory maximum of eighty-three percent.

Id.

20. 42 U.S.C. § 1396(b)(a)(7) (1988); Brief Amicus Curiae of United States at 2, *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

21. Health Care Financing Administration, Dep't of Health and Human Services, *Medicaid Financial Management Report: Fiscal Year 1988*, as cited in Brief Amicus Curiae of United States at 2, *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

22. *Wilder*, 110 S. Ct. at 2513.

pliance with all federal regulations.²³ The state must also designate a single agency to administer the state plan²⁴ and must design and implement an appeals process to redress provider grievances.²⁵

Furthermore, the provider is prohibited from implementing any cost-sharing methodologies for eligible recipients²⁶ and must accept Medicaid reimbursement as payment in full.²⁷ The Secretary is granted the authority pursuant to the Act to terminate or reduce funding for a state's non-compliance with the enumerated conditions of participation.²⁸

Unlike the state's participation, describing the provider's participation in the program as "voluntary" is misleading. Non-profit and public hospitals that have received construction funds under the Federal Hill-Burton Act²⁹ are obligated to administer a state Medicaid program, and are not free to terminate participation in the program.³⁰ Moreover, hospitals that have emergency rooms and participate in the federal Medicare³¹ program are required to provide emergency care to all who enter the emergency room, including Medicaid patients.³² Thus, a provider who is dissatisfied with Medicaid reimbursement rates and

23. 42 U.S.C. § 1396a (1988). In developing rates, states must take into consideration the situations of hospitals serving a disproportionate number of low income patients, must find that its rates are reasonable and adequate, and must assure Medicaid patients reasonable access to care. *Id.* at § 1396a(a)(13)(A).

24. 42 U.S.C. § 1396a(a)(5) (1988).

25. 42 C.F.R. § 447.253(c) (1990). References to the Secretary throughout this Note will encompass references to the Administrator or Regional Administrator mentioned throughout the C.F.R.

26. Pub. L. No. 90-248, § 235(a), 81 Stat. 908 (1968). Cost-sharing methodologies, such as the use of premiums, coinsurance, deductibles and percentages, may be applied to offset Medicare payments to eligible beneficiaries. *See* 42 U.S.C. § 1396(d)(3)(A-D) (1988).

27. 42 C.F.R. § 447.15 (1990).

28. *Id.* at § 430.35.

29. Hospital Survey and Construction Act, 42 U.S.C. § 291 (1982). Known commonly as the Hill-Burton Act, this Act was designed to provide federal grants to encourage hospital construction. A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 223, 303, 305-08 (1988).

30. 42 U.S.C. § 291 (1982); 42 C.F.R. § 124.603(b)(1) (1984).

31. Unlike the state-administered Medicaid program, Medicare is a federally subsidized health insurance program administered by the Secretary of Health and Human Services to specifically benefit the elderly and the disabled. 42 U.S.C. § 1395(c) (1988).

32. 42 U.S.C. § 1395dd(a) (1988) as cited in Brief for Respondent at 45, *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

who prefers to withdraw from participation may be legally bound to accept Medicaid patients because of its participation in either federal program.

B. History of the Medicaid Reimbursement Provisions Leading to the Boren Amendment

From its inception in 1965 until 1972, the Medicaid Act's reimbursement provisions required states to reimburse providers for the costs they actually incurred ("actual cost standard").³³ In 1972, in recognition of the rising costs associated with this methodology,³⁴ Congress amended the Medicaid Act and encouraged states to develop alternative reimbursement schemes.³⁵ Between 1972 and 1980, reimbursement rates were to be determined "on a reasonable cost-related basis, as determined in accordance with methods approved and verified by the Secretary" ("reasonable cost standard").³⁶

The actual cost and reasonable cost standards translated into highly inflationary "retrospective" reimbursement policies³⁷ that premised payment on actual costs incurred.³⁸ Health care providers consequently had little incentive to promote efficiency because the more services they provided, the more they were reimbursed.³⁹ During this period, state-determined rates were subject to direct review by the Secretary, and providers could directly challenge individual rate determinations by appealing to the HCFA.⁴⁰

33. *Friedman v. Perales*, 668 F. Supp. 216, 222 (S.D.N.Y. 1987), *aff'd*, 841 F.2d 47 (2nd Cir. 1988).

34. Between 1970 and 1971 alone, the annual percent change in federal Medicaid expenditures was 32.2%. However, in 1972, after implementation of the reasonable cost standard, the growth of federal expenditures slowed to 23.5%. By 1982, after implementation of the Boren Amendment's efficiency and economy standard, growth in federal expenditures had been reduced to an annual rate change of 6.6%. See Wing, *American Health Policy in the 1980's*, 36 CASE W. RES. L. REV. 608, 655 (Table 8) (1986).

35. *Friedman*, 668 F. Supp. at 222.

36. See 42 U.S.C. § 1396a(a)(13)(E) (1979), as amended by Pub. L. No. 96-499 § 962(a) (1980).

37. Retrospective reimbursement methodologies base payment rates on actual charges or costs incurred, and thus are inflationary. See SOUTHWICK, *supra* note 29 at 223.

38. See Wing, *supra* note 2, at 53.

39. See SOUTHWICK, *supra* note 29, at 223.

40. 42 C.F.R. § 447.261(d)(6) (1979).

In anticipation of continued reductions in federal Medicaid funding to the states, and in light of the inflationary nature of the reasonable cost standard previously employed, Congress passed the Boren Amendment to the Medicaid Act in 1980 to encourage cost-consciousness.⁴¹ The Boren Amendment mandates reimbursement through

*rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care . . . in conformity with . . . state and federal . . . quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to . . . inpatient hospital services . . .*⁴²

Pursuant to these amended provisions, the Secretary's scrutiny of state-implemented reimbursement rates is limited to a review of the reasonableness of the state's assurances that its rates are "reasonable and adequate," and does not encompass a direct review of rate determination challenges brought by providers.⁴³

The main purpose of the Boren Amendment was to increase a state's flexibility and discretion in establishing reimbursement methodologies that promote efficient delivery of services, while maintaining federal oversight at the "minimum necessary to assure proper accountability" ⁴⁴ The new "efficiency and economy" standard promotes use of prospective reimbursement schemes where rates are determined prior to actual expenditures and thus are expected to encourage cost containment.⁴⁵

C. *Effects of Restrictive or Inadequate Reimbursement Practices*

While one policy objective of the Medicaid Act is to encourage provider participation, in practice, providers are being driven away through arbitrary or inadequate payment rates.⁴⁶

41. 42 U.S.C. § 1396a(a)(13)(A) (1988).

42. *Id.* (emphasis added).

43. See *infra* notes 65-72 and accompanying text.

44. S. REP. No. 139, 97th Cong., 1st Sess. at 478 (1981), reprinted in 1981 U.S.C.C.A.N. 744. See also 48 Fed. Reg. 56,046 (1983).

45. See generally 46 Fed. Reg. 47,964-47,973 (1981).

46. Brief of Respondent Virginia Hosp. Ass'n at 45, *Wilder v. Virginia Hospital*

The states have exploited the broad discretion to determine reimbursement rates given to them under the Boren Amendment by setting unreasonably low rates.⁴⁷ Many providers have responded to these inadequate rates with a reluctance to treat Medicaid patients at all,⁴⁸ thereby reducing the availability of and access to needed services for the poor.⁴⁹ Providers that have continued to accept Medicaid patients are given the incentive to engage in inappropriate medical practices such as "patient dumping"⁵⁰ and skimping on services to reduce costs.⁵¹ Many Medicaid patients are thus limited to receiving treatment from public facilities or from "Medicaid Mills," which are high volume, low quality clinics.⁵²

Health care providers nationwide are experiencing financial troubles as a result of inadequate reimbursement rates by state Medicaid agencies.⁵³ Restrictive reimbursement policies fall hardest on facilities such as public hospitals and clinics that serve a disproportionate number of Medicaid patients and that are indispensable providers of care to the poor.⁵⁴ Since 1985, approximately 300 public hospitals have been forced to close, due in large part to low Medicaid reimbursement.⁵⁵

Congress has acknowledged that public hospitals and teaching hospitals serving a high number of Medicaid and low income patients "are particularly dependent on Medicaid reimbursement," and has called on states to "take into account the special situation that exists in these institutions in developing their

Ass'n, 110 S. Ct. 2510 (1990) (No. 88-2043).

47. See Wing, *supra* note 2, at 11.

48. *Id.*

49. *Id.* at 13.

50. Patient dumping is the practice by private hospitals of unloading unprofitable patients on public facilities. Diana Vance-Bryan, *Medicare's Prospective Payment System: Can Quality Care Survive?*, 69 IOWA L. REV. 1417, 1420-21 n.42 (1984). See also Lowell C. Brown, "Patient Dumping" After OBRA 1989: New Problems For Hospitals and Physicians Alike, 4 THE HEALTH LAWYER 1, 15 (Spr.-Sum. 1990) (discussing congressional prohibitions against patient dumping).

51. Vance-Bryan, *supra* note 50, at 1420.

52. Raup, *supra* note 3, at 1414 n.149.

53. See *infra* notes 58-63 and accompanying text.

54. See Wing, *supra* note 2, at 89 n.294.

55. Brief Amicus Curiae of Gray Panthers Advocacy Committee at 18, *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

rates.”⁵⁶ Despite this congressional mandate, many states have continued to adopt restrictive reimbursement policies that financially drain the hospitals.⁵⁷

Two California counties recently cited under-funding by Medi-Cal (California’s Medicaid program) as the single cause of the current crisis that has imperiled the health and safety of mothers and newborns at their obstetric facilities.⁵⁸ These public hospitals are experiencing an overload of patients who are rejected from private facilities that have the additional capacity, but refuse to accept Medicaid patients at the current reimbursement rates.⁵⁹

Inner-city hospitals, which almost exclusively treat the poor, cannot continue to operate without participating in the Medicaid program because they would be rendering care to a majority of their patients without any reimbursement at all.⁶⁰ If Medicaid payments are inadequate, these hospitals may be forced to close or to declare bankruptcy.⁶¹

One inner-city hospital experienced a deficit of approximately \$15 million in 1989, which included \$12 million in losses resulting from services provided to Medicaid patients.⁶² The inability of inner-city hospitals to cut costs is caused in part by the need to offer high salaries to attract personnel to the area, the need to offer unique services to attract higher paying patients, and the need for additional security and parking

56. H.R. CONF. R. No. 208, 97th Cong., 1st Sess. at 902 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1324.

57. *See* Wing, *supra* note 2, at 89 n.294.

58. *Money Problems from Birth*, L.A. TIMES, Feb. 23, 1990, at B6 (Metro).

59. *Id. See also Obstetrics Crisis*, L.A. TIMES, Mar. 23, 1990, at B6 (Metro).

60. Brief Amicus Curiae of Temple University at 6, *Wilder v. Virginia Hospital Ass’n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

61. During 1987 and 1988, three Northern Philadelphia hospitals filed for bankruptcy; three more in the area experienced severe financial difficulty and one South Philadelphia hospital closed. *Id.* at 11 n.11. In June, 1990, Marina Hills Hospital in Ladera Heights, California, was forced to close following a period of operation under bankruptcy protection. A hospital administrator cited the failure of the State Medi-Cal System to pay its current hospital bills as the “final blow” which led to the closing. Nieson Himmel & John Kendall, *Financial Crisis Forces Hospital to Shut Doors*, L.A. TIMES, June 3, 1990 at B15 (Metro).

62. Brief Amicus Curiae of Temple University at 3, *Wilder v. Virginia Hospital Ass’n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

facilities.⁶³

The hospital closings, staff reductions, and service cuts in the Boren Amendment's wake are clearly inconsistent with Congress' mandate that the quality of care not be sacrificed to achieve a state's desired level of cost-efficiency.⁶⁴ Because compliance with the congressional mandate seems minimal at best, and because cost-containment policies continue to encourage restrictive reimbursement patterns and the improper withholding of benefits due, providers must have access to a forum where their challenges to state-implemented rates will be subject to meaningful review.

III. Available Forums for Review of State Reimbursement Violations

A. Federal Oversight

The federal Medicaid regulations require states participating in the Medicaid Program to submit a conforming state plan⁶⁵ to the Secretary, to make findings and to give annual "assurances"⁶⁶ that their rates are "reasonable and adequate."⁶⁷ However, the regulations no longer require the establishment of any formal procedures for providers to bring reimbursement rate grievances directly to the Secretary's attention.⁶⁸

The Secretary's scrutiny of state plans and reimbursement rates is currently limited by federal regulation to a review only of the reasonableness of state assurances, and does not encompass a review of the actual data and methodology used by the states to arrive at their reimbursement rates.⁶⁹ Moreover, the Secretary is not mandated to investigate the propriety of state assurances at all. Pursuant to the regulations implementing the Medicaid Act, a state's assurances "will be deemed accepted and approved" if the Secretary fails to notify the state of his deter-

63. *Id.* at 4 n.4.

64. *See infra* notes 250-51 and accompanying text.

65. 42 U.S.C. § 1396a(a) (1988).

66. *Id.* at § 1396a(a)(13)(A) (1988).

67. *Id.* *See also supra* note 23.

68. *See* 42 C.F.R. §§ 447.1-447.371 (1990).

69. 48 Fed. Reg. 56,046, 56,055 (1983).

mination within ninety days of receipt of those assurances.⁷⁰ One court has found the Secretary's role so significantly reduced that it held that the Secretary had appropriately approved a state's assurances and overall plan even though subsequent litigation revealed that the assurances were in fact false.⁷¹ Accordingly, referring to the Secretary's limited supervisory role, courts have denied the existence of a private right of action against the Secretary for failing to compel the states to comply with the Medicaid Act.⁷²

The Secretary retains final authority to approve rates and is authorized to withhold all or part of the designated federal funds for a state's noncompliance after reasonable notice and an opportunity for a hearing.⁷³ However, in practice the statutorily authorized funding cutoffs are not frequently used.⁷⁴ One commentator has noted that the reluctance to apply this sanction stems from the likelihood of ultimate harm to the individual recipients of the program — the Medicaid patients.⁷⁵ Yet, the Secretary's failure to limit or cease funding in the wake of state violations of federal funding conditions serves to encourage continued noncompliance by the states.⁷⁶

B. *The Administrative Appeals Process*

In addition to the requirement that states establish reasonable and adequate reimbursement schemes, the Social Security

70. 42 C.F.R. 447.256(b) (1989). The Secretary has concluded that the Medicaid Act does not require him to analyze or verify the state's findings, but only to satisfy himself that there is a reasonable basis on which the states' assurances may be accepted. 48 Fed. Reg. 56,046, 56,051 (1983). Testimony of an official at the Department of Health and Human Services reveals that the accepted practice is not to "look behind" the assurances given by any state. *West Virginia Univ. Hosp. Inc. v. Casey*, 701 F. Supp. 496, 510 (M.D. Pa. 1988), *aff'd in part, rev'd in part*, 885 F.2d 11 (3d Cir. 1989). *See also* *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1425 n.11 (N.D. Ill. 1989).

71. *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983).

72. *See, e.g.*, *Rush v. Parham*, 625 F.2d 1150, 1154 n.5 (5th Cir. 1980); *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1423-25 (N.D. Ill. 1989).

73. 42 C.F.R. § 430.35 (1990).

74. Leonard Weiser-Varon, *Injunctive Relief from State Violations of Federal Funding Conditions*, 82 COLUM. L. REV. 1236, 1242 (1982). *See also* *Cannon v. University of Chicago*, 441 U.S. 677, 705 n.38 (1979).

75. *Id.* at 1242-43.

76. *Id.*

Act also requires participating states to implement an appeals or exception process by which providers may challenge their payment rates.⁷⁷ The initial regulations mandated that state Medicaid agencies "provide an appeals procedure that allows individual providers an opportunity to . . . request prompt administrative review of payment rates."⁷⁸

However, in 1983 the regulation was rewritten to reflect the congressional desire to maximize states' discretion in Medicaid program administration in an effort to encourage cost containment.⁷⁹ The amended regulation only required an appeals procedure for reimbursement rates "with respect to such issues as the [state] agency determines appropriate."⁸⁰ According to one court, this "permissive language give[s] the [state] agency greater authority to select issues for determination" and allows it to "reject review of challenges to the validity of its methodology in its administrative appeals system."⁸¹ Thus, at this juncture, a state may effectively insulate its reimbursement methodology from any substantial challenge. Accordingly, twenty-four states currently limit challenges on appeal to the correction of errors in calculation of rates, or to adjustment of rates due to a provider's changed circumstances, such as extraordinary capital expenditures.⁸² Also, twenty-three states expressly prohibit appeals of some aspects of the rate-setting methodology.⁸³

State agencies are encouraged, but are not mandated by federal regulation, to make retroactive payments to providers when erroneous deprivation of an entitlement is established at

77. 42 U.S.C. § 1396a(a)(37)(B) (1988); 42 C.F.R. § 447.253(c) (1990).

78. 46 Fed. Reg. 47,964 (1981).

79. 48 Fed. Reg. 56,046, 56,052 (1983).

80. 42 C.F.R. § 447.253(c) (1990). Section 447.253 provides:

(c) *Provider Appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

Id.

81. *West Virginia Univ. Hosp., Inc. v. Casey*, 885 F.2d 11, 31 (3d Cir. 1989). *See also* Weiser-Varon, *supra* note 74, at 1243 (state agency hearings "unlikely to be useful for review of . . . general administrative practice . . .").

82. Brief Amicus Curiae of American Health Care Association at Appendix B-2, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

83. *Id.* at Appendix B-3.

an administrative hearing.⁸⁴ However, since the determinable issues at such hearings may be limited by the states,⁸⁵ providers are likely to receive reimbursement only for previous factual errors, such as those made in the calculation of rates, and will be deprived of retroactive payments for erroneous reimbursement methodology or policies.⁸⁶

C. *Federal Court Adjudication — The Section 1983 Action*

In addition to the administrative appeals process, the section 1983 action provides an aggrieved health care provider with an alternative forum to present the merits of its Medicaid reimbursement challenge.⁸⁷ The Supreme Court has held that state administrative procedures may be completely bypassed in favor of federal court adjudication under section 1983.⁸⁸ However, Congress retains the authority to require the exhaustion of administrative remedies as a prerequisite to commencement of a section 1983 action.⁸⁹

1. *The Evolution of the Section 1983 Action*

Section 1983 was originally enacted during the Reconstruction Era as part of the Civil Rights Act of 1871 to redress southern violence against African-Americans.⁹⁰ Although application of section 1983 initially focused on civil rights violations, the section is now generally used to redress state deprivations of all federally protected rights.⁹¹

Section 1983 provides a remedy for "the deprivation of any rights, privileges or immunities secured by the Constitution and laws."⁹² In *Maine v. Thiboutot*,⁹³ the Supreme Court held that a

84. 48 Fed. Reg. 56,048, 56,052 (1983).

85. See *supra* note 80 and accompanying text.

86. See Weiser-Varon, *supra* note 74, at 1252-53 n.93.

87. See *infra* notes 142-46 and accompanying text.

88. *Patsy v. Board of Regents of Florida*, 457 U.S. 496 (1982).

89. *Id.* at 513.

90. See *Old Federalism*, *supra* note 17, at 1007-09.

91. *Id.* at 1008-09.

92. 42 U.S.C. § 1983 (1988). Section 1983 provides in part:

Every person who, under color of any statute, ordinance, regulation, custom or usage, of any State . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be

section 1983 remedy is available for the denial of rights created by federal statutes.⁹⁴

However, in *Wright v. City of Roanoke Redevelopment and Housing Authority*,⁹⁵ the Supreme Court discussed two exceptions to the enforcement of section 1983 relief for claims of statutory violations.⁹⁶ First, the establishment of a comprehensive and specific remedial scheme within a statute will be construed as congressional intent to foreclose a section 1983 remedy.⁹⁷

Second, for a section 1983 remedy to be available, the statute must create "rights, privileges or immunities" enforceable by the parties.⁹⁸ A statutory right will accrue to a plaintiff if he "is one of a class for whose special benefit a statute was enacted . . ."⁹⁹ Thus, a section 1983 challenge will be available to the intended beneficiary of a statutory enactment who can prove that the statute created absolute obligations for the state on his behalf.¹⁰⁰

In *Pennhurst State School and Hospital v. Halderman*,¹⁰¹ the Supreme Court ruled that section 6010 of the Developmentally Disabled Assistance and Bill of Rights Act of 1975, which called for "appropriate treatment" for the developmentally disabled "in the least restrictive environment," did not create a substantive right to any specific level of care.¹⁰² The Court, relying on the context of the statute, the legislative history, and the fact that compliance with the provision was not a condition of receipt of funding, found that Congress intended only to reveal a

liable to the party injured in an action at law, suit in equity or other proper proceeding for redress.

Id.

93. 448 U.S. 1 (1980).

94. *Id.* at 4.

95. 479 U.S. 418 (1987).

96. *Id.*

97. *Id.* at 423-24. For example, in *Middlesex County Sewerage Auth. v. National Sea Clammers*, 453 U.S. 1 (1981), the Court found that the availability of non-compliance orders, elaborate citizen-suit provisions, and criminal sanctions expressly established in the Federal Water Pollution Control Act supplanted any remedy that would be available under 42 U.S.C. § 1983 by creating a comprehensive, remedial alternative.

98. *Wright*, 479 U.S. at 423.

99. *Coos Bay Care Ctr. v. State of Oregon, Dep't of Human Resources*, 803 F.2d 1060, 1063 (9th Cir. 1986), *vacated as moot*, 484 U.S. 806 (1987).

100. *Id.*

101. 451 U.S. 1 (1981).

102. *Id.* at 18.

preference for appropriate treatment.¹⁰³ The Court concluded that congressional "declarations of policy . . . serve as a nudge in the preferred direction" and do not give rise to an enforceable right.¹⁰⁴ However, where the grant of federal funds is expressly conditioned on a state's compliance with regulatory provisions, and where the mandate is sufficiently specific that the state may make an "informed choice" to participate, the state has accepted a binding obligation enforceable under section 1983.¹⁰⁵

Plaintiffs are generally not required to exhaust state judicial remedies before asserting section 1983 claims in federal courts because the cause of action is intended to supplement and not replace state judicial remedies.¹⁰⁶ In fact, Congress declined to adopt an exhaustion requirement for all section 1983 actions, but rather may incorporate a limited exhaustion requirement into specific statutory enactments.¹⁰⁷

2. *Limitations of the Section 1983 Action*

Because the financial viability of many hospitals depends on receipt of adequate Medicaid reimbursement payments,¹⁰⁸ recovery of funds wrongfully withheld and state implementation of complying rates are crucial to the facilities' continued existence.¹⁰⁹ In response to the limited relief available through federal and state administrative agencies, plaintiffs are continuously turning to the courts for a remedy by employing the section 1983 action.¹¹⁰ One benefit of the section 1983 suit is that once it has been properly authorized, attorney fees and expenses may be awarded at the court's discretion to the prevailing parties.¹¹¹ Yet, in many circumstances, the courts are unable to offer

103. *Id.* at 19.

104. *Id.* (quoting *Rosado v. Wyman*, 397 U.S. 397, 413 (1970)).

105. *Id.* at 24-25. See also *Wright v. Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418 (1987) (holding that regulations adopted pursuant to the Brooke Amendment to the Housing Act, specifying rent ceilings, were sufficiently definite to qualify as an enforceable right under § 1983).

106. See *Old Federalism*, *supra* note 17, at 1018-20; *Patsy v. Board of Regents of Florida*, 457 U.S. 496, 506 (1982).

107. *Patsy*, 457 U.S. at 502-12.

108. See *supra* notes 19-20 and accompanying text.

109. See *supra* notes 53-63 and accompanying text.

110. See *infra* note 202 and accompanying text.

111. See 42 U.S.C. § 1988 (1988). Section 1988 provides in relevant part:

deprived beneficiaries a full range of remedial relief.¹¹²

a. The Eleventh Amendment Bar to Retroactive Relief

The health care provider, deprived of funds wrongfully withheld due to statutory noncompliance with federal conditions, is barred by the eleventh amendment from obtaining retroactive reimbursement.¹¹³ Although the amendment appears on its face to bar only those suits against one state that are brought by citizens of another, it has "consistently" been construed by the Supreme Court as barring suits against a state brought by its own citizens as well.¹¹⁴

In *Edelman v. Jordan*,¹¹⁵ the Supreme Court held that pursuant to the eleventh amendment a federal court is not authorized to award retroactive monetary relief for a prior "breach of legal duty . . . by state officials."¹¹⁶ However, the Court found that awards of prospective relief are exempt from the eleventh amendment bar because such fiscal consequences to state treasuries are the incidental, yet necessary result of continued program compliance.¹¹⁷

The *Edelman* holding is applicable only to suits instituted

In any action or proceeding to enforce . . . section . . . 1983, . . . the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.

Id. The Third Circuit Court of Appeals in *West Virginia Univ. Hosp. Ass'n v. Casey*, 885 F.2d 11, 32 (3d Cir. 1989), found that expert witness fees may be included in such an award even though the fees may be extremely costly due to the extraordinary data compilation and analysis entailed in a typical Medicaid reimbursement rate challenge. *See also Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1296 (8th Cir. 1985); Owen M. Field, *The Application of Section 1983 to the Violation of Federal Statutory Rights — Maine v. Thiboutot*, 30 DE PAUL L. REV. 651, (1981).

112. *See Weiser-Varon, supra* note 74, at 1250.

113. 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. See, e.g., Quern v. Jordan, 440 U.S. 332, 337 (1979); *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1426 (N.D. Ill. 1989); *Worthington Nursing Home, Inc. v. Creasy*, 4 Ohio App. 3d 92, 98 (1982).

114. *Edelman v. Jordan*, 415 U.S. 651, 662 (1974).

115. *Id.*

116. *Id.* at 668.

117. *Id.*

in federal courts.¹¹⁸ Providers seeking retroactive reimbursement may pursue compensation in state courts for benefits wrongfully withheld.¹¹⁹ However, many states, concerned with protecting state treasuries, bar retroactive relief by applying the doctrine of sovereign immunity to preclude state court adjudication of cases alleging state liability.¹²⁰ Thus, because beneficiaries in many states may be unable to obtain retroactive reimbursement at the state or federal level, the limited remedies available under the section 1983 cause of action will perpetuate the irretrievable losses to grant-in-aid program beneficiaries.¹²¹

b. Availability and Effectiveness of Prospective Remedies

Because of a federal court's inability to grant retroactive relief, the federal grant of prospective relief becomes more significant.¹²² The courts typically respond to state noncompliance with federal regulations in three distinct ways.¹²³ First, a federal court may order an injunction terminating the state's use of federal funds.¹²⁴ However, like the fund-termination authority granted to the Secretary by Congress, this form of relief ultimately will harm the beneficiaries of the program that the funding was designed to assist.¹²⁵ Second, the courts may delay termination of funding by granting the state an adequate opportunity to amend or correct its violative practices.¹²⁶ This approach comports with the Congressional desire to allow states to rely on their own discretion in administering their Medicaid programs within the broad federal guidelines.¹²⁷ This delay gives the states an extension of time to comply with the order during

118. See Weiser-Varon, *supra* note 74, at 1253.

119. *Id.* at 1254.

120. *Id.* at 1254-56.

121. *Id.* at 1260.

122. *Id.* at 1262-63. See also *Quern v. Jordan*, 440 U.S. 332 (1979); *Illinois Health Care Ass'n v. Suter*, 719 F.Supp. 1419, 1426 (N.D. Ill. 1989).

123. Weiser-Varon, *supra* note 74, at 1263.

124. *Id.*

125. *Id.*

126. *Id.* at 1264. See also *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 35 (3d Cir. 1989)(directing defendant to formulate a complying reimbursement methodology within 90 days).

127. Weiser-Varon, *supra* note 74, at 1274.

which they are not enjoined from using federal funds nor required to comply with funding conditions.¹²⁸ Thus, the intended beneficiaries of the statutory framework will continue to suffer by being denied their legal entitlements for an additional period of time.

The third prospective relief option is to grant an injunction ordering immediate compliance with federal conditions.¹²⁹ This alternative avoids any continued deprivation caused by the use of noncomplying reimbursement rates. Yet, an injunction mandating a state to implement a particular practice or policy chosen by the court interferes with both the Congressional scheme that delegated rate-making authority to the states and the intended federal/state balance of power.¹³⁰

c. Encouragement of Forum Splitting

Health care providers seeking federal injunctive relief to bar the use of a state's noncomplying reimbursement rates may choose to file subsequent state court claims to obtain retrospective compensation if the state has waived its right to sovereign immunity.¹³¹ Thus, time-consuming and costly forum-splitting or piecemeal litigation may provide the only means possible under current law to obtain both a federal court adjudication of noncompliance issues and restitution of benefits unreasonably withheld.¹³²

Providers are free to seek both prospective and retrospective relief in state courts. Yet, most beneficiary suits are adjudicated in federal forums¹³³ to avoid the feared prejudice associated with the state court system. Such adjudication of federal funding violations is favored because of the federal courts' ability to provide uniformity of interpretation of federal requirements, which state courts are unable to offer.¹³⁴ Federal courts

128. *Id.* at 1264.

129. *Id.* at 1265. See *Pinnacle Nursing Home v. Axelrod*, 719 F. Supp. 1173, 1183 (S.D.N.Y. 1989)(defendants ordered to employ specific reimbursement adjustment factor).

130. Weiser-Varon, *supra* note 74, at 1269.

131. *Id.* at 1254-55. See also *supra* notes 113-21 and accompanying text.

132. Weiser-Varon, *supra* note 74, at 1254.

133. *Id.* at 1253-54.

134. *Id.* at 1253 n.98.

may more adequately safeguard the federal government's interest in monitoring federal expenditures and may have greater expertise in interpretation and enforcement of complex federal statutes and regulations.¹³⁵

3. *Conflict Among the Lower Courts*

Medicaid reimbursement rate challenges initiated in the state and federal courts have resulted at times in inconsistent rulings and have failed to provide a clear articulation of the appropriate analysis in a section 1983 action. In considering whether the health care provider is the intended beneficiary of the Boren Amendment, some courts have held that individual Medicaid patients are the only intended beneficiaries of the provisions and that providers therefore do not have a claim under section 1983.¹³⁶ One court has insisted that health care providers are merely the "instruments" through which Congress channels aid to the real beneficiaries of the program.¹³⁷

The Ninth and Tenth Circuits have found that Medicaid patients and providers have "parallel interests" in the Medicaid legislation and thus both may institute a section 1983 challenge.¹³⁸ However, the United States District Court for the Eastern District of Virginia has expressly rejected the notion of "parallel interests" advanced by the Ninth and Tenth Circuits, finding rather that "recipients and providers are each invested with certain specific enforceable rights"¹³⁹

The federal District Court for the Western District of Wis-

135. *Id.*

136. *Silver v. Baggiano*, 804 F.2d 1211, 1216-17 (11th Cir. 1986); *Ohio Academy of Nursing Homes v. Barry*, No. 88AP-826, 1989 Ohio App. LEXIS 2482 (Jun. 22, 1989) (holding that providers' interests do not rise to the level of a right since nothing in the statute shows a congressional intent to confer benefits on providers for their own sake) *aff'd in part, rev'd in part*, 56 Ohio St.3d 120, 564 N.E.2d 686 (Ohio 1990) (On appeal, the court reversed, finding that providers do have a substantive right to reasonable and adequate rates in light of the decision in *Wilder v. Virginia Hosp. Ass'n*, 110 S.Ct. 2510 (1990)).

137. *Ohio Academy*, No. 88AP-826, 1989 Ohio App. LEXIS 2482, at *9 (June 22, 1989).

138. *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1164 n.5 (10th Cir. 1988); *Coos Bay Care Ctr. v. Oregon Dep't of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), *vacated and remanded*, 484 U.S. 806 (1987).

139. *Vantage Healthcare Corp. v. Virginia Bd. of Medical Assistance Servs.*, 684 F. Supp. 1329, 1333 (E.D. Va. 1988).

consin has found that although a private right of action pursuant to section 1983 was available in provider challenges to Medicaid reimbursement methodology, the federal court should abstain from granting relief.¹⁴⁰ Abstention was justified by this court because substantial rate-making discretion was conferred upon the states and because the issues were considered predominantly local.¹⁴¹

A number of courts have found that the provider is the intended beneficiary of the Medicaid Act and accordingly have addressed the merits of the section 1983 reimbursement rate challenge.¹⁴² These courts have consistently refrained from substituting their own judgement for that of the agency by applying a deferential standard of review,¹⁴³ and by attaching a presumption of validity to such state agency action.¹⁴⁴ Consequently, state implemented rates were invalidated only on a finding of arbitrary and capricious state action¹⁴⁵ or for abuse of the state's discretion.¹⁴⁶

IV. *Wilder v. Virginia Hospital Association*

A. *The Facts*

In response to the Boren Amendment to the Medicaid Act, Virginia adopted a prospective reimbursement system, effective July 1, 1982.¹⁴⁷ The new program categorized hospitals by "peer groups" based on number of beds and facility location, and set ceiling reimbursement rates for each peer group.¹⁴⁸ Initial ceiling rates were calculated based on actual cost data for the 1981 base year, to be adjusted by a "reimbursement escalator" on an an-

140. *Saint Michael Hosp. of Franciscan Sisters v. Thompson*, 725 F. Supp. 1038 (W.D. Wisc. 1989).

141. *Id.*

142. *See Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987). *See also Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511 (5th Cir. 1983).

143. *Mississippi Hosp. Ass'n*, 701 F.2d at 516; *Friedman v. Perales*, 668 F. Supp. 216, 221 (S.D.N.Y. 1987), *aff'd*, 841 F.2d 47 (2d Cir. 1988).

144. *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 23 (3d Cir. 1989).

145. *Id.*

146. *Friedman*, 668 F. Supp. at 221.

147. *Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891, 895 (E.D. Va. 1985).

148. *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2514 (1990).

nual basis.¹⁴⁹ Virginia relied on the national Consumer Price Index ("CPI") as its reimbursement escalator.¹⁵⁰

Virginia Hospital Association ("VHA") is a nonprofit association of public and private Virginia hospitals established to represent the interests of its members.¹⁵¹ In 1986, VHA instituted an action against the Governor and other Virginia officials claiming that Virginia's Medicaid reimbursement procedures violated the requirements of the Medicaid Act.¹⁵² Specifically, VHA charged that (1) the reimbursement rates under Virginia's plan did not "reasonably and adequately meet the costs incurred by efficiently and economically operated hospitals;" (2) the "reimbursement escalator" linked to the CPI would lead to inadequate future rates; and (3) Virginia's appeals procedures for individual hospitals were inadequate.¹⁵³ VHA sought declaratory and injunctive relief, including an order that Virginia promulgate a new state plan and corresponding new rates, as well as reimbursement in the interim period at rates commensurate with payments under the Medicare program.¹⁵⁴

B. *Procedural History*

1. *The District Court Decisions*

The United States District Court for the Eastern District of Virginia granted summary judgment in the State's favor, finding that VHA was collaterally estopped from litigating those issues which had previously been decided¹⁵⁵ in *Mary Washington Hospital, Inc. v. Fisher*.¹⁵⁶ The Court of Appeals for the Fourth Circuit reversed and remanded, finding that collateral estoppel was not applicable against VHA, which was not a party to the previous case and did not have an opportunity to litigate.¹⁵⁷ Furthermore, by the time of VHA's suit, Virginia had since promulgated a new appeals mechanism, and employed a different reimburse-

149. *Virginia Hosp. Ass'n v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

150. *Wilder*, 110 S. Ct. at 2514 n.3.

151. *Id.* at 2514.

152. *Id.*

153. *Id.* at 2514 n.3.

154. *Id.* at 2514-15.

155. *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653, 656 (4th Cir. 1989).

156. 635 F. Supp. 891 (E.D. Va. 1985).

157. *Virginia Hosp. Ass'n v. Baliles*, 830 F.2d 1308, 1313 (4th Cir. 1987).

ment escalator, both of which were at issue in the subsequent litigation.¹⁵⁸ On remand, the district court denied the State's motion for summary judgment which was predicated on several theories of nonjusticiability, including a claim that the Medicaid Act does not create a right actionable under section 1983 for health care providers.¹⁵⁹

2. *The Court of Appeals Decision*

On appeal from denial of the State's motion for summary judgment, the Fourth Circuit affirmed, holding that VHA could challenge Virginia's reimbursement procedures under section 1983 because health care providers are intended beneficiaries of the reimbursement provisions of the Medicaid Act, and because Virginia failed to establish a congressional intent to foreclose such enforcement.¹⁶⁰ The court acknowledged the State's concern that a section 1983 action "may lead to crushing financial burdens that participating states could not have foreseen when they elected to participate in the Medicaid program."¹⁶¹ However, the court reasoned that finding a cause of action in favor of plaintiff-providers would be the only reading of the provisions that "protects the balance for which Congress has striven between ensuring health care to the poorest citizens and imposing a manageable burden on . . . state treasuries."¹⁶²

The court of appeals also determined that the suit against Virginia officials was not barred by eleventh amendment immunity for suits that charge state officials with violations of federal law, even though a "substantial ancillary effect on the state treasury" might result from this grant of prospective relief.¹⁶³ Because the Medicaid program is both a federal and a state concern, the court also denied the state's claim under *Burford v. Sun Oil Co.*¹⁶⁴ that the district court should have abstained from

158. *Virginia Hosp.*, 868 F.2d at 661-62.

159. *Id.* at 656.

160. *Id.*

161. *Id.* at 659.

162. *Id.*

163. *Id.* at 662 (quoting *Papasan v. Allain*, 478 U.S. 265, 278 (1986)).

164. 319 U.S. 315 (1943). In *Burford*, the Court found that it was proper for a federal court to abstain from deciding a matter of substantial state concern where the state maintained a comprehensive regulatory scheme, where uniform decision-making in the

deciding the issue.¹⁶⁵

3. *The Supreme Court Decision*

The United States Supreme Court granted certiorari to review this section 1983 claim of health care providers.¹⁶⁶ Thereafter, in a five-to-four decision written by Justice Brennan, the Court adhered to the reasoning employed in both *Pennhurst*¹⁶⁷ and *Wright*,¹⁶⁸ and concluded that the Boren Amendment imposes an obligation to adopt "reasonable and adequate" rates that is binding on state Medicaid agencies and enforceable under section 1983.¹⁶⁹ In affirming the decision of the court of appeals,¹⁷⁰ the Supreme Court ruled that providers were not merely entitled to enforce a state's procedural compliance with the Boren Amendment, but found, rather, that "the Act provides a *substantive* right to reasonable and adequate rates as well."¹⁷¹

Using the two-step analysis employed in *Wright*, the Court first inquired whether the Boren Amendment created a "federal right" that was "intended to benefit the putative plaintiff."¹⁷² The Court determined that there was "little doubt" that providers are the "intended beneficiaries of the Boren Amendment" because the amendment established a system for reimbursement of health care providers.¹⁷³

The Court determined that a federal right was created in favor of health care providers to obtain reasonable and adequate reimbursement because the Boren Amendment is cast in "mandatory rather than precatory" terms.¹⁷⁴ The majority rea-

specific area was needed, and where intervention by the lower federal courts would cause the type of nonuniformity that the state regulatory system was designed to avoid. *Id.* at 327-34.

165. *Virginia Hosp.*, 868 F.2d at 664.

166. *Virginia Hosp. Ass'n v. Baliles*, 110 S. Ct. 49 (1989).

167. 451 U.S. 1 (1981). *See supra* note 101 and accompanying text.

168. 479 U.S. 418 (1987). *See supra* note 98 and accompanying text.

169. *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2517 (1990).

170. *Id.* at 2525.

171. *Id.* at 2517 (emphasis added).

172. *Id.* (quoting *Golden State Transit Corp. v. Los Angeles*, 110 S. Ct. 444, 448 (1989)).

173. *Id.* at 2517.

174. *Id.* at 2519.

soned that such a right must have been intended because the Boren Amendment explicitly states that the state plan “*must* provide for payment of hospitals”¹⁷⁵ and because the grant of federal funds is expressly conditioned on compliance with the terms of the Medicaid Act’s state plan provisions.¹⁷⁶

The *Wilder* Court rejected Virginia’s claims that the broad discretion given to states to implement reimbursement rates imposed an obligation that was “too vague and amorphous” to be judicially enforceable.¹⁷⁷ Rather, the Court noted that in determining the appropriate judicial standard of review, the courts should consider the fact that the states have the authority to set rates within their broad discretion.¹⁷⁸

The second part of the Court’s analysis focused on the State’s claims that Congress had foreclosed enforcement of the Medicaid Act under section 1983 by the establishment of an administrative appeals procedure and by granting the Secretary authority to audit noncomplying state plans.¹⁷⁹ Citing the standard promulgated in *Middlesex County Sewerage Auth. v. National Sea Clammers Ass’n*,¹⁸⁰ the Court found that the Medicaid Act did not contain adequate provisions for private judicial or administrative enforcement.¹⁸¹ Although states are required to adopt an appeals process by which individual providers may obtain administrative review of reimbursement rates, the Court found that this avenue of review was insufficient to foreclose a section 1983 remedy because the states may, in their discretion, limit appealable issues to those that they deem appropriate.¹⁸²

Specifically, the Court found that Virginia’s administrative appeals process excluded the following issues from appeal: “(1) the organization of peer groups; (2) the use of the reimbursement rates established in the plan; (3) the calculation of the initial group ceilings as of 1982; (4) the use of the consumer price

175. *Id.* (citing 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V 1987)(emphasis added)).

176. *Id.*

177. *Id.* at 2522.

178. *Id.* at 2523.

179. *Id.* at 2523-25.

180. 453 U.S. 1 (1981).

181. *Wilder*, 110 S. Ct. at 2524.

182. *Id.*

index; and (5) the time limits set forth in the state plan [for appeal]."¹⁸³ Thus, the Court found that VHA would have been unable to challenge Virginia's reimbursement methodology if forced to rely on the state-implemented appeals process as an avenue of review.¹⁸⁴ The Court also determined that the Secretary's limited oversight, including the authority to audit state-submitted plans, was insufficient to constitute an alternative remedy that would foreclose a section 1983 suit.¹⁸⁵ In the absence of a comprehensive remedial scheme, the Court found no congressional intent to foreclose health care providers from the relief available under section 1983.¹⁸⁶

Although the Court declined to articulate specific guidelines for review, it acknowledged the application of a deferential standard as generally applied by the courts of appeals.¹⁸⁷ The Court also noted that there will be a "range of reasonable rates" beyond which no court could find compliance with the Medicaid regulations.¹⁸⁸

4. *The Dissenting Opinion*

Speaking for the dissent, Chief Justice Rehnquist sharply objected to the majority's holding that health care providers have an enforceable substantive right under section 1983.¹⁸⁹ The dissent argued that the only enforceable right guaranteed by the statute is that the state Medicaid agencies comply with the bare procedural requirements set forth in the Medicaid Act.¹⁹⁰

Relying on a plain reading of the statute's text, Rehnquist contended that Congress had not conferred any identifiable, enforceable rights on Medicaid service providers; rather, it had merely established one of many conditions for the receipt of funds.¹⁹¹ In the absence of an express "focus" on providers as beneficiaries, there is no dispositive evidence of Congress' intent

183. *Id.* at 2525 n.20.

184. *Id.* at 2524-25.

185. *Id.* at 2524.

186. *Id.*

187. *Id.* at 2523 n.18.

188. *Id.* at 2523.

189. *Id.* at 2525-27.

190. *Id.* at 2526-27.

191. *Id.* at 2526.

to create rights in favor of that class.¹⁹²

Furthermore, the dissent contended that the Medicaid Act establishes a two-step, congressionally mandated procedure for setting reimbursement rates which first requires the states to make findings and then requires states to make assurances to be reviewed by the Secretary, and not the courts.¹⁹³ The dissent concluded that a provider may bring a section 1983 action only to compel compliance with that procedure.¹⁹⁴ Finally, the dissent forecast that, under the majority's holding, Medicaid providers may bring section 1983 actions to "avoid the process rather than to seek its implementation."¹⁹⁵ Thus, the dissent noted that successful provider-plaintiffs seeking to enjoin and substitute state-implemented rates cause the displacement of rates determined by states pursuant to the statutory mandate, undermine the discretionary authority granted to the states by the Boren Amendment, and circumvent the congressionally established remedial schemes.¹⁹⁶

V. Implications of the *Wilder* Decision

A. *An Explosion of Litigation and Devastating Expenses*

The *Wilder* Court's endorsement of the section 1983 suit as a remedy for state noncompliance with the federal Medicaid program threatens to cause an explosion of litigation in the federal courts.¹⁹⁷ In fact, expansive application of the section 1983 remedy to all grant-in-aid programs would potentially expose over 700 existing cooperative federal-state programs to costly federal litigation¹⁹⁸ and unintended supervision.¹⁹⁹ A critic of us-

192. *Id.* at 2527.

193. *Id.*

194. *Id.*

195. *Id.* (emphasis added).

196. *Id.*

197. See Note, *supra* note 17, at 1019.

198. Richard B. Capalli, *Federal Grants and the New Statutory Tort: State and Local Officials Beware!*, 12 URB. LAW. 445, 446 (1980). See also *Maine v. Thiboutot*, 448 U.S. 1, 22 (1980) (Powell, J., dissenting) (arguing that "literally hundreds of cooperative regulatory and social welfare enactments may be affected"). See generally David C. Frederick, *Comprehensive Remedies and Statutory Section 1983 Actions: Context as a Guide to Procedural Fairness*, 67 TEX. L. REV. 627 (1989).

199. See *infra* notes 213-21 and accompanying text.

ing the section 1983 remedy for Medicaid program violations claims that "year-by-year, provider-by-provider" litigation over each provision of each state's regulations will become commonplace, in derogation of Congress' clear intent to reduce federal oversight of the reimbursement rate process.²⁰⁰

Many states have already been forced to defend their reimbursement policies repeatedly in the federal judicial forum.²⁰¹ Accordingly, it is likely that the routine rate challenge will be transformed unnecessarily into a federal case.²⁰² Since millions of state and federal dollars are potentially at stake in each lawsuit,²⁰³ the defense of multiple claims can be devastating on government treasuries.

Although one purpose of the Boren Amendment was to decrease the expense previously associated with the extensive reporting requirements,²⁰⁴ the increased litigation likely to result from the encouragement of section 1983 suits will most certainly create an explosion of paperwork that is at least as oppressive.²⁰⁵ The state and federal governments are now being exposed to considerable financial burdens in defense of section 1983 claims despite the fact that a major policy objective of the Boren Amendment was to contain government costs.²⁰⁶

Increasingly scarce resources are being diverted from Medicaid programs to litigation.²⁰⁷ Unfortunately, any cost savings

200. Brief Amicus Curiae for Alaska at 4,5, *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043) (noting that it is "distinctly ironic" that a congressional intent to eliminate burdensome federal oversight "has become the impetus for a mounting tide of litigation and potential liability").

201. As soon as *Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), was adjudicated, VHA filed its claim. While VHA's claim was pending, *Vantage Healthcare Corp. v. Virginia Bd. of Medical Assistance Servs.*, 684 F. Supp. 1329 (E.D. Va. 1988), was decided. Pennsylvania was forced to defend five separate reimbursement rate challenges simultaneously. Brief for Gerald L. Baliles at 25 n.18 *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

202. Brief Amicus Curiae for Alaska at iv, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

203. Brief Amicus Curiae for United States at 21, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

204. 48 Fed. Reg. 56,046 (1983).

205. Brief Amicus Curiae for California Ass'n of Hosp. and Health Sys. at 28 n.13, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

206. Brief Amicus Curiae for National Governors' Ass'n at 2, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

207. See George D. Brown, *Whither Thiboutot? Section 1983, Private Enforcement*

realized as a result of the Boren Amendment's underlying cost containment policies will be spent on reimbursement rate litigation, rather than on improving access to and quality of medical services for the nation's poor.²⁰⁸ This result could not have been envisioned or accepted by a Congress devoted to securing "quality care for the poor."²⁰⁹

Commentators have urged that an increased caseload in the federal courts is not a sufficient reason to deny grant beneficiaries the same protection afforded other holders of federal rights.²¹⁰ However, when the costs of increased litigation begin to threaten the availability of state and federal funds, which otherwise could be used to increase the quality of health care services available to the poor, an increase in caseload does become a significant concern. The authorized awards of attorneys' fees and costs further divert financial resources from the very needs Congress intended to address by adoption of the grant-in-aid program.²¹¹

B. *The Section 1983 Remedy Allows Providers to Avoid Intentionally Limited Remedial Schemes*

Through the Boren Amendment, Congress intentionally limited federal oversight of the rate-setting process by reducing federal administrative supervision to a level "adequate to ensure proper accountability."²¹² Yet, the *Wilder* Court's endorsement of reimbursement rate litigation in the federal courts contradicts Congress' express intent to keep federal oversight to a minimum.²¹³ Thus, plaintiffs may employ the section 1983 action to avoid remedial schemes purposefully limited by Congress and may thereby undermine congressional intent.²¹⁴

and the Damages Dilemma, 33 DE PAUL L. REV. 31, 40 (1983).

208. Brief Amicus Curiae for United States at 3, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

209. S. REP. NO. 139, 97th Cong., 1st Sess. 478 (1981), reprinted in 1981 U.S.C.C.A.N. 744.

210. See *Old Federalism*, supra note 17, at 1020.

211. See *Brown*, supra note 207, at 40.

212. See supra note 44 and accompanying text.

213. See Brief Amicus Curiae of United States at 10-11, *Wilder v. Virginia Hosp. Ass'n*, 110 S.Ct. 2510 (1990) (No. 88-2043).

214. See *Frederick*, supra note 198, at 646.

Application of section 1983 may disrupt administrative appeals and enforcement procedures that have been authorized by the Medicaid statute.²¹⁵ The result may be a circumvention of the administrative authority that Congress often regards as a critical element in a regulatory scheme.²¹⁶ This circumvention results because exhaustion of state administrative remedies is not a prerequisite for bringing a section 1983 claim.²¹⁷

A dual system of review is created because the federal courts and administrative agencies are engaging in often duplicative functions. Simultaneous enforcement of the section 1983 action and state appeals procedures creates an overlapping review system that was not intended by Congress, and that may disrupt the states' ability to administer their Medicaid programs effectively.²¹⁸ Under the system endorsed by the *Wilder* majority, states' costs will be compounded because they will remain obligated, by federal regulation, to fund an administrative appeals procedure²¹⁹ only to find that it frequently may be bypassed by providers who have been authorized to proceed directly to the federal courts.²²⁰

C. *The Grant of a Section 1983 Remedy is Not Meaningful*

Because health care providers rely so heavily for financial viability on reimbursement revenues from third party payers such as Medicaid, and because the Boren Amendment to the Medicaid Act deals directly with the calculation of those rates, there is strength in the majority's finding that providers are the intended beneficiaries of the Act with corresponding rights. However, while the Court has confirmed the availability to health care providers of a section 1983 claim, it is clear that these plaintiffs have not yet won the right to a plenary review of

215. *Id.*

216. Cass R. Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. CHI. L. REV. 394 (1982).

217. *Patsy v. Board of Regents of Florida*, 457 U.S. 496 (1982).

218. Petition for writ of certiorari at 8, *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

219. *Id.* at 29.

220. Brief Amicus Curiae of United States at 2, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043); Brief Amicus Curiae for National Governors' Ass'n at 25, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

state reimbursement methodology. The deferential standard of review, and the limited remedies available even to the successful plaintiff, render the section 1983 action an ineffective means of safeguarding the federal interest in proper expenditure of funds and protection of the nation's elderly and poor.²²¹

The *Wilder* Court has found that the Secretary's administrative oversight has been intentionally limited by Congress to the approval of state-submitted assurances of the reasonableness and adequacy of its rates.²²² In this capacity, the Secretary is currently not required to review the actual data used by the states to arrive at their reimbursement rates and methodology.²²³ Thus, the state reimbursement plan is not, at this juncture, subject to meaningful scrutiny.

The *Wilder* Court also found that this avenue does not guarantee a comprehensive review of reimbursement rates, because the mandatory appeals process for review of reimbursement rates is restricted to issues that the state finds "appropriate."²²⁴ As the Court noted, the Virginia Medicaid agency, as is typical of many state Medicaid agencies, has opted not to allow as an issue for review the means of calculation or application of its rates.²²⁵ Thus, it has effectively insulated its reimbursement methodology from any substantial challenge.²²⁶

In light of the inadequacies presently inherent in the administrative appeals process and the Secretary's oversight, access to the federal courts pursuant to section 1983 may, at first glance, appear to be the providers' only avenue to obtain adequate review. However, the providers still will not be afforded a meaningful review of state-implemented reimbursement rates.

According to the Supreme Court in *Wilder*, the courts will merely employ a deferential standard of review of reimbursement rates in recognition of the broad discretion bestowed upon the states by Congress in the Boren Amendment.²²⁷ The Court failed to articulate specific guidelines for judicial review of state

221. See *supra* notes 113-135 and accompanying text.

222. *Wilder*, 110 S. Ct. at 2521.

223. *Id.* at 2520.

224. *Id.* at 2525.

225. *Id.* at 2524-25.

226. See *supra* notes 80-83 and accompanying text.

227. See *supra* notes 179, 188-89 and accompanying text.

rates, concluding rather that the courts were competent to calculate a "range of reasonable rates."²²⁸ Accordingly, states would be enjoined from implementing their proposed rates only if they were found to be unreasonable or arbitrary — beyond what might be reasonably calculated within the parameters of their broad discretion.

Although state reimbursement rates might generally be considered reasonable, an individual provider whose costs, due to some special circumstances, are not adequately covered by those rates will find this level of review inadequate.²²⁹ This is especially true for public or inner-city hospitals that treat a disproportionate number of Medicaid patients.²³⁰

The section 1983 action cannot offer aggrieved health care providers a prompt remedy,²³¹ and often cannot provide compensation for past benefits wrongfully withheld.²³² In light of the limited remedies available to the section 1983 complainant, the extreme costs of the suit are not justified. Yet, because the alternative administrative schemes provide ineffective relief for violations of federal funding conditions, the volume of federal suits is likely to be high, for lack of a better option.

D. *State and Federal Administrative Forums Favored*

Commentators agree that review of state implemented reimbursement rates is best accomplished at the federal and state administrative levels rather than by the federal judiciary.²³³ Such challenges often require courts to make determinations for which they lack expertise and fact-finding ability in comparison with the established agency.²³⁴

Congress specifically delegated oversight of grant programs to federal agencies with expertise in specific program adminis-

228. *Wilder*, 110 S. Ct. at 2523.

229. *See supra* notes 54-57 and accompanying text.

230. *See supra* notes 60-63 and accompanying text.

231. *See Sunstein, supra* note 216, at 416-17.

232. *See supra* notes 115-21 and accompanying text.

233. *See Old Federalism, supra* note 17, at 1013. *See also Sunstein, supra* note 216, at 428; *Rosado v. Wyman*, 397 U.S. 397, 405 (1970) (because of its expertise, HEW better suited than the courts to review alleged inconsistency between federal statute and state scheme).

234. *Sunstein, supra* note 216, at 416.

tration because they are better able to respond to changes in regional conditions and to apply uniform standards.²³⁵ Consequently, these agencies have been established to supplant the courts as an avenue for review of regulations.²³⁶

Even under the more burdensome pre-Boren provisions,²³⁷ supervision of the state rate-setting process by the Secretary would have caused less delay and disruption in the administration of Medicaid than will result from federal litigation.²³⁸ The Boren Amendment does envision hospital challenges of "arbitrary and capricious" reimbursement rates.²³⁹ However, because Congress has delegated authority to the Secretary to determine if state payment systems are satisfactory, the Secretary should be responsible for detecting unreasonable state action.²⁴⁰ Adequate review could thus be accomplished at an earlier, preventive stage by the Secretary before state plans are approved.

Similarly, the state administrative agencies are particularly well-suited to determine whether rates are reasonable. The state Medicaid agency deals on a daily basis with the intricacies of the grant-in-aid program and its beneficiaries, and is able to review and assess the local needs of individual providers more readily.²⁴¹ Again, reimbursement challenges may be resolved by expenditure of fewer scarce resources at the state administrative level than by costly section 1983 actions.²⁴²

E. *The Current Scheme of Review Contravenes Congressional Intent*

Where a statutory framework "exudes deference" to an administrative agency, the Supreme Court has found that the language precludes any meaningful standard of review by the courts

235. *Id.*

236. *Id.* at 429.

237. *See supra* note 40 and accompanying text.

238. Brief Amicus Curiae for Alaska at 7, *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

239. 48 Fed. Reg. 56,048, 56,052 (1983).

240. *See Reply Brief for Gerald L. Baliles at 8-9, Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

241. Brief Amicus Curiae for United States at 15, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

242. Brief Amicus Curiae for National Governors' Ass'n at 29, *Wilder*, 110 S. Ct. 2510 (1990) (No. 88-2043).

because implementation has been committed by Congress to agency discretion.²⁴³ Congress may decline to elaborate the details of agency compliance and may choose rather to incorporate a standard of "reasonableness" into a statute.²⁴⁴ Commentators interpret the "reasonableness" standard to be a broad grant of authority to administrative agencies based on congressional intent and recognition that the agencies specialize in a particular area and may have expertise in balancing factors relevant to policy-making.²⁴⁵

Furthermore, unlike the courts, administrative agencies may be subject to political influences which affect the agencies' enforcement of an ambiguous "reasonableness" standard.²⁴⁶ Although the agency administering the statutory scheme may have a different political agenda than that of the Congress enacting the statute, the broad grant of authority to the agencies effectively sanctifies their enforcement of the regulations in response to perceived political pressures. The courts, however, may enforce a statute against classes of defendants that Congress purposefully insulated from federal monitoring.²⁴⁷ Thus, the use of judicial remedies, such as the section 1983 action, may subsequently alter the political balance intended by Congress to be achieved by administrative review.²⁴⁸

In addition, in enacting the Boren Amendment, Congress specifically sought to avoid two evils that it envisioned might result from the broad grant of discretion in state rate-setting. First, Congress expressly cautioned that cost-containment efforts should not "result in arbitrary and unduly low reimbursement levels for hospital services."²⁴⁹ Second, Congress warned that payment reductions that adversely affect the quality of care for the needy would not be tolerated.²⁵⁰

Unfortunately, both evils have resulted in the wake of fed-

243. *Webster v. Doe*, 486 U.S. 592, 596 (1988).

244. See Sunstein, *supra* note 216 at 428.

245. See, e.g., *id.* at 428-30.

246. See Raup, *supra* note 3, at 1394 (stating that the price that a state Medicaid program will pay for health services is set by a political force, not by the market). See also Sunstein, *supra* note 216, at 429.

247. See Sunstein, *supra* note 216, at 418.

248. *Id.*

249. H.R. REP. NO. 158, 97th Cong., 1st Sess. 293-94 (1981).

250. S. REP. NO. 139, *supra* note 210, at 478, *reprinted in* 1981 U.S.C.C.A.N. at 744.

eral budget cuts that have financially overburdened the Medicaid program.²⁵¹ Not only has Congress' intent in enacting the Boren Amendment been thwarted,²⁵² the legislative purpose of the entire Medicaid Act has been contravened. The Medicaid program was designed to provide adequate medical care, including sufficient access to services, to those classes of recipients deemed "in need" by Congress. Yet, in enforcing the Boren Amendment through the federal courts, and specifically by the section 1983 action endorsed by the *Wilder* Court, scarce funds are being diverted from achievement of the goal of care for the needy to defense of challenges which could be adequately addressed in alternative and less costly administrative forums.

While health care providers should be encouraged to participate in the Medicaid program, they are instead being driven away through inadequate reimbursement rates.²⁵³ Moreover, the potential defense of repeated section 1983 claims will deter participation in grant programs in contravention of congressional intent to offer an adequate range of needed services to the poor.²⁵⁴

F. *A Proposed Alternative Remedy*

Congress' goal of providing adequate health care to the needy is being jeopardized by the *Wilder* Court's expansion of the section 1983 action — a remedy that is not practical in light of the growing number of indigent patients who are unable to obtain adequate health services.²⁵⁵ Because the Court's decision promises an explosion of unproductive and costly litigation that cannot adequately address the needs of aggrieved health care providers or Medicaid recipients,²⁵⁶ the issue is now ripe for legislative resolution.

Although Congress has intentionally reduced the Secretary's oversight role in the cooperative Medicaid program scheme, its intent that the Secretary review state assurances to "ensure

251. See *supra* note 57 and accompanying text.

252. See *supra* notes 41-45 and accompanying text.

253. See *supra* notes 46-57 and accompanying text.

254. See Brown, *supra* note 207, at 40.

255. See *supra* notes 48-52 and accompanying text.

256. See *supra* notes 202-12 and accompanying text.

proper accountability”²⁵⁷ cannot be ignored. To ensure that the Secretary’s role is not reduced to that of a mere “rubber stamp,”²⁵⁸ especially where he has accumulated useful knowledge and expertise, Congress should first amend the Medicaid Act to include a “look-behind” provision.²⁵⁹ Such a provision would require the Secretary to review or look behind the actual findings upon which the states’ assurances are based, rather than to blindly accept state assurances of reasonableness of rates on their face. This measure would prevent arbitrary reimbursement plans from ever being implemented, and thus would reduce costs associated with the retrieval of entitlements improperly withheld. The Secretary should employ the funding termination powers granted by Congress to encourage state compliance with funding conditions. The early assessment of state reimbursement plans, coupled with the real threat of fund termination by the Secretary, would reduce the need for providers to institute costly court challenges against rate-making agencies.

Next, provider appeal regulations implemented by the HCFA²⁶⁰ should be revised so that state administrative agencies may not limit the issues determinable on appeal.²⁶¹ Consistent with congressional intent, such an amendment would not infringe on the agency’s discretion to develop rates, and would offer providers a more meaningful forum for rate review at a significantly reduced cost to all parties. The state agency is also not restricted in its ability to compensate for any benefits wrongfully withheld,²⁶² and thus may offer providers a retrospective remedy which is not available through the courts.²⁶³ Through these two revisions, both prospective and retrospective relief may be granted. The overburdened courts would experience much

257. 48 Fed. Reg. 56,046, 56,047 (1983).

258. Brief Amicus Curiae for Connecticut at 15, *Wilder v. Virginia Hosp. Ass’n*, 110 S. Ct. 2510 (1990) (No. 88-2043).

259. See *supra* note 70. See, e.g., 42 U.S.C. § 1396a(a)(33)(B) (1988).

260. 42 C.F.R. § 447.253(c) (1990).

261. See *supra* notes 79-82 and accompanying text.

262. 48 Fed. Reg. 56,046, 56,052 (1983). Although no prescriptive Federal requirement exists for retroactive or prospective adjustments, “the intent behind the Federal appeals provision is to provide a means for facilities to seek reimbursement relief upon a proper finding by the State agency. . . . [F]air and reasonable rate adjustments are implicit in an appeals process. . . .” *Id.*

263. See *supra* note 116 and accompanying text.

needed relief as well.

The HCFA has declined to develop national standards and definitions for the terms used in the statutory language of the Boren Amendment, such as "reasonable and adequate" rates and "efficiently and economically operated facilities."²⁶⁴ Rather, the HCFA has reasoned that the states are better able to establish methods and standards because they are "more informed of individual providers' circumstances and they can be more responsive to individual needs when dealing with a limited number of providers than the federal agency."²⁶⁵ Under this same reasoning, the state administrative agencies would be better suited than any other entity, including the Secretary and the federal courts, to review challenges by providers to state-implemented reimbursement rates.

After revising the role of the Secretary and the administrative appeals process, Congress should then incorporate an "exhaustion clause"²⁶⁶ into the Medicaid statute. An exhaustion clause is a legislative option available when statutory schemes are fully capable of providing the relief sought by a beneficiary.²⁶⁷ In the related context of Medicare, for example, the Supreme Court has found that dissatisfied program beneficiaries must avail themselves of all administrative remedies before they are authorized to enter federal court.²⁶⁸ Exhaustion is required when Congress finds that the potential for premature judicial intervention in the administrative process outweighs the hardship to beneficiaries caused by delays in the administrative process.²⁶⁹ Accordingly, an exhaustion provision would safeguard against the extensive burden placed on the parties and the courts when section 1983 actions are given broad application.

Finally, as a protection against wrongful state action, the section 1983 action should be reserved for plaintiffs who have exhausted administrative remedies but who believe the administrative resolution has been inadequate.²⁷⁰ The proposed reme-

264. 48 Fed. Reg. 56,046, 56,048 (1983).

265. *Id.*

266. *See Old Federalism*, *supra* note 17, at 1018-20.

267. *Id.* at 1019.

268. *Heckler v. Ringer*, 466 U.S. 602 (1984).

269. *Id.* at 619 n.12.

270. *See Old Federalism*, *supra* note 17, at 1019.

dial scheme retains the balance between state discretion and federal oversight that Congress has intended to achieve,²⁷¹ but does so at a reduced cost. Such cost savings may be used to improve the quality of medical care and access to services — a result that is consistent with the overall congressional purpose of the federal-state Medicaid program.²⁷²

VI. Conclusion

The *Wilder* Court's holding that health care providers have an enforceable right to adequate and reasonable Medicaid reimbursement rates permits use of the federal courts as initial claims adjusters to prevent states from adopting reimbursement schemes that do not comply with federal regulations. The courts, however, will merely apply a deferential standard of review to assess the reasonableness of the state's chosen reimbursement methodology. Furthermore, the federal courts are unable to provide retrospective reimbursement for funds wrongfully withheld and thus are limited in the relief they may grant to successful complainants. Federal section 1983 actions are extremely costly, diverting needed funds from the Medicaid program beneficiaries, for whom the funds were earmarked, in contravention of congressional intent. Inadequate administrative procedures have made the section 1983 action more attractive to aggrieved health care providers, even though it is far from a panacea.

Much unnecessary litigation may be avoided, however, by congressional amendment of the current administrative appeals process. Rather than act as a rubber stamp, the Secretary should be mandated to take a preventive role by reviewing the findings upon which states make their assurances. Furthermore, the state Medicaid agencies should be required to provide a forum for providers to challenge reimbursement rate "methodology." Because the revision would only apply to the appeals process, the congressional desire to maximize states' discretion in the setting of reimbursement rates would be retained. The state administrative agencies possess a higher degree of expertise in the field than the federal courts, and would be able to dispose of chal-

271. 48 Fed. Reg. 56,046, 56,047 (1983).

272. See *supra* note 16 and accompanying text.

lenges more efficiently and effectively. Unfortunately, the *Wilder* Court's decision will perpetuate the tide of costly litigation to the Medicaid recipients' detriment until such legislative action is taken.

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