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Health Law - Provider Challenge to State Medicaid Reimbursement Plan

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In 1965, Congress responded to the growing demand for governmental assistance in the area of health care financing by enacting the Medicare and Medicaid programs. Medicare was created as a “nationwide health insurance program for people aged sixty-five and over, [and] for certain disabled persons,” while Medicaid was created “for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.” Jointly funded by the federal and state governments, the Medicaid program provides health care coverage to the indigent and medically needy.

3. Robert J. Buchanan & James D. Minor, Legal Aspects of Health Care Reimbursement 17 (1985). Medicare is a federal health insurance program available to qualified beneficiaries regardless of income. Id. The program is funded through payroll taxes and premiums and is uniformly administered throughout the United States. Id.
4. Harris v. McRae, 448 U.S. 297, 301 (1980). One commentator has noted:

Though adopted together, Medicare and Medicaid reflected sharply different traditions. Medicare was buoyed by [the] popular approval and acknowledged dignity of Social Security; Medicaid was burdened by the stigma of public assistance. While Medicare had uniform national standards for eligibility and benefits, Medicaid left the states to decide how extensive their programs would be. Medicare allowed physicians to charge above what the program would pay; Medicaid did not and participation among physicians was far more limited. The objective of Medicaid was to allow the poor to buy into the “mainstream” of medicine, but neither the federal government nor the states were willing to spend the money that would have been required.

5. See Deborah M. Naglak, Medicare/Medicaid Reimbursement Issues—A Provider’s Perspective, 34 Soc. Sec. Rep. Serv. 3, 4 (1991). Participation in the Medicaid program is optional, but once a state elects to participate, it must comply with all federal requirements. Harris, 448 U.S. at 301. Reimbursement under Medicaid encompasses payment for health care services provided to both the indigent and medically needy. Id. at 301 n.1. The covered services include inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility care, pediatric screening and diagnosis, family planning services and physician care. Id. at 301-02.

Eligibility for Medicaid is different than that for Medicare because Medicaid

(1081)
Under the original Medicaid programs, providers of inpatient health care services to Medicaid patients received reimbursement that was calculated retrospectively based on the actual costs incurred in treating those patients. Prior to 1972, such “actual costs” were reimbursed based on federally developed “reasonable cost” reimbursement principles. Beginning in 1972, Congress permitted states “to develop is a welfare program. Starr, supra note 4, at 370. Medicaid eligibility is primarily based on economic need; each Medicaid recipient “must show that his or her income and resources fall below certain levels set by the states pursuant to broad federal guidelines.” Barry R. Furrow et al., The Law of Health Care Organization and Finance 232 (2d ed. 1991).

Medicaid recipients fall within two broad categories. The first group of Medicaid recipients is the “categorically needy,” which includes those persons whose below-poverty-level income qualifies them for Medicaid benefits. Id. at 232-33. The “categorically needy” are sometimes referred to as the “deserving poor.” Id. at 232. The second group of Medicaid recipients is the “medically needy,” which includes those persons whose income is above the financial eligibility standards but who incur substantial medical expenses that when taken into consideration, drop the recipient’s income level below federal standards. Id. at 233. For a general discussion of the Medicaid program, see Buchanan & Minor, supra note 3, at 137-45.

6. Medicaid programs reimburse both inpatient and outpatient health care providers, including hospitals and private physicians, for delivering care to Medicaid recipients. Buchanan & Minor, supra note 3, at 137-38.

In Temple University v. White, 941 F.2d 201 (3d Cir. 1991), cert. denied, 112 S. Ct. 873 (1992), only inpatient acute-care hospitals challenged the Medicaid reimbursement rate. Therefore, all references in this Casebrief to “health care providers” refer only to the Medicaid reimbursement process as it relates to inpatient acute-care hospitals.

7. See Karl A. Thallner, Jr., Prospective Payment System: Preclusion of Review of Hospital Base Year Cost Calculations, 6 J. Legal Med. 509, 511-12 (1985). The “actual” hospital charges were subject to a “reasonableness” standard. Id. at 511-12 & n.29. Essentially, this standard permitted the government to deduct from such actual costs those costs that were “unnecessary for the efficient delivery of needed health services.” Id. at 512 n.29 (citing 42 U.S.C. § 1395x(y)(1)(A) (1982)); see also Naglak, supra note 5, at 3-4.

Understanding the fine distinctions between “actual costs” and “reasonable costs” can be facilitated by knowing which hospital costs are reimbursable under Medicare and Medicaid. The federal and state programs reimburse hospitals not only for the costs directly associated with the care of a qualified recipient, but also for a percentage of general expenses, such as overhead, capital costs and direct medical education costs. See Buchanan & Minor, supra note 3, at 35-43. Therefore, when hospitals submitted actual costs, including these general expenses, for reimbursement and the costs were not considered “unreasonable” (unnecessary for efficient delivery of care), full reimbursement was received. Thallner, supra, at 511-12 & n.29.

8. See Buchanan & Minor, supra note 3, at 147. The original Medicaid statute used the “reasonable cost” terminology and provided for retrospective “reasonable cost” reimbursement. Id. at 147-48. The Medicaid statute requirements permitted the states to reimburse inpatient hospitals using the rates set by the Secretary of the Department of Health and Human Services (HHS) for Medicare reimbursement. Id. The Medicare rates were established by the Medicare Act based on guidelines such as historical costs and current average costs. See generally Naglak, supra note 5, at 4-5 & n.10. The statutes, however, were perceived as investing too much control in a federal agency. Wil-
their own reasonable cost payment system for hospital care." The state-developed reimbursement structures, however, could not establish Medicaid reimbursement rates that exceeded either the hospital's customary charges or the federally imposed caps. In addition, both the federally determined and the state-determined reimbursement plans continued to utilize retrospective reimbursement. Accordingly, the rates were based on the actual hospital costs resulting from the treatment of Medicaid recipients, qualified by "reasonable cost" reimbursement principles.

The escalation of health care costs and the increasing percentage of federal funds spent on Medicare/Medicaid programs prompted Congress to enact a variety of reforms. In 1980, Congress enacted the Boren Amendment which "repealed the 'reasonable cost' standard of reimbursement existing under the prior law, replacing it with a standard which required reimbursement at rates that [were] 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.'" Under the Boren Amendment, the

10. Id. at 149. For the current federal regulations specifying these requirements, see 42 C.F.R. §§ 447.253(b)(1), 447.271(a) (1992).
11. Thallner, supra note 7, at 511-12.
13. See Thallner, supra note 7, at 512-15. Prior to these reforms, the majority of Medicaid reimbursement plans were based on retrospective cost-based reimbursement. Buchanan & Minor, supra note 3, at 147-48. The legislative history reveals that as part of the reforms, Congress wanted to encourage states to switch to a prospective payment system. H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981). Generally, a prospective payment system utilizes reimbursement rates that are predetermined based on diagnosis and treatment factors. Thallner, supra note 7, at 515-16. As part of the health care reform package, the federal government developed a prospective payment system for Medicare reimbursement. Id. at 514-15. State Medicaid reimbursement plans, on the other hand, were not required to use the federal prospective payment system—each state could develop its own system of payment. Buchanan & Minor, supra note 3, at 148-52. The states, however, did revise existing Medicaid reimbursement plans; by 1984, thirty-three states adopted "prospective rate-setting system[s]." Id. at 152. For a discussion of Pennsylvania's prospective payment system, see infra notes 33-37 and accompanying text.
14. Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1309 (2d Cir. 1991) (quoting 42 U.S.C. § 1396(a)(13)(A) (1988)). The Boren Amendment recites that a state will provide for payment . . . of the 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 hospi-
states were charged with the responsibility for and control of Medicaid reimbursement rate setting.\textsuperscript{15}

Although the states are responsible for the development of Medicaids, 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 . . .


The change in terminology from "reasonable costs" to "costs reasonable and adequate" reflected Congress' desire to advance two aims: 1) the transfer of control over reimbursement plan development from the federal level to the state level; and 2) the encouragement of states to develop individualized Medicaid programs while continuing to provide "reasonable and adequate" reimbursement. Cusenbary, Note, supra note 12, at 525, 528-29. The purposes of the Boren Amendment were: "(1) to provide the states with greater flexibility in developing methods of reimbursing skilled nursing facilities, intermediate care facilities, and inpatient hospital services; and (2) to increase the economy and efficiency of all plans." Pinnacle Nursing Home, 928 F.2d at 1309-10 (citing S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981), reprinted in 1981 U.S.C.C.A.N. 396, 744). Nonetheless, "[t]he flexibility given the States [was] not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care." Id. at 1310 (quoting S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981), reprinted in 1981 U.S.C.C.A.N. 396, 744).

15. See 42 U.S.C. § 1396(a)(13)(A). The Boren Amendment transferred the primary responsibility for the development of reimbursement rates from HHS to the state Medicaid agencies. Cusenbary, Note, supra note 12, at 526. The transfer of control from the federal to the state level occurred because Congress associated rising Medicaid costs with the complex and rigid federal regulations. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 292-93 (1981); S. Rep. No. 471, 96th Cong., 1st Sess. 11-15, 28-29 (1979). Congress envisioned the Boren Amendment as providing greater latitude to the states to develop alternative reimbursement plans, while continuing to provide reasonable rates to health care providers. The amendment's legislative history states:

The [Boren Amendment] provides States with additional flexibility in determining the rate for inpatient hospital services. The bill deletes the current provision requiring States to reimburse hospitals on a reasonable cost basis. It substitutes a provision requiring States to reimburse hospitals at rates (determined in accordance with methods and standards developed by the States) that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. The section further requires States to provide assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital and periodic audits by the State of such reports . . .

The committee continues to believe that States should have flexibility in developing methods of payment for their Medicaid programs and that application of the reasonable cost reimbursement principles of the medicare program for hospital services is not entirely satisfactory. These principles are inherently inflationary and contain no incentives for efficient performance. . . . The flexibility given the States is not
 Medicaid reimbursement plans, the Boren Amendment contains both procedural and substantive requirements that each state's Medicaid reimbursement plan must meet.\(^16\) To satisfy the Boren Amendment's procedural requirements, each Medicaid-participating state must follow specified procedures annually, or whenever a new state Medicaid plan is implemented.\(^17\) First, the state must perform a "findings" process, based on proper methods and standards, to obtain adequate information to support the reimbursement payment structure in the state plan.\(^18\) Second, the state must provide assurances to the Health Care Financing Administration (HCFA) that all federal requirements have been met.\(^19\) The three substantive requirements of the Boren Amendment are:

1. [That state's] rates take into account the circumstances of hospitals serving a disproportionate share of low-income patients;
2. [that] its "rates are reasonable and adequate to meet the necessary costs of an efficiently operated hospital;" and
3. [that] its rates are reasonable and adequate "to assure intended to encourage arbitrary reductions in payment that would adversely affect the quality of care.


In Pennsylvania, the Department of Public Welfare (DPW) is responsible for the state Medicaid plan. Temple Univ. v. White, 941 F.2d 201, 205 (3d Cir. 1991), cert. denied, 112 S. Ct. 873 (1992). DPW developed a Medical Assistance Program (MAP) that sets forth Pennsylvania's Medicaid reimbursement payment system. \(^{16}\) Pinnacle Nursing Home, 928 F.2d at 1313, 1316-17.


19. Id.; see also 42 U.S.C. § 1396(a)(13)(A) (Boren Amendment) (requiring "assurances" satisfactory to Secretary). For the specific language of the Boren Amendment, see supra note 14. For the statutory and regulatory language that sets forth these requirements, see 42 C.F.R. §§ 447.252(b) (agency must "specify comprehensively the methods and standards used by the agency to set payment rates"); 447.253(b)(1) (payment of rates state finds are "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities"); 447.253(a) (agency must provide assurances to Health Care Financing Administration (HCFA) that standards have been met) (1992).

The procedural requirements mandate that a state "submit to the Secretary [of HHS] assurances, based on findings made by the state, that its Medicaid plan complies with federal requirements for such plans." Pinnacle Nursing Home, 928 F.2d at 1313. These findings are vital to provide a basis for the conclusions used by the state in revising a Medicaid reimbursement plan. \(^{16}\) Pinnacle Nursing Home, 928 F.2d at 1313. These findings are vital to provide a basis for the conclusions used by the state in revising a Medicaid reimbursement plan. Id. In conjunction with these findings, a state is required to make assurances to the Secretary of HHS regarding the validity of the state's Medicaid reimbursement plan. Amisub, 879 F.2d at 796-97. The Amisub court commented that "[m]ere recitation of the wording of the federal statute is not sufficient for procedural compliance. There is a presumption that a state will engage in a bona fide finding process before it makes assurances to HCFA that the required findings have been made." Id. at 797.
medicaid patients of reasonable access to inpatient hospital care."\textsuperscript{20}

Since the enactment of the Boren Amendment, a significant amount of litigation has resulted from health care provider allegations of improper reimbursement planning by state agencies.\textsuperscript{21} The United States Court of Appeals for the Third Circuit's decision in \textit{Temple University v.} 


\textsuperscript{21} \textit{See, e.g.,} West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989) (holding that Pennsylvania Medicaid reimbursement plan substantively violated Boren Amendment in plan's application to out-of-state hospitals), \textit{aff'd}, 111 S. Ct. 1138 (1991); \textit{Amisub}, 879 F.2d 789 (holding that Medicaid payment rates were arbitrary and capricious and did not meet procedural and substantive federal requirements); \textit{Multicare Medical Ctr. v. Washington}, 768 F. Supp. 1349 (W.D. Wash. 1991) (requiring that state identify and determine economically and efficiently operated hospital facilities to meet "findings" requirement); \textit{Michigan Hosp. Ass'n v. Babcock}, 736 F. Supp. 759 (W.D. Mich. 1990) (concluding that state failed to make proper findings prior to providing assurances to HCFA regarding Medicaid reimbursement plan).

Suits by health care providers had also been commonplace in federal courts prior to the enactment of the Boren Amendment. For examples of pre-Boren Amendment suits, see Cusenbary, Note, \textit{supra} note 12, at 527 \& n.35.

As enacted in 1980, the Boren Amendment initially applied to nursing homes and long-term and intermediate care facilities. Naglak, \textit{supra} note 5, at 6. Medicaid reimbursement is important to the financial solvency of many nursing homes because "[t]he Medicaid program has become the largest government purchaser of long-term care in the United States." \textit{Buchanan \& Minor, supra} note 3, at 185. For example, "[t]he Medicaid program pays for approximately 67\% of all nursing home patient days in Washington State. This percentage is comparable to, although slightly higher than, that seen in other states . . . . Thus, the Medicaid program is the principal payer for nursing home care in the United States." \textit{Folden v. Washington State Dep't of Social \& Health Servs.}, 744 F. Supp. 1507, 1513 (W.D. Wash. 1990). For examples of litigation by nursing home owners alleging Boren Amendment violations, see the following cases: \textit{Pinnacle Nursing Home v. Axelrod}, 928 F.2d 1306 (2d Cir. 1991) (holding that state findings did not establish nexus between cost of operating efficient and economic nursing home and reimbursement rates provided); \textit{Nebraska Health Care Ass'n, Inc. v. Dunning}, 778 F.2d 1291 (8th Cir. 1985) (concluding that budgetary restrictions on rate increases without presence of adequate findings was procedural violation of Boren Amendment), \textit{cert. denied}, 479 U.S. 1063 (1987); \textit{Illinois Health Care Ass'n v. Bradley}, 776 F. Supp. 411 (N.D. Ill. 1991) (stating that failure to make findings and failure to establish reasonable reimbursement rates were procedural and substantive violations of Boren Amendment); \textit{Lapeer County Medical Care Facility v. Michigan}, 765 F. Supp. 1291 (W.D. Mich. 1991) (concluding that arbitrary 30\% budget reduction of nursing home reimbursement rates without proper findings was violation of Boren Amendment); and \textit{Independent Nursing Home v. Simmons}, 732 F. Supp. 684 (S.D. Miss. 1990) (holding that inadequate notice of state plan revision was procedural violation of Boren Amendment requirements). For a discussion of suits brought following the 1981 expansion of the Boren Amendment to hospitals, see \textit{infra} notes 55, 64 \& 68-76 and accompanying text. For a general discussion of Medicaid and long-term care reimbursement, see \textit{Buchanan \& Minor, supra} note 3, at 185-235.
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White is representative of such litigation and reveals the extent to which federal courts are willing to protect the financial stability of the hospitals that deliver medical care to Medicaid recipients. In Temple University, a number of Pennsylvania hospitals brought suit against the Department of Public Welfare (DPW), the state agency charged with administrative control of the Pennsylvania Medicaid plan. The plaintiffs alleged that the reimbursement plan developed by DPW to pay hospitals for inpatient treatment of Medicaid recipients was inadequate under the Boren Amendment's procedural and substantive requirements. The United States District Court for the Eastern District of Pennsylvania held that the Pennsylvania Medicaid plan violated the procedural and substantive requirements of the Boren Amendment. The district court ordered the state to revise the Medicaid plan and provided interim injunctive relief to the affected hospitals during the revision period. On appeal, the United States Court of Appeals for the Third Circuit agreed with the district court that the DPW plan violated the Boren Amendment requirements and upheld the remedy tailored by the district court to correct the Medicaid reimbursement plan inadequacies.

II. CASE ANALYSIS

A. Facts

In Temple University, over 140 Pennsylvania hospitals challenged the Pennsylvania Medical Assistance Program (MAP)—the reimbursement payment structure established by the Pennsylvania DPW pursuant to federal Medicaid requirements. Specifically, the plaintiffs alleged that the 1988-1989 DPW reimbursement plan failed to meet the requirements of the Boren Amendment. The attack on the MAP plan was twofold. First, the plaintiffs alleged that the MAP plan did not comply

23. Id. at 205.
24. Id. For a discussion of the Boren Amendment requirements, see supra notes 14-20 and accompanying text.
26. Id. at 1100-01. For a discussion of the district court findings and the remedy granted, see infra notes 28-49 and accompanying text.
27. Temple University, 941 F.2d at 220.
28. Id. at 205; see Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396s (1988). The hospitals challenged the validity of the payment rates established by DPW to reimburse hospitals that provided inpatient health care services to Medicaid recipients. Temple University, 941 F.2d at 205. The suit was brought against DPW, the agency responsible for the development and implementation of the Medicaid reimbursement plan. Id.
29. Temple University, 941 F.2d at 205. The Boren Amendment shifted responsibility and control of state reimbursement plans from the Secretary of HHS to the states. Cusenbary, Note, supra note 12, at 526.
with the procedural requirements of the Boren Amendment because "findings" were not made as to whether the methods and standards of the MAP plan were proper. Second, the plaintiffs alleged that the MAP plan did not comply with the substantive requirements of the Boren Amendment because: 1) the MAP payment rates were unreasonable and inadequate; and 2) the MAP plan did not adequately address the payment structure for hospitals providing care to a disproportionate share of low-income patients.

In order to understand the factual allegations in and holding of the Temple University decision, a brief discussion of the Pennsylvania Medicaid reimbursement plan is necessary. A review of the history of Medicaid reimbursement in Pennsylvania reveals that prior to June 30, 1984, the MAP plan provided that hospitals be retrospectively reimbursed based on the actual costs expended in providing care to Medicaid patients. In response to the passage of the Boren Amendment, DPW revised the MAP plan and changed the method of reimbursement to a prospective payment system. Under the prospective payment system, "the operating costs of most acute care inpatient hospital stays are reimbursed by a flat payment per discharge that is a multiple of the hospital's 'payment rate' and a 'relative value' assigned to the diagnostic related...

30. Temple University, 941 F.2d at 205. The Boren Amendment requires states to "find" and make assurances to the Secretary of HHS that the state reimbursement plans are based on proper methods and standards. See 42 U.S.C. § 1396(a)(13)(A). For the text of the Boren Amendment, see supra note 14. When interpreting this language, courts have declined to read this procedural requirement as "mere surplusage." See Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1313 (2d Cir. 1991). For a discussion of suits in other jurisdictions where the courts agree with the characterization of meaningful findings as a procedural requirement of the Boren Amendment, see infra notes 60-64 and accompanying text. For a discussion of the congressional intent behind the language of the Boren Amendment, see supra notes 14-15. For a discussion of the procedural requirements of the Boren Amendment, see supra notes 17-19 and accompanying text.

31. Temple University, 941 F.2d at 205. For a discussion of the substantive requirements of the Boren Amendment, see supra note 20 and accompanying text. For a discussion of a prior Third Circuit case that analyzed allegations of substantive violations of the Boren Amendment, see infra notes 69-76 and accompanying text.

32. Temple University, 941 F.2d at 208. Pennsylvania's MAP plan had been based on a retrospectively calculated actual cost reimbursement process that mirrored the standard method of federal reimbursement under Medicare/Medicaid. See generally Thallner, supra note 7, at 511-12; Cusenbary, Note, supra note 12, at 525-26. For a discussion of the retrospective and prospective reimbursement rates issues, see supra notes 7-13 and accompanying text.

33. Temple University, 941 F.2d at 208. Most prospective payment systems, including Pennsylvania's system, reimburse at a flat fee which is determined in advance based in part on factors such as the medical diagnosis, treatment and resource use of the patient. Thallner, supra note 7, at 515-16. For such calculations, each patient discharge is classified into a diagnostic related group (DRG). Temple University, 941 F.2d at 208. For a discussion of the congressional intent to encourage states to develop prospective payment systems, see supra note 13.
group ('DRG') into which the particular case falls." In order to determine the "relative value" portion of the reimbursement rate, DPW identified 477 categories of DRGs based on a variety of medical diagnoses and calculated a flat reimbursement rate for each DRG. In order to determine the "payment rate" portion, DPW then classified Pennsylvania hospitals into groups "in an effort to treat similarly situated institutions in similar fashion." Within each group, the reimbursement

34. Temple University, 941 F.2d at 208. Each hospital's reimbursement was affected by two major factors: 1) the relative value assigned to each patient's diagnosis on discharge, and 2) the hospital's payment rate. Id.

A DRG consists of medical diagnoses that are "clinically coherent and homogenous with respect to resource use," and, therefore, a sum of money is assigned to each DRG to reflect the cost of treatment based on data from previous years." Thallner, supra note 7, at 515-16 (footnote omitted). The provider receives this flat fee regardless of how much is spent on the specific patient. Id. at 516. The objective is to encourage providers to maximize the efficient utilization of health care resources and lower the need for federal financing. Id. For example, if a patient is admitted and diagnosed as having coronary artery disease, the DRG would be calculated based on this primary disease, the type of treatment provided (surgical or medical) and the presence of any other secondary diagnoses or health problems (such as diabetes, asthma and/or age). One of the 477 DRG categories includes a pre-established payment rate for a patient who has coronary artery disease and a secondary diagnosis, and who is undergoing surgical treatment. Therefore, the hospital would receive, as the relative value portion of the reimbursement, the prospectively determined payment amount for this DRG. See generally Buchanan & Minor, supra note 3, at 31-36; Furrow, supra note 5, at 392-94.

35. Temple Univ. v. White, 729 F. Supp. 1093, 1096-97 (E.D. Pa. 1990), aff'd, 941 F.2d 201 (3d Cir. 1991), cert. denied, 112 S. Ct. 873 (1992). Under the Pennsylvania MAP plan, DPW calculated the relative value of each DRG by taking the historical costs of each diagnosis and dividing it by the number of cases of that diagnosis among Medicaid patients. Id. at 1097. The standardized cost for each DRG was then divided by the average costs of all DRGs to determine the relative value of each DRG. Id. The most expensive DRGs were then excluded. Id. "Thus," as the district court noted, "historical costs for similar kinds of hospital admissions are the starting point for calculating reimbursements under the plan." Id.

36. Id. at 1097. Four broad categories of cost-factors—teaching, medical assistance volume, environment and cost grouping—with a total of thirteen variables were used to define pertinent indices for each hospital. Id. The variables taken into account were:

[The] number of full-time employed physicians/residents/interns per bed; [the] number of full-time equivalent physicians, residents and interns; and [the] number of residency programs (the teaching concept variables); [the] medical assistance reimbursable in-patient costs . . . ; [the] acute care in-patient medical assistance in-patient days . . . (medical assistance volume concept); [the] percentage of persons below the poverty level in that county, [the] median family income in that county, [the] percentage of unemployment in that county (environmental characteristics); and [the] Medicare area wage index, total in-patient expenses adjusted for direct medical education and capital/total in-patient admissions; and [the] total in-patient expenses adjusted for direct medical education and capital/total in-patient days (hospital costs concept).

Id.
rate was "somewhat more than the costs incurred by the lowest-cost hospital within that group, but considerably less than the costs incurred by the average hospital within that group." 37

Temple University Hospital (Temple) was one of eight hospitals in the highest cost-factor group.38 The district court found that given its position within the group, it was "simply impossible for . . . Temple, which ranks high in the group, to receive payments equal to its costs," because within each group, the "payment rate" portion of the reimbursement was closest to the lowest-cost hospital in the group.39

The district court identified two additional aspects of the MAP plan, that when combined with Temple's group ranking, further limited the Medicaid reimbursement received by Temple.40 First, DPW included a "budget neutrality" adjustment as part of the revised MAP plan.41 The

DPW assigned numerical ranks to each hospital based on the scores obtained from the different variables. Id. After a particular hospital's numerical rank was established, it was placed into one of eight groups. Id. One group solely contained the state's three children's hospitals, while all other acute-care hospitals were distributed in the remaining seven groups. Id. "Group 1" hospitals had the highest cost-factors and "Group 7" had the lowest cost-factors. Id. 37. Id. (emphasis added). The district court identified two major problems with DPW's grouping approach. Id. at 1097-98. First, hospitals at the high end of one given group could be encouraged to become less efficient in an effort to move up into the low end of the next higher cost-factor group. Id. at 1097. Second, one of the goals of hospital group placement was to achieve groups of near equal size. Id. at 1098. Therefore, wide variations occurred in the cost-factor scores of the hospitals within each group. Id.

38. Id. at 1098. Group 1 had the highest numerical rankings in the teaching, medical assistance volume, environment and cost factors. Id. The Group included the six Philadelphia-area teaching hospitals and two community hospitals with high cost-factors. Id.

The district court's opinion explained the reasons behind Temple's high cost-factor rating. Temple University Hospital is located in a decaying urban environment where the majority of residents live in poverty. Id. at 1095. The district court noted that "[50%] of Temple's patients have Medicaid insurance coverage; 20% are covered by Medicare; and 5% have no coverage." Id. The Temple patient population has an infant mortality rate twice the national average and a greater incidence of nutritional deficiencies, drug abuse problems and sexually transmitted diseases. Id. at 1095-96. Temple also faced greater difficulties than the other hospitals in Group 1 in retaining an adequate ratio of nursing staff to occupied beds, and its professional liability insurance costs were rising dramatically. Id. at 1096. In addition to these problems, because of the MAP plan, Temple only received approximately 81% of its actual costs and lost between $2.5 million and $7 million per year on acute in-patient care to medical assistance patients since Pennsylvania's prospective payment reimbursement began. Id.

39. Id. at 1098. Plaintiffs' expert showed at trial that within the MAP groupings, the rank of the hospital and not its efficient use of resources determined its cost reimbursement. Id. Temple "presented a mass of evidence, which stands unrebutted, to the effect that it has cut costs in every conceivable way, and that, as a practical matter, no further 'efficiency' or 'economy' is possible." Id. at 1096.

40. Id. at 1098-99.

41. Id. at 1098. DPW advanced two justifications for the budget neutrality
adjustment resulted in a fourteen percent across-the-board reduction in reimbursement payments to all health care providers.\(^{42}\) Second, under the Medicaid statute, hospitals such as Temple were authorized to receive additional reimbursement as compensation for providing care to a "disproportionate share" of low-income patients in comparison with other hospitals.\(^{43}\) Accordingly, the Pennsylvania MAP plan permitted Temple to receive a disproportionate share rate of two and one-half percent.\(^{44}\) The district court, however, found that the disproportionate share rate did not adequately reimburse Temple for its disproportionate share expenses.\(^{45}\)

Because DPW did not make meaningful findings as to whether the methods and structure of the Pennsylvania MAP plan were proper prior to restructuring the reimbursement rates, the district court concluded that the MAP plan violated the procedural requirements of the Boren Amendment.\(^{46}\) The district court also concluded that substantive violations existed in the MAP plan because the reimbursement rates were not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities," and they did not ade-

adjustment. First, DPW stated the adjustment was necessary, as part of the transition to a prospective payment plan, to ensure that payments did not exceed those reimbursed under the prior system. \(\text{Id.}\) Second, DPW noted that "shrinkage" commonly occurred between the initial unaudited cost figures submitted by hospitals under the retrospective payment plan and the final audited reimbursable cost figures. \(\text{Id.}\) DPW asserted that the budget neutrality adjustment was designed to replace the "shrinkage" concept under the prospective payment plan. \(\text{Id.}\) The district court rejected both justifications as "entirely budget driven." \(\text{Id.}\) The court noted that the normal "shrinkage" discrepancy under the retrospective plan rarely exceeded two percent and that the DPW had not performed any analysis of cost differences between the retrospective and prospective payment systems to support their justifications. \(\text{Id.}\)

In Temple University, the Third Circuit's dissatisfaction with the DPW's budget-driven reduction was similar to the Tenth Circuit's response to a nearly identical budget adjustment factor in Amisub (PSL), Inc. v. Colorado Department of Social Services, 879 F.2d 789 (10th Cir. 1989), \(\text{cert. denied, 110 S. Ct. 3212 (1990).}\) In Amisub, the Colorado Medicaid Plan included a final 46% reduction in provider reimbursement that the court characterized as having "no relation to the actual costs of hospital services." \(\text{Id. at 792.}\) The Amisub court rejected the budget reduction factor because even efficiently and economically operated hospitals could not recover actual costs under the plan. \(\text{Id.}\)

\(^{42}\) Temple University, 729 F. Supp. at 1098.


\(^{44}\) Temple University, 729 F. Supp. at 1099.

\(^{45}\) \(\text{Id.}\) The district court noted that according to Temple's calculations, the disproportionate share rate should have been at least 16%. \(\text{Id.}\) DPW's calculations, however, established a range of four to five percent. The DPW range was never implemented. \(\text{Id.}\)

\(^{46}\) \(\text{Id. at 1100.}\) The district court found that DPW did not perform studies "on such matters, for example, as the characteristics of an efficient and economical hospital operation, the impact of the proposed reimbursement rates upon hospitals' ability to survive, etc.—but merely certified that its plan complied with the statutory requirements." \(\text{Id.}\)
quately address Temple's disproportionate service to low-income patients.\textsuperscript{47} The district court's remedy included a declaratory judgment and injunction in favor of Temple that required DPW to bring the Pennsylvania MAP plan within the Boren Amendment requirements.\textsuperscript{48} The district court provided interim relief by altering the hospital group mix, decreasing the budget neutrality reduction percentage and increasing the disproportionate share percentage add-on to more adequately reflect Temple's costs.\textsuperscript{49}

The United States Court of Appeals for the Third Circuit affirmed the district court's ruling in an appeal that consolidated the challenges of over 140 hospitals to DPW's MAP plan.\textsuperscript{50} In its approval of the actions taken and the results reached by the district court, the Third Circuit affirmed the finding that both procedural and substantive violations of federal Medicaid law existed in the Pennsylvania MAP plan.\textsuperscript{51}

\textsuperscript{47} Temple Univ. v. White, 732 F. Supp. 1327, 1329 (E.D. Pa. 1990), aff'd, 941 F.2d 201 (3d Cir. 1991), cert. denied, 112 S. Ct. 873 (1992). Judge Fullam found that because a portion of the prior reimbursement came from the federal government's share of Medicaid, the Eleventh Amendment precluded the imposition of any retroactive relief to compensate Temple for its losses. \textit{Id.} at 1328.

In order to correct the most basic inadequacies in the MAP plan, Judge Fullam fashioned a reimbursement plan to be used until a revised MAP could be implemented by the state. \textit{Id.} The first remedial change altered the hospital mix in Group 1 to eliminate the most dissimilar hospitals, thereby making the group more homogenous. \textit{Id.} In addition, Judge Fullam decreased the budget neutrality reduction from 14\% to 2.4\% and increased the disproportionate share add-on from 2.5\% to not less than 10\%. \textit{Id.} at 1328-29. These changes increased Temple's base reimbursement rate from $2,695.51 to $3,643.09. \textit{Id.} Judge Fullam also declined to require that Temple post a security bond to guarantee repayment if the interim relief payment exceeded the ultimate reimbursement rates under the revised MAP plan. \textit{Id.} at 1329. The financial problems of Temple coupled with the ongoing relationship between Temple and DPW were the factors cited by Judge Fullam in refusing to require a bond posting. \textit{Id.}

\textsuperscript{50} Temple Univ. v. White, 941 F.2d 201, 295 (3d Cir. 1991), cert. denied, 112 S. Ct. 873 (1992). A number of other Pennsylvania hospitals had filed suits requesting relief similar to that requested by Temple. \textit{Id.} at 206. Following the district court ruling in \textit{Temple University}, similar orders were granted in these pending cases “for the reasons stated . . . in \textit{[Temple University]} (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features).” \textit{Id.} (quoting Albert Einstein Medical Ctr. v. White, 732 F. Supp. 1329, 1329 (E.D. Pa. 1990), aff'd, 941 F.2d 201 (3d Cir. 1991), cert. denied, 112 S. Ct. 873 (1992)).

During the appeal interval, Sacred Heart Hospital requested and was granted emergency relief in the form of a $2 million advance from DPW. \textit{Id.} For a discussion of Sacred Heart's need for emergency relief, see \textit{infra} notes 92-94 and accompanying text.

\textsuperscript{51} \textit{Temple University}, 941 F.2d at 220. The suits were brought by Temple and the other providers under 42 U.S.C. \textsection{} 1983 (1988), which provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any
B. Procedural Violation Issues

As previously stated, the procedural requirements of the Boren Amendment mandate that each state participating in the Medicaid program follow specific procedures when a revision of the state Medicaid plan is implemented.52 First, the state must perform a “findings” process to obtain adequate information to support the proposed revision of the reimbursement structure.53 Second, the state agency must provide “assurances” to the HCFA that all federal requirements have been met.54 As articulated by the Tenth Circuit in an influential holding, the plain language of the Boren Amendment requires, “at a minimum, ... ‘findings’ which identify and determine (1) efficiently and economically operated hospitals; (2) the costs that must be incurred by such hospitals; and (3) payment rates which are reasonable and adequate to meet rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. 42 U.S.C. § 1983 (1988). Suits brought under § 1983 for alleged violations of the Boren Amendment were frequently filed, but they were also frequently challenged by the state defendants as improper. See, e.g., West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 18 (3d Cir. 1989) (WVUH) (holding that federal Medicaid legislation gave hospitals private rights enforceable under § 1983 and congressional intent absent to preclude suit under § 1983), aff'd, 111 S. Ct. 1138 (1991); Amisub (PSL), Inc. v. Colorado Dep't of Social Servs., 879 F.2d 789, 793 (10th Cir. 1989) (Boren Amendment implies private right of action under § 1983), cert. denied, 495 U.S. 935 (1990); Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1295 (8th Cir. 1985) (same). The controversy over § 1983 challenges to the Boren Amendment focused on whether the Medicaid statutes created enforceable rights and whether health care providers, rather than Medicaid recipients, were the intended beneficiaries of such rights. WVUH, 885 F.2d at 17-22. The Supreme Court answered both questions affirmatively in Wilder v. Virginia Hospital Ass'n, 496 U.S. 498 (1991).

In *Wilder*, Virginia hospitals filed suit alleging that the state Medical Assistance Plan violated the procedural and substantive requirements of the Boren Amendment. *Id.* at 503. The Court held that the Boren Amendment created substantive rights that obliged states participating in Medicaid to adopt reasonable and adequate reimbursement rates. *Id.* at 509-10. The mandatory, rather than precatory, language of the Boren Amendment and the requirement of federal approval of state plans were seen as setting forth “a congressional command, which is wholly uncharacteristic of a mere suggestion or ‘nudge.’” *Id.* at 512 (quoting *WVUH*, 885 F.2d at 20 (quoting Pennhurst State Sch. and Hosp. v. Halderman, 451 U.S. 1, 19 (1981))). The *Wilder* Court reasoned that health care providers were the intended beneficiaries of such substantive rights, and therefore, they were able to enforce the rights through § 1983 challenges. *Id.* at 509-10. The Supreme Court also rejected the argument that Congress had foreclosed private enforcement of the Medicaid Act under § 1983 by providing for an administrative appeal process. *Id.* at 523. For analysis of the *Wilder* decision, see Cusenbary, Note, *supra* note 12.


53. *Amisub*, 879 F.2d at 796.

54. *Id.*; see 42 U.S.C. § 1396(a)(13)(A) (Boren Amendment). For the precise language of the Boren Amendment, see *supra* note 14.
the reasonable costs of the state's efficiently and economically operated hospitals.  

In *Temple University*, the Third Circuit applied the criteria established by the Tenth Circuit to the Pennsylvania MAP plan and determined that the plan violated the procedural requirements of the Boren Amendment. Pursuant to these criteria, the Third Circuit opined that DPW was required to make sufficient findings regarding issues such as reasonable rate setting, adequate disproportionate share adjustments and assurances of continued access to inpatient hospital care by Medicaid recipients. The Third Circuit emphasized DPW's failure to collect adequate information or to make sufficient findings. The court stated,
"[i]n the absence of essential data and information, DPW was in no position to make findings, and clearly did not do so. Any assurances DPW made to the Secretary were, therefore, without foundation." 59

The Third Circuit’s conclusion was in accord with other court opinions evaluating procedural challenges to Medicaid reimbursement plans. For example, in Missouri Health Care Ass’n v. Stangler, 60 a group of long-term care facilities challenged Missouri’s Medicaid reimbursement plan. The plaintiffs alleged that the state failed to make adequate findings prior to a revision of its reimbursement rates. 61 The Stangler court found that although the state made “legitimate and thorough” findings regarding the costs incurred by Medicaid facilities and the rates that would be reasonable and adequate to meet such costs, it failed to make the findings necessary to determine which facilities were efficiently and economically operated. 62 Accordingly, the Stangler court concluded that the state’s “findings” process was inadequate under the Boren Amendment. 63 Therefore, because the reasonableness of the reimbursement rate structure was suspect without adequate findings by the state, the Stangler court invalidated the reimbursement plan. 64

Court opinions that address Medicaid reimbursement plan issues reveal a trend that reflects a willingness to protect the right of health

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59. Id.
61. Id. at 1413-14.
62. Id. at 1415.
63. Id.
64. Id. at 1416; see also Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1313-15 (2d Cir. 1991) (holding that state decision to revise plan to increase reimbursement to nursing homes with high labor costs without making findings was without basis and was procedural violation of Boren Amendment); Amisub (PSL), Inc. v. Colorado Dep’t of Social Servs., 879 F.2d 789, 796-97 (10th Cir. 1989) (noting that state relied on findings made ten years prior to reimbursement rate revision, violating annual findings requirement), cert. denied, 495 U.S. 935 (1990); Multicare Medical Ctr. v. Washington, 768 F. Supp. 1349, 1391 (W.D. Wash. 1991) (“Mere recitation of the wording of the federal statute is insufficient for procedural compliance. The State must engage in a bona fide finding process before it submits its assurances to HCFA.”) (quoting Amisub, 879 F.2d at 797); Michigan Hosp. Ass’n v. Babcock, 736 F. Supp. 759, 763 (W.D. Mich. 1990) (showing that under state reimbursement plan no Michigan hospital received complete cost reimbursement established lack of findings to identify efficiently and economically operated facilities). But cf. Folden v. Washington State Dep’t of Social & Health Servs., 744 F. Supp. 1507, 1534 (W.D. Wash. 1990) (indicating Washington made proper findings prior to giving assurances to HCFA, and did not just “parrot the regulations”).
care providers to receive reasonable reimbursement for services to Medicaid patients. In its Temple University decision, the Third Circuit followed this trend by invalidating the state reimbursement plan and providing interim relief to the plaintiff hospitals during the period of the reimbursement plan's revision.

C. Substantive Violation Issues

The major substantive focus of the Boren Amendment is the requirement that each Medicaid-participating state utilize its findings to set reimbursement rates that are "reasonable and adequate to meet the costs . . . [of] efficiently and economically operated facilities." After affirming the presence of significant procedural violations in the Pennsylvania MAP plan, the Temple University court briefly discussed the substantive inadequacies of the plan. The discussion was brief because, as the Third Circuit noted, it had previously established and extensively discussed the substantive Boren Amendment requirements that the Pennsylvania MAP plan must meet in West Virginia University Hospitals, Inc. v. Casey (WVUH).

In WVUH, a West Virginia hospital that provided a significant amount of health care to Pennsylvania Medicaid recipients challenged the same DPW MAP plan that was challenged in Temple University. The

65. See Pinnacle Nursing Home, 928 F.2d at 1310 ("The flexibility given the States [ , however, was] not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care." (quoting S. REP. No. 139, 97th Cong., 1st Sess. 478 (1981), reprinted in 1981 U.S.C.C.A.N. 396, 744)). The various remedies imposed, however, also reflect a willingness of courts to support the congressional goal of passing greater control and flexibility to the states in the area of Medicaid reimbursement planning. For a discussion of the congressional intent behind the passage of the Boren Amendment, see supra notes 14-15. Such remedies alter or restrict the state reimbursement plans rather than require a total invalidation and mandatory use of a court imposed plan. For a discussion of the remedies imposed by other courts, see infra notes 81-83 and accompanying text.


The Supreme Court noted in Wilder v. Virginia Hospital Ass'n that the courts of appeals generally agree that once the procedural requirements of the Boren Amendment are met, the federal courts employ a deferential standard of review. Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 520 n.18 (1990). The Court declined to express an opinion as to the appropriateness of that standard of review. Id.


69. Id. at 14-15. West Virginia University Hospital (WVUH) is located six miles south of the Pennsylvania-West Virginia border and serves as the tertiary referral center for many Pennsylvania Medicaid recipients. Id. at 14. The Third Circuit noted that "[f]or the years 1984 to 1987, WVUH gave inpatient hospital care to more Pennsylvania Medicaid patients than did over one-half of the hospitals located in Pennsylvania." Id.
MAP plan created even greater hardships for the hospital involved in \textit{WVUH}, however, because the plan treated out-of-state hospitals differently than it treated Pennsylvania hospitals.\textsuperscript{70} For example, instead of placing each out-of-state hospital into a "similarly situated group" as was done with Pennsylvania hospitals, DPW grouped all out-of-state hospitals together and reimbursed them at the level of average payments made to Pennsylvania hospitals.\textsuperscript{71} In addition, under the MAP plan at issue in \textit{WVUH}, DPW elected not to reimburse out-of-state hospitals for any direct medical education expenses and paid a much lower capital cost reimbursement rate to out-of-state hospitals.\textsuperscript{72}

In \textit{WVUH}, the Third Circuit identified three substantive requirements of the Boren Amendment that the Pennsylvania MAP plan had to meet:

- The first requirement . . . mandates that a state's reimbursement rates take into account the situations of those hospitals serving a disproportionate number of low income patients.
- The second and third requirements . . . require a state to find that its rates are reasonable and adequate to meet the necessary costs of an efficiently operated hospital and to assure medicaid patients of reasonable access to inpatient hospital care.\textsuperscript{73}

Using these criteria, the Third Circuit in \textit{WVUH} concluded that:

- 1) the MAP plan did not adequately address or reimburse for \textit{WVUH}'s status as a disproportionate share provider;\textsuperscript{74}
- 2) the MAP plan could potentially interfere with Medicaid recipients' reasonable access to quality health care;\textsuperscript{75}
- 3) the MAP plan failed to provide rates that were

\textsuperscript{70} \textit{Id.} at 16.

\textsuperscript{71} \textit{Id.} The grouping of all out-of-state providers together for reimbursement rate purposes had a disparate impact on \textit{WVUH} because the hospital was a tertiary referral center with higher costs than primary or secondary hospitals, and because \textit{WVUH} was the largest out-of-state provider of medical services to Pennsylvania Medicaid patients. \textit{Id.} at 14-15. The result of the DPW MAP reimbursement plan was that the average in-state Pennsylvania hospital was reimbursed approximately 95\% of its actual costs for treating Medicaid patients, while \textit{WVUH} recouped only 54\% of its actual costs. \textit{Id.} at 25.

\textsuperscript{72} \textit{Id.} at 16-17. Given \textit{WVUH}'s status as a large tertiary hospital with medical residency programs, these decisions adversely affected the reimbursement rate received by \textit{WVUH}. \textit{Id.} at 28. For a discussion of the factors considered during the development of the Pennsylvania MAP plan, see \textit{supra} notes 34-36 and accompanying text.

\textsuperscript{73} \textit{WVUH}, 885 F.2d at 22.

\textsuperscript{74} \textit{Id.} at 24-25. The \textit{WVUH} court noted that DPW made no attempt to study or make findings concerning the effect of the MAP disproportionate share element on out-of-state providers. \textit{Id.} at 24. Because 38\% of \textit{WVUH}'s patient mix was low-income patients (although only 5\% of \textit{WVUH}'s admissions were Pennsylvania Medicaid recipients), the Pennsylvania MAP plan violated the federal requirement that such disproportionate share providers be reimbursed for this excess load. \textit{Id.} at 24-25.

\textsuperscript{75} \textit{Id.} at 25. The Third Circuit evaluated the district court's findings that
In Temple University, the Third Circuit focused on the procedural violations inherent in the MAP plan. Consequently, it did not address in detail the alleged substantive violations. The Third Circuit did hold, however, that without findings to provide adequate (or even any) information regarding the substantive concerns, as identified in WVUH, the MAP plan must fail.

D. Interim Injunctive Relief Issues

Generally, once a successful procedural and/or substantive challenge of a state Medicaid reimbursement plan is found, a court may institute a variety of available remedies. These remedies include an order requiring a state to reformulate its reimbursement plan, an injunction preventing a state from applying a deficient reimbursement plan for one fiscal year, and an injunction preventing a state from applying an arbitrary across-the-board budgetary reduction. In Temple University, the relief that the district court afforded the plaintiffs was continued reimbursement under the MAP plan at issue could increase the likelihood that WVUH would withdraw from the Pennsylvania Medicaid plan. Such a withdrawal could require Pennsylvania Medicaid recipients to travel as much as 70 miles for tertiary hospital care. The Third Circuit, however, stopped short of invalidating the Pennsylvania MAP plan on this basis because the record did not contain clear evidence that WVUH seriously considered withdrawal from the Pennsylvania Medicaid program.

76. Id. at 26, 29. The WVUH court decided that the dual reimbursement scheme allowed WVUH to be reimbursed at a significantly lower rate despite similarities between WVUH and tertiary teaching hospitals within Pennsylvania. Such disparity was found to be outside the "zone of reasonableness." The court rejected as inadequate rationales such as Pennsylvania's preference for its own hospitals and the increased administrative burden associated with transacting with an out-of-state provider.

77. For a discussion of the portion of the Temple University opinion that focused on the procedural violations of the Boren Amendment, see supra notes 52-66 and accompanying text.


79. Id. The Third Circuit noted that DPW insisted that proper findings had been made, but no specific findings were entered into the record to support this contention despite repeated questioning by the court. Id. at 211 n.12.

80. For a discussion of these various remedies, see Leonard Weiser-Varon, Injunctive Relief from State Violations of Federal Funding Conditions, 82 COLUM. L. REV. 1236 (1982).

81. See, e.g., West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 35 (3d Cir. 1989), aff'd, 111 S. Ct. 1138 (1991). The Third Circuit gave the Pennsylvania DPW 90 days to reformulate its MAP plan to provide reimbursement to WVUH that conformed with federal law. Id.

82. See, e.g., Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1294 (8th Cir. 1985).

more sweeping than any of these alternatives because the district court ordered that specific interim changes be made to the MAP plan to increase the reimbursement rates provided to the plaintiffs.  

On appeal, DPW challenged the relief granted on a number of grounds. First, DPW argued that the district court erred in extending the specific findings of the Temple University suit to other hospitals which had brought similar but separate actions. The Third Circuit, however, concluded that this argument was meritless under the doctrine of collateral estoppel. In so holding, the court noted that “the issues raised by the hospitals in their related cases were raised, actually litigated, and decided against DPW in the Temple case[...].”  

Second, DPW argued that the interim relief granted by the district court was an invalid preliminary injunction because the district court failed to find that irreparable harm had occurred. The Third Circuit disagreed with DPW’s characterization of the interim relief and instead, identified the interim relief granted as a permanent injunction. This characterization by the Third Circuit, however, failed to resolve the issue of whether the district court was required to find that irreparable harm existed in order to grant a permanent injunction. Courts hold conflicting opinions regarding whether a plaintiff must establish the

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85. See Temple University, 941 F.2d at 212. The multiple actions were consolidated into one appeal before the Third Circuit. Id. at 205.

86. Id. at 212. Under the doctrine of collateral estoppel, the plaintiffs were required to prove:

1. The issue decided in the prior adjudication was identical with the one presented in the later action;
2. There was a final judgment on the merits;
3. The party against whom the plea is asserted was a party or in privity with a party to the prior adjudication; and
4. The party against whom it is asserted has had a full and fair opportunity to litigate the issue in question in the prior action.

Id. (quoting Gregory v. Chehi, 843 F.2d 111, 121 (3d Cir. 1988)).

87. Id.

88. Id. at 213. In characterizing the interim relief as a preliminary injunction, DPW averred that irreparable harm must be shown. Id. Prior to granting a request for a preliminary injunction, the trial court must find:

1. The likelihood that the applicant will prevail on the merits at final hearing; (2) the extent to which the plaintiffs are being irreparably harmed by the conduct complained of; (3) the extent to which the defendants will suffer irreparable harm if the preliminary injunction is issued; and (4) the public interest.


89. Temple University, 941 F.2d at 213.

90. Id.
presence of irreparable harm in order to obtain a permanent injunction. 91 The Third Circuit declined to address the issue because it found that evidence of irreparable harm was present throughout the record. 92 Therefore, the Third Circuit upheld the injunctive relief fashioned by the district court. 93

Another district court order contained within the consolidated appeals before the Temple University court required DPW to make a two million dollar advance payment to Sacred Heart Hospital in order for the hospital to stave off insolvency. 94 DPW argued that irreparable harm was not adequately shown to exist and that Sacred Heart’s insolvency was not related to DPW’s MAP plan. 95 In rejecting DPW’s argument, the Third Circuit upheld the relief, concluding that the district court’s ruling was not clearly erroneous and that the district court did

91. Compare Natural Resources Defense Council, Inc. v. Texaco Ref. & Mktg., Inc., 906 F.2d 934, 938 (3d Cir. 1990) (noting that it had “repeatedly held that the basis for injunctive relief in the federal courts has always been irreparable injury and the inadequacy of legal remedies” (quoting Weinberger v. Romero-Barcelo, 456 U.S. 305, 312 (1982))) with Roe v. Operation Rescue, 919 F.2d 857, 867 n.8 (3d Cir. 1990) (noting that three prerequisites for permanent injunctive relief include showing that balance of equities tips in favor of injunctive relief, but does not include identifying need for irreparable harm) and Ciba-Geigy Corp. v. Bolar Pharmaceutical Co., 747 F.2d 844, 850 (3d Cir. 1984) (noting that once party succeeds on federal claims, permanent injunction is upheld “so long as the balance of equities favors injunctive relief”), cert. denied, 471 U.S. 1137 (1985).

92. Temple University, 941 F.2d at 213-14. Irreparable harm was present because, without a working MAP plan (invalidated by the district court), Medicaid reimbursement would not be given to hospital-providers until the completion of a revised plan. Id. at 214. The Third Circuit also noted that the other elements required to obtain permanent injunctive relief were present. Id. at 215. First, Temple was successful on the merits of its claim. Id. Second, because of Eleventh Amendment restrictions on retroactive relief, only an equitable remedy was available. Id. For a discussion of the Eleventh Amendment issue, see supra note 49.

93. Temple University, 941 F.2d at 215, 220. The Third Circuit was “satisfied that the district court had inherent discretion to fashion a remedy in aid of, and in implementation of, its own judgment which required DPW to formulate a new MAP.” Id. at 215. The district court’s discretion in such a setting is to affirmatively correct the conditions present by “balancing the individual and collective interests.” Id.; see Swann v. Charlotte-Mecklenburg Bd. of Educ., 402 U.S. 1, 15-16 (1971); Resident Advisory Bd. v. Rizzo, 564 F.2d 126, 145 (3d Cir. 1977), cert. denied, 435 U.S. 908 (1978).

94. Temple University, 941 F.2d at 216. The payment was an advance against future medical assistance payments. Id. The district court determined that the DPW MAP plan substantially contributed to Sacred Heart’s potential financial collapse. Id. at 218. The decision was based on the “underpayment of Medicaid rates to Sacred Heart in past years; DPW’s failure to promulgate a new MAP providing for a higher payment rate; and the need ‘to make some appropriate adjustment for the interim period . . . which will prevent the insolvency [sic] or a bankruptcy of Sacred Heart Medical Center at least in that interim period.’ ” Id. (quoting Appendix at 154, Temple University (No. 90-1661)).

95. Id. at 217.
not abuse its discretion in issuing the injunctive relief.\(^{96}\)

**III. Conclusion**

In *Temple University*, the Third Circuit joined other courts of appeals in upholding the right of health care providers to insist that state Medicaid reimbursement plans provide “reasonable and adequate” rates to cover the costs of “efficiently and economically” operated health care facilities.\(^{97}\) Decisions such as *Temple University* guarantee that the procedural and substantive requirements Congress established in the Boren Amendment will be followed.\(^{98}\) These courts require states to affirmatively make detailed findings prior to the implementation of their revised Medicaid reimbursement plans because they find that “[m]ere recitation of the wording of the federal statute is not sufficient.”\(^{99}\) In fact, the Third Circuit went further than previous courts by upholding a remedy fashioned by the district court which affirmatively altered the state Medicaid reimbursement plan until the court-mandated revision would become operational.\(^{100}\)

Currently, a high level of interest in the topic of health care financing exists. Decisions such as *Temple University* reveal a judicial willingness to intervene when governmental reimbursement to health care providers delivering services to Medicaid recipients is inadequate. In Pennsylvania, the Third Circuit’s complete affirmation of the district court order has led to improved reimbursement to those hospitals that provide necessary health care treatment to the indigent and medically needy. How judicial opinions like *Temple University* will co-exist with the current political plans to decrease the federal and state support of Medicare and Medicaid programs is an open question.\(^{101}\) The reality that

\(^{96}\) *Id.* at 218-19. The Third Circuit stated that “[f]rom any standpoint, and particularly considering the fact that no legal remedy was either adequate or available, we conclude that the district court’s injunctive order was well within its broad discretionary power.” *Id.*

The Third Circuit also affirmed the district court’s decision to order this advance payment without requiring Sacred Heart to post a bond pursuant to Federal Rule of Civil Procedure 65(c). *Id.* Relying on Crowley v. Local No. 82, Furniture & Piano Moving, 679 F.2d 978 (1st Cir. 1982), rev’d on other grounds, 467 U.S. 526 (1984), the *Temple University* court held that the ongoing relationship between Sacred Heart and DPW, as well as the dire financial straits of Sacred Heart, were sufficient to waive the bond requirement. *Temple University*, 941 F.2d at 219-20.


\(^{98}\) For a discussion of the procedural and substantive requirements of the Boren Amendment, see supra notes 16-20 and accompanying text.

\(^{99}\) Amisub (PSL), Inc. v. Colorado Dep’t of Social Servs., 879 F.2d 789, 797 (10th Cir. 1989), cert. denied, 496 U.S. 935 (1990).

\(^{100}\) For a discussion of the district court remedy, see supra notes 48-49 and accompanying text.

\(^{101}\) See Russell E. Eshleman, Jr. & Robert Zausner, *Casey Plan Cuts Funds for Welfare, Education*, PHILA. INQUIRER, Feb. 6, 1992, at A1, A18 (calling for cuts in
there are limited dollars for health care may hinder the ability of states
to provide adequate reimbursement. Therefore, despite the presence of
judicial support in decisions such as Temple University, Pennsylvania hos-
pitals may still find it difficult to obtain adequate reimbursement for the
care of Medicaid recipients.

Mary J. Mullany

state medical assistance plan and describing plan as "the uncontrolled, runaway
locomotive that is driving most state budgets"); Michael Wines, Bush Unveils Plan
for Health Care, N.Y. Times, Feb. 7, 1992, at A1 (commenting that proposed plan
to improve overall national access to health care could be financed, in part, by
limiting growth of Medicare and Medicaid).