Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions under the Boren Amendment

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Because of the active role assumed by the courts in Medicaid nursing facility reimbursement, and because that role changed over time, federal intervention in this area provides a useful window through which to examine the role of the federal judiciary in oversight of state health policy making. Findings support the proposition that because judicial influence extends beyond program outcomes to include the organizational structure and beliefs of key stakeholder groups, the effects of case decisions, and the statutes under which they are litigation, may be deeper and longer lasting than their usefulness as a litigation tool. Findings also support the proposition that neither the executive nor the judiciary acts in isolation but instead they serve as tandem institutions guiding federal oversight of state policy making. Data for this analysis derive from archival documents, secondary sources, and 101 in-depth interviews.

The role of the courts in shaping federal regulation of state policy decisions in the health sector is especially important for understanding the course of health policy in the United States. This is because, while federal statutes and regulations establish the broad parameters within which programs such as Medicaid operate, federal administrative review and judicial oversight ultimately determine whether particular policy actions fall within the scope of federal guidelines. But despite the importance of the courts, relatively few consider the relationship between the judiciary and federal regulation of state health policy decisions. In contrast, most discussions of federalism in health policy focus on the role of Congress and the federal bureaucracy in overseeing states’ policy-making choices. This is reflected in descriptions of the federal system (Thompson 2001; Sparer 2003) and proposals for its reform (Marmor, Mashaw, and Oberlander 1996; Holahan, Weil, and Wiener 2003), in addition to studies that systematically evaluate the effects of federal influence relative to other policy-making determinants (Gamkhar and Sim 2001;
Gormley and Boccuti 2001). Thus, outside of discussions of Supreme Court decisions and their implications for the relative balance of power between state and federal officials (Wise and O’Leary 1992; Gostin 2000), the role of judiciary in federal oversight of state policy decisions in the health sector remains little examined.

One area, where the courts have played a significant role in federal oversight of state policy making is Medicaid nursing facility reimbursement. Perhaps this is best reflected in the Boren Amendment1 [Section 962 of the Omnibus Reconciliation Act (OBRA) of 1980; Public Law 96–499], which between its passage in 1980 and its repeal in 1997, represented the federal government’s main foray into regulating Medicaid payment levels for nursing homes and other institutional providers. Congress enacted Boren to replace more stringent Medicaid reimbursement policy standards with less stringent requirements that states find and make assurances to the Department of Health and Human Services (DHHS) that payments were “reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.” Over the years, and culminating with its repeal with the Balanced Budget Act of 1997, there were a number of legislative and regulatory changes to Boren, including requirements in the Omnibus Budget Reconciliation Act of 1987 that states account for the cost of nursing home quality reform, also promulgated by that Act, when establishing reimbursement. Numerous providers also challenged state rate setting procedures in the courts, including a 1990 Supreme Court decision, *Wilder v. the Virginia Hospital Association* (VHA),2 which found that providers had enforceable rights to invoke judicial oversight of state policy making in this area.

Because of the way it was interpreted by the judiciary, the Boren Amendment contributed to wider discussion regarding the proper balance of power between the national and state governments and whether greater responsibility for Medicaid program functions should be devolved to the states. Indeed, what makes the Boren Amendment unique is its transformation. Although Boren began as a measure favored by state officials who desired greater control over provider payments, it ended as a measure opposed by those who decried unwarranted judicial interference in state policy making. Health care providers were initially wary of Boren because it downgraded federal administrative review of state Medicaid program changes but later grew to support it because it enabled them to challenge state rates and rate setting methods in the courts. Thus, while the Boren Amendment was enacted as a way to enhance state discretion, the way it was implemented served to constrict state flexibility by transferring federal oversight from the executive to the judiciary.

Although Congress ultimately sought to enhance state discretion once again by replacing the Boren Amendment with simple requirements that states provide public notice of proposed rate changes, the rate of litigation had already declined
considerably by the time the Amendment was repealed. In all, there were at least 84
nursing facility lawsuits in 34 states under Boren, with the pace of litigation
increasing from an average of 3.2–9.3 cases decided per year between 1981–1990
despite the sharp decline in the number of cases brought by providers, and even
greater success among states in the cases that were brought, state officials remained
firmly opposed to the Boren Amendment in the years immediately preceding
the repeal (National Governors’ Association 1997, 2). In contrast, nursing home
industry representatives remained firmly supportive of the Amendment (American
Health Care Association 1996, 12), even though the courts increasingly ruled
against their Boren Amendment claims and improving economic conditions led to
fewer reductions in the levels of reimbursement.

This article presents a case study that explores the changing role of the courts in
federal regulation of Medicaid nursing facility reimbursement at the state level.
It applies the concept of policy legacies to better understand the ways in which
judicial intervention under federal law influenced key stakeholder groups, thereby
explaining persistence in state and provider beliefs regarding Boren’s efficacy
despite prevailing evidence to the contrary. It also applies the concept of tandem
institutions developed by Mark A. Peterson (1990) to better understand the
interactive relationship between federal administrative review and the courts in
federal oversight of state policy making in this and other areas. I begin by drawing
on the concepts of policy legacies and tandem institutions to develop the two
major propositions examined. This is followed by description of my data, which
include archival documents, secondary sources, and in-depth interviews with 101
national- and state-level experts. Subsequently, I present my case study, which
examines the history of federal intervention in Medicaid nursing facility reim-
bursement, starting with the inception of the Medicaid program through the
passage the Boren Amendment and its repeal. I conclude by discussing the impli-
cations of my findings, both for the topic area studied and for understanding the
judicial role in federal oversight of state policy making more generally.

Policy Legacies and Tandem Institutions

The policy legacy framework highlights why policy developments in one era may
significantly impact future conditions, perceptions, and policy alternatives in
subsequent eras (Oliver 2004, 335). Paul Pierson (1993) observes that public
policies have both interpretive effects and resource/incentive effects. Whereas the
former focuses on the cognitive consequences of public policies in creating
preexisting mental frames through which social actors interpret the world, the latter
focuses on the structural consequences of public policies that result from altering
resources and incentives in the political environment. What Pierson (2000, 259)
recognizes is that “public policies may encourage individuals and organizations to invest in specialized skills, deepen relationships with other individuals and organizations, and develop particular political and social identities.” “Once established,” Pierson (2000, 260) argues, “basic outlooks on politics, ranging from ideologies to understandings of particular aspects of government or orientations toward political groups or parties are generally tenacious.” This is because “actors who operate in a social context of high complexity and opacity are heavily biased in the way they filter information into existing ‘mental maps.’” Confirming information tends to be incorporated, and disconfirming information is filtered out (Pierson 2000, 260). Since public policies embed historical experience into organizational structures and beliefs that are difficult to change, their influence often persists beyond the historical circumstances within which they were adopted and implemented, resulting in lags in adjustment by political actors to changing conditions (March and Olsen 1989, 167). Applying these insights to courts, Proposition 1 states:

Judicial influence under federal law should extend beyond program outcomes to include the organizational structure and beliefs of key stakeholder groups, and as such, the effects of court decisions and the statutes under which they were litigated may be deeper and longer lasting than their usefulness as a litigation tool.

In the present context, this translates into the expectation that judicial influence extended beyond Medicaid reimbursement levels to include the procedures and beliefs of state officials and providers, thereby contributing to persistence in their respective positions regarding the Boren Amendment’s efficacy despite prevailing evidence to the contrary.

The senior–junior partner model in intergovernmental relations presumes the dominance of one set of institutions relative another, whether it be the federal government in relation to the states or federal administrative review in relation to the courts. According to Robert F. Rich and William D. White (1996, 3–4), the senior–junior partner model presumes an intergovernmental system in which the “federal government can exercise dominance whenever it chooses and set policy at will, either assuming complete responsibility for policy areas or delegating selected administrative and fiscal responsibilities to the states as weak junior partners, while retaining full control over setting policy.” However, contrary to the myth that federal control is constant and all embracing, state and local governments continually help to shape national policies, often resulting in programs that minimize federal influence and maximize state and local flexibility (Anton 1997, 695–696). Indeed, understanding intergovernmental relations requires recognizing that federal-state relations “proceeds in the context of a muddled intergovernmental division of labor, in which federal, state, and local governments generally
share [responsibility], and a fragmented political system in which multiple groups of providers, employers, insurers, advocates, and others vie for influence and power” (Sparer 2003, 245–246). “This American brand of pluralism,” according to Nathan (2006b, 5), “with multiple points of access and maneuver, both horizontally and vertically, has produced cycles of activism alternating between the national government and the states, depending on the conditions and values in the society.” Whereas the role of state governments as a source of innovation and spending tends to be enhanced when conservative coalitions control the national government, the role of the federal government tends to be enhanced during more liberal periods (Nathan 2006a, 2006b). The overall effect is an opportunistic federalism characterized by the oscillation of national and state action.

Just as the intergovernmental system cannot be understood with reference to only one set of institutions—federal oversight of state policy making must recognize multiple actors. Because there is often difficulty in defining the particular tasks that constitute government intervention, and because there is frequently ambiguity or conflict in the goals that policymakers hope to achieve, William M. Sage (2003, 388–389) suggests that comparisons of litigation with regulation are invariably indeterminate and that interaction between the two takes on greater significance in understanding the federal regulatory system than the analysis of either in isolation. Rather than comparing the judiciary with other institutions for purposes of proving that one is a more dominate policymaker or regulator than the other, therefore, Proposition 2 states:

Neither federal administration nor the judiciary acts in isolation but instead serve as tandem institutions guiding federal oversight of state policy making. By drawing on the tandem institutions perspective, I highlight the many reciprocal, interdependent, and often cumulative impacts of federal administrative review and the courts, a perspective often neglected in examinations of federal–state relations in the health sector and other areas.

Methods

Because I desired to illustrate, (i) the multiple ways in which judicial oversight influences the perceptions, strategies, procedures, and routines of key stakeholders, and (ii) the interrelationships among the courts, federal administrative apparatus, key stakeholders, and socioeconomic and political factors over time, I undertook an in-depth case study of intergovernmental relations in the Medicaid nursing facility reimbursement area. In performing my analyses, I relied on grounded theory techniques, which involve the systematic discovery of theory from data, with the aim of producing insights that “fit or work” because they were derived from in-depth knowledge of the context at hand (Glaser and Strauss 1967). I culled data
from a variety of sources, including archival documents, secondary analyses, and in-depth interviews. Archival resources derive from materials generated by the federal government and other sources. Interview data derive from conversations with national- and state-level experts in Medicaid nursing facility reimbursement. At the national level, I interviewed representatives from the major consumer groups, nursing home associations, and intergovernmental lobbies. I also interviewed federal bureaucrats at the Health Care Financing Administration (HCFA) (now the Centers for Medicare and Medicaid Services or CMS) who were either currently or formally responsible for regulating state activity in this area, in addition to policy experts, consultants, and attorneys also working in the field. At the state-level, I interviewed at least one Medicaid agency official and industry representative in each state studied. In choosing subjects, I relied on a combination of purposive and snowball sampling. Initially, I based my choices on my own knowledge regarding which people would best inform my study. Later, however, I based my choices on information provided by my respondents, both in terms of the individuals and states that might provide fruitful information.

Interviews were completed between September 9, 2000 and March 1, 2001 either in person \((n=21)\) or over the telephone \((n=80)\). In all, 101 individuals were recruited, including thirty-four national policy experts and seventy-seven state policy experts. National-level experts included ten federal bureaucrats, sixteen lobbyists, consultants, and attorneys working for the states or nursing home industry, five policy researchers, a patient advocate, a former congressional aide, and a former senator. State-level interviews included thirty-three Medicaid officials, twenty-eight industry representatives, and six elder advocates. Twenty-eight states are represented. Analysis of interviews involved coding, which was conducted using QSR NUD*IST 5.0, a widely used program for qualitative study.

Interviews were semi-structured, providing information on subjects’ perceptions regarding policy adoption in the Medicaid nursing facility reimbursement area. To the degree that the perceptions of subjects, who represented a variety of different roles and locations, converged, the more likely that those perceptions provided a reasonably accurate portrayal of the policy process being studied. With national-level subjects, I focused primarily on gathering information on federal regulation from before the Boren Amendment through its passage and repeal. The particular emphasis varied, however. With bureaucrats, for example, my interviews tended to focus on the regulatory process, while with attorneys they tended to focus on litigation issues. State-level interviews generally followed a different path. I would usually begin by asking subjects to describe the details of their current reimbursement systems and to list any significant changes in rates and methodologies during their tenures. If, as was usually the case, multiple examples of change were provided, I would take each example one at a time and explore why it occurred and what its impact may have been, including what role, if any,
the Boren Amendment may have played in the strategies, procedures, routines, and beliefs of states officials and industry representatives and the organizations within which they worked.

The Boren Amendment

Federal nursing facility reimbursement standards passed from the “reasonably cost-related” principles of the pre-Boren era (1978–1980) to Boren’s “economically and efficiently operating principles” (1980–1997) to public notice requirements left in the wake of Boren’s repeal (1997–Present). Each era represented a successive reduction in the requirements necessary to receive federal administrative approval of state methodologies for reimbursing nursing homes. The following examines each subsequent era with an eye toward understanding how judicial oversight under federal law influenced the behavior and beliefs of state officials and industry representatives, as well as the relationship between the judiciary and federal administrative intervention during the time period studied.

The Pre-Boren Years: “Reasonably cost-related”

There was very limited federal administrative review during the early years of the Medicaid program. Consequently, states had enormous discretion in setting nursing facility payment rates, and many states used this flexibility to develop rates solely on the basis of budgetary considerations, and to reimburse facilities with little, if any attention to nursing homes’ actual costs (Bovbjerg and Holahan 1982, 46). Concerned with seemingly arbitrary rate setting practices, however, Congress enacted Section 249 of the Social Security Amendments of 1972 (Public Law 92-603), which required that states pay nursing homes on a reasonable cost-related basis. Unlike previous standards, Section 249 involved intensive federal review of state Medicaid plans by the DHHS. Not only did states have to submit detailed explanations with their proposed methods for reimbursement, but DHHS also conducted independent analyses to ensure that what had been submitted complied with federal standards.

The Boren Years: “Economically and Efficiently Operating”

Whereas Section 249 ushered in an era of intensive DHHS review of state Medicaid plans, the Boren Amendment led to federal administrative disengagement from this area. Boren was enacted, in part, due to criticisms of burdensome federal oversight under Section 249 and rising state Medicaid nursing home spending under cost-based retrospective reimbursement (which facilitated federal review if adopted) (Senate Finance Committee 1980, 44). The Boren Amendment replaced 249’s reasonable cost-related standards with the requirement that state rates be “reasonable and adequate to meet the costs which must be incurred by efficiently
 Congress enacted Boren to grant states flexibility to adopt less inflationary approaches to reimbursing nursing homes and other institutional providers (Senate Finance Committee 1980, 45), a sentiment also reflected in Boren’s implementing regulations (DHHS 1983, 56,047). Rather than conducting their own analyses to ensure state compliance with federal standards, as had been done previously, HCFA neither received nor examined states’ findings or the background data on which they were based. The agency simply based approval on state assurances that such findings had been made, thereby making it easier for states to adopt more restrictive reimbursement systems in the years immediately following Boren’s enactment (Bovbjerg and Holahan 1982, 45). HCFA also declined to define key statutory phrases such as “reasonable and adequate payments” and “efficiently and economically operating” and did not require states to come up with their own definitions (Anderson and Scanlon 1993, 90; DHHS 1983, 56,050). Finally, states could implement proposed changes prior to receiving federal approval.

Though rate setting flexibility provided by Boren helped stem growth in nursing home spending during the 1980s (Congressional Research Service 1993, 857), state officials expressed frustration with uncertainty deriving from a lack of federal administrative guidance. Part of this stemmed from HCFA’s laissez faire implementation of Boren’s provisions. Part of it stemmed from the vagaries of judicial involvement, which ultimately served to fill the gap left by the lack of federal administrative oversight.

Enter the Judiciary
Given limited federal review of state compliance with the Medicaid Act’s payment requirements, providers increasingly filed lawsuits claiming that states did not meet the rate setting standards set forth in the Boren Amendment, which, over time, gradually shifted the locus of federal oversight from DHHS to the courts (Harkins 2002, 178). Though nursing homes had sued states under Boren since the early-1980s, the pace of litigation picked up considerably after the Supreme Court’s 1990 decision in Wilder v. the Virginia Hospital Association (VHA), which in a 5- to 4-vote, ruled in favor of providers, thereby settling a long standing dispute as to whether providers could use Boren to sue state governments in federal court under Section 1983 of the Civil Rights Act of 1871. This landmark decision was especially timely for nursing homes that had become progressively more concerned with states’ reimbursement policy choices in light of serious recession and subsequent state budget trimming, increasing costs of nursing facility staff, higher patient acuity (after 1983, resulting, in part, from shorter hospital stays spurred by
Medicare’s prospective payment system for hospitals), and the costs of meeting new quality standards adopted with OBRA 1987 (Manard 1997, 12).

In the four years after *Wilder*, the courts decided at least thirty-seven cases challenging nursing facility reimbursement rates under Medicaid compared to thirty-two in the previous ten years (Miller 2006b). In many cases, courts held state Medicaid plans invalid and ordered states to revise their plans to demonstrate compliance. Whereas providers prevailed in thirty-two of the eighty-four Boren Amendment cases brought by nursing homes (38 percent), states prevailed in thirty-nine cases (47 percent). Furthermore, both parties prevailed in various aspects of eleven cases (13.1 percent) and neither in two (2 percent) (Miller 2006b). Although nursing homes and states prevailed in a similar percentage cases in the four years following *Wilder* (43 and 46 percent, respectively) as in the ten years preceding *Wilder* (41 and 44 percent), there were significantly more cases decided per year (nine versus three, on average). There was also a higher percentage of cases brought by associations (51 versus 38 percent), which were much more likely to devote the resources necessary for making global challenges to basic reimbursement system characteristics affecting the industry as a whole (e.g., inflation factors, caps on allowable costs). This is in contrast to the pre-*Wilder* era where more challenges were initiated by individual facilities seeking redress from specific reimbursement characteristic affecting their own particular interests and not those of the entire industry. Not surprisingly, officials in a number of states felt increasing pressure to raise payment rates in *Wilder’s* wake (Holahan et al. 1993, 32).

**Promulgating Judicial Principles**

Following *Wilder* and other decisions, the judiciary articulated several principles when adjudicating Boren’s substantive and procedural claims. However, the courts’ substantive principles were especially difficult to meet and providers often found it difficult to sustain Boren Amendment challenges in this area. Particularly problematic were, (i) proving that there were aggregate, statewide shortfalls rather than shortfalls for any particular home, (ii) demonstrating that rates did not fall within a range or “zone of reasonableness,” as opposed to meeting precise requirements for reimbursement, and (iii) overcoming the deferential standard of review frequently applied to the actions of state rate setting agencies. In contrast, providers normally found it easier to sustain procedural challenges because states often ignored or misinterpreted Boren’s procedural requirements, or resorted to “best case” or results-driven analyses when validating their rates (Dozier and Smith 1997, 13–15). Thus, whereas nursing homes prevailed in just 24 percent of forty-two substantive cases, they prevailed in 52 percent of fifty-six cases challenging state procedures in this area (Miller 2006b).

Particular procedural principles developed through the case law included the notion that states had to make findings that established a nexus between their rates
and the costs of operating efficiently and economically operated facilities,\textsuperscript{12} and that they engage in a bona fide fact finding process based on some reasonably principled analysis that was sufficient to support their assurances to DHHS.\textsuperscript{13} Some courts also adhered to a three-step process for meeting Boren’s “findings” requirement, including identification and determination of: (i) efficiently and economically operated facilities, (ii) the costs that must be incurred by these facilities to comply with applicable requirements, and (iii) the payments that are reasonable and adequate to meet those costs.\textsuperscript{14} Though courts barred rate setting solely on the basis of budgetary considerations,\textsuperscript{15} they found that states could consider budgetary constraints as long as their rates complied with federal requirements for reasonable and adequate payment.\textsuperscript{16} Courts also recognized DHHS’ limited procedural role, and as such, “generally refused to defer to the Secretary’s approval of a state’s payment plan” when evaluating compliance with Boren’s standards (Harkins 2002, 170).

**Influencing State Policymakers: Procedures and Beliefs**

Adjudication of the Boren Amendment influenced the strategies, procedures, routines, and beliefs of state policymakers. Indeed, most Medicaid officials interviewed believed that Boren affected how their agencies conducted business. Though many states had not developed sufficient documentation to demonstrate the empirical and policy basis for reimbursing nursing homes during Boren’s early years, most eventually implemented additional mechanisms with which to justify their rates and rate setting methodologies. Many described these efforts as time consuming. One respondent explained that “here within the department we worked to make our assurances to HCFA, to make sure we got the timing down on all of the notices, had proper meetings and all that kind of more or less procedural stuff that caused us a lot more work.” Some states established specially designated “Boren Amendment Committees” whose sole purposes were to document the procedures through which nursing home rates had been established. Others hired outside consultants to perform these tasks. No matter what approach was taken the primary goal was, first and foremost, to avoid going to court, which respondents usually described as expensive and a drain on resources and manpower, but secondarily, to succeed, when and if nursing homes decided to take legal action. As a former state Medicaid official observed, “we made very certain that all of the changes we made were heavily documented and we spent a good portion of our time analyzing data and writing findings so that we were armor-plated when we went into those lawsuits.”

Not surprisingly, most Medicaid officials characterized the Boren Amendment in negative terms, generally describing it as “highly inflationary” and as “limiting state flexibility.” Even respondents from states that experienced no lawsuits reported Boren as being a “threat that was constantly being held over our heads by the
nursing homes.” The following comments by a former state Medicaid director summarizes what state officials reported experiencing:

[Boren] was always the elephant in the room. It was used by nursing homes in their negotiations with us. It affected how we established our reimbursement. The fact that we... made a fairly elaborate effort to calculate what was an efficient and economically operated facility... It also had an effect on budgeting... I mean, everybody talks about how Medicaid doesn’t pay for shit when it comes to physicians and clinics and other services... It’s because of the damn Boren Amendment in large measure, which created a decision matrix that always said first money goes here, second money goes there, and anything that’s left over goes to everybody else groveling at the plate...

Due to the high stakes associated with litigation, state representatives convened to learn about the latest litigation strategies and case law developments. Soon after Wilder, for example, the State Medicaid Directors’ Association sponsored a conference, to help state officials meet Boren’s “evolving” requirements through “state-of-the-art” information on the finding process, legal strategies, and analyses of reimbursement methodologies (Medicaid Management Institute 1992). Because the requisites of litigation in this area were simply beyond the expertise and resources of states’ attorneys general, most soon opted to retain the same Washington, DC-based firm, which, over time, developed extensive experience litigating cases under Boren. In general, respondents reported bringing this firm in because of the large amount of money involved, the complexity of the litigation, and the uniqueness of the subject matter.

Influencing Provider Representatives: Procedures and Beliefs

In addition to state officials, adjudication of the Boren Amendment influenced the strategies, procedures, routines, and beliefs of nursing home industry representatives. Although some were less sanguine about the usefulness of the Boren than others, most believed that it did, in fact, provide a certain degree of protection vis-à-vis reimbursement. Thus, while some considered Boren the “most critical bulwark against attempts to underfund nursing facilities” and as a “firewall for unilateral destruction of payment systems by the state,” others described it as a “quasi-inhibitor on truly outrageous reductions,” and as “a right, but a very difficult right to exercise.” For the most part, the procedures and routines developed by the nursing home industry as a result of Boren paralleled those developed by state Medicaid agencies. Consequently, most state associations formed committees charged with tracking state reimbursement policy changes and their implications. While some associations developed all of their technical expertise in house, others relied on outside consultants to perform the majority of these tasks,
including “running shadow rates,” “checking the state’s numbers,” “analyzing proposed changes,” “identifying holes in the system,” “estimating winners and the losers,” and “countering” with proposals more favorable from the industry’s point-of-view. As with the states, moreover, nursing homes usually relied on one of a handful of Washington, DC-based law firms as most local attorneys simply did not have the experience and expertise necessary to sustain a Boren Amendment challenge. They also met frequently to discuss the Boren Amendment and its ramifications. Perhaps the most important source of Boren-related information were the annual meeting of the National Health Lawyers Association (NHLA), which provided yearly updates on case law changes, in addition to workshops advancing the position of providers vis-à-vis their substantive and procedural Boren Amendment claims (NHLA 1977–2001).

Repealing the Boren Amendment

By the mid-1990s, the pace of Boren Amendment litigation had abated considerably, with the number of nursing home cases decided under Boren declining from an average of 9.3 per year during 1991–1994 to 3.0 during 1995–1997 (Miller 2006b). Overall, there were just fifteen Boren Amendment cases brought after 1994 compared to thirty-seven immediately post-Wilder (1991–1994). Furthermore, just three cases (20 percent) were won by providers compared to eight (53 percent) by states and four by both parties (27 percent). In contrast to the immediate post-Wilder era, moreover, almost all Boren Amendment cases (87 percent) were brought by individual facilities rather than associations; as a consequence, most were initiated by just a handful of nursing homes seeking redress from one or more reimbursement characteristic affecting specific facilities and not the industry as a whole (Miller 2006b).

One reason for the decline in cases is that providers found it increasingly difficult to sustain their Boren Amendment challenges. On the one hand, states eventually adopted defense strategies, which according to some industry representatives, significantly increased the costs of litigation. This was a conscious strategy on the part of one Midwestern state, for example, which spent nearly half a million dollars per month during some periods to defend itself against multiple lawsuits, but figured, according to one former official, that “it was a good investment because we were talking about hundreds of millions of dollars in reimbursement terms one way or another.” States also had a number of other advantages, including the deferential standard of review used by many courts, the Eleventh Amendment’s prohibition on federal courts awarding retroactive monetary damages against states, and federal reimbursement of half of a state’s attorneys’ fees.

Furthermore, states experienced budgetary surpluses and low unemployment that reduced the number of individuals applying for Medicaid coverage. States also learned to better satisfy Boren’s procedural requirements by developing
“an explicit findings process, with documents prepared by consultants specializing in such matters” (Manard 1997, 18). At the same time, courts became increasingly amendable to state claims that although they had not performed specific studies or analyses, the definition of an efficiently and economically operated facility was nonetheless implicit in their methodologies. Some courts also applied less stringent substantive requirements, which made it more difficult for providers to challenge the adequacy of the rates themselves. Thus, the likelihood of nursing homes winning decisions decided on procedural grounds declined from twelve times that of states during 1981–1990 to six times during 1991–1994 to essentially equal thereafter. Furthermore, the percentage of substantive cases won by nursing homes declined from 33 percent during 1981–1990 to 21 percent during 1991–1994 to just one case in the years leading up to the repeal (Miller 2006b).

One might presume that the marked decline in litigation and reduced scope and decreased success among nursing homes in the cases that were brought would have changed provider and state government views regarding litigation, with states now favoring the Boren Amendment and providers being opposed. However, this was not the case as both state officials and industry representatives continued to believe strongly in the Amendment’s efficacy as a litigation tool, furthering providers claims to higher reimbursement. Through the National Governors’ Association (NGA) the states had long sought the repeal of Boren, arguing that although it had been passed to give states greater flexibility in establishing reimbursement, it had unnecessary restricted state activity in this area as a result of litigation (NGA 1997, 2). State officials asserted that judges were “peculiarly unqualified” to “dictate” reimbursement levels and methodologies. At best, they felt that the inability of courts to develop a “coherent, consistent, and sensible construction” of Boren left them uncertain as to what constituted legal rates. At worst, they felt that they were paying too much for institutional care while having to devote valuable staff and resources to defending themselves in “epic litigation wars that can [tie a state up] for years” (State Coalition Legislative Proposal 1993). The nursing home industry countered that the NGA’s proposal was a request for the “freedom to cut eligibility and services and to pay providers at less than the costs of services”—freedom they fully expected states to take (Willging 1996, 2–3). They argued that Medicaid was a greatly underfunded program even with Boren as the standard and that without it providers were going to enter an economic downward spiral that would compromise their economic viability and reduce their ability to provide quality services. Given the lack of federal administrative oversight, industry representatives viewed the capabilities of the judiciary much more favorably than state officials did (Ronai and Rorick 1992).

Though state officials’ efforts to amend the Boren Amendment never reached fruition (State Coalition Legislative Proposal 1993), they were soon replaced by a
movement to eliminate the Amendment altogether. Indeed, despite its increasingly rare use in litigation, efforts to repeal Boren picked up steam during the 1995–1997 balanced budget debate, eventually resulting in its repeal with the Balanced Budget Act (BBA) of 1997.\textsuperscript{17} Thus, with the blessings of a Republican Congress and Democratic President, Boren was replaced with new provisions simply requiring states to provide public notice of proposed rate changes and the methods used to establish them, with both the Republicans and President Clinton (a former governor) proving sympathetic to state requests for greater flexibility in this and other areas (e.g., welfare reform, children’s health insurance, managed care).\textsuperscript{18} Whereas the Senate Finance Committee (1997, 95) suggested that the repeal primarily reflected a reaction to judicial interpretations of Boren that restricted state flexibility over reimbursement policy, the House Budget Committee (1997, 591) warned that “following enactment of [the repeal], neither [the new public notice requirements] nor any other provision of [the Medicaid Act] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.”

The Post-Boren Years: Impact of the Repeal

Repealing the Boren Amendment reduced federal oversight of Medicaid nursing facility reimbursement to levels not seen since the 1970s. This is true both in regard to federal administrative and judicial oversight of state policy making in this area. Following the repeal, in particular, HCFA sought to minimize its role in reviewing state plan amendments governing reimbursement beyond even the minimal standards established by Boren (Richardson 1997). In a proposed rule issued in 1999, for example, HCFA suggested basing plan amendment approval on simple assurances that a public process had been used when adopting reimbursement policy changes. This could be reflected in either a one-time, single-sentence statement included in a state plan; or a preprinted page, provided by HCFA and signed by the state (DHHS 1999).

Although repeal of the Boren Amendment eliminated special substantive and procedural standards for reimbursing institutional providers, Medicaid nursing home reimbursement continues to be subject to additional federal requirements that remain in place (Harkins 2002, 197, 198). Perhaps most salient are substantive standards often referred to as the “equal access provision,” which applies to all providers, and requires states to establish payment for care that are “consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available” at least to the same extent as the general population. Several recent court decisions, though, cast doubt on ability of nursing homes to sue state governments under the purview of existing federal law.
Perhaps this is best reflected in the rulings of several federal circuit courts, which have concluded that the “equal access provision” was intended to benefit Medicaid recipients, not providers, and that providers therefore do not have enforceable rights to invoke judicial oversight of state compliance under Section 1983 (Freisthler 2003, 1397–1400). In *Evergreen Presbyterian Ministries Inc. v. Hood*, for example, the Fifth Circuit ruled that in contrast to the Boren Amendment, it is recipients, not providers who may invoke judicial oversight, an argument the Court supported, in part, by referring to the legislative history of Boren’s repeal, where Congress expressed its intent “to free the states from federal regulation and increased rates and to eliminate a basis for causes of action by providers to challenge reimbursement rates” under any provision of the Medicaid Act. Together with a recent Supreme Court decision in *Gonzaga University v. Doe*, which ruled that nothing “short of an unambiguously conferred right to support a cause of action” must appear in a federal statute for a plaintiff to bring a claim under Section 1983, nursing homes will find it even more difficult to challenge state payment systems. Thus, in *In Re NYHSA Litigation*, the US District Court for the Northern District of New York granted the state’s motion for summary judgment, arguing that none of the sections of the Medicaid Act on which providers based their claims, including the ‘equal access provision’ and public notice requirements that replaced the Boren Amendment, creates a federal right for providers that is privately enforceable under Section 1983.

**Impact on Reimbursement**

Despite judicial setbacks and minimal federal administrative oversight, there were a variety of factors that limited the extent to which state officials chose to reduce Medicaid nursing facility reimbursement in the years immediately following Boren’s repeal. Not only did these include the booming economy and budgetary surpluses of the late-1990s, and unfavorable reports regarding the quality of care provided in the nation’s nursing homes (Office of the Inspector General 1999; U.S. GAO 1999), but they also include low levels of unemployment that reduced the number of individuals applying for coverage. States were also able to draw in additional federal money for nursing homes using loopholes in the law.

It should not be surprising then that most respondents interviewed for this study reported that the repeal did not result in major reimbursement reductions. This perception is reinforced by DHHS’ evaluation report to Congress, which concluded that states had not responded to Boren’s repeal by lowering rates or adopting new rate setting methods that “further divorce rates from actual incurred costs” (Bishop, Visconti, and Long 2004, 23–25). It is also reinforced by a U.S. GAO report (2003, 3), which found that only six of the nineteen states studied reduced or froze reimbursement during fiscal years 1998 through 2003, as well as
by another survey, which found that average reimbursement rates increased in most states during 1999–2002 (Grabowski et al. 2004, W4-367–W4-368).

Although the repeal did not result in wholesale reductions in Medicaid nursing home reimbursement, there was a “downward pressure” on the growth in Medicaid rates (HCFA 2000, 2/12), along with an “attitude adjustment” in negotiations between industry and government officials (Wiener, Stevenson, and Kasten 2000, 16), related to the inability to sue, or threaten to sue, that Boren had once provided. On the one hand, this is reflected in an industry-sponsored study which found that, in 2004, nursing home costs for Medicaid-covered residents exceeded Medicaid payment rates by an average of $12.58 per resident day in the thirty-five states included in the study (BDO Seidman 2006, 2). On the other hand, it is reflected in concern that inflation-adjusted reimbursement has failed to keep pace with the rising disability levels in the nation’s nursing homes resulting, in part, from the growth in home- and community-based alternatives for lower acuity residents (Grabowski et al. 2004, W4-368). That the repeal affected rate setting, moreover, is indicated by surveys performed for DHHS’ evaluation where in only five states did respondents report that “they saw no effect of Boren’s repeal, whether on the process or implementation of the rate method” (Bishop, Visconti, and Long 2004, 8). Because of the repeal, for example, one Medicaid official observed that “[the state] just increased the funding level…at a lower percentage than [it] had in the past. So in the past [the industry] always used to get four to eight percent rate increases…[but] last year [it] was two and a half [percent] and this year it’s two percent.” This dynamic has not been uncommon (HCFA 2000, 2/12-2/17; U.S. GAO, 2003, 43–50).

Impact on State Policymakers: Procedures and Beliefs
Though some respondents believed that Boren’s repeal did not change the way their agencies operated—they still sought to justify their rates, held committee meetings, hired outside consultants, and convened to learn about the latest developments in law and regulation—others detected changes, both in terms of how they established rates and how they interacted with industry representatives. Whereas some reported being more “aggressive” in their rate setting decisions, others echoed the sentiments of one agency official, who noted that “from a negotiating standpoint [the repeal] makes life easier for us, because [the nursing homes] can’t hit us with the Boren stick anymore.” In general, there were fewer administrative burdens reported. Thus, although the repeal did not have a great impact on state behavior according to one consultant, it had enabled the state agencies he worked with to “concentrate on the bigger picture without having to worry about the minutia or details that constitute the findings process and whether or not all the T’s were crossed and the I’s were dotted.” “Well, it’s sort of liberating, ‘observed one agency official,’ every time you do something you don’t have to run
the Boren findings... You can do things that seem like a good idea... Its just a whole area where you don’t have to stress out and mess around and try and make the numbers fit where they don’t.” “Its not just the physical work,” noted another, “but the fact that it is less of a strain to do something. It’s a whole factor that you don’t have to account for anymore.”

Impact on Provider Representatives: Procedures and Beliefs
“In any effective advocacy,” according to one industry representative, “you must have a three-prong approach—regulatory, legislative, and legal. But with Boren going away, essentially you took away the third prong, and the only approaches you have now to fair and adequate reimbursement are regulatory and legislative.” Indeed, the loss of the “judicial prong” and its implications for reimbursement were highlighted by most respondents. Industry representatives were particularly fearful that states would enact significant reductions in reimbursements once the economy began to decline. A former industry lobbyist predicted that the industry would “test” other legal mechanisms in efforts to protect itself against “arbitrary and capricious rate reductions.” Others doubted the efficacy of alternative legal approaches, noting that they had not been all that successful in the past. Recent court decisions ruling that Medicaid recipients and not providers are the intended beneficiaries of the Medicaid Act’s remaining reimbursement policy provisions have proven just how difficult it is to challenge state reimbursement systems in the post-Boren environment. Not surprisingly, nursing homes continued to monitor state reimbursement methods and rates closely, while hiring consultants and convening to learn about the latest developments (NHLA 1977–2001; BDO Seidman 2006). They have also lobbied Congress to reinstate a federal floor on reimbursement, whether it be the Boren Amendment or some reasonable facsimile thereof.

The Latest in Reimbursement
Given even more limited federal administrative review than existed under Boren, and recent court decisions that cast doubt on the ability of nursing homes to sue state governments under the purview of existing federal law, federal oversight in this area is at its lowest ebb since the early-1970s, when quality and access concerns spurred Congress to adopt special payment requirements for institutional providers in the first place. Thus, regardless of the strategies that the industry has adopted in the wake of Boren’s repeal, it is likely that its fears concerning reimbursement were exacerbated once the economy indeed slowed and states faced pressures to restrain Medicaid program growth. Not only was there a stronger commitment to avoiding tax increases, but state officials also quickly exhausted the usefulness of a variety of short-term budget-reduction measures, including rainy day funds, hiring freezes, workforce reductions, and tobacco settlement revenues (Holahan, Weil, and Wiener 2003, 13–15). Although state fiscal outlooks have improved (Smith et al. 2006),
twenty-four states expect revenues to lag behind expenditures during one or more subsequent years—FY2007, FY008, and/or FY2009 (National Conference of State Legislatures 2006). Furthermore, it is likely that states will face pressure to reduce spending now that $20 billion in temporary federal fiscal relief has expired, and CMS has issued regulations limiting their ability to use intergovernmental transfers to draw additional federal dollars into their treasuries.24 Medicaid cuts adopted in 2006 reduced federal Medicaid spending by $26.5 billion over ten years (Schneider, Ku, and Solomon 2006). The primary mechanism through which states have controlled spending has been cuts or freezes in provider reimbursement. In FY2006, fourteen states adopted reductions or freezes in nursing home reimbursement compared to thirty-seven which raised payments (Smith et al. 2006), though whether growth in payments represent actual growth in real terms, or are sufficient to cover increases in costs, remains open to question.

**Discussion and Conclusion**

This study examined federal oversight of Medicaid nursing facility reimbursement. In doing so, it sought to examine the various ways in which the judiciary influenced key actors (i.e., state governments, nursing home providers), in addition to the interplay among federal administrative review and the courts over time. Results indicate that whether or not judicial action under federal law influenced state policy, it influenced the behaviors and beliefs of key stakeholders. It also found that the role of the courts in federal oversight of state policy making depends, in part, on how the judiciary interacts with the statutory basis on which that oversight is based, the intensity of executive intervention, and prevailing socioeconomic and political conditions. Thus, whereas federal administrative review and the courts served as tandem institutions guiding federal oversight from the inception of the Medicaid program on through the passage of the Boren Amendment and its repeal, policy legacies from case decisions reinforced attitudes that the Boren Amendment empowered providers and constrained state officials despite mounting evidence to the contrary.

That the Boren Amendment constrained state flexibility is indicated by a recent study, which revealed that, all else being equal, states that lost lawsuits tended to adopt smaller reductions in Medicaid per diem rates than states that were not sued or were sued and won (Miller 2006a). The policy legacy framework, however, suggests that judicial intervention also influences key stakeholders by embedding historical experience into formal structures, beliefs, and relationships with other actors. This is confirmed by findings, which indicate that the courts articulated several principles that became incorporated into state Medicaid agencies and industry associations, including adoption of internal procedures and committees to
justify/challenge reimbursement methods and rates and development of the in-house expertise and external relationships necessary for doing so. Consequently, Boren Amendment case decisions had implications for state officials and providers that extended well beyond the levels of the reimbursement rates themselves. Indeed, belief that the Boren Amendment empowered providers and constrained state officials became a taken-for-granted assumption that persisted despite changing evidence regarding the Amendment’s relevance and effectiveness in the years leading up to the repeal (Meyer and Rowan 1977). One reason that the belief in Boren’s efficacy persisted is that providers could still threaten to sue as long as the Amendment remained in effect. Another reason is that the economy would inevitably decline and Boren might once again facilitate litigation as it had during the late-1980s and early-1990s. But perhaps the most immediate reason is that as a result of litigation the Boren Amendment became incorporated into the way state Medicaid agencies and provider associations conducted business.

Among the judicial principles articulated under the Boren Amendment was establishment of a bona fide fact-finding process based on some reasonable principled analysis that was sufficient to support state assurances, as well as adoption of a three-step administrative process for determining the appropriate levels of reimbursement. These principles became integrated in the ways that state Medicaid agencies and provider associations operated. This is reflected in the formal routines and procedures used to justify and track compliance with Boren’s substantive and procedural requirements, including the adoption of special committees and other mechanisms and protocols with which to evaluate state rates and rate setting methodologies, as well as recruitment of the requisite administrative personnel and data analytic capacities for doing so. It is also reflected in extensive participation in formal meetings and forums on the latest litigation strategies and case law developments, and in establishment of formal relationships with outside consultants, lawyers, and other experts. Due, in part, to widespread institutionalization of Boren Amendment principles into procedures and routines such as these, key stakeholders continued to believe that Boren empowered providers and constrained state officials despite prevailing evidence to the contrary. This helps explain why state officials remained firmly opposed to Boren and industry representatives firmly supportive notwithstanding the marked decline in the extent and scope of litigation, and increased success among states in the cases that were brought, during the years leading up to the repeal. Moreover, even after removal of Boren, when the prospect of litigation was eliminated altogether, some states did not change the way their agencies operated, though fewer administrative burdens, less strain, and a stronger negotiating position relative to the industry were reported. Even states that reported change still maintained some of the trappings of the Boren era, whether seeking to justify their rates, holding committee meetings, hiring outside consultants, or convening with other like-minded parties.
This was especially true of the industry, which continued monitoring reimbursement closely in the hopes of convincing Congress to reinstate some sort of federal reimbursement floor.

The policy legacies notions provide two important lessons for understanding the judicial role in federal oversight of state policy making. Conceptually, it informs us that because judicial impact extends beyond the outcomes of particular cases to include the organization and beliefs of interested actors, the effects of judicial oversight may be deeper and longer lasting than the relevance of the statutes or case law under which they were litigated. This is because the principles articulated by the courts become embedded in the way state officials and other interested actors operate and in the way they think about their jobs, resulting in lags in strategies, procedures, routines, and beliefs to changing socioeconomic and political conditions. This implies that to fully understand the role of the judiciary in federal oversight of state policy making requires an investigative strategy grounded not only in the positivist but also in the interpretive research tradition. Whereas the positivist tradition seeks to establish cause and effect, mainly, though not exclusively through quantitative data and statistical techniques, the interpretivist tradition seeks to establish meaning and understanding, through such means as interviews, observation, textual analysis, and other qualitative methodologies (Linn 1998). Traditionally, examinations of the judicial role adopt the positivist lens in seeking evidence as to whether individual court decisions (or any other discrete institutional stimuli, including federal statutes and regulations) result in clear unmistakable changes in the behavior of targeted individuals. This is in contrast to the interpretive lens that seeks to understand the subtle, variable influences of the judiciary beyond achieving particular results. Regardless of whether judicial decisions influence program outcomes, they may nonetheless influence the beliefs and procedures of key actors as well as how they relate to one another. Indeed, the “question concerns less whether law matters per se than the complex disparate and ambiguous terms of ‘how’ it matters and what that means” for differently situated actors (McCann 1996, 480). By highlighting alternative manifestations of judicial, statutory, and regulatory influence, the policy legacies framework opens up additional avenues for future federalism research.

In addition to policy legacies, my results support the tandem institutions dynamic posited earlier. Sometimes federal statutes invite litigation by the explicit inclusion of a private cause of action. Other times the lack of federal administrative review creates opportunities for judicial involvement where a private cause of action has not been excluded. This latter scenario is consistent with my findings, which indicate that litigation served, in part, to fill the void created by the relaxation of federal administrative review. Although the Boren Amendment did not explicitly include a private cause of action, it did not explicitly rule one out
either, thereby enabling the U.S. Supreme Court’s decision *Wilder v. Virginia Hospital Association*, which upheld the right of providers to sue and opened up the flood gates to litigation during the early-1990s.

Peterson (1990) initially developed the concept of tandem institutions as a correction to the presidency-centered perspective in legislative-executive relations, which presumes presidential dominance in dealings with Congress. Like the presidency-centered perspective, most examinations of the judicial role in federal oversight of state policy making assume a zero-sum competition between the judiciary and other policy-making bodies, in which the ascendancy of one institution must come at the expense of the other (Melnick 1983, 1994). In contrast, viewing federal administrative review and the courts as tandem institutions recognizes that federal oversight of state policy making ultimately encompass both institutions. It also recognizes that whereas Congress sometimes writes laws using litigation rather than executive oversight as the key enforcement strategy (Farhang 2003), judicial intervention is often a reaction to federal administrative actions, which reflects Sage’s (2003, 389) observation “that apparent increases in the amount of health care litigation are best explained in terms of ‘unfinished business’—historical, structural, and conceptual incompleteness in health care system design that channels major issues in health policy into” the courts. Indeed, one advantage of the tandem institutions perspective is that it acknowledges that the role that the judiciary plays in relation to federal administration depends on the particular circumstances within which that interaction takes place.

Not only does the tandem institutions perspective highlight interaction among the judiciary and federal administrative apparatus in guiding federal oversight of state policy making, but it also recognizes that the role that the judiciary plays in relation to federal administrative review may vary over time. Sometimes the courts undermine the direction favored by the political branches of government. This is reflected in the hey-day of the Boren Amendment, where minimal oversight by federal agencies combined with declining socioeconomic conditions and the Supreme Court’s decision in *Wilder* to spur increasing numbers of providers to sue state governments under Boren’s provisions. Other times the courts reinforce the direction favored by the political branches. This is reflected in the post-Boren environment, where even more limited federal administrative review has combined with recent court decisions declaring Medicaid recipients and not providers the intended beneficiaries of the Medicaid Act’s remaining reimbursement policy provisions to impede provider litigation. In sum, portraying federal administrative review and the courts as tandem institutions transforming the locus of federal oversight introduces a certain degree of neutrality into the analysis. In contrast to those who automatically assume an ineffectual or counterproductive judiciary (Horowitz, 1977; Melnick, 1983, 1994), the tandem institutions perspective
recognizes that federal oversight of state policy making almost always involves multiple branches of government, with the dominant branch potentially shifting from one time period to the other.

What the Boren Amendment case illustrates is that judicial influence on state policy making takes place within the context of an interactive process between the executive and the judiciary, and that regardless of how one views judicial involvement, its influence extends beyond the achievement of particular outcomes to include the procedures and beliefs of key stakeholder groups. Judicial involvement in state policy making flows from frequent interaction with legislative and regulatory precedents, not to mention key stakeholder groups and changing socioeconomic and political conditions. Keeping in mind the applicability of these lessons to a broad array of policy areas, more widespread adoption of the tandem institutions perspective should help policy designers better anticipate and plan for the type of judicial–executive interaction desired, whereas greater awareness of policy legacies should help them better anticipate and plan for the potential effects of judicial involvement, including the unanticipated ones so often highlighted in the literature.

Notes

1. The Boren Amendment is named after former Senator David Boren, from Oklahoma, who sponsored the Amendment for inclusion as part of the Omnibus Reconciliation Act of 1980.
3. States represented in my interviews include: Alabama, Arkansas, California, Colorado, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Virginia, Washington, and Wisconsin.
4. Codified as 42 U.S.C. 1396(a)(13)(E). Section 249 required that by July 1, 1976 states pay for “...skilled nursing facility and intermediate care facility services...on a reasonable cost basis, as determined in accordance with the methods and standards which shall be developed by the states on the basis of cost-finding methods approved and verified by the Secretary...”
5. Although the Boren Amendment was passed initially in 1980 solely in reference to skilled nursing facility services and intermediate care facility services, it was modified in 1981 to include hospitals as well. Six years later, Boren was amended again with OBRA 1987 to require that when setting payment rates state Medicaid programs had to submit yearly plan amendments, beginning in 1990, that accounted for the costs that nursing facilities would incur when complying with new quality standards also promulgated by that Act, a provision that was further clarified with OBRA 1990.
7. Indeed, the U.S. GAO (1986, 3) concluded that HCFA neither established sufficient guidelines to be followed by states when submitting their assurances, nor had the agency adequately reviewed the basis on which those assurances had been made.

8. In 1983, the federal government adopted Medicare’s prospective payment system for hospitals, which resulted in “quicker and sicker” discharges of hospital patients to nursing homes and other non-hospital settings. Under prospective payment, the federal government pays hospitals a fixed amount per episode of care, no matter how many days a patient remains hospitalized. This creates incentives for hospitals to discharge patients as quickly as possible, resulting in a more costly mix of patients served by nursing homes and other postacute providers.

18. The new provisions required that states publish proposed and final rates and the methodologies and justifications underlying them, and that providers, beneficiaries and their representatives, and other concerned residents be given reasonable opportunity for review and comment.

23. Although the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 meant that states could no longer take advantage of loopholes in the Medicaid law that enabled them to draw in billions of additional federal dollars, they were also still able to draw in some additional federal money using provider taxes and donations and intergovernmental transfers.

24. Previously, a loophole in the Medicaid law allowed states to overpay publicly owned nursing homes, thereby enabling them to draw in additional federal matching dollars under the Medicaid program, with excess funds subsequently being transferred back to the state from those homes as intergovernmental transfers.

References


