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Ellen A. Mercer

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I. Health Care Providers Have Private Right of Action Under the Federal Medicaid Act

In Anco, Inc. v. State Health and Human Services Finance Commission¹ the South Carolina Supreme Court held that private health care providers have a private right of action under the federal Medicaid Act.² After finding that the health care providers had standing under 42 U.S.C. § 1983,³ the supreme court reversed a permanent injunction and allowed the South Carolina Health and Human Services Finance Commission (Commission) to implement a new reimbursement policy that limits nursing home providers' long-term capital lease agreement costs to historical capital costs. The costs are limited now to depreciation and interest as incurred by nursing home providers that own their own facilities.⁴

As part of the Medicaid program, enacted as Title XIX of the Social Security Act,⁵ Congress provided for a federal and state partnership to allocate the costs of providing health care to qualified individuals. Under the Act, each state must designate a single state agency to administer the state Medicaid plan.⁶ The state designated the Commission as the agency to administer the Medicaid plan in South Carolina.⁷ Within the context of a federally approved state Medicaid plan,⁸ the Commission provides for reimbursement payments to skilled and intermediate care nursing facilities. At all times, the Commission must assure the federal government, specifically the U.S. Department of Health and Human Services, that the payments under the plan "are reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated facilities . . . ."⁹

In Anco the plaintiffs included many nursing home providers that contracted with the state to provide health care services to Medicaid eligible patients on a per day, per patient rate. Providers received re-

6. Id. § 1396a(a)(5).
imbursement for their capital costs associated either with the lease or with ownership of their nursing home facility as part of their operations costs. The plaintiffs leased the nursing homes in which they provided services. The state Medicaid plan, administered by the Commission, provided for capital cost reimbursement with a ceiling of $7.79 per patient per day.\textsuperscript{10} The nursing home providers’ specific capital costs were either the actual lease costs for these facilities that were leased by providers or depreciation and interest for providers that owned their own facility.

The Commission amended the state plan to provide that the capital cost reimbursement for providers that leased their facilities was limited to the historical cost (depreciation and interest) of providers who owned their own facilities. The policy applied only to lease agreements entered into prior to December 15, 1981, because a similar policy already had been in effect for those lease agreements entered into after December 15, 1981.\textsuperscript{11}

Each plaintiff in this case had long-term lease agreements that had been executed prior to December 15, 1981. The plaintiffs consolidated their claims and sought a permanent injunction to prohibit the implementation of the amended state plan and corresponding reductions in their capital reimbursement rates. The trial court granted a permanent injunction and held that the state plan (1) violated the Boren Amendment (federal Medicaid statute), (2) constituted a deprivation of property without just compensation, (3) violated the equal protection clause, (4) was arbitrary and capricious, and (5) violated 42 U.S.C. § 1983.\textsuperscript{12}

On appeal, the Commission first argued that the plaintiffs did not have standing under 42 U.S.C. § 1983 to contest the proposed reimbursement policy under the Medicaid Act because Congress had not created a specific, enforceable statutory right.\textsuperscript{13} The court disagreed and held that plaintiffs had standing under \textit{Virginia Hospital Association v. Baliles}.\textsuperscript{14} In \textit{Baliles} the Fourth Circuit interpreted the Medicaid Act’s statutory language and legislative history to imply a “congressional intent to allow providers a right of action against State failure to comply with federal Medicaid requirements.”\textsuperscript{16} Accordingly, the plain-
tiffs’ challenge was allowed under 42 U.S.C. § 1983.
Second, the Commission argued that the state’s proposed reimbursement rate limitations did not violate the Medicaid Act or related federal regulations. According to the Act, the state must reimburse providers using rates that are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.” The providers challenged the state’s specific capital reimbursement rate as inadequate because their individual facility costs were the result of efficient and economic operations. Relying on Friedman v. Perales the supreme court disagreed and held that the proper analysis is to examine the Commission’s overall reimbursement rates within the context of the Act.
Furthermore, the Anco court held that the evidence did not indicate that the proposed reimbursement rate limitations were arbitrary and capricious cutbacks based solely on budgetary considerations. Rather, the Commission claimed the impetus for the proposed policy was to enable providers to shift their money expenditures from facility costs to patient services costs.
Third, the Commission argued that the proposed reimbursement policy did not deny the plaintiffs equal protection under the law. In 1981 the Commission decided to use historical costs as the basis for capital cost reimbursement. Consequently, the plaintiffs in this case already had negotiated long-term leases prior to 1981 that were not subject to the new policy. The supreme court, therefore, held that the proposed policy supported, rather than violated equal treatment of all nursing home providers under the state’s Medicaid reimbursement plan.

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17. Anco Inc., 300 S.C. at 438, 388 S.E.2d at 783.
20. Id.
21. Id. at 441, 388 S.E.2d at 785-86.
Fourth, the Commission argued that the proposed policy did not constitute inverse condemnation. The supreme court agreed for three reasons. First, in *Wilmac Corp. v. Heckler* a Pennsylvania District Court stated that "[a]s long as [the provider] continues to receive reasonable and adequate reimbursement, it has not been deprived of its property interest, if any, in Medicaid funds." Second, the supreme court noted that in its prior decision, the plaintiffs failed to show that the proposed reimbursement policy violated the "reasonable and adequate" standard. Accordingly, the plaintiffs also failed to show sufficient basis for their inverse condemnation claim. Finally, the court noted that provider participation in the Medicaid program is voluntary.

Fifth, the Commission argued that the proposed reimbursement policy was not retroactive or arbitrary rule making. The court held that the policy had not been applied retroactively because it only had prospective application and it merely extended the future application of a rule which applied already to the majority of nursing home providers. Finally, the court held that the policy was not arbitrary because the court acknowledged the policy's purpose to shift provider expenditures from facilities to patient case services, an outcome that it related to a legitimate governmental purpose.

*Ellen A. Mercer*

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23. *Id.* at 1008.
26. *Id.*