

the principles and character of this great nation.

No potential conflict of interest relevant to his article was reported.

Senator Baucus (D-MT) is the chairman of the Senate Finance Committee.

Editor's note: We have also invited Senator Charles Grassley (R-IA), the ranking member of the Senate Finance Committee, to provide his views on health care reform.

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Litigation amidst Reform — The Boston Medical Center Case

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Nearly 175 years ago, Alexis de Tocqueville wrote in *Democracy in America*, “There is hardly a political question in the United States which does not sooner or later turn into a judicial one.” If de Tocqueville had it right, it should not be surprising that as we debate health care reform, litigation has commenced. On July 15, 2009, Boston Medical Center (BMC), Massachusetts’ largest safety-net hospital, and its affiliated health care plan filed suit in state court challenging the state’s Medicaid reimbursement formula. The case raises critical questions about the Massachusetts model of health care reform as well as litigation’s role in health care reform debates.

BMC was created in 1995 through a merger of the publicly owned Boston City Hospital (BCH) and its privately owned neighbor, Boston University Medical Center. At the time, public leaders vowed that BMC would continue BCH’s historical mission of treating the poor and uninsured. That commitment was made explicit in Chapter 147 of the 1995 Massachusetts Acts and Resolves, which authorized the merger and instructed the new hospital “to consistently

provide excellent and accessible health care services to all in need of care, regardless of status or ability to pay.”

In 2006, Massachusetts enacted sweeping health care reform. The reform law, Chapter 58 of the 2006 Massachusetts Acts and Resolves, provides a model for many reform proposals now under debate in Washington. The Massachusetts reform combined individual and employer mandates and health insurance reforms with increased access to Medicaid and other government-sponsored programs, the creation of a health insurance exchange, and subsidies for low-income individuals and families. To help pay for reform, the state looked in part to funds that had previously been used to pay for uncompensated care, assuming that reform would reduce the number of uninsured patients. However, the new law also recognized that swift and deep cuts would harm safety-net hospitals, which would continue to serve many uninsured and expensive-to-treat patients. Hence, the reform law sought to ease the transition by authorizing the state to provide BMC and Cambridge Health Alliance, the state’s

other large safety-net provider, with 3 years of supplemental payments consistent with the funding they had received for uncompensated care in 2006.

In many ways, health care reform in Massachusetts has been a great success. Less than 3% of state residents are now uninsured.¹ Nevertheless, health care costs have continued to rise, even as the recession has slashed state revenues. In response, the state established a special commission in 2008 to recommend ways to stem costs. Before the commission’s work could begin, the Massachusetts Executive Office of Health and Human Services (EOHHS) attempted to contain Medicaid costs by revising the state’s Medicaid reimbursement formula from one that based per diem rates primarily on a hospital’s own reasonable costs to one that relies largely on statewide average costs.

On July 15, 2009, as debates about health care cost controls heated up in anticipation of the release of the special commission’s report calling for the adoption of global budgets, BMC went to court, charging the state with paying for reform on the

backs of safety-net hospitals. This contention may resonate around the country, as policy-makers, seeking to help finance expanded insurance access, look to the supplemental payments that states and the federal gov-

ernment currently make to hospitals that provide a “disproportionate share” of care to Medicaid beneficiaries and the uninsured.

Although the facts and backdrop of the case are unique, BMC’s decision to go to court is not. During the 1990s, many providers sued states under the so-called Boren Amendment, which required state reimbursement rates to be “reasonable and adequate.”

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The complaint in *Boston Medical Center Corp. v. Secretary of the Executive Office of Health and Human Services* raises several complex legal claims, including that the state failed to follow a section of the Massachusetts General Laws stating that: “for disproportionate share hospitals, [EOHHS] shall establish rates that equal the financial requirements of providing care to recipients of medical assistance [Medicaid].”² BMC also alleges that the EOHHS violated the state and federal constitutions by taking its property without just compensation and that the state failed to pay the supplemental safety-net funds authorized by the 2006 reform law.

On September 11, 2009, the state filed its answer with the court, claiming that it had paid BMC the remaining supplemental funds in August. The state also argued that BMC could not complain about the state’s new

Medicaid rates, since it had signed a contract with the state agreeing to treat Medicaid patients and abide by state regulations, and pointed out that state law requires only that hospitals be paid for their “reasonable” costs, not necessarily their actual costs. More generally, the state argued that the dispute was about policy rather than law.

Although the facts and backdrop of the case are unique, BMC’s decision to go to court is not. During the 1990s, many providers sued states under the so-called Boren Amendment, which required state reimbursement rates to be “reasonable and adequate.”³ Congress eventually repealed the amendment, in part because of all the lawsuits. Since then, health care providers have continued to sue, but they have often had trouble prevailing in court. For example, in 2003, the Massachusetts Supreme Judicial Court rejected a challenge to the state’s revised formula for setting Medicaid rates for nursing homes, emphasizing the deference that should be given to the state agency charged with rate setting.⁴ Although that case was decided under a statute not applicable in the BMC case that requires courts to “give due weight to the experience, technical competence, and specialized knowl-

edge of the agency,” its general principle of deference is likely to apply to the BMC case as long as the court finds that the EOHHS complied with the relevant statutes. Critical to that determination is whether the state’s new rate formula will cover BMC’s reasonable costs.

BMC’s constitutional claims also face high hurdles. The hospital contends that in requiring BMC to treat patients without providing full payment, the state engaged in a “regulatory taking” — essentially, using the hospital’s property without paying for it. The state, however, argues that BMC’s property was not taken, since the hospital had agreed to treat Medicaid patients. But even if BMC’s treatment of Medicaid patients was not voluntary, courts are reluctant to conclude that state health laws are unconstitutional takings. Just this past August, the U.S. Court of Appeals in Boston rejected a hospital’s claim that Maine’s free-care law was unconstitutional because it required hospitals to treat patients without providing full compensation.⁵ The court noted that Maine’s law did not jeopardize the hospital’s economic viability, that hospitals operate in a highly regulated environment, and that the law did not undermine the hospital’s core rights as property owner to decide what happens on its property.

Although BMC’s legal claims face considerable challenges, the hospital may have served itself well simply by going to court. By filing suit, BMC has reminded lawmakers that there is no pain-free way to pay for health care reform. Expanded access to insurance does not remove all the burdens borne by safety-net hos-

pitals. BMC has also made it clear that it will fight hard for its own economic well-being as the state ponders global budgets and further Medicaid cuts.

Some observers may see the BMC litigation as proof that the Massachusetts reform model has failed. But interpreting it in this way would be a grave mistake. Medicaid litigation occurred before reform and would have continued without it. Indeed, the dispute between BMC and Massachusetts probably stems more from the state's long-running bat-

tle to cut Medicaid costs than from any innovation brought about by health care reform. Nevertheless, the case demonstrates that the Massachusetts model cannot solve all the problems faced by our health care system. Nor will it end all litigation. As long as powerful interests clash over limited health care resources, parties will do what they have always done: go to court.

Ms. Parmet reports serving on the boards of directors of Health Care for All and Health Law Advocates. No other potential conflict of interest relevant to this article was reported.

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Payment Reform for Safety-Net Institutions — Improving Quality and Outcomes

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In the U.S. health care system today, many hospitals have the market power to raise the prices of their services without showing evidence of improvements in the quality of care.¹ In an effort to realign incentives, health care reformers are now proposing to link provider payments to quality of care and health outcomes. As we move toward such a payment system, however, we must ensure that reimbursement is adjusted for patients' coexisting conditions so that hospitals cannot get high marks for quality by choosing to treat only patients who are considered to be at low risk.

Although risk adjustment has long been an interest of both insurers and providers, health risks have yet to be defined with sufficient granularity for hospitals to bear the full financial risks of caring for high-risk patients in a non-fee-for-service environment.

Low-income patients are more likely than high-income patients to have multiple coexisting conditions, and hospitals serving a high proportion of low-income, high-risk patients may therefore have to do more than other hospitals to achieve the same outcomes. We believe that given the same level of quality, safety-net institutions should therefore be reimbursed more per patient under any pay-for-quality scheme that is implemented.

Achieving high-quality health care and positive outcomes in safety-net institutions can be extremely challenging. Social status and health outcomes are linked the world over, and recent research highlights how unfavorable social conditions can directly interact with genetic and biologic processes. As a group, low-income people have a greater predisposition to a range of illnesses than

their higher-income counterparts, and they often have more severe forms of illness when they arrive at a health care facility.

Even when they have health insurance, people with low income often have more difficulty gaining access to the care they need. They may be faced with such challenging circumstances as disconnected telephones, transportation difficulties, multiple or inflexible jobs, unaffordable copayments for medication, and often cultural and language barriers as well. For low-income patients who manage to obtain care, adherence to treatment plans may also be complicated by competing priorities. Many low-income families must make tradeoffs between health care and other basic needs, such as housing, food, and heat.² In part because of the necessity of such juggling acts, safety-net institutions are more likely than