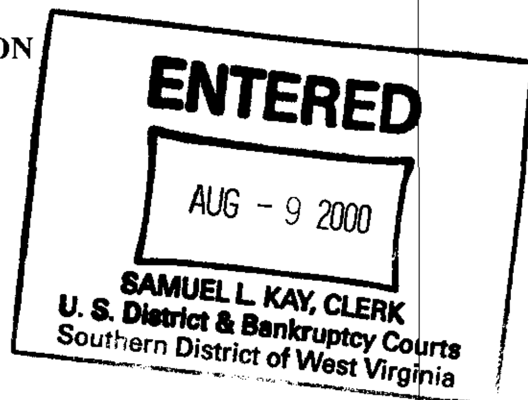
IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

HUNTINGTON DIVISION



BENJAMIN H., by his next friend, Georgann H.,
DAVID F., by his guardian, Carolyn B.,
LORI BETH S., by her next friend, Janie J.,
THOMAS V., by is next friend, Patricia V., and
JUSTIN E., by his next friend, Sherry E.,
individually and on behalf of all others
similarly situated,

Plaintiffs,

v. CIVIL ACTION NO. 3:99-0338

JOAN OHL, Secretary of the Department
of Health and Human Resources,

Defendant.

MEMORANDUM OPINION AND ORDER AS TO COUNT VIII

INTRODUCTION

1. On April 30, 1998, the plaintiffs filed suit under 42 U.S.C. §§ 1983 and 12133. Their complaint asserted five violations of Title XIX of the Social Security Act, that is, the provisions establishing Medicaid, 42 U.S.C. § 1396 *et seq*. In addition, the complaint asserted one violation of the Due Process Clause of the United States Constitution, or in the alternative, the due process provisions of Medicaid, and one violation of the Americans With Disabilities Act, 42 U.S.C. §§ 12101 – 12213 (the "ADA").

2. Prior to trial, the parties reached a settlement on all claims except that contained in Count VIII of the plaintiffs' amended complaint relating to the reimbursement rate for residential habilitation and two respite care services through the Medicaid home and community based

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MR/DD waiver program. Only these three services are challenged by plaintiffs as violating the requirement that reimbursement rates be sufficient to enlist enough providers to meet the standard imposed by the Medicaid program, as discussed in this Opinion's conclusions of law.

3. On March 7, 2000, the parties presented testimony and other evidence relating to the adequacy of the reimbursement rate during a one day bench trial. The parties presented additional evidence by way of evidentiary depositions conducted on March 14, 2000. After all the evidence was submitted, the parties filed post-trial memoranda. A hearing on the issues raised in the bench trial was held on July 24, 2000. Based on the evidence, arguments, and authorities presented, the Court **FINDS** in favor of Defendant and makes the following findings of fact and conclusions of law pursuant to Rule 52 of the Federal Rules of Civil Procedure.

FINDINGS OF FACT

The Services at Issue

4. Under the MR/DD Waiver Program, there are a number of home and community based services which may be available to an individual based on his or her Individualized Program Plan ("IPP"). This plan is developed by the Interdisciplinary Team and specifies the services that the recipient needs to maintain and/or increase his or her ability to function independently. The State's Medicaid program reimburses providers of these services.

5. The three particular services at issue in this case are referred to as Respite I, Respite II and Residential Habilitation 1:1 (one provider working with one recipient). The reimbursement

rates for the services at issue are as follows: Residential Habilitation – $9 per hour; Respite II – $8 per hour; and Respite I (non-emergency) – $6 per hour.

6. The goal of respite care is to have a respite worker come into the home to provide care for individuals who are unable to care for themselves while the parents or custodians are not home. Under Respite I, the workers are "non-agency," meaning they are not employees of a behavioral health center ("BHC") or a similar entity. They may be specialized family care providers or simply family members who do not reside with the recipient. Under Respite II, the providers must be employees of a BHC.

7. Residential habilitation services provide individuals with mental retardation or developmental disability with "assistance with acquisition, retention, or improvement in skills related to activities of daily living, such a personal grooming, and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting."

Services as Provided

8. Recipients often have very complex, difficult problems which require special care. (See this Court's description of the named plaintiffs in its Memorandum Opinion and Order entered July 15, 1999). Given the physical and mental difficulties from which many of the recipients suffer, the workers need to be qualified to provide these specific services and trained to deal with individuals who have significant mental and physical impairments.

9. Plaintiffs' witnesses consisted of parents of several Waiver services recipients and individuals who run or work with BHCs or other advocacy agencies. As they described their

experience with the Waiver program, residential habilitation services are often sporadic and plagued by a high turnover in staff. Recipients also have scheduling problems with staff, interrupting the intended structure of programs for recipients. Respite care is also sporadic with high turnover in staff.

10. Several BHCs reported annual turnover rates from 35% to as high as 60% for both residential habilitation and respite care workers. Some witnesses testified that no respite care was available for periods of more than a year, while others reported numerous workers coming and going in relatively short periods. For instance, one recipient had about 60 workers over a six year period.

11. Respite care and residential habilitation workers generally have no special education in health care to qualify them for this employment. They need only be high school graduates, at least 18 years of age and have a valid driver's license. The BHCs often provide two days of training when a new employee begins. These employees are often cross-trained to perform both respite and habilitation care.

12. High turnover contributes to a lack of continuity and structure in care, causing injurious effects on the recipients and their families. The lack of continuity and structure in care directly affects the recipients, who often are unable to function to their capabilities without a sustained program of care. Also, the recipients have a difficult time developing a relationship and feeling comfortable with workers who are only there for a short period of time. Periods of inactivity are counterproductive for the recipients. During these periods, a recipient's progress is often set back, making it very difficult to sustain any level of progress. Lack of available workers also causes stress for the family members who then

must provide the needed care on a full time basis, at the expense of other family members or employment.

13. There are some centers which are unable to supply any residential habilitation to recipients whose IPPs require it. Eligible recipients can go without staff for extended periods of time, ranging from a few days to several months.

14. Generally, workers are most likely to quit within the first month to a year after they begin this type of work. Many witnesses testified that low pay and difficult working conditions were the cause of high turnover, but their information was generally second-hand or anecdotal.

15. West Virginia's reimbursement rates are lower than the reimbursement rates in states bordering West Virginia.

16. Workers who provide the care at issue are usually paid between $5 and $7 per hour, depending on where they are employed. Some BHCs provide limited benefit packages to their employees, and others provide no benefits at all. Workers are not paid transportation time for going to and from the recipient's home to work.

17. There is a broad based tax on gross receipts of all payments received by health care providers in West Virginia. Behavioral health services are taxed at 5%. This tax is frequently passed on to the workers, in that it is deducted by the providers from the actual wages paid, thus resulting in lower pay for employees.

18. A center's typical cost per employee is approximately $10 per hour. The BHCs report very little, if any, profit from providing these services. However, centers may generate enough revenue from other Waiver services or other sources to offset any loss or increase overall

profitability. Also, reimbursement rates for residential habilitation services at higher provider-to-recipient ratios are generally profitable for the centers.[1]

19. Comparing the pay rates for these services with pay rates for aides in local schools is otiose, since the evidence presented merely demonstrates the latter are paid higher wages. Though the services are factually similar, and in some cases involve the same recipients, that evidence does not establish that Defendant's rates are insufficient. [2]

20. The lack of adequate training contributes to high turnover, in that the work proves to be more challenging than new workers may anticipate. Likewise, the daily travel to and from a recipient's home in a rural part of the State may make the position less attractive. These factors become more significant to low paid workers who have more opportunities to find other jobs when the economy is relatively strong.

21. The practices of employers, such as the BHCs, have a significant effect on the conditions of employment and the work environment which contributes to the high turnover. These factors include the employer's work scheduling policies, the actual wage rates paid by the employer, and the employer's benefit package.

22. The services at issue in this case are not available to the general population at the present time. Private health insurance does not cover such services on a long-term basis.

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[1] Defendant's evidence consisted mostly of her efforts to negotiate an agreed change with the BHCs, through their association, in several rates. The goal of these discussions was to lower some rates to free funds to increase the subject rates. Though commendable, this effort does not excuse Defendant from her statutory duty.

[2] Defendant has moved for admission of the contract between Greenbrier County Schools and Open Doors to provide community school services that include residential-type services to a disabled individual. The contract is admitted.

CONCLUSIONS OF LAW

1. This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 and 42 U.S.C. § 1434(3).

2. Since West Virginia has decided to participate in the Medicaid program, the State must comply with the Medicaid Act ("the Act,") 42 U.S.C. § 1396 *et seq*. To qualify for federal funds, the State must submit a plan to the Secretary of Health and Human Service in compliance with the Act. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Contained in this State plan, must be a system for reimbursing costs incurred by health care providers in providing services to Medicaid recipients. *See Wilder*, 429 U.S. at 502.

3. In relation to reimbursement rates set by the State for providers, the Act requires States to "provide methods and procedures relating to utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204. The "purpose of this subsection is to ensure adequate access and quality of care in the context of noninstitutional Medicaid providers." *Arkansas Medical Society v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993). The plaintiffs allege that the reimbursement rates set by the State for three particular services violate the access requirement of the statute.

4. The plaintiffs' amended complaint alleges "[t]he defendant's failure to adequately reimburse direct care in-home services as a part of Title XIX MR/DD Waiver violates the defendant's duty to 'assure that payments . . . are sufficient to enlist enough providers so that care and services are available under the [State Medicaid] Plan at least to the extent that such care and service [sic] are available to the general population . . . .'" Given these allegations, the Court concludes that only the adequate access issue, and not the quality of care issue, is properly before the Court. While the Defendant may have waived, by failing to raise it, any objection that the quality of care issue is not properly before the Court, the Court is not inclined to rule on the issue since the trial proceeded on only the adequate access portion of the statute. Only in the post-trial memoranda did the parties direct argument towards the quality of care issue. In the Court's view, the quality of care issue involves intricate questions of both law and fact which have not been fully litigated in the present posture of this case. As a result, the Court declines to make any conclusion as to the adequacy of the reimbursement rate vis-a-vis quality of care.[3]

5. Adequate access in this case must be analyzed in the context of the Waiver program. Medicaid covers a broad range of medical and related services, many of which are typical to every family, such as routine doctor visits or treatment for physical illnesses or injuries. In that context, adequate access is relatively simple to gauge because the general population receives such services as commonly as Medicaid recipients. Here, however, the general

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[3] The Court is of the opinion, however, that if the evidence presented is indicative of the experience of recipients generally, the defendant is very vulnerable to this claim. If the plaintiff presented evidence which would sufficiently link the high turnover to the pay and reimbursement rates, there would likely be strong evidence to conclude that the low pay results in high turnover which in turn results in poor quality of care.

population rarely needs or receives the types of services MR/DD individuals are entitled to receive in the Waiver program. Obviously, Congress did not intend to deny recipients reasonable access just because the general population rarely needs similar services. Furthermore, the Waiver program determines the level and frequency of these services, and if high turnover interferes with the IPP goals, access cannot be adequate.

6. A review of the existing case law reveals that essential to compliance with § 1396a(a)(30)(A) is the State taking necessary steps to ensure that rates are consistent with efficiency, economy, quality of care and access.

7. Courts have taken different approaches for reviewing a State's compliance with the statutory factors. Some courts review the process used by the State in setting the reimbursement rate, while others review only the result flowing from thc rate and determine if the result produced by the State's reimbursement rate comport with the statutory requirements. *Compare Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997), *cert. denied* 522 U.S. 1044 (1998), *Arkansas Medical Soc'y v. Reynolds,* 819 F. Supp. 816 (E.D. Ark. 1993), *aff'd* 6 F.3d 519 (8th Cir.) *and Ohio Hosp. Ass'n v. Ohio Dep't of Human Serv.*, 579 N.E.2d 695, 698-99 (Ohio S.Ct. 1991) *with Rite Aid of Pennsylvania v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999) *and Methodist Hosp. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996).

8. The Court finds that these cases are instructive regardless of whether a plaintiff is challenging the imposition of a new reimbursement rate or whether a plaintiff is challenging an existing reimbursement rate.

9. The Court further concludes that the results oriented standard is appropriate in assessing the State's compliance with the requirements of § 1396a(a)(30)(A) in a case where plaintiffs are

challenging the State's substantive compliance with the adequate access requirement of the statute. The courts which have looked to the procedure undertaken by the State in setting reimbursement rates were concerned with ensuring statutory compliance for a new, and in some cases yet to be implemented, rate plan. In the Court's view, the best way to assess a new plan where results are not yet available, is to look at the procedures that the State used to ensure the results comport with the requirements of § 1396a(a)(30)(A). However, in cases where the rate has been in place, the courts appear to be more concerned with the results flowing from those existing rates and whether those rates achieve the mandates of the statute. *See, e.g., King v. Sullivan*, 776 F. Supp. 645 (D. R.I 1991); *Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) *aff'd in part and vacated in part on other grounds sub nom. Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992); *DeGregorio v. O'Bannon*, 500 F. Supp. 541 (E.D. Pa. 1980). Indeed, the best evidence of the adequacy of existing reimbursement rates is the effect that the rate is having on services. Additionally, the Court notes that the plaintiffs, from the evidence presented at trial as well as the allegations alleged in the complaint, challenge, not the procedural methods employed by the State in determining the reimbursement rate, only the substantive impact of the existing reimbursement rate on services provided to eligible Medicaid recipients.[4] *Cf. Rite Aid*, 171 F.3d at 850 (emphasizing that the plaintiffs in that case had not challenged the substantive impact or results of the revised rates).

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[4] Given the allegations in the complaint as quoted in paragraph 2 of the Conclusions of Law, the Court concludes that plaintiffs' challenge is to the defendant's substantive compliance with § 1396a(a)(30)(A), as opposed to the procedural methods undertaken by the State in setting the reimbursement rate.

10. The Court finds, therefore, that in cases such as the present one, where there is a challenge to existing reimbursement rates, as opposed to a new reimbursement plan, the adequacy of the reimbursement rate vis-a-vis § 1396a(a)(30)(A) should be evaluated, not by analyzing the process of establishing the rates, but by determining whether the existing rates are consistent with the statutory factors of efficiency, economy, quality of care and whether the existing rates are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[5] Stated simply, the existing rates must allow for adequate access and quality care.[6]

11. The Court further concludes that reimbursement rates provided by surrounding states may be relevant in determining whether West Virginia's reimbursement rate is in compliance with the Act. However, rates of other states are not dispositive as to whether a rate is adequate under the statute or whether the defendant is ensuring adequate access since the statute does not contemplate a comparison of the availability of services by state.

12. Additionally, the Court notes that while several surrounding states have higher reimbursement rates, the plaintiffs have failed to prove much more than that. For instance, there is no evidence that the ills of which the plaintiffs complain in West Virginia do not exist in neighboring states despite their higher reimbursement rate. Thus, in this particular

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[5] The Court is not faced with, nor is it deciding, which standard to apply in a case where a plaintiff is challenging a new rate plan, or something other than the substantive results of an existing rate.

[6] As the Court previously noted, however, only the issue of adequate access is before the Court for this decision.

case, the Count finds that the evidence of higher reimbursement rates of neighboring states in the same regional area as West Virginia is insufficient, standing alone, to meet Plaintiffs' burden.

13. Under the above articulated standard, the Court concludes that while the plaintiffs have proven that there are serious problems with the in-home care provided to eligible recipients, they have failed to prove that the reimbursement rates set by the State for residential habilitation and respite care services are the cause of the problems evidenced at trial.

CONCLUSION

There was a great deal of speculation and anecdotal testimony at trial that the reimbursement rate is the cause of the problems experienced by recipients.[7] However, speculation and hearsay do not supplant evidence. Plaintiffs offered no expert witnesses, such as vocational or employment specialists, to testify as to the relationship among wages, reimbursement rates, and high turnover. Witnesses from the BHCs surmised that the high turnover was caused, in part, by low wages but could not support their suppositions with surveys or exit interviews to confirm the cause of the turnover. While the high turnover is a problem, and low pay may be the cause, the evidence in the record on which the Court must rely is insufficient to support the conclusion that the reimbursement rate is the cause of the problems alleged by Plaintiffs. Plaintiffs have failed to prove that the reimbursement rate does not allow for adequate access.

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[7] Plaintiffs' witnesses provided a compelling description of the inadequacies of the Waiver program in these two critical services. Though the Court does not question their testimony, and Defendant offered no evidence to rebut it, the Court is reluctant to rely on the quantum of evidence submitted. Before finding the defendant in violation of either the adequate access or quality care duties arising under § 1396a(a)(30)(A), the Court insists on having evidence that the witnesses' complaints are representative of the class, that is, pervasive and recurring among Waiver recipients.

The Court, therefore, finds that judgment should be entered for the defendant. The Court **DIRECTS** the Clerk to send of copy of these Findings of Fact and Conclusions of Law to counsel of record and any unrepresented parties.

ENTER: August 9, 2000

ROBERT C. CHAMBERS
UNITED STATES DISTRICT JUDGE