ANNALS OF HEALTH LAW
Advance Directive

VOLUME 21 FALL 2011 PAGES 22-34

The Equal Access Provision: A Destiny of Ambiguity

Peter Nozicka·

I. INTRODUCTION

Medicaid is a joint federal-state welfare program in which the federal government shares costs with states that choose to participate in the program.[1] To participate, a state must submit a "plan for medical assistance" to the Secretary of Health and Human Services. The plan must describe the scope and nature of the state's Medicaid program and demonstrate that it complies with the requirements of the Medicaid Act.[2] If the Secretary approves the state's plan, they can submit quarterly expense reports and be reimbursed of a portion of the administrative costs and a portion of the costs paid to healthcare providers for their services.[3] If a state fails to comply with the Medicaid Act's requirements, including those related to provider reimbursement rates, the Secretary is authorized to revoke federal funding.[4]

· Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2013. Mr. Nozicka is a staff member of *Annals of Health Law*.
[1] Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 794 (2009).
[2] 42 U.S.C. § 1396a (2006) (listing the requirements for state Medicaid plans to receive federal funding).
[3] Rosemary B. Guiltinan, *Enforcing a Critical Entitlement: Preemption Claims as an Alternative Way to Protect Medicaid Recipients' Access to Healthcare*, 51 B.C. L. REV. 1583, 1590-91 (2010).
[4] 42 U.S.C. § 1396c (2006) (describing when the Secretary may refuse to make payments to a state's Medicaid program).

One such requirement is a provision in the Medicaid Act requiring payments to be "consistent with efficiency, economy, and quality of care" and "sufficient" to ensure that Medicaid patients' access to services is equivalent to the access of the general population of the same geographic area.[5]

This article will attempt to show the problem of state decisions to cut Medicaid reimbursement rates to providers, which leads to unequal access to the Medicaid program. It will also highlight the statutory ambiguity that has prevented the states from developing a proper metric to ensure compliance with the equal access provision. This paper will further address the circuit court decisions that have attempted to resolve the ambiguity of the equal access provision. Then, it will address the proposed rules recently promulgated by the Office of Health and Human Services, which attempt to provide the states with guidance on data measures to be used to gauge compliance with the equal access provision. Finally, this paper will attempt to show that the proposed regulations, as they stand today, do not help the states solve the aforementioned ambiguity of the provision, but create additional ambiguities for the state to overcome in order to comply with the regulations themselves.

II. THE PROBLEM: WHEN REIMBURSEMENT RATES LEAD TO DISPARATE ACCESS

In 2008, Medicaid reimbursement rates were, on average, only seventy-two percent of Medicare rates, while reimbursement rates for primary care services were even lower, at around sixty-six percent of Medicare rates.[6] "During the same period, Medicare itself paid twelve percent less than private insurers."[7] Within the bounds of the Federal Medicaid Act, states frequently use the cost-saving strategy of reducing reimbursements to healthcare providers for services that Medicaid recipients consume.[8] Cog-

[5] 42 USC § 1396a(a)(30)(A) (hereinafter "the equal access provision").
[6] Guiltinan, *supra* note 3, at 1585.
[7] *Id.*
[8] Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 673-74 (2006).

nizant of the temptation to pay providers too little, Congress included the equal access provision in the Medicaid Act, a key safeguard, which requires payments to be "consistent with efficiency, economy, and quality of care" and "sufficient" to ensure that Medicaid patients' access to services is equivalent to the access of the general population of the same geographic area.[9]

The sweeping and ambiguous "equal access provision" has led to frustration for states and litigation for Medicaid stakeholders.[10] The equal access provision has led to litigation by providers and patients, challenging states' Medicaid reimbursement payment rates.[11] The federal appellate courts have thus far been inconsistent in their interpretations of the equal access provision.[12] The Centers for Medicare & Medicaid Services (CMS) "points out that states currently do not have [any real] guidance on how to determine compliance with the statutory access requirements. . . ."[13] This is a dangerous proposition as, due to the recent economic downturn, "most states have experienced a decrease in revenues coupled with a sharp increase in Medicaid enrollment."[14] This disparity has led a number of states to further explore provider payment reductions as an answer to their budget imbalances.[15] Budget pressure led thirty-three states to cut or freeze reimbursement rates in fiscal year 2009; thirty-nine states did so in fiscal year 2010, and thirty-seven states are planning reimbursement rate restrictions for fiscal

---

[9] 42 USC § 1396a(a)(30)(A), *supra* note 5.
[10] *See* Moncrieff, *supra* note 8, at 674.
[11] *Id.*
[12] *Id.*
[13] Debra A. McCurdy, *CMS Proposed Rule on Methods for Assuring Access to Covered Medicaid Services*, HEALTH INDUSTRY WASHINGTON WATCH (May 13, 2011), http://www.healthindustrywashingtonwatch.com/2011/05/articles/regulatory-developments/hhs-developments/other-cms-developments/cms-proposed-rule-on-methods-for-assuring-access-to-covered-medicaid-services/.
[14] Am. Ass'n. of Med. Colleges, *CMS Releases Medicaid Equal Access Proposed Rule*, (May 20, 2011), https://www.aamc.org/advocacy/washhigh/highlights2011/189868/cmsreleasesmedicaidequalaccessproposedrule.html.
[15] VERNON K. SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FUND., THE CRUNCH CONTINUES: MEDICAID SPENDING, COVERAGE AND POLICY IN THE MIDST OF A RECESSION; RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2009 AND 2010 5-6 (2009), *available at* http://www.kff.org/medicaid/upload/7985.pdf.

year 2011.[16]

A Government Accountability Office survey has found that physicians nationwide who participate in Medicaid and Children's Health Insurance Program (CHIP) are generally less willing to accept children covered by CHIP as new patients than privately insured children.[17] For example, about seventy-nine percent participating physicians are accepting all privately insured children as new patients, while only accepting forty-seven percent of children in Medicaid and CHIP.[18] Further, according to a survey of physicians, those surveyed experienced unique and significant difficulties when they attempted to refer children covered by Medicaid and CHIP to specialty care.[19] As such, reimbursement rate cuts leading to disparate access becomes a very real problem, and the equal access provision is the key safeguard to ensure that beneficiaries are getting the care they need.

III. THE CONFUSION, HOW CIRCUIT COURTS HAVE INTERPRETED THE EQUAL ACCESS PROVISION

The circuit courts have been less than consistent in their interpretations of the equal access provision of the Medicaid Act.[20] In deciding cases that have been brought by either providers or patients against state health agencies, the courts have disagreed as to the proper analytical framework for determining the legal adequacy of reimbursement rates in the context of their compliance with the language of the equal access provision.[21]

The Seventh Circuit and the Fifth Circuit have focused their analyses on the language of the last clause of the equal access provision.[22] Under this type of analysis, the only issue in determining state compliance with the

---

[16] *Id.*
[17] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-624, MEDICAID AND CHIP: MOST PHYSICIANS SERVE COVERED CHILDREN BUT HAVE DIFFICULTY REFERRING THEM FOR SPECIALTY CARE 11 (2011).
[18] *Id.* at 11.
[19] *Id.* at 20.
[20] *See* Moncrieff, *supra* note 8, at 674.
[21] *See generally,* Moncrieff, *supra* note 8, at 673.
[22] *See Evergreen Presbyterian Ministries, Inc v. Hood*, 235 F.3d 908, 927–32 (5th Cir. 2000); *see also Methodist Hosp., Inc v. Sullivan,* 91 F.3d 1026, 1029 (7th Cir. 1996).

equal access provision of the Medicaid Act is whether Medicaid patients have the same access to services that their private-market counterparts do.[23] This interpretation of the equal access provision has led the Seventh Circuit and the Fifth to apply what has been called an "access metric."[24] Under the access metric scheme, plaintiffs must prove that Medicaid recipients are less able to access healthcare services than their privately insured counterparts.[25] In *Methodist Hospitals, Inc. v. Sullivan*, hospitals challenged the state of Indiana's amended reimbursement scheme, claiming that the state violated the equal access provision by failing to conduct adequate cost studies prior to setting a new reimbursement rate.[26] Prior to the challenged amendment, Indiana reimbursed hospitals based on their "customary billing" rate.[27] The amendment proposed to reimburse hospitals on a flat rate, irrespective of the hospital's actual costs.[28] This flat rate was calculated by adding fifty percent of Medicare's rate plus fifty percent of the statewide median amount paid for service.[29] In this oft-cited opinion, the Seventh Circuit stated that the equal access provision does not require states to conduct studies before setting reimbursement rates.[30] The court was not concerned with the methodology; only the result of each State's scheme, stating that the equal access provision "requires each state to produce a result, not to employ any particular methodology for getting there."[31] The test, simply stated, is whether enough providers are participating in Medicaid, and focuses exclusively on the equal access language of the equal access provision stating, "[u]nder §1396a(a)(30), . . . states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not,

---

[23] *Id.*
[24] *See* Moncrieff, *supra* note 8, at 678.
[25] *Id.*
[26] *Sullivan*, 91 F.3d at 1026.
[27] *Id.* at 1028.
[28] *Id.*
[29] *Id.*
[30] *Id.* at 1030.
[31] *Id.*

the state may (and under §1396a(a)(30), must) raise the price until the market clears."[32]

The Fifth Circuit later adopted the same reasoning and test in *Evergreen Presbyterian Ministries v. Hood*.[33] This action arose from a state decision by Louisiana to cut payments by seven percent in order to recover from budgetary shortfalls.[34] The Fifth Circuit rejected a district court opinion that would have required the state to take into account the impact of the cut on providers.[35] Instead, the court framed the issue as, "whether evidence exists in the record that supports a finding that after the reimbursement rate reduction, recipients will not have access to medical care equal to that of the non-Medicaid population in the same geographic area."[36] In the same vein as the Seventh Circuit's test, the Fifth Circuit's interpretation of the equal access provision is not concerned with the "economy, efficiency, or quality" considerations of a state's chosen rate. Thus, state plans in these jurisdictions need not make any showing of these considerations. They must only show that the state plans do not impair access.[37]

Unlike the Fifth and Seventh Circuits' interpretations of the equal access provision, which are preoccupied with the result of the rate setting procedure, the Ninth Circuit has set forth an interpretation that addresses the procedure of rate setting itself through "all four factors included in §30(A)—efficiency, economy, quality, and access—giving this interpretation a more solid textual foundation than the access metric."[38] To comply with the equal access provision, states would need to create a payment rate that is both consistent with efficiency and economy and reflects the actual costs to the providers.[39] Further, the court added that the reimbursement rates "must bear a reasonable relationship to provider costs, unless there is some justifi-

---

[32] *Id.*
[33] *Evergreen Presbyterian Ministries, Inc.*, 235 F3d at 932.
[34] *Id.* at 909.
[35] *Id.*
[36] *Id.* at 932.
[37] *Id.*
[38] *See* Moncrieff, *supra* note 8, at 689.

cation for rates that do not substantially reimburse providers their costs."[40] This ruling established what has been called the "cost metric"[41] and was affirmed by the Ninth Circuit in 2009.[42] In the Ninth Circuit, plaintiffs must show that the state neglected to study or consider providers' costs when setting rates, and thus the question becomes whether the state based its reimbursement rates on "reliable cost studies."[43] This creates a duty on state plans to conduct such studies.[44]

Other litigation over compliance with the equal access provision has occurred in the Eighth and Third Circuits.[45] These Circuits have declined to set forth a bright-line metric for compliance and instead give great deference to state rate-setting designs, holding such rate setting to an "arbitrary and capricious" standard.[46] These holdings have left states without any bright line guidance and have subjected the states to additional burden as they attempt to design new payment schemes that satisfy the equal access provision.[47]

IV. A MISSED OPPORTUNITY FOR CLARITY, THE PROPOSED RULES

In 2009, Congress created the Medicaid and CHIP Payment and Access Commission (MACPAC)[48] "specifically to study and make recommendations on beneficiary access to care in

Medicaid and CHIP."[49] MACPAC created a recommended method on

---

[39] *Orthopedic Hospital v Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997).
[40] *Id.* at 1499.
[41] *See* Moncrieff, *supra* note 8 at 688-89.
[42] *See*, *Independent Living of Southern California v. Maxwell-Jolly*, 572 F.3d 644, 652 (9th Cir. 2009)
[43] *Id.*
[44] *Orthopedic Hospital*, 103 F.3d at 1496.
[45] *See Rite Aid of Pennsylvania, Inc v. Houstoun*, 171 F.3d 842, 851 (3rd Cir. 1999); *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).
[46] *See Rite Aid of Pennsylvania*, 171 F.3d at 853 (3rd Cir. 1999); *Arkansas Medical Society, Inc.*, 6 F.3d at 529 (8th Cir. 1993).
[47] *See* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 88, 26343 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447) [hereinafter Medicaid Program].
[48] Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 506, 123 Stat. 8, 91 (2009).
[49] *See* Medicaid Program, *supra* note 47, at 26343.

how to measure access to care for beneficiaries after reviewing decades of research and significant consulting with key Medicaid stakeholders.[50] As a result, the MACPAC recommendation promulgated a three-pronged analytical framework for states to adopt in order to be sure their plans are in compliance with the equal access provision.[51] The MACPAC-recommended framework adopted in the proposed rule considers: "(1) enrollee needs; (2) the availability of care and providers; and (3) utilization of services."[52]

In the May 6, 2011 edition of the Federal Register, CMS published "Methods for Assuring Access to Covered Medicaid Services."[53] In the proposed rules, CMS adopts the MACPAC three-part framework, providing the first Congressionally authorized expert guidance on how to analyze beneficiary access to care.[54] A first look at these proposed regulations reveals that the rule is more concerned with data gathering strategies for states to implement than setting forth strategies that would provide criteria for compliance with the equal access provision.[55]

The access metric has been criticized as being difficult for courts to administer, too narrow and thus against congressional intent, and in violation of Medicare because it does not compare Medicaid rates with those of private insurers or Medicare.[56] The rules themselves seem to work towards alleviating this criticism because contrary to the access metric, the proposed rules deal with factors other than just results of the rate-setting procedures.[57] In fact, they deal with the data methods states use in ensuring compliance with the equal access provision, and do not set any criteria or goals for states in terms of the results.[58]

The cost metric has been criticized as being "too restrictive of state au-

---

[50] *Id.*
[51] *Id.* at 26344.
[52] *Id*.
[53] Am. Ass'n. of Med. Colleges, *supra* note 14
[54] *See* Medicaid Program, *supra* note 47, at 26344.
[55] Medicaid Program, *supra* note 47, at 26349 (the agency notes that it considered and rejected uniform data measures as well as uniform substantive access thresholds).
[56] *See* Moncrieff, *supra* note 8*,* at 681-82.
[57] Medicaid Program, *supra* note 47*,* at 26344.

tonomy, preventing the states from using reimbursement rates as a means of controlling utilization," and thus creating administrative burdens on state agencies.[59] The logic behind this criticism is that "the state carries a substantial administrative burden because it must conduct or acquire 'responsible cost studies' and must justify any deviation from providers' costs if it wants to implement a creative payment scheme."[60] The rule states that one of its principal goals is to "develop a coordinated and streamlined data solution aimed at reducing redundancy, administrative burden, and to maximize business value."[61] The rule replaces the duty imposed under the cost metric to conduct reasonable cost studies with a duty to make ongoing reports about how states are gathering data that will ensure compliance with the equal access provision.[62] Thus, it seems to replace one administrative burden with another. However, CMS does estimate modest state administrative costs associated with the rule.[63]

The proposed regulation text also describes the timeframe for states to conduct the data

review and make the information available to the public.[64] States must review a subset of Medicaid services each year, with all covered services undergoing a full review at least once every five years.[65] The rationale behind providing for the five-year window is to "allow States to determine the best use of available State resources in conducting the access review and to prioritize the review in light of program changes or particular access con-

---

[58] *Id.* at 26349.
[59] *See* Moncrieff, *supra* note 8, at 691.
[60] *Id.* at 694.
[61] Medicaid Program, *supra* note 47, at 26346.
[62] *Id.* at 26361.
[63] *Id.* at 26354-57 (estimating that each access data review will cost slightly more than $18,000, with an entire estimated annual cost for state reviews of slightly more than $900,000. Ongoing access monitoring would cost slightly less than $90,000 annually for affected states, beneficiary feedback mechanisms, slightly less than $230,000 for all states, and annual corrective actions about $37,000 annually for all affected states.)
[64] *Id.* at 25353.
[65] *Id.* at 26345.

cerns."[66] However, if a state proposes reducing or restructuring provider rates, the state must submit, along with its state plan amendment, a completed access review.[67] In addition to the access review that states will be required to submit when proposing to reduce or restructure provider rates, states considering such measures will be required to solicit input from affected stakeholders as to the likely impact of the proposed changes.[68] The Rule would put a duty on states to set up sufficient channels for ongoing access input from beneficiaries and other stakeholders.[69] Promoting the use of electronic media to fulfill this, CMS recommends surveys, hotlines, and ombudsmen.[70]

If the access review or such ongoing monitoring shows impediments to access below the standard required in the equal access provision, the state will now be required to submit, within ninety days, a corrective action plan that details specific steps and dates to remedy the identified problems.[71] In instances when the access reviews identify conflicts between the state plan and the equal access provision, the rule does not impose an affirmative duty on states to consult directly with beneficiaries, but rather leaves it to the discretion of the states.[72] Instead, "in circumstance[s] when changes [to provider rates] could result in access issues," the agency must submit the results of its access review along with any proposed state plan amendment to reduce or restructure provider rates.[73] These reviews "must demonstrate sufficient access for any service for which the State agency proposes to reduce payment rates or restructure provider payments in circumstances when

---

[66] *Id.* (further stating that the burden associated with an annual review would likely be high and may not demonstrate any changes in access to care if the payment rates and service delivery systems remain stable.)
[67] *Id.* at 26354. (stating that CMS believes this is appropriate so that States consider the impact that such proposals may have on access to care and demonstrate compliance with the equal access provision.)
[68] *Id.* at 23360.
[69] *Id.*
[70] *Id.*
[71] *Id.* at 26347.
[72] *Id.* at 26360-61.
[73] *Id.* at 26361.

the changes could result in access issues."[74]

While stating that payment levels are a factor to consider in their analysis under the rule and imposing a duty to collect specific information on payment levels, CMS also claims that access can be improved through improving provider enrollment and retention, offering incentive payments for allowing off-hours appointments, or structuring rates to encourage the development or expansion of clinics in underserved areas.[75] State reviews would be required to include specific data on payment levels, including: Medicaid rates as percentages of average customary provider charges; Medicaid rates as a percentage of Medicare rates, average commercial payer rates, or the applicable Medicaid allowable cost of the service; and an estimate of the average percentage increase or decrease resulting from any proposed change in payment rates within one year.[76]

While these measures are laudable in that they force the states to give heavy consideration to how their potential reimbursement cuts will affect beneficiary access to services, they do not address the core problem of the statutory ambiguity itself. As such, while states will be forced to collect data on the extent to which their plans are in compliance with the statute, the rule gives no guidance on how to apply these data.[77] This problem becomes daunting for beneficiaries as there is pending litigation in front of the Supreme Court that could end beneficiaries' and providers' rights to bring judicial challenges to state Medicaid provider payment reductions that threaten to reduce access to care.[78] With no guidance on requirements of compliance, and no judicial review of decisions, there will be no effective means to ensure that the safeguard of the equal access is anything other than a dead letter.

---

[74] *Id.*
[75] *Id.* at 26347.
[76] *Id.* at 26361.
[77] *Id.* at 26349 (the agency notes that it considered and rejected uniform data measures as well as uniform substantive access thresholds).
[78] *See* Sara Rosenbaum, *Medicaid and Access to the Courts*, 16 NEW ENG. J. MED. 364, 1489-91 (2011).

V. SHORTFALLS OF THE PROPOSED RULE

The first major criticism of the proposed rules is that they have only a narrow reach, as they only apply to fee-for-service arrangements.[79] Thus, they are completely inapplicable to other arrangements, such as risk-based managed care arrangements, as those arrangements are governed by separate regulatory requirements.[80] Approximately seventy percent of all Medicaid beneficiaries are in managed care arrangements.[81] While CMS notes that managed care is governed by separate regulatory requirements, nothing in the Medicaid statute exempts such arrangements from the requirements of the equal access provision.[82] Next, the proposed rule requires public notice when "significant" changes in payment standards are proposed.[83] However, CMS fails to define what a "significant" change might be anywhere in the proposed

rule.[84] Also, there is a disconnect between the wording of the proposed rule and the wording of the equal access provision itself. The rule focuses on enrollee needs and provider availability for Medicaid beneficiaries, but the equal access provision focuses on availability in relation to other populations in the same geographic area.[85] Thus, the rule does not provide the states any guidance on compliance with an essential element of the statute.

Finally, a state must submit access reviews of relevant information gathered within the year preceding the date of a proposed rate reduction only if its changes "could result in access issues."[86] This statement is similarly vague to the aforementioned "significant change" language and could cause additional problems for states seeking to be in compliance with the equal

---

[79] Medicaid Program, *supra* note 47, at 26344.
[80] *Id.*
[81] KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FUND., MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2010), *available at* http://www.kff.org/medicaid/upload
/8046.pdf.
[82] 42 USC § 1396a(a)(30)(A), *supra* note 5 (1396a applies to all state plans, this necessarily includes both fee-for-service and managed care arrangements).
[83] Medicaid Program, *supra* note 47, at 26347.
[84] *Id.* (specifically stating that the term "significant" is undefined).
[85] 42 USC § 1396a(a)(30)(A), *supra* note 5.

access provision. While it should be noted that this is only a proposed rule that is subject to change, the rule is more focused on procedures to obtain data to promote compliance with the equal access provision and misses an opportunity to provide criteria or outcome goals to ensure that the states are actually in compliance with the equal access provision.

VI. CONCLUSION

In the midst of the epidemic state budget shortfalls, one of the major ways states are trimming their bottom-line is by cutting reimbursement rates for healthcare providers who participate in Medicaid. These cuts lead to less provider participants, which in turn create problems for beneficiaries who are seeking access to the provider's services. They key safeguard against the extreme consequences of this cycle is the equal access provision. However, the language of the provision is broad, and as such courts have not provided consistent guidance on the measures states need to take to comply with the provision. HHS and CMS have released regulations that charge states with mandatory data collection and reporting on compliance with the equal access provision, but these regulations are unlikely to be helpful as they only apply to fee-for-service arrangements, and because they do not provide any uniform data measures or uniform substantive access thresholds. Thus, the ambiguity of this vital provision is likely to continue.

---

[86] Medicaid Program, *supra* note 47, at 26345.