Essay

Thirty-Five Years of Inaction: The Unfulfilled Promise of the Medicaid Equal Access Provision

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INTRODUCTION

In 1989, Congress amended the Social Security Act to ensure that Medicaid recipients would have the same access to medical providers as people covered by private insurance and Medicare.[1] This was meant to remedy the wide disparities in access to care faced by Medicaid beneficiaries. Congress placed the responsibility for bringing that promise to reality in the hands of the Department of Health and Human Services (HHS). Nearly 35 years later, HHS and the Centers for Medicare and Medicaid Services (CMS), which HHS oversees, have failed to take meaningful steps to ensure that Medicaid recipients have adequate access to medical care. When CMS finally promulgated equal access regulations in 2015 and 2016, it focused exclusively on data collection and transparency.[2] In May 2023, CMS proposed updated equal access regulations.[3] Yet again, the proposed regulations promise improved data collection and transparency, not action. Medicaid recipients continue to face significant disparities in access to care—with far fewer providers accepting their

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1. 42 U.S.C. § 1396a(a)(30)(A).

2. 42 C.F.R. § 447 (2015).

3. Various federal regulations would be subject to the updated regulations, including: 42 C.F.R. § 431 (2016); 42 C.F.R. § 433 (2016); 42 C.F.R. § 438 (2016); 42 C.F.R. § 440 (2016); 42 C.F.R. § 457 (2016); 42 C.F.R. § 495 (2016).

insurance than those who accept privately insured patients. CMS must take appropriate action under the Social Security Act's statutory mandate to improve access to care for Medicaid recipients or face litigation under the Administrative Procedure Act (APA).

I. MEDICAID AND ACCESS TO CARE

Medicaid is the single largest insurer of Americans.[4] Half of low-income Americans receive health insurance through Medicaid plans.[5] As of May 2023, over eighty-six million, or more than one in five, Americans were enrolled in Medicaid.[6] Over seven million children were enrolled in the Child Health Insurance Program (CHIP)[7] and eighty-one percent of children living below the federal poverty line are Medicaid enrollees.[8]

The Medicaid program faces many criticisms, including that it is plagued by high administrative burdens and decentralization, but one of the most pressing problems faced by enrollees is inadequate access to providers.[9] Nationally, only about sixty-five

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4. *Medicaid*, AM. HOSP. ASS'N (2024), https://www.aha.org/node/2828 [https://perma.cc/SS4U-RASU].

5. Abbi Coursolle, Jane Perkins & Daniel Young, *Medicaid's Equal Access Regulations in Danger of Being Eliminated*, NAT'L HEALTH L. PROGRAM (Sept. 10, 2019), https://healthlaw.org/medicaids-equal-access-regulations-in-danger-of-being-eliminated [https://perma.cc/7Q2J-DWZQ].

6. *May 2023 Medicaid & CHIP Enrollment Data Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 28, 2023), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html [https://perma.cc/T5WS-9Q76]. These numbers are expected to decrease over the next 6 to 12 months, as states have begun the redetermination process—reevaluating eligibility for the first time since the COVID-19 pandemic began and a Public Health Emergency (PHE) was declared. Regardless, seventy-one million individuals were enrolled in Medicaid or CHIP in February 2020, accounting for over 20 percent of the U.S. population. For full data sets that may be searched by timeframe, see *Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment*, KFF (2023), https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment [https://perma.cc/5UT5-8BND].

7. *May 2023 Medicaid & CHIP Enrollment Data Highlights*, *supra* note 6.

8. Robin Rudowitz, Alice Burns, Elizabeth Hinton & Maiss Mohamed, *10 Things to Know About Medicaid,* KFF (June 30, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid [https://perma.cc/C743-PDXA].

9. *E.g.*, *Report to Congress on Medicaid and CHIP*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 134 (2017), https://www.macpac.gov/wp-content/uploads/2017/03/March-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf

percent of medical care providers accept Medicaid patients, while over ninety percent accept privately insured patients and nearly eighty percent accept Medicare enrollees.[10] Almost five percent of academic medical health centers and hospitals refuse to accept Medicaid, while nearly one hundred percent accept privately insured patients.[11] There are particularly large disparities in access to certain types of specialty care. For example, 45.5 percent of psychiatric care providers do not accept Medicaid, compared to about thirty percent who do not accept privately insured patients.[12] Children with special health needs also face high barriers to accessing care. Research by the Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan legislative branch agency that analyzes data related to Medicaid and CHIP, shows that children with special health needs who are on Medicaid or CHIP have more problems finding doctors who accept their health insurance than those on private insurance.[13] They found the same to be true for adults under the age of sixty-five who have disabilities.[14]

Medicaid beneficiaries' lack of access to providers is also a racial justice issue. People of color are disproportionately affected by access to care issues because Medicaid enrollees are disproportionately non-white. In 2021, only forty percent of Medicaid enrollees were white, compared to about nineteen percent who were Black and twenty-nine percent who were Hispanic.[15]

[https://perma.cc/Z9Q9-R2DS] ("[A]dults and children with Medicaid coverage have more problems than privately insured individuals in obtaining care, that is, they experience longer wait times for appointments, have more difficulty finding a provider who will treat them, have more trouble obtaining transportation, or have to wait longer at the provider's site of care").

10. *National Electronic Health Records Survey (NEHRS)*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 15, 2024), https://www.cdc.gov/nchs/nehrs/about.htm [https://perma.cc/U47E-KZGG].

11. *Id.*

12. *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 3 (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf [https://perma.cc/6BLZ-ES3M].

13. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 9, at 135.

14. *Id.*

15. *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, KFF (2023), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId

The states with the lowest reimbursement rates have higher nonwhite enrolled populations.[16] Non-white individuals are not only more likely to be enrolled in Medicaid, they are also more likely to face access to care issues than white Medicaid enrollees. For example, Black and Hispanic Medicaid enrollees have been shown to be less likely to receive primary or mental health care than white enrollees over a twelve-month period.[17] This translates into worse health outcomes, with, for example, white non-Hispanic children being more likely to report having good or excellent health than those in other racial and ethnic groups.[18]

A. Low Reimbursement Rates and Inadequate Access to Care

Why do Medicaid patients face such large disparities in access to care? Overwhelming evidence suggests that the key reason is that Medicaid programs underpay providers, as compared to private insurers and even Medicare.[19] In 2020, hospitals received eighty-eight cents for every dollar they spent treating Medicaid patients.[20] Over the course of a year, this translated into a $24.8 billion shortfall for hospitals.[21] Underpayment rates are far higher for public payers, i.e., Medicaid and Medicare programs, than for private insurers.[22] This disparity is particularly

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%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/U4PC-CPQL].

16. Tiffany Ford & Jamila Michener, *Medicaid Reimbursement Rates Are a Racial Justice Issue*, THE COMMONWEALTH FUND (June 16, 2022), https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue [https://perma.cc/GY85-SUXF].

17. *Access in Brief: Experiences in Accessing Medical Care by Race and Ethnicity*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 2 (Feb. 2022).

18. *Id.*

19. *See infra* notes 30–34 and accompanying text (describing the rates and policy guidelines that state utilize when determining healthcare payment structures).

20. *Underpayment by Medicare and Medicaid Fact Sheet*, AM. HOSP. ASS'N, 2 (Feb. 2022), https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf [https://perma.cc/A8GM-KEJC].

21. *See* Ford & Michener, *supra* note 16.

22. Paige VonAchen, Dipika Gaur & Walter Wickremasinghe, *Assessment of Underpayment for Inpatient Care at Children's Hospitals*, 175 JAMA PEDIATRICS 972, 972 (2021) ("Of the 216, 935 admissions analyzed, 35.6% resulted in underpayment. Underpayment was more prevalent with public [versus] private payers (51.2% [versus] 17.9%).").

pronounced in children's hospital admissions, with 51.2 percent of claims submitted to Medicaid leading to underpayment, as compared to 17.9 percent of claims submitted to private insurance companies.[23] Hospitals that serve a majority Black population are disproportionately affected by underpayment because they serve a significantly larger Medicaid population than other hospitals.[24] This results in diminished financial resources for these hospitals, which, in turn, can lead to reduced resources for care. [25]

Part of the reason for low payment rates is that Medicaid is underfunded.[26] The other is that Medicaid is not uniformly administered nationwide, resulting in some states having much lower payment rates than others.[27] Medicaid is jointly funded by federal and state governments and Medicaid programs are state-run with some federal oversight. The Centers for Medicare and Medicaid (CMS), which falls under the Department of Health and Human Services (HHS), issue federal guidelines, but states largely administer their individual Medicaid programs independently of the federal government.

States can choose to operate their Medicaid programs using a fee-for-service model or by contracting with a managed care organization (MCO). MCOs are generally large insurance companies, such as Blue Cross/Blue Shield or United Healthcare.[28] These MCOs are responsible for contracting with providers and monitoring quality standards, including adequate access to

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23. *Id*.

24. Gracie Himmelstein, Joniqua N. Ceasar & Kathryn EW Himmelstein, *Hospitals That Serve Many Black Patients Have Lower Revenues and Profits: Structural Racism in Hospital Financing*, 38 J. GEN. INTERNAL MED. 586, 586 (2023).

25. *Id*.

26. Seema Verma, *I'm the Administrator of Medicaid and Medicare. A Public Option Is a Bad Idea*, WASH. POST (July 24, 2019), https://www.washingtonpost.com/opinions/a-public-option-for-health-insurance-is-a-terrible-idea/2019/07/24/fb651c1a-ae2e-11e9-8e77-03b30bc29f64_story.html [https://perma.cc/PRR2-7PB6].

27. *Medicaid-to-Medicare Fee Index*, KFF (2019), https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/AK4L-2D9F].

28. *Characteristics of Medicaid Managed Care Plans,* MEDICAID & CHIP PAYMENT & ACCESS COMM'N (2024), https://www.macpac.gov/subtopic/characteristics-of-medicaid-managed-care-plans [https://perma.cc/VBH7-J5WV].

care.[29] The state provides capitated payments to the MCOs.[30] These are fixed monthly payments the state makes per enrollee to cover all of that enrollee's medical costs, regardless of actual costs incurred.[31] This, in turn, means that the MCO is incentivized to minimize its per person expense—because it will not be reimbursed by the state for any additional expenses made (and, on the flip side, it can pocket any difference between the state capitation rate and actual expenses as profits). CMS oversees this process by requiring that MCOs set actuarily sound capitation rates.[32] This means that the rates, which are set annually, must consider utilization, cost, and service use data, among other factors.[33] Notably, however, CMS regulations do not require that MCOs 1) factor access to services in their calculation of an actuarily sound capitation rate or 2) reimburse providers at a certain minimum rate.[34] The former means that MCOs can set rates without considering whether the rates are so low that they will deter care providers from accepting Medicaid patients at all. The latter means that after receiving the capitation payment, MCOs have full autonomy over how they administer their program and the rate at which they reimburse providers for services. By and large, CMS is more concerned with the ceiling for reimbursement rates, not the floor—meaning that CMS wants to ensure that states are not paying MCOs more for services than necessary, but is less concerned with the effect of rates on access to services.

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29. *Monitoring Managed Care Access*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (2024), https://www.macpac.gov/subtopic/monitoring-managed-care-access [https://perma.cc/S6YU-5SBW].

30. *Medicaid Managed Care Payment*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (2024), https://www.macpac.gov/subtopic/medicaid-managed-care-payment [https://perma.cc/K7RT-EAG4].

31. *Id.*

32. 42 C.F.R. § 438.4 (2016); *2022-2023 Medicaid Managed Care Rate Development Guide for Rating Periods Starting between July 1, 2022 and June 30, 2023*, U.S. DEP'T OF HEALTH & HUM. SERVS. 2 (Apr. 2022), https://www.medicaid.gov/medicaid/managed-care/downloads/2022-2023-medicaid-rate-guide-03282022.pdf [https://perma.cc/7BML-YB83].

33. Elizabeth Hinton & MaryBeth Musumeci, *Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic*, KFF (Sept. 9, 2020), https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic [https://perma.cc/CG47-HTJ4].

34. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 32, at 16–18.

The vast majority of states, thirty-nine of them as of 2020, rely on MCOs.[35] This means that nearly seventy-five percent of all Medicaid enrollees receive coverage through an MCO. A minority of states use a fee-for-services model, which means that they administer their own insurance programs, directly paying private care providers for services.[36]

B. LOW MEDICAID REIMBURSEMENT RATES CAUSE POOR ACCESS TO CARE

There is widespread scholarly consensus that low reimbursement rates help drive the shortage of medical care providers accepting Medicaid. In 2019, Seema Verma, the then Administrator of CMS, wrote about low reimbursement rates, noting that low Medicaid payments were the reason that a "substantial proportion of providers . . . do not accept new patients on Medicaid."[37] Economic research has confirmed this theory. The Affordable Care Act (ACA) included a temporary mandate to increase Medicaid payments for certain primary care services to match Medicare reimbursement rates. This increase has been shown to have led to an improvement in access to care.[38] A ten dollar increase in Medicaid payments was linked with a thirteen percent decrease in the number of adult Medicaid patients that were told their doctor does not accept their insurance.[39] The mandate expired in 2015 and has not been renewed since, resulting in most states reducing rates back to 2012 levels. The decrease was linked with a return to lower Medicaid acceptance rates, providing further evidence of a causal link between payment levels and likelihood of Medicaid acceptance.[40] Research based on these changes in Medicaid policy shows that a forty-five dollar increase in Medicaid payments could eliminate over

35. Elizabeth Hinton & Jada Raphael, *10 Things to Know About Medicaid Managed Care,* KFF (Mar. 1, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/#:~:text=More%20than%20two%2Dthirds%20(72,care%20through%20risk%2Dbased%20MCOs [https://perma.cc/D5TY-ELTN] (see Figure 2, noting the states with MCOs and the share of Medicaid beneficiaries enrolled in said program).

36. *Id.*

37. Verma, *supra* note 26

38. Diane Alexander & Molly Schnell, *The Impacts of Physician Payments on Patient Access, Use, and Health*, NAT'L BUREAU OF ECON. RSCH. 2 (July 2019), https://www.nber.org/papers/w26095 [https://perma.cc/6K3M-MVH5].

39. *Id.*

40. *Id.* at 3–4.

two thirds of disparities in access to care between Medicaid and privately insured adult patients and would completely eliminate these disparities for child patients.[41]

II. THE EQUAL ACCESS PROVISION

Despite regulations promulgated in 2015 and 2016 and repeated litigation efforts, the reality of access to care, and, relatedly, underpayment for services, has not improved. This violates the law. The Social Security Act requires that all Medicaid beneficiaries have adequate access to providers.[42] Per the Act, this means that states must set payment rates high enough to ensure Medicaid enrollees have similar access to providers as privately insured and Medicare patients in the same geographic area.[43]

Between 1989, when the Medicaid equal access provision was passed and 2015, CMS did not promulgate any regulations based on the statutory mandate.[44] With no federal guidance, states varied widely in their compliance with it, with some

41. *Id.* at 3.

42. 42 U.S.C. § 1396a(a)(30)(A) (Requiring that states "provide such methods and procedures . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and 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.").

43. Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 677 (2006); H.R. REP. NO. 101-247, at 390–91 (1989) ("The Committee expects that the Secretary, in determining whether services are available to Medicaid beneficiaries at least to the extent that services are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage . . . . It is obvious that Medicaid beneficiaries are likely to have better access to care than individuals without insurance coverage and without the ability to pay for services directly. The question which the Secretary must ask is whether Medicaid beneficiaries have access to provider services that is at least as great as that of others in the area who have third party coverage.").

44. CMS did propose a rule based on the equal access provision in 2011, decades after the statutory mandate was enacted, but it did not promulgate a final rule following notice and comment. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (proposed May 6, 2011). *See also* Sara Rosenbaum, *Medicaid and Access To Care: The CMS Equal Access Rule*, HEALTHAFFAIRS (Nov. 19, 2015), https://www.healthaffairs.org/content/forefront/medicaid-and-access-care-cms-equal-access-rule [https://perma.cc/D8UM-PF6V].

making a concerted effort to ensure adequate access to providers and others developing metrics that were all but guaranteed to demonstrate equal access where it did not exist. In 2014, the Office of the Inspector General evaluated the adequacy of access to care for Medicaid managed care beneficiaries, for example, and found a great deal of state-by-state variation in how access to care was measured.[45] Almost all of the surveyed states set a maximum allowed amount of travel time or distance for enrollees to have to travel to reach a primary care provider.[46] However, this maximum time or distance varied widely—ranging from five miles to sixty miles—and did not account for differences *within* states, namely, between urban and rural areas.[47] Similar variation existed in standards based on number of providers per capita.[48] Some states defined adequate access to mean that there was one primary care provider that accepted Medicaid for every one hundred enrollees, while others defined it as one primary care provider per 2,500 enrollees.[49] There was also tremendous variation in how states determined whether their Medicaid programs were complying with their own standards. The vast majority of surveyed states did not even directly assess access to care, relying instead on external indicators, such as self-attestations by MCOs or phone number directories of providers, with no evidence that the MCO has validated the directory to ensure that providers actually accepted Medicaid patients.[50] The few states that did use direct tests, such as using "secret shopper" calls to ask providers to ask if they accept Medicaid, were most likely to find violations of access standards, indicating the utility and sensitivity of these measures, as compared to indirect tests.[51]

During this same time period, Medicaid providers and beneficiaries occasionally secured legal relief when states reduced

45. Suzanne Murrin, *State Standards for Access to Care in Medicaid Managed Care*, DEP'T OF HEALTH & HUM. SERVS. 13–15 (Sept. 2014), https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf [https://perma.cc/8J5Y-2N4A].

46. *Id.* at 8–9.

47. *Id.*

48. *Id.* at 10–11.

49. *Id.* at 10.

50. *Id.* at 13.

51. *Id.*at 14.

Medicaid provider payment rates.[52] That became impossible in 2015, when the Supreme Court held in *Armstrong v. Exception Child Center* that the equal access provision did not create a private right of action, meaning that providers, and presumably beneficiaries, could not enforce it in court.[53] In *Armstrong*, the Court held that the sole remedy under the Medicaid Act's access to care requirement is for the Secretary of Health and Human Services to withhold Medicaid funds—in the Court's view, Congress made clear its intent to give exclusive enforcement of the statute the regulatory agency.[54] The Court's decision in Armstrong foreclosed direct legal relief for providers and beneficiaries, leaving CMS regulatory efforts as the only possible path for enforcing the equal access provision.[55]

III. CMS RULES ON EQUAL ACCESS TO CARE IN 2015 AND 2016

Despite ongoing evidence of poor access to providers, as well as the inequality in measuring and reporting access between states, CMS did not promulgate any regulations based on the equal access provision until after the Supreme Court's decision in *Armstrong*.[56] It finally did then because, as it noted:

> further delaying this rule could result in confusion as to the application of the access requirement . . . especially given the Supreme Court's decision in *Armstrong v. Exceptional Child Center*, which specifically stated that providers do not have a private right of action to enforce [the equal access requirement] and that CMS is ultimately responsible for enforcing the statutory requirements.[57]

The two rules CMS promulgated in 2015 and 2016 were historic, given the many years of litigation over the equal access provision since its passage in 1989, as well as the fact that CMS had initially proposed a final rule implementing the provision in

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52. *E.g.*, Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1499 (9th Cir. 1997); Christ the King Manor, Inc. v. Sec'y U.S. Dep't of Health & Hum. Servs., 730 F.3d 291, 297 (3d Cir. 2013).

53. Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 331 (2015).

54. *Id.* at 332.

55. Michael H. Cook, *How Can Providers Challenge Medicaid Underpayment After* Armstrong v. Exceptional Child Care Center*?*, 8 J. HEALTH & LIFE SCIS. L. 3, 3–4 (2015).

56. *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 9, at 135.

57. Medicaid Program; Methods of Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,576, 67,581 (Nov. 2, 2015).

2011, but failed to promulgate a final rule after the notice and comment period ended.[58] The rules, however, fell far short of the statute's promise.

The 2015 rule, which is still in effect today, focuses solely on fee-for-services Medicaid plans and does not apply to MCO arrangements. The main goal of the rule is to increase transparency.[59] Under the rule, states are required to submit access monitoring review plans to CMS every three years or whenever they reduce their payment rates.[60] These plans lay out the state's approach to evaluating the adequacy of access to medical care. Plans must include the state's methodology for measuring access to care.[61] CMS does not formally approve these plans; it solely reviews them and requires that states submit a plan of corrective action if the state itself identifies access to care issues.[62] States have twelve months to resolve any identified issues by taking steps such as increasing provider rates.[63] Such rules gives states a great deal of autonomy in how to define and measure adequacy access to care.

CMS published a similar rule regulating states with MCO programs in 2016.[64] The 2016 rule requires that states that contract with a MCO have a written strategy to assess the quality of services offered by the MCO and that each MCO provides the state with an annual assessment plan.[65] This self-assessment should show that the MCO has the capacity to serve the enrolled beneficiaries and provide adequate access to services. The rule

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58. *See* Rosenbaum, *supra* note 44.

59. Noting, in the agency's summary of the rule, that it "provides for a transparent data driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act (the Act) and to address issues raised by that process." Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 67,576 (Nov. 2, 2015). For further related discussion, see *supra* note 45 and accompanying text.

60. *Id.* at 67,580.

61. *Id.* at 67,578.

62. *Id.* at 67,577.

63. *Id.* at 67,580.

64. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,497 (May 6, 2016).

65. *E.g.*, *2021 Update to the Quality Assessment and Performance Improvement Strategy*, DIV. OF TENNCARE 3 (n.d), https://www.tn.gov/content/dam/tn/tenncare/documents/qualitystrategy.pdf [https://perma.cc/995P-DJ8J].

similarly grants both states and MCOs a great deal of autonomy, asking MCOs to submit documentation, with no methodological guidance, attesting that they "maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."[66] Based on the MCO report, states are then expected to submit an "assurance of compliance" to CMS that the MCO meets the state's own requirements for availability of eservices.[67] Unlike the FFS rule, the MCO rule does not require states to submit corrective action plans when an MCO is failing to comply with access standards.[68]

These final rules have significant shortcomings. First, and most importantly, neither rule imposes meaningful methodological requirements or uniform standards on how states assess adequate access to care.[69] Because states are responsible for holding themselves accountable, they are incentivized to tailor their assessment methodology to ensure that they are unlikely to find access to care issues. To that end, most states assess access to care using tools such as consumer complaint hotlines, instead of the approaches recommended in the inspector general's report discussed above, such as secret shopper calls.[70] Relatedly, neither rule requires states to compare beneficiary's access to care with privately insured individuals.

These rules also fail to compel states to take specific, actionable steps to improve access to care, with sanctions for failure to comply. The MCO rule does not impose any meaningful corrective action requirements. Instead, it grants states the autonomy to determine whether an MCO has violated any requirements and to impose sanctions as it sees fit.[71] The FFS rule does require

66. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,497, 27,702 (May 6, 2016).

67. *Id.* at 27,878.

68. *Id.* at 27,764–66.

69. For example, the 2015 rule notes, "While we are not adopting any specific metrics at this time, we are continuing to evaluate the feasibility of establishing a set of core metrics and thresholds and are soliciting input from stakeholders on these." Medicaid Program; Methods of Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,576, 67,589 (Nov. 2, 2015).

70. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 9 at 137.

71. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,497, 27,519 (May 6, 2016).

a plan of corrective action, but gives states wide latitude in determining what type of corrective action to take.[72] As the rule made clear, this means that a state could propose a reduction in reimbursement rates, find that its Medicaid program is falling short on access measures, and proceed with the proposed rate reduction.[73]

Finally, when an access review plan is required, states only need to assess access to primary care, behavioral health services, and certain physician specialist services, not other key services, such as residential services for certain disabled children.

These rules have done little to equalize access to health care for Medicaid recipients. As mentioned above, there continue to be large disparities in access to care between Medicaid beneficiaries and privately insured individuals.[74] Even compared to Medicare recipients, individuals who are insured by Medicaid have a significantly harder time finding medical care providers who will accept their insurance.[75]

IV. CMS 2023 PROPOSED RULES

In April of last year, CMS proposed two new rules to "better promote health equity for Medicaid beneficiaries."[76] The rules are meant to focus on access issues—in its announcement, CMS noted that the rules would "address a range of access-related challenges that affect how beneficiaries are served by Medicaid."[77] The proposed rules are a step forward in improving access to health care providers in some ways. They propose to set maximum appointment wait time standards for certain types of

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72. Medicaid Program; Methods of Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67576, 67586 (Nov. 2, 2015).

73. *Id.*

74. *See supra* notes 10–14 and accompanying text.

75. *See supra* notes 10–14 and accompanying text.

76. Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27,960 (May 3, 2023); Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28,092 (May 3, 2023).

77. *Summary of Medicaid and CHIP Payment-Related Provisions: Ensuring Access to Medicaid Services (CMS 2442-P) and Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 27, 2023), https://www.cms.gov/newsroom/fact-sheets/summary-medicaid-and-chip-payment-related-provisions-ensuring-access-medicaid-services-cms-2442-p [https://perma.cc/S53E-43FM].

medical care, for example, and require states to conduct annual secret shopper surveys to ensure that MCOs are complying with these requirements and are maintaining accurate provider directories.[78] However, the proposed rules fall far short of the equal access provision's promise yet again.

Despite CMS' acknowledgment that the Social Security Act requires Medicaid provider payments to be "sufficient to enlist enough providers to ensure beneficiaries have sufficient access to covered care," the proposed rules fail to take any meaningful action toward equalizing access.[79] They are, yet again, focused only on data collection and transparency. They require states to publish data on Medicaid payment rates and conduct analyses comparing Medicaid and Medicare rates for certain medical services.[80] This transparency is important. But CMS does not require any action based on this data—if a state publishes data showing that its rates fall far below Medicare rates, it is not clear that anything will happen. Why are states not required to set rates to be at least a certain percent of Medicare rates? The only universal rate rule that CMS does propose is to set a *ceiling*, rather than a floor, on reimbursement rates. Per the proposed rule governing MCO arrangements, payment levels of hospital services at academic medical centers[81] would not be able to exceed the average commercial rate in the area.[82] This means that some Medicaid programs might actually have to reduce the rates they pay to providers.

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78. Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27,960, 27,998 (May 3, 2023); Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28,092, 28,095 (May 3, 2023).

79. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS, *supra* note 77.

80. Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27,960, 27,967 (May 3, 2023) ("The provisions of this proposed rule, as discussed in more detail later, would better achieve this balance through improved transparency of Medicaid FFS payment rates, through publication of a comparative payment rate analysis to Medicare and payment rate disclosures, and through a more targeted and defined approach to evaluating data and information when States propose to reduce or restructure their Medicaid payment rates.").

81. Academic medical centers are defined as "a facility that includes a health professional school with an affiliated teaching hospital." Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28,092, 28,123 (May 3, 2023).

82. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28,122 (May 3, 2023).

There is also no discussion of why CMS is requiring states to compare Medicaid rates with Medicare rates, instead of private insurance rates. As noted above, privately insured patients have the best access to medical care providers. Also, the majority of insured patients are insured through private insurance, not Medicare,[83] which only serves individuals who are sixty-five and older, making private insurance rates and access measures a more meaningful point of comparison. A more useful metric might be a comparison of the percent of providers that accept private insurance and those that accept Medicaid, as well as the reimbursement rates provided by each plan.

CMS claims that the changes it is proposing will increase transparency and accountability – that more data will allow the agency "to evaluate the possible effects on access to care of any rate reduction or restructuring proposal that does not meet the above conditions."[84] The agency made nearly identical claims when it promulgated the access to care rules in 2015 and 2016.[85] To date, seemingly no action has been taken on the basis of the data already collected. If these new measures show, yet again, that payment rates are too low and that Medicaid beneficiaries have poor access to care, will CMS propose yet another set of regulations focused on collecting even more data? There are already copious data showing both that Medicaid rates are comparatively lower than Medicare and private insurance rates and that reimbursement rates are linked with access to care.[86] What is needed now are universal standards and enforcement mechanisms.

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83. Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2021*, U.S. DEP'T OF COM. 2 (Sept. 2022), https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf [https://perma.cc/H6ER-HHMQ] ("In 2021, private health insurance coverage continued to be more prevalent than public coverage, at 66.0 percent and 35.7 percent, respectively.").

84. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS, *supra* note 77.

85. *E.g.*, *CMS Strengthens Access to Essential Health Care Services for Medicaid Beneficiaries*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 29, 2015), https://www.cms.gov/newsroom/press-releases/cms-strengthens-access-essential-health-care-services-medicaid-beneficiaries [https://perma.cc/224E-UZGD] ("The intent of this final rule is to provide a framework for us to use to make better informed, data-driven decisions.").

86. *See supra* Part I.

V. CONTINUED INACTION BY CMS

To promulgate regulations that hold up the promise of the Social Security Act's equal access provision, CMS should start by incorporating access to care measures in its rate-setting rules. The agency's regulations on payment rates have always been solely concerned with the first portion of the Social Security Act's statutory mandate, requiring that Medicaid payments be "actuarily sound," and "consistent with efficiency, economy, and quality."[87] These regulations, which guide how managed care organizations set reimbursement rates, currently focus only on actuarial guidelines. For example, CMS' 2022-23 Medicaid Managed Care Rate Development Guide is based solely on regulatory actuarial soundness requirements.[88] It does not mention parity in access to care or a comparison between Medicaid and Medicare reimbursement rates anywhere.[89] Instead, the guidelines instruct states to consider factors such utilization, projected benefit costs and risk-sharing only.[90]

CMS has the authority, under the equal access provision, to update its approach to rate setting so as to ensure improved access to care. For example, CMS could require all states, those with managed care and fee-for-services Medicaid programs, to include factors such as the percent of primary care providers that accept Medicaid, as compared to private insurance and Medicare, in their calculations when setting reimbursement rates. CMS could also require that states with poor access to care increase reimbursement rates to be at least on par with Medicare reimbursement rates, a measure which, as noted above, has been proven to improve access inequities.

In addition to taking these steps, CMS could improve data collection beyond what it proposed in May. For example, it could require that states with a ten percent or greater difference in the number of primary care providers that accept Medicaid, as compared to private insurance, create remedial access plans. These plans should include provisions requiring states to interview medical care providers about why they do not accept Medicaid patients and committing to take actionable steps based on findings.

87. 42 C.F.R. § 438.4 (2016).

88. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 32, at 3–4.

89. *Id.*

90. *Id.*

These measures might seem too costly, but sixteen states already achieve near parity in access, with less than a ten percent difference in the proportion of medical care providers that accept Medicaid, as compared to privately insured patients.[91] At least thirteen states with fee-for-services programs have reimbursement rates that are ninety percent or more of Medicare rates in the state.[92] This demonstrates that higher reimbursement is within reach if states choose to make it a priority.

Because the Court's decision in *Armstrong* eliminated the possibility of lawsuits on behalf of providers and, likely, beneficiaries, CMS must take action. If it fails to do so, the only legal recourse is for beneficiaries to file suit under the APA. By failing to comply with the statutory requirement of equal access, CMS is unlawfully withholding legally required action.[93] The equal access provision does not require that CMS merely collects data on disparities on access or that it shares that data with stakeholders and the public. If we take the text at its word, the provision requires that HHS ensure that states implement Medicaid programs with payments that "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."[94]

CONCLUSION

When Congress passed the Social Security Act's equal access provision in 1989, it intended to improve the disparities in access to medical care providers faced by Medicaid beneficiaries.[95] Congress placed the authority to enforce this provision squarely in the hands of the Secretary of Health and Human Services, who oversees CMS. CMS, however, took no action based on the statutory requirement for decades. When it finally did so, in 2015 and 2016, it focused almost exclusively on collecting data and increasing transparency, not taking meaningful action to improve access to care.[96] Medicaid enrollees continue to face

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91. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 12, at 7–8.
92. *See e.g.*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 28.
93. 5 U.S.C. § 706(1) (2012). *See e.g.,* Norton v. Southern Utah Wilderness Alliance, 524 U.S. 55 (2004).
94. 42 U.S.C. § 1396a(a)(30)(A).
95. *Id.*
96. *See supra* Part III.

disparities in access to care and the most recently proposed regulations fail, yet again, to improve access to care.[97] It is CMS' responsibility to bring the equal access provision's promise to reality. It has had nearly thirty-five years to collect data.[98]

97. *See supra* Part IV.

98. Sara Rosenbaum, *The Medicaid Access Proposed Rule Would Undermine Access, Not Promote It*, HEALTHAFFAIRS (Apr. 2, 2018), https://www.healthaffairs.org/content/forefront/medicaid-access-proposed-rule-would-undermine-access-not-promote [https://perma.cc/ZX7R-VJAP].