



Perspective

Medicaid and Access to Health Care — A Proposal for Continued Inaction?

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Since Medicaid was enacted in 1965, its coverage guarantee for millions of the poorest Americans has faced a substantial vacuum in actual access to health care. Multiple factors contribute to this problem:

severe shortages of physicians and hospitals in many low-income inner-city and rural communities; low rates of participation in Medicaid among available providers, owing to low payment rates; state administrative practices that drive providers away; and the economic, clinical, educational, and cultural characteristics of Medicaid beneficiaries.¹ Where they are operating, federal programs such as community health centers, federally funded family planning agencies, the National Health Service Corps, local public health agencies, and public and children's hospitals help to mitigate the situation. But thousands of U.S. communities lack such programs, and even where they do

exist, they don't address the specialized long-term care needs of beneficiaries with severe disabilities.

For decades, as the access problem festered, successive federal administrations proved either unable or unwilling to act. Congress therefore entered the fray in 1989, enacting legislation that requires participating states to assure that payments to providers are not only consistent with efficiency, economy, and high-quality care, but also "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."²

Ironically, this language was lifted verbatim from an earlier federal regulation that had been allowed to languish on the books.³

Congressional intervention did not, however, serve as a wake-up call. For the past 20 years, subsequent administrations have failed to firmly implement the 1989 amendments. No administration has issued regulations that delineate the standards by which access is to be measured, define the methods states must use for such measurement, set forth clear reporting requirements, or specify actions that the federal government will take to reduce or eliminate barriers to access. The federal government lacks a comprehensive body of research evaluating the effects of state policies and practices on access to care, and no administration has ever issued comprehensive recommendations aimed at guiding and encouraging im-

provements in access. In short, meaningful federal enforcement — through either rulemaking or active engagement and partnership — has been utterly absent.

A serious problem even in good economic times, this extraordinary federal silence has been particularly deafening in the current economic and political climate, when the need for Medicaid has never been greater, the success of health care reform for nearly one quarter of the population rests on successful implementation of a reformed Medicaid program, and states are especially prone to cut Medicaid provider payments because of grim financial conditions.

Not surprisingly, perhaps, given the sustained record of federal inaction, providers and beneficiaries, relying on long-standing Constitutional principles, have turned to the federal courts to halt ongoing state violations of federal law. A series of lawsuits over the past 20 years has challenged states' deficient administration of their obligations to maintain access to care for Medicaid beneficiaries. In particular, plaintiffs have sought to halt reductions in provider payments that threaten access, health, and safety, as well as the economic survival of safety-net providers serving the most disabled and vulnerable beneficiaries.

Over the years, such lawsuits have met with both success and failure. But beginning in 2008, the U.S. Court of Appeals for the Ninth Circuit, relying on these long-standing Constitutional principles of access to the courts as well as the provisions of the 1989 law, issued a series of rulings that have prevented California from instituting steep reduc-

tions in provider payments. The U.S. Supreme Court is now poised to hear California's appeal of one of these decisions. California argues that contrary to the established Constitutional guarantee of access to federal courts to stop ongoing state violations of law, only the secretary of health and human services is empowered to review state conduct. In a shocking move, the solicitor general of the United States, representing the Obama administration, has entered the case on the side of the state, arguing that the courts are closed to private individuals where Medicaid-access litigation is concerned and that all power lies with the secretary of health and human services.⁴

As if to bolster the solicitor general's arguments, the administration recently issued a proposed access rule.⁵ But rather than being a forceful implementation of the law, the proposed rule is a model of inaction. The first sign of the administration's refusal to intervene appears in the explanatory materials that accompany the rule, which emphasize that the administration does not intend to stop reductions in Medicaid provider payments. The proposal goes on to establish what might charitably be characterized as an information-gathering exercise. States are given a few broad parameters by which access will be measured: enrollee characteristics, availability of providers, and utilization. The proposal offers no standards against which the federal government will measure states' access to care, no methods for measuring access, and no federally developed databases. The rule lacks any uniform reporting system capable of comparing state practices and

statistics and provides no explanation of what sanctions might apply, other than an oblique reference to general agency enforcement powers that have proven ineffectual, at best, throughout Medicaid's history.

Even this information-gathering exercise is wanting. The proposed rule exempts Medicaid managed care from review, despite the fact that the access statute protects all beneficiaries, including the 70% who receive their care through managed care plans. Moreover, the proposed rule gives states an inordinately long 5 years to measure access within their residual fee-for-service programs, which overwhelmingly serve the beneficiaries with the most severe physical and mental health conditions.

In the event that a state plans to reduce provider payments, the proposed rule requires submission of access information gathered within the year preceding the date of the proposed reduction. But a state must submit such information only if its changes "could result in access issues." The wording of this requirement is so vague that it's unclear whether the state or the secretary would make the determination that "access issues" are even a possibility. A state could conclude that its planned reduction raises no such issues, in which case no data would be required and the secretary would be powerless — under the terms of the secretary's own rule — to contest the state's actions.

Indeed, because the rule specifies neither standards for adequate access nor an independent evidentiary process, it would be nearly impossible for the federal government to enforce the rule.

Unlike the federal courts, moreover, the Department of Health and Human Services lacks the power to stop a payment reduction before it occurs. Were it to attempt to deny federal funding after the fact (the only sanction it is empowered to impose), an appeal could take years.

There is, of course, no way of knowing whether this weak proposed rule will emerge with even its minimal provisions intact. Proposed rules take a long time to be finalized and are subject to enormous political pressures from states that oppose any effort to create measurable accountability.

What is clear, however, is that even were the rule to emerge in final form intact, it would not even remotely amount to the type of comprehensive federal enforcement scheme that would justify a decision by the U.S. Supreme Court to overturn generations of Constitutional precedent and foreclose access to the courts by millions of beneficiaries and the health care providers who serve them.

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