

## COMMENTS

### **Payments to Medicaid Doctors: Interpreting the “Equal Access” Provision**

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#### INTRODUCTION

Medicaid—a joint federal-state program providing health insurance to the poor—accounts for a substantial and growing percentage of states’ budgets. In fact, 15 percent of all state spending goes to Medicaid, ranking the program second to education in terms of dollars spent.<sup>1</sup> In their 2005 fiscal outlooks, thirty states listed spiraling Medicaid costs as one of their top three fiscal priorities,<sup>2</sup> and sixteen states anticipated Medicaid-induced spending overruns in 2005.<sup>3</sup> As a result, many states are trying to cut their Medicaid programs.<sup>4</sup>

Within the bounds of the federal Medicaid Act,<sup>5</sup> states may control costs through a number of strategies: altering payment systems, regulating input costs, decreasing eligibility, reducing benefits, increasing copayments, or reducing reimbursement rates.<sup>6</sup> States regularly use all of these cost-control methods, but they are hesitant to push for large-scale reductions in eligibility or benefits because excluding needy people from existing welfare programs is politically unattractive and may be financially unwise.<sup>7</sup>

The states therefore frequently prefer—and frequently utilize—the cost-saving strategy of reducing reimbursements to healthcare

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<sup>1</sup> See *The Medicaid Dilemma: Shrinking Budgets, Difficult Choices*, 5 Am Hospital Assn Trend Watch 1, 1 (June 2003), online at <http://www.aha.org/ahapolicyforum/trendwatch/content/tw2003vol5no2pt1.pdf> (visited Mar 28, 2006) (citing recent dramatic growth in Medicaid expenditures as the states’ motivation for targeting the program during budget cuts).

<sup>2</sup> See National Conference of State Legislatures, *State Budget Update: November 2004* 20 (2004), online at <http://www.ncsl.org/print/fiscal/sbu2005-0411.pdf> (visited Mar 28, 2006).

<sup>3</sup> See *id.* at 6–7.

<sup>4</sup> See *Medicaid Dilemma*, 5 Am Hospital Assn Trend Watch at 1 (cited in note 1).

<sup>5</sup> 42 USC § 1396 et seq (2000).

<sup>6</sup> See *Medicaid Dilemma*, 5 Am Hospital Assn Trend Watch at 4 (cited in note 1).

<sup>7</sup> See *id.* at 5–6.

providers<sup>8</sup> for services that Medicaid recipients consume. In so doing, the states accept some political consequences from injuring providers, but they avoid the political and financial consequences of reducing coverage.<sup>9</sup> Initially, this strategy may seem like the best policy option if the program's goal is to give more people access to some services, but cutting providers' reimbursements may cause providers to refuse Medicaid patients, leaving program recipients with a welfare entitlement that buys them nothing.<sup>10</sup>

Recognizing the temptation to pay providers too little, Congress included 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 privately insured patients' access.<sup>11</sup> Under this provision, providers and patients have brought lawsuits challenging Medicaid reimbursements,<sup>12</sup> many of which have reached the federal appellate courts. In deciding those cases, the circuit courts have offered inconsistent interpretations of the Medicaid statute. While the Fifth and Seventh circuits have measured rates' adequacy by reference to access outcomes, the Third, Eighth, and Ninth circuits have measured rates' adequacy by reference to rate-setting methodologies.

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<sup>8</sup> The term "providers" includes individual physicians, institutional providers such as hospitals and nursing homes, and nonphysician health practitioners such as podiatrists, psychologists, and nurses.

<sup>9</sup> Thirty-seven states reduced provider payments in 2003, the second most popular cost-saving strategy after controlling drug costs. See *Medicaid Dilemma*, 5 Am Hospital Assn Trend Watch at 4 (cited in note 1).

<sup>10</sup> See Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 Am J L & Med 191, 193 (1995) (noting that 25 percent of American physicians "refuse to treat Medicaid patients" and claiming that the primary rationale for limiting participation is "low Medicaid reimbursement"). See also *Memisovski v Maram*, 2004 US Dist LEXIS 16772, \*128 (ND Ill) (finding that "the rates Illinois Medicaid pays simply do not entice medical providers to participate in Medicaid").

<sup>11</sup> 42 USC § 1396a(a)(30)(A) (hereinafter § 30(A) or "the equal access provision"). The label "equal access provision" applies only to the language following "and are sufficient," which was appended to the section in 1989. When this Comment refers to "the equal access provision," it refers only to the access language. When this Comment intends to refer to all of § 30(A), including the language mandating consistency with efficiency, economy, and quality, it will refer to "§ 30(A)" or to "the provision." This distinction is not universally observed, however; many of the sources cited herein use "equal access provision" to refer to the complete statutory section.

<sup>12</sup> There is an ongoing debate as to whether providers or patients have standing to enforce § 30(A). The consensus view seems to be that patients have a right of action under 42 USC § 1983 while providers do not. See generally Marlaine S. Freisthler, *Unfettered Discretion: Is Gonzaga University v. Doe a Constructive End to Enforcement of Medicaid Provider Reimbursement Provisions?*, 71 U Cin L Rev 1397, 1399–1400 (2003) (focusing on the effect of recent Supreme Court decisions on providers' rights when it comes to enforcement of § 30(A)). See also *Evergreen Presbyterian Ministries, Inc v Hood*, 235 F3d 908, 928 (5th Cir 2000) (holding that providers lack a right of action but recipients have a right of action). But see *Sanchez v Johnson*, 416 F3d 1051, 1068 (9th Cir 2005) (holding that neither recipients nor providers have standing).

This Comment analyzes the circuit split that has arisen as courts have confronted challenges to Medicaid payments. Part I provides background on the Medicaid program and the circuit split, and it identifies and explicates two competing rules for measuring adequacy of Medicaid payments: the Fifth and Seventh circuits' "access metric" and the Ninth Circuit's "cost metric." Parts II and III identify problems with these two rules, and criticizes them as inconsistent with the statute's text, purpose, and intent. Part IV proposes a new rule, an "MCO metric,"<sup>13</sup> and explains why that rule is the best interpretation of Medicaid's reimbursement provision.

## I. BACKGROUND

### A. The Medicaid Program

Before 1965, healthcare services were described as "dual-tracked": the wealthy received care from private physicians while the poor—if they accessed services at all—received care in ambulatory clinics and emergency rooms. Medicaid's goal was to eliminate the lower track, providing everyone with access to private physicians and high quality hospitals.

Congress added Medicaid to the Social Security Act in 1965 as Title XIX of the Act.<sup>14</sup> Creating a complex regulatory program of cooperative federalism, Congress sought to give the poor and disabled access to "mainstream" medical services.<sup>15</sup> Under Title XIX, states develop medical assistance plans that must comply with a list of federal requirements.<sup>16</sup> Although that list has lengthened over time, the program was self-consciously created as an experiment in state creativity.<sup>17</sup> Even with the growing list of federal requirements, therefore, the states retain a large degree of flexibility in determining requirements for eligibility, in establishing the scope of benefits coverage, and in setting

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<sup>13</sup> For further explanation of managed care organizations (MCOs), see note 105.

<sup>14</sup> See Grants to States for Medical Assistance Programs Act (the Medicaid Act), Pub L No 89-97, 79 Stat 343 (1965), codified at 42 USC § 1396 et seq (2000).

<sup>15</sup> See Medicare and Medicaid, Hearings before the Senate Committee on Finance, 91st Cong, 2d Sess 57 (1970) (statement of Honorable John G. Veneman, Under Secretary, Department of Health, Education, and Welfare) (testifying that providing "'mainstream medical care' for all the people of this country" was "[t]he whole purpose of the 1965 act"). See also *Memisovski v Maram*, 2004 US Dist LEXIS 16772, \*138-39 (ND Ill) (describing Medicaid's goal as providing the poor with access to "mainstream" services); *Bay Ridge Diagnostic Laboratory, Inc v Dumpson*, 400 F Supp 1104, 1106 (ED NY 1975) (same).

<sup>16</sup> See 42 USC § 1396a(a).

<sup>17</sup> See *New State Ice Co v Liebmann*, 285 US 262, 311 (1932) (Brandeis dissenting) ("It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

rates for reimbursement. Furthermore, Medicaid continues to allow the states to conduct various experiments with their medical assistance plans, occasionally granting waivers to states that wish to innovate beyond the bounds of federal regulations.<sup>18</sup> Because of the continuing flexibility granted to the states and because of the variance in state systems that such flexibility produces, it is impossible to describe the details of a typical Medicaid program.

Nevertheless, the federal regulations do produce some basic commonalities among the states. First, for example, Medicaid eligibility in every state is means-tested—that is, eligibility depends on one's income and assets.<sup>19</sup> Second, the states must provide certain services such as pediatric and gynecological services. Third (and most important for this Comment), Medicaid programs rely on existing private businesses to serve beneficiaries rather than creating public healthcare providers.

States' Medicaid programs interact with private providers according to one of two models. Either Medicaid acts as a third-party payor, purchasing private-market care on behalf of Medicaid participants, or it pays private managed care organizations (MCOs) to provide both insurance and services to Medicaid patients. Regardless of which model a state chooses, it is universally true that Medicaid programs spend state money on private services rather than providing services directly through government-run hospitals, clinics, or physicians' offices.

## B. Regulating Provider Payments

Because the states supply Medicaid beneficiaries with private services, they must reimburse providers for the care that Medicaid patients consume. Although the states have flexibility in setting the amount that they are willing to pay for healthcare services or for

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<sup>18</sup> The most recent initiative in state flexibility has been the enactment of the Health Insurance Flexibility and Accountability Initiative (HIFA), which created a new Medicaid waiver program under § 1115 of the Social Security Act, 42 USC § 1315 (2000). See generally National Association of State Medicaid Directors, *Medicaid Waivers* (2005), online at <http://www.nasmd.org/waivers/waivers.htm> (visited Mar 28, 2006) (describing the various waiver options available under Medicaid). See also generally Jonathan R. Bolton, Note, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 Colum J L & Soc Probs 91 (2003) (criticizing the HIFA program as enhancing state management authority at the cost of reducing the efficacy of the federal Medicaid program by shrinking coverage for current beneficiaries while doing little to enhance coverage for the uninsured); Watson, 21 Am J L & Med 191 (cited in note 10) (praising Tennessee's Medicaid program, TennCare, which was created under waiver).

<sup>19</sup> Medicaid eligibility is tied to Social Security's supplemental security income, to states' Aid to Families with Dependent Children (AFDC) programs, and to the federal poverty level. See Center for Medicaid and State Operations, *Medicaid At-a-Glance 2005: A Medicaid Information Source* 1 (2005), online at <http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf> (visited Mar 28, 2006).

managed care coverage, Title XIX sets a ceiling and a floor on payments. One of the sixty-five federal requirements regulating state plans is the so-called "equal access provision,"<sup>20</sup> codified at § 30(A) of Title XIX, which requires states to reimburse healthcare providers at a rate that is low enough to incentivize efficiency and economy but high enough to incentivize quality and participation. In pertinent part, the provision reads as follows:

A state plan for medical assistance must . . . provide such methods and procedures relating to . . . the payment for[] care and services available under the plan . . . as may be necessary . . . 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.<sup>21</sup>

Essentially, § 30(A) requires that payments be no more than the cost of providing medical services efficiently and economically, but no less than the cost of providing recipients with access to the same quality of services to which private-market and Medicare patients<sup>22</sup> have access.

### C. The Circuit Split

In attempts to enforce the § 30(A) requirements, both providers and patients have sued state health agencies, claiming that state-set rates are legally insufficient. In deciding these cases, the courts have offered inconsistent interpretations of § 30(A). Specifically, circuit courts have disagreed as to the appropriate metric for determining rates' legal adequacy.

The Fifth and Seventh circuits have focused nearly exclusively on the provision's "equal access" language: the last clause of the provision, requiring rates to be "sufficient to enlist enough providers."<sup>23</sup> These courts have held that the only relevant inquiry in determin-

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<sup>20</sup> 42 USC § 1396a(a)(30)(A).

<sup>21</sup> *Id.*

<sup>22</sup> It is not facially obvious that this provision intends to compare Medicaid patients exclusively to privately insured and Medicare patients (rather than including uninsured patients in the comparison), but see Omnibus Budget Reconciliation Act of 1989, HR Rep No 101-247, 101st Cong, 1st Sess 391 (1989) (noting that Medicaid patients obviously will "have better access to care than individuals without insurance coverage and without the ability to pay for services directly," so the relevant question is whether Medicaid beneficiaries' access is equal to "that of others in the area who have third party coverage").

<sup>23</sup> 42 USC § 1396a(a)(30)(A).

ing § 30(A) compliance is whether Medicaid patients have the same access to healthcare services as do private-market patients.<sup>24</sup>

By contrast, the Ninth Circuit has focused primarily on the “efficiency” and “economy” requirements of § 30(A), holding that rates violate the Medicaid statute if they do not reflect the costs of providing care, even if the rates are sufficient to sustain equal access. Consequently, the court simply reviews states’ rate-setting processes to determine whether the agencies based rates on healthcare costs.<sup>25</sup>

The Third and Eighth circuits have also decided § 30(A) cases, but neither provide a generally applicable metric for determining rates’ adequacy.<sup>26</sup> Instead, those courts reviewed rate setting under an “arbitrary and capricious” standard,<sup>27</sup> requiring the courts to uphold any rate that bears a reasonable relationship to statutory factors. While this rule requires states to base their rates on considerations of efficiency, economy, quality, and access, it allows courts to evaluate statutory adequacy on a case-by-case basis. Such review, therefore, does not require the courts to announce a substantive metric.

The disagreement among the circuits has created confusion as to the appropriate interpretation of § 30(A). Unfortunately, this confusion has developed at a time when an increasing number of states are facing budgetary crises and cutting Medicaid rates as a means of managing those crises. The remainder of this Comment seeks to provide insight into the legal and practical considerations that might inform a court’s interpretation of Medicaid’s reimbursement provision and to propose a new metric for measuring rates’ adequacy.

## II. THE ACCESS METRIC: FIFTH AND SEVENTH CIRCUITS

In determining adequacy of provider payments under § 30(A), the Fifth and Seventh circuits apply an “access metric.” In both circuits, plaintiffs must prove that Medicaid recipients are less able than privately insured patients to access healthcare services. This Part ar-

<sup>24</sup> See *Evergreen Presbyterian Ministries, Inc v Hood*, 235 F3d 908, 929–32 (5th Cir 2000); *Methodist Hospitals, Inc v Sullivan*, 91 F3d 1026, 1029 (7th Cir 1996).

<sup>25</sup> See *Orthopaedic Hospital v Belshe*, 103 F3d 1491 (9th Cir 1997).

<sup>26</sup> See *Rite Aid of Pennsylvania, Inc v Houstoun*, 171 F3d 842 (3d Cir 1999) (holding that Pennsylvania’s rate-setting methodology was not arbitrary or capricious); *Arkansas Medical Society, Inc v Reynolds*, 6 F3d 519 (8th Cir 1993) (holding that Arkansas’s reimbursement cuts were arbitrary and capricious because the state failed to consider statutory factors). See also *Visiting Nurse Assn of North Shore, Inc v Bullen*, 93 F3d 997, 999–1002, 1006–07 (1st Cir 1996) (deferring to the agency’s rate setting without addressing the rates’ substantive adequacy).

<sup>27</sup> See *Citizens to Preserve Overton Park, Inc v Volpe*, 401 US 402, 414 (1971) (interpreting the Administrative Procedure Act, 5 USC § 706 (Supp V 1964), as limiting the Court’s review such that it must uphold any agency decision that is not “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law”).

gues that the access metric centers on a misinterpretation of § 30(A)—the rule is inconsistent with the text, purpose, and intent of the statute. Furthermore, the access metric is difficult for courts to administer. This Part summarizes the courts' holdings and then presents and analyzes each of the objections to the rule that they create.

#### A. The Access Metric

In deciding § 30(A) challenges, both the Fifth and Seventh circuits rejected the argument that payments are legally inadequate if the state's rate setting was procedurally defective. In *Methodist Hospitals, Inc v Sullivan*,<sup>28</sup> the Seventh Circuit confronted the question of whether Indiana's reimbursement system violated § 30(A). Indiana, which had previously reimbursed hospitals based on their "customary billing" rate, amended its reimbursement formulas to pay all hospitals a flat rate regardless of their actual costs or typical charges. The rate that Indiana set was 50 percent of Medicare's rate plus 50 percent of the "statewide median amount paid for [the] service."<sup>29</sup> Hospitals challenged the new reimbursement scheme on procedural grounds, claiming that Indiana's failure to conduct adequate cost studies prior to setting the new rate violated § 30(A).

The Seventh Circuit determined that § 30(A), unlike a since-repealed provision regulating inpatient payments,<sup>30</sup> does not require states to conduct studies before setting rates. The court reasoned that

<sup>28</sup> 91 F3d 1026 (7th Cir 1996).

<sup>29</sup> *Id* at 1028.

<sup>30</sup> In the same bill in which Congress removed the cap from § 30(A), it also passed the Boren Amendment. See Boren Amendment, Omnibus Budget Reconciliation Act of 1981 § 2173, 95 Stat at 808, codified at 42 USC § 1396a(a)(13) (repealed in 1997). The Boren Amendment's explicit purpose was to grant states greater flexibility in setting payments for inpatient services, removing the requirement that institutional providers be reimbursed for their "reasonable cost[s]." See Omnibus Budget Reconciliation Act of 1981, 2 HR Rep No 97-158, 97th Cong, 1st Sess 293 (1981). By 1997, states were claiming that even the looser requirements of the Boren Amendment were too restrictive, and they successfully lobbied for the amendment's repeal. See Balanced Budget Act of 1997, HR Rep No 105-149, 105th Cong, 1st Sess 590-91 (1997). See also Malcolm J. Harkins, *Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care*, 4 J Health Care L & Policy 159, 172-96 (2001) (describing the full legislative history of the Boren Amendment). Throughout this debate, the states have argued that federal requirements restricting their payment methodologies are too burdensome; and Congress has always acquiesced. It is evident from the Boren debate, therefore, that state autonomy has been—and remains—a genuine concern to Medicaid policymakers. See note 18 and accompanying text. While the debate over § 30(A) has been less explicitly focused on state autonomy, it seems likely that the same federalism concerns motivated Congress to mandate equal access rather than equal rates. By 1989, Congress had learned that dictating specific payment methodologies would evoke backlash. See *Orthopaedic Hospital v Belshe*, 103 F3d 1491, 1497 (9th Cir 1997) ("Congress wanted to . . . allow states more flexibility in devising ways to make services available, while at the same time containing costs.").

the provision “requires each state to produce a *result*, not to employ any particular methodology for getting there.”<sup>31</sup> The Seventh Circuit also stressed that, despite the rate reduction, plaintiff hospitals had not “withdrawn from the outpatient market.”<sup>32</sup> In making this last observation, the court implied that any rate will suffice as long as providers continue serving Medicaid patients. The test that emerged asks whether providers have either gone out of business or opted out of Medicaid; only if one of those two outcomes occurs will payments be said to violate § 30(A).

In the *Methodist Hospitals* opinion, the Seventh Circuit made a memorable and oft-cited statement encapsulating the economic logic behind the access metric:

Under § 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, the state may (and under § 1396a(a)(30), must) raise the price until the market clears.<sup>33</sup>

For the Seventh Circuit, therefore, the test of rates’ adequacy is whether enough providers are actually participating in Medicaid; the lowest legal rate is the market-clearing rate.<sup>34</sup> This test, centered on provider participation, focuses exclusively on the equal access language, without inquiring into payments’ consistency with efficiency, economy, and quality of care.

Several years after *Methodist Hospitals* was decided, the Fifth Circuit adopted the same test in *Evergreen Presbyterian Ministries v Hood*.<sup>35</sup> In *Evergreen*, hospitals and beneficiaries challenged Louisiana’s decision to cut payments by 7 percent as a means of recovering a budgetary shortfall.<sup>36</sup> The court identified the question before it 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.”<sup>37</sup> The Fifth Circuit thus rejected the district court’s alternative interpretation of § 30(A), which would have required the state

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<sup>31</sup> *Methodist Hospitals*, 91 F3d at 1030.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> Note, however, that the court provided no definition of “enough providers.” Because the hospitals relied wholly on the argument that the states should be required to conduct studies before setting their rates, *Methodist Hospitals* provides no guidance as to how one might measure sufficiency of provider participation or patient access.

<sup>35</sup> 235 F3d 908 (5th Cir 2000).

<sup>36</sup> *Id.* at 914.

<sup>37</sup> *Id.* at 932.



to make a “determination of the impact the seven percent . . . reduction would have on providers.”<sup>38</sup> The district court’s interpretation would have required the state to study the impact of Medicaid cuts on providers in order to ensure that financially motivated rate reductions would do no harm to protected beneficiaries. The Fifth Circuit rejected this ex ante requirement in favor of an ex post analysis of harm to patients. Like the Seventh Circuit, the Fifth Circuit was silent as to rates’ consistency with efficiency, economy, and quality.<sup>39</sup>

In short, the Fifth and Seventh circuits have required a plaintiff wishing to challenge reimbursement rates to be armed with statistics showing that Medicaid patients’ access to providers is actually unequal to privately insured or Medicare patients’ access to providers. Only if plaintiffs can show unequal access will they win a § 30(A) challenge.<sup>40</sup>

#### B. Problems with the Access Metric

There are four problems with the Fifth and Seventh circuits’ rule. First, an interpretation of § 30(A) that focuses exclusively on the equal access language is a misinterpretation of the provision as a whole; it ignores the statute’s efficiency, economy, and quality requirements. Second, the access-metric interpretation might allow the healthcare industry to maintain a dual-tracked quality, thereby defying Medicaid’s purpose. Third, the access metric defies congressional intent by failing to require any comparison of Medicaid rates to private-market or Medicare rates. Fourth, because “equal access” defies simple defini-

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<sup>38</sup> Id (internal quotation marks omitted).

<sup>39</sup> The likely practical reason that neither court addressed the efficiency, economy, and quality requirements is that plaintiffs in both cases argued only that § 30(A) requires ex ante impact studies. In neither case did plaintiffs attempt to win on the ground that payments were substantively inadequate. If the Fifth and Seventh Circuits had established nothing more than the nonexistence of a procedural requirement, then the two opinions would have announced a correct interpretation of the provision. See Part III.C.2. (Note, too, that Indiana’s reimbursement system, by tying its rates to Medicare and private-market rates, probably would survive scrutiny under the MCO metric that this Comment proposes. See Part IV. To that extent, therefore, this Comment does not quarrel with the Seventh Circuit’s disposition.) In both opinions, however, the courts announced an enforcement guide for future cases, and that guide focuses too narrowly on access without addressing the other statutory factors. For further analysis of the narrow focus, see Part II.B.1. For speculation as to the likely logic justifying the access metric’s narrow focus and for criticism of that logic, see text accompanying notes 48–54.

<sup>40</sup> A third case, coming out of the First Circuit, strongly implied that the access metric was the right way to enforce § 30(A), but that case ultimately disposed of the question on different grounds. See *Visiting Nurse Association of North Shore, Inc v Bullen*, 93 F3d 997, 1011 (1st Cir 1996) (noting that plaintiffs wishing to show substantive noncompliance must prove “that (1) the methods and procedures adopted by the State were inadequate to ensure ‘equal access,’ or (2) the bottom-line reimbursement figures derived under that methodology were too low to retain health care providers in the Massachusetts Medicaid program”).

tion, the access metric is difficult to administer. This Part addresses each objection in turn.

1. The access metric fails to enforce a significant portion of the provision's text.

The first place to look for the correct interpretation of a statutory provision is to the text of the statute itself.<sup>41</sup> The access metric, however, defies the text of § 30(A) by focusing only on the last clause of the provision, to the exclusion of the preceding clause. Section 30(A) requires states to offer payments that “are consistent with efficiency, economy, and quality of care *and* are sufficient to enlist enough providers so that” patients have equal access to services.<sup>42</sup> The provision contains four distinct metrics for determining rates’ adequacy—efficiency, economy, quality, and access—requiring rates to be “consistent” with the first three and “sufficient” to accomplish the fourth. The conjunctive “and” denotes a requirement that rates satisfy all four metrics. Rates providing sufficient access, therefore, do not satisfy the text of § 30(A) if those rates are inconsistent with efficiency, economy, or quality.<sup>43</sup> The converse is also true, of course: rates are inadequate if they are consistent with efficiency, economy, and quality but are insufficient to provide equal access.

The Fifth and Seventh circuits, however, have held that plaintiffs must prove insufficient access in all cases, regardless of whether they are able to demonstrate payments’ inconsistency with efficiency, economy, and quality. In the Seventh Circuit’s oft-cited summary, it focused on the rates’ ability to “bring[] forth an adequate supply,” saying nothing of the quality or cost of that supply.<sup>44</sup> Although the *Methodist Hospitals* plaintiffs apparently offered no evidence of payments’ inconsis-

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<sup>41</sup> Where the text of a statute is clear, the majority of scholars and judges believe that it should control courts’ interpretations. Those who advocate purposivist or intentionalist approaches to statutory interpretation typically do so only when the text of the statute does not provide a clear answer. See, for example, *Caminetti v United States*, 242 US 470, 485 (1917) (“It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain . . . the sole function of the courts is to enforce it according to its terms.”).

<sup>42</sup> 42 USC § 1396a(a)(30)(A) (emphasis added).

<sup>43</sup> The Department of Health and Human Services takes this requirement seriously when interpreting “efficiency” and “economy” as imposing a cap on provider reimbursements. See 42 CFR § 447.250(b) (2004); 42 CFR § 447.253(b)(2) (2004). The most common administrative use of § 30(A) is in justifying a disallowance of federal financial participation on the grounds that the payment amount exceeds regulatory upper payment limits. See, for example, *New Hampshire Department of Health and Human Services v CMS*, Medicare & Medicaid Guide (CCH) P 120, 490 (2003).

<sup>44</sup> *Methodist Hospitals*, 91 F3d at 1030.

tency with efficiency, economy, or quality,<sup>45</sup> the court's opinion made no allowance for those factors to play a role in future cases. Instead, the court insisted that a successful case must prove inadequate access in every instance. In *Evergreen*, even though plaintiffs did offer evidence of the impact that rate cuts would have on providers' efficiency, economy, and quality,<sup>46</sup> the court dismissed those arguments. The Fifth Circuit required plaintiffs to present "information on the actual impact on the comparability to the general population of the recipients' access to medical care."<sup>47</sup> This requirement explicitly relies on the equal access language while ignoring the requirements contained in the first half of § 30(A).

It may be that the Fifth and Seventh circuits, by focusing narrowly on access, assumed that equal access would always be a sufficient proxy for the vague mandate of consistency with efficiency, economy, and quality. In other words, the courts probably believed that the market-clearing rate would, in every case, also be a rate that meets the other § 30(A) requirements and, therefore, that mandating the market-clearing rate would implement the entire statutory text without requiring independent evaluation of rates' consistency with efficiency, economy, and quality. This logic, however, is flawed.

The link between reimbursement rates and provider participation is, in fact, quite tenuous in some sectors of the healthcare industry.<sup>48</sup> In the context of emergency room services, for example, a provision of the Medicare Act known as EMTALA<sup>49</sup> requires trauma centers to treat all patients regardless of their ability to pay.<sup>50</sup> Because emergency rooms are required to serve Medicaid patients whether the hospitals

<sup>45</sup> See note 39.

<sup>46</sup> 235 F3d at 933 (noting that some of the plaintiffs' evidence "predicted that the providers would experience financial distress").

<sup>47</sup> *Id.*

<sup>48</sup> See *Orthopaedic Hospital*, 103 F3d at 1498 (describing "other" factors that sustain equal access in the face of low payments).

<sup>49</sup> See Emergency Medical Treatment and Active Labor Act of 1986, Pub L No 99-272 § 9121(b), 100 Stat 164 (1986), codified at 42 USC § 1395dd (2000).

<sup>50</sup> The Medicare Act is located at Title XVIII of the Social Security Act, passed at the same time as the Medicaid Act, 79 Stat at 343-53. Medicare is a federal program providing coverage to all seniors, regardless of income. See Health Insurance for the Aged Act, Pub L 89-97, 79 Stat 290-343 (1965), codified at 42 USC § 1395 et seq (1964 & Supp I 1965). EMTALA is a requirement imposed on hospitals that operate a trauma center and that serve Medicare patients. Hospitals, therefore, may escape EMTALA only by closing their emergency rooms or by opting out of Medicare. Of course, even if low Medicaid rates forced hospitals to close their emergency rooms in order to avoid serving all patients, Medicaid recipients still would be incapable of proving unequal access because they still would have the same access as private-market patients; hospitals must serve all patients or no patients. The second option for escaping EMTALA, opting out of Medicare, is simply implausible because Medicare patients account for an enormous percentage of hospitals' business.

participate in Medicaid or not, it is rational for them to participate for even nominal compensation in order to recover some portion of their costs. Under the access metric, plaintiffs would never be able to prove that emergency room reimbursements violate § 30(A) because hospitals simply may not “opt out” of serving Medicaid patients.<sup>51</sup> Rates, therefore, could be entirely inconsistent with efficiency, economy, and quality, but they still would suffice to sustain equal access to emergency room services.<sup>52</sup>

Another reason that low Medicaid rates might not drive providers out of the market is that providers frequently overcharge some patients while undercharging others. This phenomenon, known as cost shifting, allows providers to serve Medicaid patients for below-cost compensation without suffering a net loss.<sup>53</sup> This habit sustains equal access even when proffered payments are “not economic, efficient or attentive to adequate access.”<sup>54</sup>

Because EMTALA requires emergency rooms to treat Medicaid patients regardless of payments and because providers treat needy patients while shifting resultant losses to privately insured patients, the access metric allows the states to pay a rate that is too low to be consistent with all four of § 30(A)’s requirements. To the extent that the Fifth and Seventh circuits focus on access because they believe that it will always suffice as a proxy for the other statutory factors, their logic is flawed. As such, the access metric, in its letter and in its effect, is inconsistent with the full text of the provision.

2. The access metric would allow maintenance of a dual-tracked medical system in defiance of Congress’s purpose.

The second problem with the access metric is that it would allow the states to maintain a “dual-tracked” medical system, thereby disregarding Congress’s purpose in creating the program. Medicaid’s stated purpose was to eliminate the lower “track” in the dual-tracked system by providing the poor with access to mainstream services.<sup>55</sup>

The Fifth and Seventh circuits’ approach frustrates that purpose because it regulates only the number of providers, not the quality of

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<sup>51</sup> See *Orthopaedic Hospital*, 103 F3d at 1498.

<sup>52</sup> Given that many Medicaid patients use emergency rooms as their primary care forum, this challenge to the access metric is significant. See *id.* (noting that emergency room services constituted 50 percent of services consumed by California’s Medicaid patients).

<sup>53</sup> See B.M. Smith, *Trends in Health Care Coverage and Financing and Their Implications for Policy*, 337 New Eng J Med 1000, 1000 (1997) (noting that “private insurance premium[s] historically” included extra compensation “for the care of others”).

<sup>54</sup> *Orthopaedic Hospital*, 103 F3d at 1498.

<sup>55</sup> See notes 14–15 and accompanying text.

providers, available to Medicaid beneficiaries. The *Methodist Hospitals* holding, which requires only a market-clearing rate,<sup>56</sup> would allow states to pay a low reimbursement rate that suffices to “bring[] forth an adequate supply” in terms of the number of providers while motivating only low quality providers to participate. Because the number of Medicaid enrollees has grown substantially since the program’s creation, a provider could sustain a low-quality practice by serving only Medicaid patients. The result of an access metric, therefore, may be that states, in order to save money, offer reimbursement rates sufficient to create a Medicaid-only market that is equal in size and access to the private market but that consists of low-quality providers serving exclusively (or at least predominantly) Medicaid patients. This result would be a reversion to the 1964, dual-tracked world that Medicaid was designed to eliminate.

3. The access metric does not require the intended comparison between Medicaid and private-market payments.

The third objection to the access metric is that it defies Congress’s specific intent in the initial passage and later development of § 30(A). Throughout the provision’s history, § 30(A) has regulated payments, always with an eye towards requiring Medicaid to track private-market rates. The access metric, however, does not require state agencies to consider private market rates at all when setting Medicaid payments.

Section 30(A) was originally passed in 1967 as a limit on reimbursements, originally including only a payment ceiling of “reasonable charges.”<sup>57</sup> By 1981, however, the Senate Finance Committee had begun to express concern that “a significant differential [had arisen] between the Medicaid payment level for physicians and the rate paid by Medicare and private individuals.”<sup>58</sup> Congress therefore removed the cap from § 30(A), leaving only the requirement that payments be “consistent with efficiency, economy, and quality of care.”<sup>59</sup>

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<sup>56</sup> See 91 F3d at 1030.

<sup>57</sup> See Social Security Amendments of 1967, Pub L 90-248 § 237, 81 Stat 911 (1967), codified at 42 USC § 1396a(a)(30) (1964 & Supp IV 1968) (requiring payments to be “not in excess of reasonable charges consistent with efficiency, economy, and quality of care”). The motivation for passing the cap seems to have been budgetary. See Social Security Amendments of 1967, Hearings on HR 12080 before the Senate Committee on Finance, 90th Cong, 1st Sess 276–83 (1967) (testimony of Wilbur J. Cohen, Under Secretary, Department of Health, Education, and Welfare) (discussing the likelihood that Medicaid would exceed its estimated cost by at least \$3 million if the program were not reformed).

<sup>58</sup> 2 HR Rep No 97-158 at 294 (cited in note 30).

<sup>59</sup> See Omnibus Budget Reconciliation Act of 1981, Pub L No 97-35 § 2174(a), 95 Stat 809 (1981), codified at 42 USC § 1396a(a)(30)(A) (1976 & Supp 1984).

By 1989, even without the mandatory cap, the problem of below-market Medicaid payments had worsened, causing a dearth of provider participation. Having assumed since Medicaid's creation<sup>60</sup> that payments were linked to participation,<sup>61</sup> Congress codified the equal access language in an effort to force reimbursement rates to "ke[ep] pace with average community rates."<sup>62</sup>

Section 30(A)'s sole function always has been to ensure that states pay an appropriate price for services, and members of Congress have implied consistently that the appropriate price is one that approximates the private-market rate. Although it would be controversial to claim that § 30(A) requires rate parity,<sup>63</sup> the provision's legislative history indicates that Congress intended to require a closer relationship between Medicaid rates and private-market rates than existed in 1989.

The problem with the Fifth and Seventh circuits' interpretation, then, is that it does not require *any* scrutiny of reimbursement rates, much less the intended comparison between Medicaid and private-market rates. While the Fifth and Seventh circuits' rule might correctly implement the equal access language, therefore, it does not implement the spirit of the 1989 amendment. This failure is all the more significant because Congress's belief that rates and participation are inextricable has proved mistaken for many sectors of the healthcare industry.<sup>64</sup>

Congress's hope in passing the equal access provision was that the states would be forced to solve problems of disparate participation by eliminating problems of disparate payments. In other words, the

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<sup>60</sup> The equal access language had been part of Health and Human Services regulations since 1966. See 42 CFR § 447.204 (2004). See also *DeGregorio v O'Bannon*, 500 F Supp 541, 549 & n 13 (ED Pa 1980) (recounting the regulation's history).

<sup>61</sup> Witnesses before the House committee insisted that provider payments were not the only cause of low participation, claiming that administrative hassles and fear of malpractice liability were equally daunting. But the chairman of the subcommittee, Representative Henry A. Waxman, said that "the one complaint [Congressmen] hear the most is the rate of payment." Medicare and Medicaid Initiatives, Hearings before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, 101st Cong, 1st Sess 113 (1989).

<sup>62</sup> HR Rep No 101-247 at 390 (cited in note 22), quoting Medicare and Medicaid Initiatives, 101st Cong, 1st Sess at 108 (cited in note 61) (statement of Richard N. Jensen, National Governors' Association).

<sup>63</sup> See Part IV.A.1.

<sup>64</sup> As Part II.B.1 described, EMTALA and cost-shifting create part of the problem by creating rate-irrelevant incentives that motivate Medicaid participation. Another part of the problem is that states have discovered methods of coercing participation at below-market compensation by creatively wielding their tremendous market power. See, for example, *Tennessee Medical Association v Corker*, 1995 Tenn App LEXIS 243, \*5 (holding that the Tennessee Medicaid Association lacked standing to challenge TennCare, Tennessee's Medicaid program); Watson, *Medicaid Physician Participation*, 21 Am J L & Med at 205-13 (cited in note 10) (describing physicians' objections to TennCare, which tied Medicaid participation to MCO participation, leading physicians to label the program coercive).

access mandate was never intended as an end in itself; it was merely a means of achieving greater rate equality.<sup>65</sup> Like the Fifth and Seventh circuits, Congress assumed that access and participation would be sufficient proxies for cost and quality, but in today's healthcare market and regulatory regime, states can too easily produce equal participation without paying equal rates. The access metric thus fails to implement Congress's intent because it focuses too narrowly on outcomes without imposing any requirements on payments.

4. The access metric is difficult for courts to administer.

The final objection to the Fifth and Seventh circuits' interpretation of § 30(A) is that it is difficult for the courts to administer because the rule leaves judges with very little guidance in determining whether "access" is equal. A 1990 case, *Clark v Kizer*,<sup>66</sup> laid out the factors that the Department of Health and Human Services (HHS) deemed relevant to § 30(A) compliance: (1) provider participation, (2) reimbursement rates, (3) opt-out rates, (4) patient complaints, and (5) utilization rates.<sup>67</sup> In order to prove substantively *unequal* access, plaintiffs would need to show not only how Medicaid fares under each of those factors but also how the private market fares, such that the two sectors could be compared.

In two recent cases, one arising under the Fifth Circuit's rule and the other arising under the Seventh Circuit's rule, plaintiffs have attempted to meet this hefty burden by presenting complex evidence related to all five factors. In the case arising under the Fifth Circuit's rule, the district court made eighty-five findings of fact related to the plaintiffs' § 30(A) claim, considering a variety of evidence demonstrating provider participation, reimbursement rates, patient complaints, and quality of care.<sup>68</sup> In the case arising under the Seventh Circuit's rule, the district court made fifty-three findings of fact, primarily considering evidence of provider participation and reimbursement rates.<sup>69</sup>

The most striking feature of these two cases is that despite their extensive findings, neither case includes evidence that offers a true

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<sup>65</sup> See *Sobky v Smoley*, 855 F Supp 1123, 1138 (ED Cal 1994) (finding, based on the legislative history, that "the equal access provision is directed at prohibiting the payment of insufficient reimbursement rates to providers").

<sup>66</sup> 758 F Supp 572 (ED Cal 1990).

<sup>67</sup> *Id.* at 576–78. See also Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients' Right to Health Care*, 17 Loyola Consumer L Rev 375, 379–380 (2005).

<sup>68</sup> See *Oklahoma Chapter of the American Academy of Pediatrics v Fogarty*, 366 F Supp 2d 1050, 1063–81 (ND Okla 2005), appeal filed, No 06-5042 (filed Feb 13, 2006).

<sup>69</sup> See *Memisovski v Maram*, 2004 US Dist LEXIS 16772, \*40–63 (ND Ill).

comparison of Medicaid patients' access to private patients' access.<sup>70</sup> The only comparative data offered in either case relate to payments, which do not reveal substantive access. The reason for plaintiffs' failure to include comparative evidence is probably the difficulty in collecting it. As one court put it, the comparative element of the access metric "present[s] high, if not insurmountable, hurdles."<sup>71</sup>

The access metric requires consideration of a number of factors that are difficult for plaintiffs to prove and for judges to understand, and the rule should require comparative evidence that is nearly impossible to obtain. To the extent that alternative interpretations of the provision are easier to administer, the access metric should be disfavored.

### III. THE COST METRIC: NINTH CIRCUIT

In contrast to the Fifth and Seventh circuits' substantive access metric, the Ninth Circuit has determined compliance with § 30(A) solely by reference to the state's rate-setting procedure, asking whether the state based its reimbursement rates on "responsible cost studies."<sup>72</sup> In order to prove a violation under the Ninth Circuit's rule, plaintiffs must show simply that the state neglected to study or consider providers' costs when it set rates.<sup>73</sup>

Although this interpretation seems more closely aligned with the provision's text and with Congress's purpose than the access metric, and although it avoids the administrative difficulties intrinsic to the access metric, it nevertheless seems contrary to Congress's specific intent in the passage and development of § 30(A). The first problem with the cost metric is that it does not allow the states to use rate setting as a utilization control. The second problem is that the cost metric imposes a substantial administrative burden on state agencies, which Congress specifically intended to avoid.

This Part summarizes the Ninth Circuit's holding, elaborates on the respects in which it seems superior to the access metric, and then discusses how it seems to deviate from congressional intent.

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<sup>70</sup> Although both cases found in the plaintiffs' favor, holding that reimbursement rates violated § 30(A), the lack of comparative evidence would make both cases vulnerable to reversal if they were appealed. It may be, however, that the Fifth and Seventh circuits would soften the access metric if these cases were appealed because both cases include more sophisticated arguments and more extensive findings than the cases appealed in *Evergreen* and *Methodist Hospitals*. Even if both cases were appealed and affirmed, however, they involve much more evidence and analysis than should be necessary. See Part IV.

<sup>71</sup> *Clark v Richman*, 339 F Supp 2d 631, 645 (MD Pa 2004) (noting the difficulty of polling large groups or examining countless records, which would be necessary in order to give a comparative perspective).

<sup>72</sup> *Orthopaedic Hospital v Belshe*, 103 F3d 1491, 1496 (9th Cir 1997).

<sup>73</sup> *Id* at 1499.



### A. The Cost Metric

In 1997, the Ninth Circuit held that payments for outpatient hospital services under California's Medicaid program, Medi-Cal, were legally inadequate. In *Orthopaedic Hospital v Belshe*,<sup>74</sup> several hospitals sued the state agency, claiming that Medi-Cal violated § 30(A) by reimbursing hospitals at the same rate that it reimbursed nonhospital providers such as ambulatory clinics and physicians' offices.<sup>75</sup> The argument's reasoning rested on the higher marginal costs that hospitals experience due to their higher fixed costs.<sup>76</sup> The hospitals claimed that § 30(A) requires the state to pay different providers differently because the payments must be consistent with the particular provider's standards of efficiency, economy, and quality. Furthermore, the hospitals insisted that a payment rate that is consistent with efficiency and economy must reflect providers' actual costs.

The Ninth Circuit agreed.<sup>77</sup> While acknowledging that § 30(A) intended to provide states with flexibility, the court held that all payment rates "must bear a reasonable relationship to provider costs, unless there is some justification for [lower] rates."<sup>78</sup> Essentially, the Ninth Circuit created a rule requiring state agencies to conduct or adopt "responsible cost studies"<sup>79</sup> and to set payment rates at a level that reflects the determined cost of care. Under this rule, a state that chooses to pay less than the determined cost bears the burden of justifying that deviation.<sup>80</sup> The court thus established a procedural requirement—"responsible cost studies"—with a substantive component arising from the burden-shifting rule; the state may set rates that substantively deviate from costs, but only if the agency is prepared to prove that payments comply with § 30(A) factors despite their deviation from the cost-based yardstick.

### B. Advantages of the Cost Metric

With regard to many of the concerns identified in Part II.B, the cost metric seems superior to the access metric. First, the Ninth Circuit's opinion addresses all four factors included in § 30(A)—efficiency, economy, quality, and access—giving the cost metric a more solid textual foundation than the access metric.<sup>81</sup> While the court's primary

<sup>74</sup> 103 F3d 1491 (9th Cir 1997).

<sup>75</sup> Id at 1493.

<sup>76</sup> See id.

<sup>77</sup> See id at 1496.

<sup>78</sup> Id at 1499.

<sup>79</sup> Id at 1496.

<sup>80</sup> See id at 1500.

<sup>81</sup> See Part II.B.1.

concern seems to have been the efficiency and economy requirements, the opinion addressed the tie between costs and quality,<sup>82</sup> and the court extensively discussed the state's attempted reliance on equal access. For example, the Ninth Circuit determined that EMTALA prevents the state from relying on de facto access equality to prove the adequacy of rates for emergency room services because EMTALA sustains access even in the face of nominal reimbursement.<sup>83</sup> The court then made the broad statement that "[d]e facto access, produced by factors totally unrelated to reimbursement levels, does not satisfy the requirement of § 1396a(a)(30)(A) that payments must be sufficient to enlist enough providers."<sup>84</sup> The Ninth Circuit, therefore, required examination of rates' adequacy even in sectors of the healthcare industry in which providers participate irrespective of proffered payments. In so doing, the cost metric requires courts to inquire into the provision's first half without reliance on the faulty access proxy. In terms of its ability to enforce the full text of the provision, therefore, the cost metric seems superior to the access metric.

Second, the cost metric seems better aligned with Medicaid's purpose than the access metric.<sup>85</sup> Assuming that any "responsible cost study" would examine the costs incurred by all providers, not just low quality providers, the cost metric would require higher payments to higher-quality providers, which presumably incur greater costs. The cost metric, therefore, is less likely than the access metric to discourage participation among middle-to-high quality providers, thereby mitigating the likelihood of maintaining or recreating a dual-tracked medical system.

Finally, the cost metric imposes less of a burden on plaintiffs and courts than the access metric.<sup>86</sup> The cost metric imposes a negligible burden on plaintiffs, who must present evidence only of providers' costs and Medicaid rates,<sup>87</sup> and the rule is easy for courts to administer because judges need only compare two numbers to determine whether they bear a "reasonable relationship" to one another.

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<sup>82</sup> See *Orthopaedic Hospital*, 103 F3d at 1497 (rejecting the state's argument "that the payments do not independently have to support quality care because quality is assured by other regulations").

<sup>83</sup> See *id.* at 1498.

<sup>84</sup> *Id.*

<sup>85</sup> See Part II.B.2.

<sup>86</sup> See Part II.B.4.

<sup>87</sup> Although beneficiaries ordinarily might have a hard time collecting evidence of providers' actual costs, providers' interests are aligned with beneficiaries' interests in § 30(A) challenges. Most cases have been brought jointly by providers and beneficiaries, and it seems likely that providers will continue to cooperate in legal challenges, particularly if they lack standing. See note 12.

### C. Problems with the Cost Metric

Although the cost metric avoids many of the access metric's pitfalls, it still deviates from Congress's specific intent in the development of § 30(A). First, the cost metric is too restrictive of state autonomy, preventing the states from using reimbursement rates as a means of controlling utilization. Second, the administrative burdens that the cost metric imposes on state agencies—not only in justifying deviations from cost-based reimbursement but also in obtaining or conducting ex ante “responsible cost studies”—violate Congress's intent to lessen states' administrative obligations.

1. The cost metric does not allow states to use payments as a utilization control.

In developing § 30(A), Congress explicitly intended to free the states from cost-based reimbursement. As originally passed, § 30(A) included an implicit reference to costs, requiring that reimbursements be “not in excess of reasonable charges.”<sup>88</sup> Similarly, the provision regulating reimbursements for inpatient services, § 13, required the states to reimburse providers' “reasonable costs.”<sup>89</sup> In 1981, however, Congress removed all references to costs from Medicaid's reimbursement provisions, removing the cap from § 30(A) and passing the Boren Amendment as a replacement for § 13.<sup>90</sup>

In justifying the Boren Amendment, the House Report asserted that freeing the states from “the reasonable cost reimbursement criterion” would allow Medicaid programs to “develop hospital reimbursement systems which would incorporate tests of efficiency and prudent buyer requirements.”<sup>91</sup> The Budget Committee reported that it “recognize[d] the inflationary nature of the current cost reimbursement system and intend[ed] to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of [ ] services.”<sup>92</sup> These justifications for the Boren Amendment make it clear that many members of Congress were anxious to allow the states to abandon cost-based reimbursement in favor of alternative approaches.

It seems likely that the logic behind Congress's wholesale abandonment of mandatory cost-based reimbursement was a desire to allow Medicaid programs to participate in an industry-wide revolution

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<sup>88</sup> See 81 Stat at 911 (cited in note 57).

<sup>89</sup> See 79 Stat at 345–46 (cited in note 14).

<sup>90</sup> See note 30.

<sup>91</sup> 2 HR Rep No 97-158 at 292 (cited in note 30).

<sup>92</sup> Id at 293.

beginning in the late 1970s and early 1980s: the move toward MCOs and prospective payment systems (PPSs).<sup>93</sup> During that time period, the health industry moved from fee-for-service plans, by which insurance companies pay for every service provided, to managed care plans, by which insurance companies pay a set rate per patient. In the past two decades, MCOs have taken over the health services industry; today, the vast majority of healthcare providers participate in at least one MCO, accepting prospective payments for at least some patients.

The House Report summarizing the 1981 Medicaid amendments specifically mentions the development of PPSs as Congress's goal: "The Committee is especially interested in the development of prospective rate methodologies as a replacement for the current reasonable cost reimbursement system under Medicaid."<sup>94</sup> The hope underlying the Medicaid amendments was the same as the hope driving the managed care revolution: that predetermined payments would create an incentive for providers to devise more efficient approaches to care, thereby curbing the health industry's startling inflation.

The Ninth Circuit, by requiring a reasonable relationship between Medicaid rates and providers' costs, returns Medicaid to the inflationary fee-for-service system that Congress was trying to escape. The court acknowledged that cost-based reimbursement would hinder the state's efforts to discourage utilization through payment schemes, providing as an example California's desire to discourage cesarean sections by reducing rates for that service.<sup>95</sup> The Ninth Circuit, however, dismissed the state's argument that low payments create useful financial incentives, claiming that the state "is still free to discourage unnecessary procedures through utilization controls without violating § 1396a(a)(30)(A)."<sup>96</sup> Furthermore, the court insisted that any reimbursement rate that "provides an incentive to use an inappropriate service" is "not consistent with efficiency, economy, and quality of care."<sup>97</sup>

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<sup>93</sup> A PPS is a reimbursement system that pays a predetermined rate for each patient. The Medicare PPS, for example, bases payments on the patient's diagnosis. In other words, a hospital provider would be paid a different amount for a diabetes patient than for a flu patient but the same amount for each diabetes patient regardless of the amount of care actually consumed. See American Hospital Directory, *Medicare Prospective Payment System*, online at <http://www.ahd.com/pps.html> (visited Mar 28, 2006) (describing Medicare's PPS, which has influenced many Medicaid programs' reimbursement schemes). See also *Visiting Nurse Association of North Shore, Inc v Bullen*, 93 F3d 997, 999–1000 (1st Cir 1996) (describing Massachusetts's transition from cost-based to prospective reimbursements).

<sup>94</sup> 2 HR Rep No 97-158 at 293 (cited in note 30).

<sup>95</sup> See *Orthopaedic Hospital*, 103 F3d at 1497–98.

<sup>96</sup> *Id.* at 1498.

<sup>97</sup> *Id.*

These arguments, however, seem dismissive of the logic behind PPSs. The hope of the managed care revolution was that giving providers a financial incentive to police utilization would be more efficient than externally enforced utilization controls, which require monitoring and review. Of course the Ninth Circuit is correct that California may prohibit the unnecessary use of cesarean sections, but such a regulation would require the state to investigate on a case-by-case basis the medical necessity of Medicaid patients' cesarean sections. The difference in efficiency between this bureaucratic policing and a PPS's incentivized self-monitoring should be obvious. At least in theory, prospective payments can accomplish the same goal as utilization controls without the wasteful bureaucracy of external enforcement.

Admittedly, the cost metric does not preclude prospective rate setting; it simply requires that prospective rates bear a reasonable relationship to costs. But one of the necessary features of a PPS, at least when used to control utilization, is its deviation from providers' costs for certain services. To work as a utilization control, a PPS must be allowed to pay less than the full cost of those services that seem to be utilized inefficiently. Allowing some imbalance in payments—allowing states systematically to underpay providers for some services—was exactly what Congress intended to do when it passed the Boren Amendment and removed the § 30(A) cap.<sup>98</sup>

By requiring the states to reimburse providers' costs, the cost metric vitiates the intended effect of the 1981 Medicaid amendments, which was to free the states from mandatory cost-based reimbursement. The cost metric therefore seems directly contradictory to Congress's intent in the development of Medicaid's payment requirements.

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<sup>98</sup> It appears from the *Orthopaedic Hospital* opinion that the state made two claims referencing utilization controls, only one of which aligns with this Comment's analysis. The state's first claim was the need to control utilization of particular services such as cesarean sections. For the reasons given in this subpart, the court's response to that argument seems inadequate. But the other argument that the state presented focused on the need to discourage Medi-Cal patients from using emergency room services rather than cheaper noninstitutional services. The Ninth Circuit's response to this argument was much better; the court pointed out (correctly) that "undercompensating hospitals gives no incentives to Medi-Cal beneficiaries to use more economical providers." *Orthopaedic Hospital*, 103 F3d at 1496. This second discussion makes the Ninth Circuit's disposition appear correct; wholesale undercompensation of emergency room services does not create the utilization incentives that the PPS's inventors envisioned. The Ninth Circuit's rule going forward, however, would prevent any prospective payments that were not tied to costs, which would frustrate the fundamental concept of PPSs as a form of utilization control. In other words, state agencies must be free to deviate from providers' costs for *some* services, assuming that undercompensation is part of a holistic system that alters providers' utilization incentives. See note 131. This Comment's quarrel with the Ninth Circuit's holding, therefore, is not that Medi-Cal's reimbursement system should have been upheld; it is simply that the mandated tie to providers' costs is not the best rule overall because it prevents states from instituting intended prospective payments.

2. The cost metric imposes severe administrative burdens on state agencies.

The other factor motivating Congress to remove the cap from § 30(A) was policymakers' desire "to remove the administrative burdens [that the reasonable charge requirement] impose[d] on the States."<sup>99</sup> Under the cost metric, however, 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. These requirements may (or may not) be less onerous than the old requirement of studying and tracking reasonable charges,<sup>100</sup> but they certainly do not effect the congressional intent of freeing the agencies from procedural strictures.

While the requirement that reimbursement rates bear a reasonable relationship to providers' costs may seem straightforward, the burden of conducting or acquiring comprehensive cost studies is substantial. As the Seventh Circuit noted in *Methodist Hospitals*, "[I]t is exceptionally difficult to determine demand and supply schedules for a single product."<sup>101</sup> Determining costs for "the entire medical segment of the economy," the Seventh Circuit claimed, "would be more than difficult; it would be impossible."<sup>102</sup> Admittedly, it seems that the *Methodist Hospitals* plaintiffs sought more comprehensive studies than those that the Ninth Circuit envisioned when it required a relationship to "responsible" cost studies. Nevertheless, the Seventh Circuit is likely correct that any responsible study of healthcare costs would be extremely expensive and difficult (if not impossible) to conduct.<sup>103</sup> The cost metric, therefore, would place a heavy administrative burden on the agency every time it wanted to adjust rates. Furthermore, the Ninth Circuit's rule probably would require Medicaid rates to keep pace with changing costs, meaning that the state would be responsible for continually studying costs in order to ensure that payments did not fall behind.

The cost metric also creates a burden for agencies by requiring states to justify departures from cost-based reimbursement. The Ninth

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<sup>99</sup> 2 HR Rep No 97-158 at 312 (cited in note 30).

<sup>100</sup> Given the many changes in the healthcare industry since 1981, it is hard to know whether tracking reasonable charges in 1981 was more or less difficult than tracking providers' costs today. Even if the cost metric's procedural requirements are less burdensome than was the reasonable charges requirement, though, it is safe to say that all forms of mandatory cost-based reimbursement violate congressional intent. Any requirement that agencies track costs imposes a kind of burden and a level of burden that Congress specifically intended to abolish.

<sup>101</sup> 91 F3d at 1030.

<sup>102</sup> *Id.*

<sup>103</sup> For more discussion on this point, see Part IV.B.2.

Circuit's rule would shift the burden of proof to the state whenever payments deviated from costs, requiring the state to prove that below-cost reimbursements satisfy § 30(A) requirements. The *Orthopaedic Hospital* opinion, however, provides no guidance for agencies wishing to offer such a justification. Beyond the court's explicit rejection of utilization control as a rationale, the opinion does not discuss reasons for below-cost payments that might be acceptable under the Ninth Circuit's incarnation of § 30(A). The state, therefore, may need to work quite hard to prove that below-cost reimbursement should be accepted for any services.<sup>104</sup>

In sum, alleviating the administrative burden of operating a Medicaid program was one of the policymakers' central intentions in eliminating mandatory cost-based reimbursement. The Ninth Circuit's interpretation of § 30(A) reinstates the agencies' obligation to measure and track healthcare costs and to defend any departures from cost-based reimbursement. These requirements are contrary to Congress's specific intent.

#### IV. THE MCO METRIC: A NEW STANDARD

Because neither of the two generally applicable metrics for rates' adequacy seems consistent with the statute's text, purpose, and intent, this Comment proposes a new rule—an MCO metric<sup>105</sup>—as the first-best interpretation of the provision. The basic idea is that Medicaid programs should be encouraged to reimburse providers at the same rate that an average managed care organization offers.<sup>106</sup> If states wish to deviate from an average MCO rate, they should be required to justify their deviation under an arbitrary and capricious standard, which imposes some administrative costs on the agencies without subjecting the agency's decision to full substantive review. The MCO metric thus

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<sup>104</sup> The burden of proof that the states would bear likely would be similar to the burden of proof that plaintiffs bear under the access metric. For discussion of the excessiveness of that burden, see Part II.B.4.

<sup>105</sup> The term "managed care organization" (MCO) is a general term encompassing several kinds of healthcare plans, including most famously the health maintenance organization (HMO). An MCO is defined by the combination of service delivery with insurance provision. In other words, MCOs are involved in both judgments of medical necessity and payments to healthcare providers. See Charles E. Phelps, *Health Economics* ch 11 (Pearson Education 3d ed 2003) (discussing health care cost-control measures generally). See also note 93 (describing prospective payment systems, another defining feature of managed care).

<sup>106</sup> Today, it would be surprising to find a provider that participates in Medicaid but does not participate in at least one MCO. Requiring Medicaid plans to pay at least the same rate that private MCOs pay, thus, essentially requires Medicaid to replicate (at a minimum) the lowest rate that providers can recover through the private market. Furthermore, requiring Medicaid to base its payments on MCO rates would not require providers to change their delivery systems. MCO payments simply would serve as a yardstick for Medicaid payments' statutory adequacy.

would create a safe harbor for Medicaid rates that track MCO rates,<sup>107</sup> but it would provide a procedural escape hatch for states wishing to pay a lower rate.

The MCO metric combines the Ninth Circuit's basic structure with the Third and Eighth circuits' deferential review. The rule follows the cost metric inasmuch as it combines a substantive yardstick with a burden-shifting requirement—in other words, the safe harbor/escape hatch structure mimics the Ninth Circuit's cost-based safe harbor and burden-shifting escape hatch. The MCO metric, however, departs from the Ninth Circuit in two respects: First, it uses MCO rates rather than providers' costs as the substantive yardstick. Second, it adopts the Third and Eighth circuits' "arbitrary and capricious" standard for reviewing deviations from MCO rates rather than shifting a full burden of proof.

This Part explicates the new metric in three stages. First, it explains the basic foundations of the standard, including the precedents that indicate reliance on private-market rates and the two opinions that propose reliance on arbitrary and capricious review. Second, it demonstrates the benefits of relying on MCO rates rather than "responsible cost studies" or substantive access for measuring adequacy. Finally, it demonstrates the benefits of relying on arbitrary and capricious review rather than outright burden shifting for states that choose to deviate from MCO rates.

#### A. Foundations: Third and Eighth Circuits and Lower Courts

Each of the MCO metric's two parts—the MCO-tracking safe harbor and the procedural escape hatch—has foundations in prior opinions. The safe harbor emerges from the Third Circuit's opinion in *Rite Aid of Pennsylvania, Inc v Houstoun*<sup>108</sup> and from several lower court and administrative opinions, all of which indicate that private-market rates serve as an acceptable benchmark for § 30(A) compliance. The escape hatch emerges from *Rite Aid* and from the Eighth Circuit's opinion in *Arkansas Medical Society, Inc v Reynolds*,<sup>109</sup> both of which apply arbitrary and capricious review. This subpart discusses, first, the legal foundations of the safe harbor and, second, the legal foundations of the escape hatch.

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<sup>107</sup> This Comment's MCO-tracking "safe harbor" is the introduction of an irrebuttable presumption that Medicaid rates tracking MCO rates are legally adequate under § 30(A). The rule would prevent plaintiffs from challenging rates' statutory adequacy as long as the state could demonstrate that a private MCO, engaged in a reasonable and competitive business, offers the same rates for the same services.

<sup>108</sup> 171 F3d 842 (3d Cir 1999).

<sup>109</sup> 6 F3d 519 (8th Cir 1993).



1. Several courts have compared Medicaid rates to private-market rates.

Although it would be controversial to assert that § 30(A) mandates rate parity,<sup>110</sup> recent cases have indicated that a comparison between Medicaid and private-market reimbursements is at least relevant in measuring § 30(A) compliance. In *Rite Aid*, the Third Circuit confronted a challenge to Pennsylvania's pharmaceutical reimbursements, and the court's reasoning suggests the relevance of private payors' rates. Pennsylvania required pharmacies "to charge the [state Health] Department the lowest rate they charged any other third-party payor, including private insurers."<sup>111</sup> The Third Circuit upheld this rate setting, finding that the state should be allowed to rely on private payors' rates and other states' rates in setting Medicaid payments. Although the opinion does not scrutinize the rates' substantive adequacy,<sup>112</sup> the court's reasoning implies that tying Medicaid rates to private-market rates suffices to ensure that payments will be substantively acceptable under § 30(A). At the very least, the Third Circuit held that the tie to private-market rates is not an arbitrary or capricious means of assuring compliance. The *Rite Aid* opinion therefore supports the proposition that private-market rates are an acceptable yardstick for statutory adequacy.

Two district courts also have considered a comparison to private-market rates as evidence of § 30(A) compliance. In two of the most recent § 30(A) challenges, *Memisovski v Maram*<sup>113</sup> and *Oklahoma Chapter of the American Academy of Pediatrics v Fogarty*<sup>114</sup> (*OKAAP*), the courts referenced the differential between Medicaid rates and private-market rates as an important datum in determining that payments were inadequate.<sup>115</sup> Neither case rested its conclusion exclusively on the rate differential,<sup>116</sup> but both cases gave rate parity serious consideration. Furthermore, in both cases, the evaluation of payments was the only piece of evidence that was truly comparative of Medicaid

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<sup>110</sup> See note 57 (recounting legislative history that indicates Congress's hesitation to mandate rate parity). See also *DeGregorio v O'Bannon*, 500 F Supp 541, 550 (ED Pa 1980) (noting that the equal access provision "does not require rate parity for [Medicaid] patients"); *Simpson v Heckler*, 630 F Supp 736, 738 (ED Pa 1986) (same); *California Association of Bioanalysts v Rank*, 577 F Supp 1342, 1359 (CD Cal 1983) (same).

<sup>111</sup> *Rite Aid*, 171 F3d at 847.

<sup>112</sup> See *id* at 850 (noting that the parties did not challenge "the substantive impact or results of the revised rates").

<sup>113</sup> 2004 US Dist LEXIS 16772 (ND Ill).

<sup>114</sup> 366 F Supp 2d 1050 (ND Okla 2005), appeal filed, No 06-5042 (filed Feb 13, 2006).

<sup>115</sup> See *OKAAP*, 366 F Supp 2d at 1076; *Memisovski*, 2004 US Dist LEXIS 16772 at \*124-30.

<sup>116</sup> See text accompanying notes 68-69 (describing the extensiveness of the two courts' evidentiary findings).

services to mainstream services, which makes the point seem decisive given that both judges were attempting to measure access *equality*.

The third authority that has focused on comparisons to private-market rates is the federal agency charged with implementing the Medicaid Act—HHS—which has mentioned rate parity in formal and informal interpretations of § 30(A). In *Kizer*, the Secretary of HHS submitted an amicus brief suggesting that the differential between Medicaid rates and private rates should be one of the two “major factors” for determining § 30(A) compliance.<sup>117</sup> More recently, in a Center for Medicaid and State Operations memorandum, the agency stated that “[o]ne way to assess whether State payments are sufficient to enlist enough providers . . . is to compare State Medicaid reimbursement rates . . . to the rates of commercial payers for comparable services.”<sup>118</sup> This rate comparison was the memorandum’s only suggestion for measuring compliance. Finally, in a formal adjudication before the Administrator of the Centers for Medicare and Medicaid Services, the agency determined that Missouri’s proposed rate was “inconsistent with economy” because it did not “accurately reflect . . . reasonable fee-for-service rates.”<sup>119</sup> This language supports the concept that comparing Medicaid payments to private-market payments is a legitimate way to determine rates’ consistency with § 30(A) factors.

In sum, a requirement that Medicaid rates track private-market rates—the majority of which are set by MCOs—is a requirement that the courts and the agency have discussed in deciding § 30(A) cases. Although no authority has held that payment differentials should be the decisive factor, rate parity has been a serious consideration.

## 2. The Third and Eighth circuits have applied arbitrary and capricious review.

Two cases, *Rite Aid* and *Arkansas Medical Society*, have determined that Medicaid rates should be upheld as long as the state agency was not arbitrary and capricious in its rate setting. Arbitrary and capricious review, a staple of administrative law, is a deferential standard requiring courts to uphold any agency actions that are based on rea-

<sup>117</sup> 758 F Supp at 576–77. The other major factor was provider participation.

<sup>118</sup> Center for Medicaid and State Operations, *Memorandum from Director to Associate Regional Administrators for Medicaid and State Operations* 3 (Jan 19, 2001), online at <http://www.healthlaw.org/library.cfm?fa=detailItem&fromFa=summarize&id=68989&appView=Topic&r=rootfolder> (visited Mar 28, 2006).

<sup>119</sup> Department of Health and Human Services, Healthcare Financing Administration, *The Disapproval of Missouri Plan Amendment No 99–29*, Decision of the Administrator, 2002 WL 1465787, \*5. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, is the division of HHS responsible for administering Medicare and Medicaid.

soned deliberation. The rule is that courts should defer to agency decisions that are not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law."<sup>120</sup> Such review "is narrow[,] and a court is not to substitute its judgment for that of the agency."<sup>121</sup> In order to benefit from this deference, however, the agency must "examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'"<sup>122</sup> In other words, the courts will defer to an agency's rate-setting decision if the agency can prove that it considered relevant statutory factors and made a rational decision related to its findings.<sup>123</sup>

In *Arkansas Medical Society*, the Eighth Circuit applied arbitrary and capricious review to Arkansas's decision to cut its Medicaid reimbursement rates. The court determined that Arkansas's health agency had acted arbitrarily and capriciously because it had based its decision exclusively on a need to recapture a budgetary shortfall, failing to consider statutory factors of efficiency, economy, quality, and access.<sup>124</sup>

The Third Circuit similarly applied arbitrary and capricious review in considering Pennsylvania's decision to cut pharmacy reimbursements. The *Rite Aid* court rejected the Ninth Circuit's view that § 30(A) requires a particular procedure (that is, that it requires cost-based rate setting), but the court asserted that the state nevertheless "may not act arbitrarily and capriciously" in setting payments.<sup>125</sup> Applying that standard, the court found that Pennsylvania's decision was sufficiently reasoned because the state had considered private payors' rates, neighboring states' rates, and pharmaceutical companies' prices.<sup>126</sup> While the *Rite Aid* court mentioned that the agency "might have done a better job in its review by considering systematically and thoroughly all the implications of its rate revisions,"<sup>127</sup> the Third Circuit ultimately determined that Pennsylvania had "made a

<sup>120</sup> *Citizens to Preserve Overton Park, Inc v Volpe*, 401 US 402, 414 (1971), quoting Administrative Procedure Act, 5 USC § 706.

<sup>121</sup> *Motor Vehicle Mfrs Assn of the U.S., Inc v State Farm Mutual Auto Ins Co*, 463 US 29, 43 (1983).

<sup>122</sup> *Id.*, quoting *Burlington Truck Lines, Inc v United States*, 371 US 156, 168 (1962).

<sup>123</sup> See *Arkansas Medical Society*, 6 F3d at 529.

<sup>124</sup> See *id.* at 530–31. It appears that the parties consented to application of the arbitrary and capricious standard to the state agency, see *id.* at 529, although this decision could be controversial given that arbitrary and capricious review arises from federal law regulating federal agencies. See *Orthopaedic Hospital*, 103 F3d at 1495–96 (noting that administrative law deference is inappropriate when considering a state agency's interpretation of federal law). But see *Visiting Nurse Association of North Shore, Inc v Bullen*, 93 F3d 997, 1000 (1st Cir 1996) (applying *Chevron* deference, which was established in *Chevron v Natural Resource Defense Council, Inc*, 467 US 837 (1984), to a state Medicaid program).

<sup>125</sup> 171 F3d at 852.

<sup>126</sup> See *id.* at 848.

<sup>127</sup> *Id.* at 854.

reasonable effort to anticipate the effects of its action.”<sup>128</sup> The court thus held that deficiencies in the agency’s decisionmaking did “not make the overall process arbitrary and capricious.”<sup>129</sup>

The rule that arises from these two cases is that the state, to benefit from deference, must conduct or rely on some studies of cost, quality, and access. As long as the state can show that it has examined rates’ likely effects on the statutory factors, courts applying arbitrary and capricious review will uphold the agency’s chosen reimbursement scheme without further inquiry.

#### B. Advantages of the MCO Metric

Applying a default requirement of MCO rate parity in combination with arbitrary and capricious review of deviations from MCO tracking avoids many of the problems that this Comment has identified with the access and cost metrics. First, the MCO metric is more compatible with the purpose and intent of § 30(A) than the other two metrics. Second, the MCO metric is easier for all parties to administer than either the cost or access metric. Finally, the MCO metric imposes a better balance of costs and incentives on the state agencies than either of the alternative metrics. This Part discusses each benefit of the MCO metric in turn.

##### 1. The MCO metric comports better with § 30(A)’s purpose and intent.

Requiring Medicaid programs to track MCO rates forces the states to provide market-based reimbursement without forcing the states into cost-based reimbursement. In three respects, this feature of the MCO metric harmonizes better than the alternative metrics with the Medicaid statute’s purpose and intent. It (1) prevents maintenance of the dual-tracked medical system, (2) requires examination of private-market rates, and (3) allows the states to use reimbursements as a utilization control.

The first benefit of the MCO-tracking requirement is that it avoids the potential creation of a low-quality Medicaid-only market, which might arise under the access metric. As Part II.B.2 discussed, one problem with the access metric is that it allows states to create a cheap Medicaid-only market that is equal in size and accessibility to the private market. The MCO metric, by contrast, would prevent the use of this cost-saving strategy because it would force Medicaid agen-

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<sup>128</sup> *Id.* at 855.

<sup>129</sup> *Id.*

cies to pay the same rate that competitive payors offer. There is therefore no risk under the MCO metric that states could defy the program's purpose by creating an alternative "track" for Medicaid patients.

The second benefit of the MCO metric is that it implements Congress's intent of narrowing the gap between Medicaid and private-market rates. As discussed in Part II.B.3, the access metric fails to require rate comparisons. Historically, § 30(A)'s target has been payments, and the access metric's effect of shifting courts' attention from rates to participation seems unjustifiable. The MCO metric cures this fault. The rule explicitly requires both agencies and courts to examine private-market rates in determining whether Medicaid rates are statutorily adequate. While the procedural escape hatch prevents the MCO metric from intruding too far on state autonomy (which would be an equal offense to legislative intent, as discussed in Part III.C.1), the MCO metric does a better job than the access metric of implementing the spirit of the equal access provision and the entirety of § 30(A).

The third advantage of the MCO metric is that requiring Medicaid programs to track MCO payments rather than "customary fees," "reasonable costs" or even "responsible costs" allows states to mimic the managed care market's containment strategies. As Part III.C.1 discussed, mandatory cost-based reimbursement, while correctly mandating examination of payments rather than participation, defies legislative intent by preventing Medicaid from using reimbursements to control utilization. By contrast, MCO tracking allows states to establish cost-containing prospective payment systems (PPSs)<sup>130</sup> because the vast majority of MCOs use similar systems.<sup>131</sup> In terms of Congress's intent to encourage prospective payments and utilization controls, therefore, the MCO metric is superior to the cost metric.

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<sup>130</sup> See note 93.

<sup>131</sup> For this rule to effect competitive rates, it would be necessary to ensure that Medicaid programs adopted a full private-market PPS rather than adopting the lowest MCO rate for each individual service; otherwise, Medicaid rates overall could be significantly lower than private-market rates. The strategy of utilization control requires underpayment for some services, but creating choice-of-care incentives requires overpayment for substitute services. In the example provided in Part III.C.1, a PPS that undercompensates cesarean sections creates a disincentive to use that option only if the system simultaneously overcompensates vaginal deliveries. If providers are undercompensated for all services, they have no incentive to choose any particular option among viable substitutes. The MCO-tracking requirement, therefore, cannot provide a safe harbor whenever the Medicaid agency is able to point to an MCO that pays the same rate for an individual service. Instead, the presumption of statutory adequacy should arise only if the Medicaid agency can point to a private-market MCO that pays the same rates for all services within the set of viable substitutes.

2. The MCO metric is easier for plaintiffs, courts, and agencies to administer.

Requiring MCO-tracking would avoid the substantial administrative burden that the cost metric imposes on the states, and it would avoid the substantial evidentiary burden that the access metric imposes on plaintiffs and courts. The MCO metric is an easier standard for all parties to administer because MCO rates are easy to discover and measure (whereas costs and access are quite difficult to discover and measure) and because MCO rates are concrete and, therefore, easy to compare (whereas “access” is indefinite and, therefore, difficult to compare).

First, the MCO metric is administratively superior to the cost metric because measuring MCO rates is easier than measuring providers’ costs. Providers have incentives to disclose as little as possible about their costs; like any entrepreneur, they would lose bargaining power if their consumers could calculate their expenses. Furthermore, to the extent that providers would be willing to divulge costs, they would have incentives to inflate their reports. For state agencies, therefore, collecting reliable evidence of providers’ costs would be extremely difficult.<sup>132</sup> By contrast, determining the rates at which MCOs reimburse providers for services is quite easy. Unlike providers, MCOs have incentives to publicize, not to hide, their true rates. Because providers participate with certain MCOs but not others, MCOs must compete against each other to enlist high quality doctors. And because providers consider reimbursements when deciding whether to join an MCO, the organizations must be willing to divulge the rates they pay. Furthermore, MCOs cannot lie about their rates without risking reputational loss. There would, therefore, be fewer barriers to determining MCO rates than there are to determining providers’ costs.

Also, the MCO metric is administratively superior to the access metric because measuring and comparing rates is easier than measuring and comparing access. First, MCO payment data is easier to gather than evidence of private patients’ access to services. As one court said about the evidence required under the access metric, “The difficulty in tracking the number of individuals with private or public insurance (versus uninsured individuals) in proportion to the number of [health-care providers] servicing discrete geographic areas would require widespread polling of those individuals, or would require scouring of countless [providers’] records.”<sup>133</sup> By contrast, the rates that MCOs pay, the reasonableness of those rates, and the competitiveness of the mar-

<sup>132</sup> See text accompanying notes 99–100.

<sup>133</sup> *Clark v Richman*, 339 F Supp 2d 631, 645 (MD Pa 2004).

ket in a geographic area (no matter how defined) are concrete and discrete measurements. Furthermore, MCO rates are simple numbers that correlate perfectly to Medicaid rates. Although it is difficult to determine equivalence of patient access or provider participation, it is easy for all parties—states, plaintiffs, and courts—to determine equivalence of reimbursement rates. Both the evidentiary and the evaluative burdens, therefore, are less onerous under the MCO metric than under the access metric.

In sum, collecting evidence of MCO rates would be easier for state agencies than collecting evidence of providers' costs, and it would be easier for plaintiffs and courts than collecting evidence of private patients' access.

3. Arbitrary and capricious review imposes the best balance of costs and incentives on state agencies.

The final advantage of the MCO metric is that arbitrary and capricious review of a state's decision to deviate from MCO rates would impose a more reasonable burden on state agencies than the cost metric's burden-shifting requirement. At the same time, arbitrary and capricious review would impose enough of a cost on state agencies that they would have incentives to stay within the MCO-tracking safe harbor absent significant evidence that MCO payments are unnecessarily high.

Because arbitrary and capricious review defers to the agency's decision as long as it is rationally connected to a reasonable investigation of statutory factors, it frees the agencies from the responsibility of proving that their rates are consistent with statutory factors. As this Comment discussed in Parts II.B.4 and III.C.2, the burden of proof under § 30(A) is hefty. The MCO metric's version of arbitrary and capricious review would allow the states to choose either to avoid that burden of proof entirely (by staying in the safe harbor) or to demonstrate a reasonable effort to meet the burden of proof, without needing to show 51 percent certainty of success.

At the same time, arbitrary and capricious review does not give the states free rein to slash rates. If the agency wants to pay less than the MCO rate and wants its rates to benefit from judicial deference, the MCO metric would require the agency to conduct or obtain studies showing the effect that lower rates would have on efficiency, economy, quality, and access, and it would require the agency to create a record demonstrating that it rationally relied on those studies in its rate setting.<sup>134</sup> Given the costs associated with these procedural re-

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<sup>134</sup> Consider *Overton Park*, 401 US at 414–15, 419–20 (establishing that the agency must produce a record in order for its decision to be entitled to arbitrary and capricious review).

quirements, the agency probably would not choose to leave the MCO-tracking safe harbor unless it had a reasonable expectation that the savings it could gain from cutting rates to the lowest level rationally allowable would exceed the costs of jumping through the procedural hoops required to obtain deference. Despite being a deferential standard, arbitrary and capricious review does not free the agency to cut rates whenever it chooses. The standard constrains the agency to deviate from MCO rates only when it can rationally claim that private-market MCOs are paying more than § 30(A) requires.

Overall, therefore, an MCO-tracking safe harbor combined with a procedural escape hatch allocates costs and incentives fairly well to ensure that states pay a rate that is consistent with efficiency, economy, and quality and is sufficient to ensure equal access. This rule avoids many of the problems that arise under the cost and access metrics, and it suffices to enforce the text, purpose, and intent of § 30(A).

#### CONCLUSION

There is no doubt that enforced MCO tracking would require dramatic increases in Medicaid spending. Medicaid rates today are a fraction of private-market rates, and the rule that this Comment proposes would require states to make up that ground in the majority of medical markets. Given that states are facing budgetary shortfalls and searching for ways to *reduce* Medicaid spending, this Comment's proposal may seem politically absurd. The result would be to require either the state or national legislature to find sources of revenue—by raising taxes if need be—to fund the governments' cooperative commitment to provide the poor with mainstream medical services.

In the end, though, enforcing § 30(A)'s requirements is necessary to ensure that Medicaid programs abide by their legal commitment to provide healthcare to the poor. The states must have flexibility in their rate-setting methodologies, but they are statutorily required—and should be judicially required—to pay a reasonable price for the services they buy.