To: Health Advocates

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Patient Protection Act clarifies the meaning of "medical assistance"

The Patient Protection and Affordable Care Act (PPA), Pub. L. No. 111-148, includes a provision that clarifies the meaning of "medical assistance" in the federal Medicaid Act. The clarification confirms the original intent of Congress that states, in providing "medical assistance," must operate their programs to ensure that beneficiaries actually receive covered services with reasonable promptness, not simply be reimbursed if they manage to acquire services on their own.

The clarification responds to a recent spate of federal court decisions that focused exclusively on the Medicaid Act's reference to medical assistance as payment and held that states had no responsibility under the Act other than to pay bills. This radical reading of the federal law conflicted with legislative history, rendered numerous other Medicaid statutory and regulatory provisions meaningless, and ignored over 40 years of case history enforcing provisions of the Medicaid Act.

Section 2304 of the PPA amends the Medicaid Act, 42 U.S.C. § 1396d(a), Social Security Act § 1905d(a), to provide that:

> The term "medical assistance" means payment of part of all of the cost of the following care and services **or the care and services themselves, or both,** (if provided in or after the third month before the month in which the recipient makes application for assistance…."

Explanation of the provision

We have quoted the legislative history of the provision fully below. We have prepared and inserted a number of footnotes into the history to explain the congressional references. The reader must understand that the footnotes do not appear in the actual legislative history.

The House Energy and Commerce Committee, which has jurisdiction over Medicaid, explained the need for the clarification as follows:

> The term ["medical assistance"] is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. The Committee, which has legislative jurisdiction over Title XIX of the Social Security Act, has always understood the term to have this combined meaning. [[1]] Four decades of regulations and guidance from the program's administering agency, the Department of Health and Human Services, have presumed such an understanding and the Congress has never given contrary indications.[[2]]

Some recent court opinions have, however, questioned the longstanding practice of using the term "medical assistance" to refer to both the payment for services and the provision of the services themselves.[[3]] These opinions have read the term to refer only to payment; this reading makes some aspects of the rest of Title XIX difficult and, in at least one case, absurd.[[4]] If the term meant

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[1] For example, when amending the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions in 1989, the House Committee stated that "[t]he EPSDT benefit is, in effect, the Nation's largest preventive health *program* for children" and that the EPSDT provisions require that "*each state must provide*, at a minimum, ... EPSDT *services*." H.R. Rep. No. 247, 101st Cong.,1st Sess. 398-399 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2124-25 (emphasis added). *Accord* S. Rep. 89-404, S. Rep No. 404, 89th Cong., 1st Sess. 1965, *reprinted in* 1965 U.S.C.C.A.N. 1943, 1950-51 (stating that "best interest of recipient" provision, 42 U.S.C. § 1396a(a)(19), was included "in order to provide some assurance that ... the State will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided").

[2] *See, e.g.*, 42 C.F.R. § 440.210(a) ("A State plan must specify that, at a minimum, categorically needy recipients *are furnished* the following services...."); *Id.* at § 440.220 (same, with respect to medically needy beneficiaries); *Id*. at § 440.230(a) (requiring state to "specify the amount, duration, and scope of *each service that it provides*") (emphasis added).

[3] *See Equal Access for El Paso v. Hawkins*, 562 F.3d 724, 728 (5th Cir. 2009) (finding reasonable promptness provision only required state to make reasonably prompt payments for services received and did not require state to take steps to ensure that recipients actually receive prompt medical care and services); *Okla. Chap. of the Am. Acad. of Pediatrics v. Fogerty*, 472 F.3d 1208, 1215 (10th Cir. 2006), *cert. denied*, 552 U.S. 813 (2007); *Mandy R. v. Owens,* 464 F.3d 1139 (10th Cir. 2006), *cert. denied*, 549 U.S. 1305 (2007); *Westside Mothers v. Olszewski,* 454 F.3d 532 (6th Cir. 2006) (remanding to allow plaintiffs to re-plead complaint); *Bruggeman v. Blagojevich,* 324 F.3d 906, 910 (7th Cir. 2003) (dicta, stating that "statutory reference to 'assistance' appears to have reference to *financial* assistance rather than to actual medical services").

[4] For example, 42 U.S.C. § 1396a(a)(23) requires that a state must "provide that (A) any individual eligible for medical assistance may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required...."). In this context, "medical assistance" can only mean services, for if it also meant payment, the statute would require participating providers to make payments to eligible individuals. This ignores that Medicaid is a vendor payment program that, for the most part,

only payments, the statutory requirement that medical assistance be furnished with reasonable promptness "to all eligible individuals" in a system in which virtually no beneficiaries receive direct payments from the state or federal governments would be nearly incomprehensible.[5]

Other courts have held the term to be payment as well as the actual provision of the care and services, as it has long been understood.[6]The Circuit Courts are split on this issue and the Supreme Court has declined to review the question. To correct any misunderstandings as to the meaning of the term, and to avoid additional litigation, the bill would revise section 1905(a) … [text of amendment omitted]…. This technical correction is made to conform this definition to the longstanding administrative use and understanding of the term. It is effective on enactment.

H.R. Rep. No. 299, 111th Cong., 1st Sess. 2009, at 649-50, 2009 WL 3321420 (Oct. 14, 2009). (footnotes added).

Conclusion

The clarifying revision in no way changes the responsibilities states assume when they accept federal Medicaid funds, as those responsibilities have until lately been universally understood. *See* 42 U.S.C. §§ 1396a(a)(32) (discussing payments under the program), 1396b (setting forth comprehensive payment rules between the federal and state governments). The clarification also does not require states to directly provide medical services by establishing state-owned or operated facilities or employing providers. It does, however, re-affirm the states' obligations as commonly understood prior to the recent circuit court decisions.

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does not make direct payments to individuals; and, it is absurd. Similarly, § 1396a(a)(65), which requires states to "issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment," would mean that the state would issue provider numbers for suppliers of payments consisting of medical equipment. Again, an absurd result.

[5] *See* 42 U.S.C. § 1396a(a)(8).

[6] *See, e.g.*, *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998); *see also, e.g., Katie A. v. Los Angeles Co.*, 481 F.3d 1150, 1162 (9th Cir. 2007); *Brown v. Tennessee Dept. of Finan. & Admin.*, 649 F.Supp.2d 780, 798-99 (M.D. Tenn. 2009) (finding State attempt to use medical assistance as payment argument was "a revisionist view of the litigation").