Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Oklahoma Health Care Authority DATE: January 25, 2005
Request for Reconsideration
of Decision No. 1924
Docket No. A-04-135
Ruling No. 2005-1

RULING ON REQUEST FOR RECONSIDERATION

On July 23, 2004, the Centers for Medicare & Medicaid Services (CMS) requested that the Board reconsider its June 14, 2004 decision in Oklahoma Health Care Authority, DAB No. 1924. Under 45 C.F.R. § 16.13, the Board may reconsider a decision "where a party promptly alleges a clear error of fact or law." CMS alleged that the Board made clear errors of law and fact in its decision. We have considered CMS's arguments and, as explained below, deny the motion for reconsideration and reaffirm our decision.

DAB No. 1924 involved a disallowance of federal financial participation (FFP) in the amount of $1,902,390 claimed by Oklahoma on behalf of Oklahoma school districts under title XIX (Medicaid) of the Social Security Act (Act). The claim was for school-based health services known as early and periodic screening, diagnostic, and treatment (EPSDT) services provided in state fiscal year 2000 to Medicaid-eligible students. States participating in Medicaid are required to include EPSDT services in their Medicaid State plans. There are no express limitations in title XIX on the availability of Medicaid FFP for these services, other than generally applicable limitations such as that they must have been provided to Medicaid-eligible students for whom the provider has sought third-party reimbursement. CMS implemented the third-party liability requirements for EPSDT services in section 5340 of its State Medicaid Manual. See California Department of Health Services, DAB No. 1285 (1991).

In 1997, CMS issued a document titled "Medicaid and School Health: A Technical Assistance Guide." The Guide includes a section on "Free Care" which states in part that "to determine

whether medical services are provided free of charge and, thus, there is no payment liability to Medicaid, a determination must be made whether both Medicaid and non-Medicaid beneficiaries are charged for the service" (emphasis added).

In the subject disallowance, CMS determined based on the Guide's "free care principle" that the school districts were not entitled to Medicaid funds for EPSDT services provided to Medicaid-eligible students because the school districts provided the services to Medicaid-ineligible students without seeking third-party reimbursement. CMS argued initially before the Board that the Guide's free care principle is a reasonable interpretation of section 1902(a)(17)(B) of the Act[1] that merely clarifies the longstanding policy in CMS's State Medicaid Manual, and that this interpretation is entitled to deference since the Secretary had broad discretion to interpret section 1902(a)(17)(B).

The Board concluded in DAB No. 1924 that the Guide's free care principle is a new condition on the receipt of Medicaid FFP which is not contemplated by the State Medicaid Manual and is not an interpretation of any language in the Act or regulations. Accordingly, we found no legal authority for CMS's disallowance of Medicaid FFP for what were indisputably covered services to Medicaid-eligible students. We also concluded that, even if the disallowance were based on a reasonable interpretation of section 1902(a)(17)(B), CMS should have waived the application of that interpretation.

In its reconsideration request, CMS reiterated its argument that the free care principle in the Guide is an interpretation of section 1902(a)(17)(B). CMS also argued that the Guide's free care principle was issued pursuant to the authority delegated to

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[1] Section 1902(a)(17)(B) states in relevant part that a State plan under title XIX must:

> include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . . .

the Secretary by that section to set standards for available resources for determining the extent of medical assistance.[2]

As explained in detail below, we find no clear error of law or fact in DAB No. 1924. We proceed from the basic premise that in order for CMS to impose a condition on state funding, the condition must be properly authorized by title XIX or its implementing regulations. As CMS concedes, there is no express provision in title XIX that places any condition on the availability of Medicaid FFP for EPSDT services to Medicaid-eligible students for whom a provider has sought third-party reimbursement. In addition, as discussed below, we correctly concluded in DAB No. 1924 that the Guide's free care principle is not an interpretation of section 1902(a)(17)(B) since the free care principle imposes a new requirement, rather than merely clarifying an already existing requirement of that section. Moreover, we reject CMS's argument (which CMS clarified in its request for reconsideration) that the Guide's free care principle was issued pursuant to the authority delegated to the Secretary by section 1902(a)(17)(B) to prescribe standards for "resources" for determining "the extent of medical assistance." That argument fails because the Guide's free care principle does not purport to be a standard prescribed pursuant to section 1902(a)(17)(B) and does not function in that manner. We therefore reaffirm our conclusion in DAB No. 1924 that the Guide's free care principle is not a proper basis for the disallowance because it was not issued pursuant to any authority in title XIX or its implementing regulations.

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[2] In its initial submission, CMS also alleged that "[t]he Board erred by failing to consider the statutory support for the 'free care principle' under section 1905(a) of the Act." CMS submission dated 7/23/04, at 6. CMS later stated that it "*withdraws* the request that the Board reconsider its holding on section 1905(a) of the Act" and asked the Board to reconsider its holding regarding section 1902(a)(17)(B) "without regard to section 1905(a)." CMS submission dated 11/1/04, at 2, n.2. (emphasis in original). We note in any event that DAB No. 1924 did not consider whether section 1905(a) supported the free care principle because CMS conceded there that this principle did not follow from the language in section 1905(a). <u>See</u> DAB No. 1924, at 10, n.13.

This reconsideration ruling is based on the record for DAB No. 1924 as well as the parties' submissions in the reconsideration proceeding.[3]

The Guide's free care principle is not an interpretation of any provision of title XIX or its implementing regulations.

CMS argues in its request for reconsideration, as it did in the original proceedings in this case, that the Guide's free care principle is a reasonable interpretation of section 1902(a)(17)(B) of the Act. An interpretative rule clarifies the meaning of an already existing statutory (or regulatory) requirement and does not impose new requirements.[4] In the original proceedings, CMS did not identify the specific language in section 1902(a)(17)(B) of which, in its view, the free care principle is an interpretation. CMS now takes the position, however, that the free care principle interprets the terms "extent of medical assistance" and "resources." CMS contends in particular that the free care principle is an "interpretation that services 'available without charge' are a resource sufficient to reduce the amount of medical assistance." CMS submission dated 11/1/04, at 5. CMS also contends that the free

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[3] The parties' submissions consist of the following: (1) The Centers for Medicare and Medicaid Services' Request for Reconsideration, dated 7/23/04; (2) The Centers for Medicare and Medicaid Services' Brief in Support of Request for Reconsideration, dated 8/16/04; (3) Response of Oklahoma Health Care Authority to the Center for Medicare & Medicaid Services Request for Reconsideration, dated 9/23/04; (4) an addendum to CMS' Brief in Support of Request for Reconsideration, dated 9/23/04, transmitting a copy of the Decision of the Administrator In the matter of: The Disapproval of the Maryland State Plan Amendment No. 02-05, dated 8/27/02; (5) Centers for Medicare and Medicaid Services' Surreply to Oklahoma Health Care Authority's Response to CMS' Request and Brief in Support of Request for Reconsideration, dated 11/1/04; (6) Rebuttal of Oklahoma Health Care Authority to the Centers for Medicare & Medicaid Services Surreply in Support of Request for Reconsideration, dated 11/15/04; and (7) CMS' Reply to Oklahoma's Rebuttal, dated 11/23/04.

[4] The Board has often commented on the distinction between interpretative and legislative rules. See, e.g., Maryland Dept. of Human Resources, DAB No. 1667, at 8-11 (1998), citing numerous court decisions as well as Kenneth Culp Davis et al., Administrative Law Treatise (3rd ed. 1994).

care principle interprets "the definition of 'medical assistance' insofar as it is ambiguous about whether a cost is charged to recipients or incurred by others. . . ." CMS submission dated 7/23/04, at 10.

CMS is not contending, however, that section 1902(a)(17)(B) itself was specifically intended to treat free care as a resource for the purpose of determining the extent of medical assistance and that the free care principle merely clarifies that intent. Instead, CMS's real argument (which we discuss in the next section of this decision) is that the free care principle was issued pursuant to the authority conferred on the Secretary by section 1902(a)(17)(B) to determine *ab initio* what constitutes "resources" for purposes of determining the extent of medical assistance. Accordingly, CMS's argument that the free care principle is an interpretation of section 1902(a)(17)(B) has no merit.

CMS also argued indirectly that the Guide's free care principle is an interpretation of sections 1902(a)(11), 1903(c), and 1911 of the Act, which make Medicaid the primary payor for 1) services offered by or through the state title V agency, 2) services included in an individualized education plan or an individualized family service plan established pursuant to the Individuals with Disabilities Education Act (IDEA), and 3) care furnished in Indian Health Service (IHS) facilities, respectively. According to CMS, the free care principle "has been implicitly ratified by Congress" because these "three exceptions . . . would be unnecessary in the absence of the free care policy." CMS submission dated 8/16/04, at 7-8. As the Board pointed out in DAB No. 1924, however, states are obligated to provide services under title V or IDEA, which would be the funding source in the absence of statutory exceptions making Medicaid the primary payor for these services. See DAB No. 1924, at 15, n.17. Similarly, absent section 1911, funds appropriated for IHS would be used instead of Medicaid funds to pay for health care services furnished in IHS facilities. Since these provisions do not indicate that Congress believed the general rule to be that Medicaid providers must seek reimbursement from liable third parties for covered services provided to non-Medicaid eligibles before the same services to Medicaid eligibles could be reimbursed, the free care principle is not an interpretation of these provisions.

2. The Guide's free care principle is not a standard prescribed by the Secretary pursuant to his delegated authority in section 1902(a)(17)(B).

In the proceedings on reconsideration, CMS argues that the Guide's free care principle was issued pursuant to the "express . . . directive to the Secretary in section 1902(a)(17)(B) to set resource standards applicable . . . to the 'extent of medical assistance.'" CMS submission dated 11/1/04, at 1. Section 1902(a)(17)(B) requires states to have standards in their Medicaid State plans for determining Medicaid eligibility and the extent of medical assistance that take into account only income and resources determined, "in standards prescribed by the Secretary," to be available to the applicant or recipient. This clearly gives the Secretary authority to prescribe standards for what constitutes available "resources" for the purpose of determining the extent of an individual's medical assistance under title XIX.[5] We conclude, however, that the Guide's free care principle does not represent an exercise of the Secretary's authority under section 1902(a)(17)(B) for the following reasons.

- The Guide was never presented as prescribing new standards pursuant to any statutory mandate. Instead, the "Purpose" section of the Guide contains the following statement (italics added):

  > Because Medicaid policy often changes and evolves, this guide *should not be considered an authoritative source in itself*. The guide is intended to be a general reference summarizing current applicable law and policy and not intended to supplant the Medicaid statute, regulations, manuals or other official policy guidance.

  Moreover, the Guide does not mention that it is intended to implement section 1902(a)(17)(B) (nor does it refer to any other section of title XIX as the authority for its issuance).

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[5] Oklahoma argues that the section 1902(a)(17)(B) standards are to address only what resources could be included in determining the availability of medical assistance, not what resources should be excluded. We need not reach this argument here, however.

- Section 1902(a)(17)(B) authorizes the Secretary to prescribe standards to determine the extent of medical assistance to which an individual is entitled under a Medicaid state plan based on the receipt or possession of a resource. However, the Guide does not set out any standards for the determination under a State plan of the extent of an individual's medical assistance based on the individual's resources. Moreover, CMS did not allege that the Secretary has ever required a State plan to include a provision regarding the extent of medical assistance that is based on the free care principle.

- The Guide is not accompanied by a transmittal from the Secretary or any official in CMS (then the Health Care Financing Administration (HCFA)) relying on a delegation from the Secretary to issue standards under section 1902(a)(17)(B). Instead, the cover page of the Guide merely indicates that it was authored by the Center for Medicaid and State Operations.

- The Guide was not published following the notice and comment procedures in the Administrative Procedure Act (APA), 5 U.S.C. § 553.[6] These procedures must be followed when a legislative rule (referred to in the APA as a substantive rule) is issued.[7] Standards issued

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[6] CMS pointed to the fact that it solicited public comment on its 2003 "Medicaid and School-Based Administrative Claiming Guide," which includes a restatement of the free care principle in the 1997 "Technical Assistance Guide," as evidence that it satisfied the APA requirement for notice and comment rulemaking. CMS submission dated 7/23/04, at 5-6, 11; CMS submission dated 8/16/04, at 12-13 (including attached declaration of Richard Strauss dated 8/16/04). However, CMS did not explain how the 2003 Guide met the notice requirements in section 553(a) of the APA, the requirement in section 553(c) that the rules adopted include "a concise general statement of their basis and purpose," or the requirement in section 553(d) that publication of a rule be made "not less than 30 days before its effective date."

[7] Although section 553(a)(2) of the APA exempts from these rulemaking procedures legislative rules regarding matters "relating to . . . grants, benefits, or contracts," and Medicaid falls under this exemption, the Secretary of the Department of Health, Education and Welfare (the predecessor of the Department
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under the Secretary's delegated authority in section 1902(a)(17)(B) are legislative rules. See, e.g., Herweg v. Ray, 455 U.S. 265, 274 (1982) (standards issued under section 1902(a)(17))(B) are entitled to "legislative effect").[8] If the Secretary had intended the Guide as a legislative rule, we presume he would have issued it pursuant to the notice and comment procedures.[9]

- The Secretary has issued regulations addressing post-eligibility financial requirements for Medicaid. See, e.g., 42 C.F.R. §§ 435.700, 435.725, 435.726, 435.733, 435.735, and 435.832. These regulations prescribe standards under section 1902(a)(17)(B) but make no reference to the Guide's free care principle. See 42 C.F.R. § 435.3(a). The fact that these regulations (either as originally issued or as amended) were published following the APA's notice and comment procedures, while the Guide was not so published,

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[7](...continued)
of Health and Human Services) in a 1971 policy statement required the Department "to utilize the public participation procedures of the APA, 5 U.S.C. 553." 36 Fed. Reg. 2532 (Jan. 28, 1971). It is well-established that the effect of this policy statement is the same as if the APA applied directly. See, e.g., Alcaraz v. Block, 746 F.2d 593, 611 (9th Cir. 1984); Buschmann v. Schweiker, 676 F.2d 352, 356, n.4 (9th Cir. 1982).

[8] Herweg specifically addressed the Secretary's authority to prescribe standards setting eligibility requirements for State Medicaid plans. However, there is no reason why standards setting the extent of medical assistance would not have the same effect.

[9] Longstanding federal caselaw holds that legislative rules adopted without following the APA notice and comment procedures are invalid. See, e.g., Buschmann v. Schweiker at 355. More recently, the Supreme Court has held that there may be reasons for according some deference to an administrative action taken pursuant to a statutory delegation of authority to implement a particular provision "even where no . . . administrative formality [such as notice and comment rulemaking or formal adjudication] was required and none was afforded." United States v. Mead Corp., 533 U.S. 218, 231 (2001). As discussed above, however, we find unpersuasive CMS's position that the free care principle was issued pursuant to a statutory delegation to issue legislative rules.

> further supports the conclusion that the Guide was not intended as a standard implementing section 1902(A)(17)(B).

Thus, the Guide's free care principle neither purports to be a standard prescribed pursuant to section 1902(a)(17)(B) nor functions in that manner.

3. CMS did not provide any basis for finding that the Board erred in holding that CMS should have waived the Guide's free care principle here.

CMS contends that the Board erred in holding in DAB No. 1924 that CMS should have waived the Guide's free care principle here. CMS argues specifically that the only waiver authority is in section 1115(a)(2) of the Act, that CMS is not obligated to grant a waiver pursuant to this provision, and that there is no evidence that CMS acted arbitrarily by granting a waiver for some states and not others. CMS submission dated 7/23/04, at 11; CMS submission dated 8/16/04, at 13-14.[10] CMS's arguments misapprehend the nature of the Board's holding, however. In essence, the Board held that even if CMS's free care principle is an interpretation of the Act, it is not reasonable as applied to the type of services in question under the particular circumstances of this case. CMS does not address any of the bases for this holding in DAB No. 1924, including the undisputed fact that efforts to obtain third-party reimbursement for the cost of EPSDT services provided in this case to non-Medicaid eligibles would have cost more than they could produce in reimbursement. In any event, this holding is not dispositive in view of our conclusion that the Guide's free care principle is not an interpretative rule.

4. CMS's other arguments have no merit.

CMS's assertions of additional errors in DAB No. 1924 reflect a misunderstanding of that decision. CMS argued that the Board erred in holding that the free care principle "cannot supersede the regulatory definition of 'resources'." See CMS submission dated 11/1/04, at 7, citing DAB No. 1924, at 15. CMS argued that "[m]erely because 'services available without charge to the community' are not included as a resource for eligibility

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[10] CMS previously stated before the Board, however, that "there is no specific statutory or regulatory provision precluding a waiver" of the Guide's free care principle. DAB No. 1924, at 22, quoting Tr. at 15.

purposes has no bearing on whether such services should or should not be excluded under section 1902(a)(17)(B) in determining the extent of medical assistance." Id. We disagree. The point the Board was making in DAB No. 1924, which we reaffirm here, was that the Secretary has already chosen to exercise his discretion under section 1902(a)(17)(B) by promulgating regulations which do not address the "free care" CMS seeks to treat as a resource here. Those regulations contain no indication that CMS had the authority to specify any resources for purposes of determining the extent of medical assistance at some later date in an informal issuance like the Guide.[11]

CMS also alleges that the Board made an error of fact in DAB No. 1924 "insofar as it misconstrued the free care policy as imposing conditions on States or providers concerning non-Medicaid users of a service." CMS submission dated 8/16/04, at 2. According to CMS, the Guide merely "suggests" that schools establish procedures, such as establishing a fee schedule and ascertaining third-party resources for non-Medicaid eligibles, "which would assure that the services would not be regarded as 'free,' thus assuring the availability of FFP." Id. at 9. CMS is correct that the Guide does not literally require that, "in order to receive funding for EPSDT services provided to students who are Medicaid eligible, the state must also seek reimbursement for services provided to the remaining, Medicaid-ineligible students, either from any third-party insurers or directly from these students or their families," as the Board stated in DAB No. 1924 (e.g., at 1).[12] However, the Guide clearly requires that a state

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[11] In DAB No. 1924, the Board cited the regulatory definition of resources for purposes of determining SSI eligibility, which is a basis for categorical eligibility for Medicaid. DAB No. 1924, at 13, citing 20 C.F.R. § 416.1201 and DAB No. 1285 at 28-29. As we noted above, however, the Secretary has promulgated regulations specifically addressing post-eligibility financial requirements for Medicaid. Although these regulations provide standards for income for the purpose of determining the extent of medical assistance, they contain no definition of resources for that purpose.

[12] The Guide states in part:

> The services would not be considered free if the following conditions are met. The provider:
>
> (1) Establishes a fee schedule for the services

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or other provider establish that services provided to Medicaid-ineligible students were not free of charge as a condition of obtaining reimbursement for providing the same services to Medicaid-eligible students. Moreover, CMS did not identify any other way in which the Oklahoma school districts could have established that the services were not free of charge other than seeking third-party reimbursement for the cost of the services to the Medicaid-ineligible students. Thus, the Guide's free care principle is not merely a suggestion, but instead functions to deprive providers of funding for mandated services based on the failure to follow a condition on that funding which was not imposed by Congress or by the Secretary pursuant to authority delegated by Congress. Cf. Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, at 17 (1981) (holding that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously") (cited at DAB No. 1924, at 19, n.23).

CMS also asserts that the Guide's free care principle "gives effect to the language in section 1902(a)(17)(B) consistent with the overall objective of preserving Medicaid as the payor of last resort." CMS submission dated 11/1/04, at 6. This argument does not provide any basis for reconsidering our decision, however. If the free care principle were an interpretation of section 1902(a)(17)(B) (or some other statutory or regulatory provision), then it would be appropriate to consider whether the interpretation is consistent with other statutory and regulatory provisions as one factor in determining whether the interpretation is a reasonable one. Since we have concluded that

[12](...continued)
provided (it could be sliding scale to accommodate individuals with low income);
(2) Ascertains whether every individual served by the provider has any third-party benefits, and
(3) Bills the beneficiary and/or any third parties for reimbursable services.

CMS stated, however, that it "would not require the schools to bill families of students." DAB No. 1924, at 8, n.10, quoting Tr. at 15. CMS's May 2003 Administrative Claiming Guide omits any reference to billing families, but states that "the provider must" establish a fee schedule, collect third-party insurance information from both Medicaid-eligible and Medicaid-ineligible students, and bill the responsible third-party insurers "[i]n order for Medicaid payment to be available" for services provided free of charge to all students, See Administrative Claiming Guide, page 20, at www.cms.hhs.gov/medicaid/schools/macguide.pdf.

the free care principle is not an interpretative rule, however, there is no reason to consider this matter here. In any event, as we noted in DAB No. 1924, the concept of the payor of last resort originates from the third-party liability requirements in section 1902(a)(25) of the Act, which apply only to services provided to Medicaid-eligible individuals.[13] DAB No. 1924, at 18-19. Thus, in requiring, as a condition of obtaining Medicaid FFP for services to Medicaid-eligible students not covered by a third-party payment, that providers pursue liable third parties in the case of non-Medicaid eligibles to whom the same services were provided, CMS is applying the concept of payor of last resort in a manner not contemplated by section 1902(a)(25).

5. The CMS Administrator's decision on Maryland's State plan amendment does not persuade us that there is any error in DAB No. 1924.

In transmitting a copy of the CMS Administrator's decision on Maryland's State plan amendment (identified in note 3 above) to the Board, CMS stated that "[t]he adjudication constitutes the Secretary's position on the issues decided" and that "[t]he Secretary's position on the free care policy supercedes CMS' brief [in the reconsideration] to the extent that CMS' brief is inconsistent with the Administrator's decision." CMS submission dated 9/23/04, at 1. CMS nevertheless specifically stated in a later submission that it was no longer relying on section 1905(a) of the Act as authority for the Guide's free care principle, although this section is the primary authority for this principle cited by the Administrator's decision. It is not clear in what other respects CMS's arguments on reconsideration are inconsistent with the Administrator's decision, nor is it clear to what extent CMS continues to rely on the Administrator's decision to support its motion for reconsideration.[14] In any

[13] Under section 1902(a)(25)(A) and (B), the state Medicaid plan must provide "that the state or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan . . . " and that the state "will seek reimbursement for such assistance to the extent of such legal liability" where it would exceed the cost of recovery.

[14] The Administrator's decision itself states that the holding in DAB No. 1924 is not applicable "because of the distinguishing facts of this case," i.e., that Maryland law

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event, none of what CMS claims are the "major points" in the Administrator's decision are indicative of an error in our decision.

According to CMS, one of the three major points made by the Administrator's decision is that "[l]ongstanding Medicaid policy, reflective of the nature of public assistance, holds that Medicaid funds will not be used to pay for services that are available 'without charge' to everyone in the community." CMS submission dated 9/23/04, at 1, quoting Administrator's decision at 21. The Administrator's decision does not cite the source of this longstanding policy. To the extent that the Administrator intended to refer to section 5340 of the State Medicaid Manual, however, we note our statement in DAB No. 1924, referring to our prior holding in DAB No. 1285, that "[t]he most significant requirement" of this section "is that all liable third parties be billed for the cost of any services provided free to Medicaid eligibles so that the services cannot be considered to have been provided 'without charge'." DAB No. 1924, at 17. In other words, DAB No. 1924 did not undercut the longstanding policy in the State Medicaid Manual, which is based on the third-party liability provisions in section 1902(a)(25), that services cannot be "without charge." What the Board found to be without any legal authority is instead the entirely new provision in the Guide that states must forego FFP for EPSDT services to Medicaid-eligible students unless they can demonstrate that third-party reimbursement was sought for Medicaid-ineligible students.

The second major point of the Administrator's decision identified by CMS is that--

> [t]here is a compelling federal interest to ensure that the Medicaid program, a purchaser of health services and items, is not paying for services otherwise provided free of charge to the community . . . the Federal government does have a compelling interest in ensuring that both Medicaid and non-Medicaid eligibles are

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[14] (...continued)
imposed an affirmative legal obligation to provide the services at issue free of charge to all children in the State's foster care program, and that the costs at issue potentially duplicated certain payments made under Medicaid. See Administrator's decision at 25-26. In addition, we note that the Administrator disapproved Maryland's State plan amendment on two additional grounds not related to the free care principle.

> treated the same with respect to third party billing for the same services.

CMS submission dated 9/23/04, at 2, quoting Administrator's decision at 24. It is not clear in what sense the Administrator believed the free care principle advances a federal interest apart from the principle itself that Medicaid should not pay for services to Medicaid-eligible students that Medicaid-ineligible students receive without charge. While CMS argues that it has an interest in "preserving Medicaid funds" that is advanced by the Guide's free care principle (CMS submission dated 11/1/04, at 2), this interest appears to be fully protected by the statutory requirement for seeking reimbursement from liable third parties for payments for Medicaid-eligible individuals.[15] In any event, even if the Guide's free care principle advances a federal interest, this would only be a factor in determining the reasonableness of the free care principle if it were an interpretative rule; it does not provide any legal authority for the free care principle.

The third major point in the Administrator's decision, according to CMS, is that there is "no specific language" in either the legislative history of section 8435 of Public Law No. 100-637 or in that law itself "limiting the third-party payor requirement to Medicaid-only users of the service and none can be imputed when the users of the service involve both Medicaid and non-Medicaid users as in this case." CMS submission dated 9/23/04, at 2. However, in DAB No. 1285, the Board held that the term "without charge" in section 8435 must have the same meaning as in section 5340 of the State Medicaid Manual because CMS had not defined that term elsewhere. The Board further held that CMS went beyond the definition of "without charge" in section 5340 of the State Medicaid Manual when it required California to show that it had charged Medicaid-ineligible individuals for the services in question.

Thus, after carefully considering the Administrator's decision, we find no basis in that decision for changing the result in DAB No. 1924.

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[15] In the proceedings in DAB No. 1924, CMS did not clearly identify any particular federal interest served by the free care principle, and that decision quotes the statement in DAB No. 1285 that the Board sees "no obvious federal interest" in whether a state seeks third-party reimbursement for the services in question in that case from Medicaid-ineligible individuals. DAB No. 1924, at 16, quoting DAB No. 1285, at 20, n.12.

Conclusion

For the foregoing reasons, we deny CMS's motion for reconsideration and reaffirm our decision in DAB No. 1924 reversing the disallowance.

Judith A. Ballard

Cecilia Sparks Ford

Donald F. Garrett
Presiding Board Member