Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

IN THE CASE OF
SUBJECT: Oklahoma Health Care Authority

DATE: June 14, 2004
Docket No. A-03-79
Decision No. 1924

DECISION

The Oklahoma Health Care Authority (Oklahoma) appealed a disallowance of $1,902,390 federal financial participation (FFP) claimed by Oklahoma under title XIX of the Social Security Act (Act) for the cost of school-based health services known as EPSDT services provided in state fiscal year 2000. CMS disallowed the claim on the ground that Oklahoma did not seek third-party reimbursement for the cost of EPSDT services provided by the schools to students who were not Medicaid eligible. CMS relied on the "free care principle" set out in a 1991 Technical Assistance Guide. Under the Guide's "free care principle," Medicaid funds are unavailable for otherwise covered EPSDT services unless third-party insurers of non-Medicaid eligible students are charged for the services. CMS acknowledged that this principle is not binding because it is not specifically authorized by the Act, but took the position that the principle is a reasonable interpretation of the Act to which the Board should defer. CMS claimed, moreover, that the Guide merely clarifies a policy in the State Medicaid Manual that the Board had already found reasonable.

As discussed in detail below, we conclude that the Guide's free care principle is not an interpretation of any provision of the Act nor indeed of any regulation implementing a provision of the Act. The only relevant provision of the Act requires a state to do precisely what Oklahoma did--seek third party reimbursement for the cost of the EPSDT services provided to Medicaid eligibles. There is no corollary requirement in the Act 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, ineligible students, either from any third-party insurers or directly from these students or their families. Such a requirement clearly goes beyond the longstanding "without charge" policy in the State Medicaid Manual that the Guide purports to summarize. Since the free care principle is not based on any language in the Act or regulations, it is not entitled to any deference as a reasonable interpretation of the Act. Even if the free care principle were entitled to deference, however, CMS's refusal to waive it would under the circumstances of this case be arbitrary and capricious. Accordingly, we reverse the disallowance in full.

The record in this case consists of the parties' written briefing and exhibits, including responses to an Order to Develop Record issued by the Board, and the transcript (Tr.) of a telephone conference held on April 8, 2004.

Legal Background

Title XIX of the Act establishes a cooperative federal-state program known as "Medicaid" to enable states to furnish medical assistance to certain needy individuals. Section 1901 of the Act. The Act and implementing regulations define the types of services a state may and must offer and the categories of recipients it may and must cover. Section 1905(a)(4)(B) of the Act includes "early and periodic screening,

diagnostic, and treatment services . . . for individuals who are eligible under the plan and are under the age of 21" as a mandatory Medicaid service. These services, known as EPSDT services, are defined in section 1905(r) as including screening services (including comprehensive health histories and examinations, immunizations, laboratory tests and health education), vision services, dental services, hearing services and "[s]uch other necessary health care, diagnostic services, treatment, and other measures [meeting the definition of 'medical assistance'] in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Pursuant to section 1905(r), CMS sets annual participation goals for EPSDT screenings for each state participating in the Medicaid program. See State Medicaid Manual, 5360. Congress recognized that schools must be an integral part of any effective EPSDT program. H.R. Rep. No. 90-544, at 127 (1967); see also S. Rep. No. 90-744, at 194 (1967).

A state's choices as to the medical assistance it offers to different categories of recipients are reflected in its Medicaid state plan, a "comprehensive written statement . . . describing the nature and scope" of a state's Medicaid program. 42 C.F.R. 430.10; see also section 1902(a) of the Act. A state plan must "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . 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 . . . ." Section 1902(a)(17)(B).

Generally, Medicaid may not make a payment to a provider unless there is no other third party that will pay for the services. Section 1902(a)(25)(A) of the Act requires that a state Medicaid agency-

> take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans . . . , service benefit plans, and health maintenance organizations) to pay for care and services under the plan . . . .

Section 1902(a)(25)(B) provides that-

> . . . in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability . . .

However, section 1902(a)(25)(E) specifically permits a state to pay a provider for certain types of services, including EPSDT services, before seeking reimbursement from potentially liable third parties, providing in pertinent part that-

> in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the State plan, the State shall-
>
> (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and
>
> (ii) seek reimbursement from such third party in accordance with subparagraph (B) . . . .

CMS Issuances

Since at least 1990, the State Medicaid Manual has contained a section in the chapter on EPSDT services, section 5340, captioned "Reimbursement," which provides in pertinent part as follows:

A. General Information.-Any service provided to EPSDT eligibles covered under the EPSDT program may be reimbursed under Medicaid, even if it is mandated by another agency or available as a community health service.

Medicaid provides financial access to health care services for individuals determined unable to pay for them, assures availability and delivery of EPSDT services, provides or arranges for covered services, and pays for them unless the beneficiary has liable third party coverage or the services are provided free of charge. Third party resources include Medicare (title XVIII), Railroad Retirement Act, insurance policies (private health, group health, liability, automobile, or family health insurance carried by an absent parent), Workers' Compensation, Veterans Administration Benefits, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Except for title V services, it is Medicaid policy that services which are available without charge to all individuals in the community may not be reimbursed. Services without charge, for purposes of Medicaid, means that no individual or family is charged for medical care and third party reimbursement is not sought.

* * * * *

The following conditions must be met if Medicaid is to be billed for medical services provided by other agencies or programs financed by Federal and State funds:

o A fee schedule is established for each service billed to Medicaid; and

o Information on third party liable resources is obtained from each Medicaid beneficiary, and billing of all third party liable resources is documented. (1)

CMS Ex. 12; Oklahoma Ex. E. (2)

In August 1997, CMS published a document titled "Medicaid and School Health: A Technical Assistance Guide." (3) Oklahoma conceded for purposes of this case that it had timely notice of the Guide. Oklahoma Supplemental Br. at 2. The Guide states that it "is intended to be a general reference summarizing current applicable law and policy . . . ." (at 5). The Guide includes a section captioned "Free Care" which states in pertinent part:

In applying the free care principle 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. Providers of Medicaid services must have the authority to charge for their services and utilize this authority, before Medicaid will make payment. If only Medicaid recipients or their third parties are charged for the service, the care is free and Medicaid will not reimburse for the service.

Schools may employ certain methods to ensure the care is not considered free, allowing Medicaid to be billed. The services would not be considered free if the following conditions are met. The provider:

(1) Establishes a fee schedule for the services 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.

At 41-42. The Guide also identifies "two exceptions to the free care rule": for Medicaid-covered services included in an individualized education plan (IEP) or individualized family services plan (IFSP) established pursuant to the Individuals with Disabilities Education Act (IDEA), and for health services and related activities provided under the Maternal and Child Health Services Block Grant program established by title V of the Social Security Act. The Guide cites as the basis for the first "exception" the language of section 1903(c) of the Act prohibiting the Secretary from refusing to pay or otherwise limiting payment for services included in an IEP or IFSP. (4) At 42. The Guide cites in connection with the second "exception" 42 C.F.R. 431.615 (implementing section 1902(a)(11)(B) of the Act), which states in pertinent part that the state plan will "[p]rovide, if requested by the title V grantee . . . , that the Medicaid agency reimburse the grantee or the provider for the cost of services furnished recipients by or through the grantee." (5) At 42-43.

The Dallas Regional Office of the Health Care Financing Administration (6) issued Dallas Regional Medicaid Services Letter No. 90-19, dated March 16, 1990, titled "Availability of FFP for Free Services" (attachment to CMS fax to Board dated 4/8/04), and Dallas Regional Medical Services Letter No. 92-105, dated October 22, 1992 (CMS Ex. 14), titled "Proposal to Maximize Federal Matching Funds for EPSDT Activities in Schools and School Districts." Both of these issuances indicate that Medicaid funds are not available unless the provider bills non-Medicaid eligibles receiving the same services. However, CMS did not rely on either of these issuances as the basis for the disallowance.

Factual Background

The following undisputed facts appear from the record.

In state fiscal year 2000, Oklahoma had 348 contracts with school districts which were enrolled as Medicaid providers to provide EPSDT and other school-based health services. Oklahoma Br. dated 9/26/03, at 6; Oklahoma Ex. 1, at 2-3 (Affidavit of Howard Pallotta). The schools provided EPSDT services to all students regardless of their Medicaid eligibility. (7) After the schools submitted claims to the Oklahoma Health Care Authority, i.e., Oklahoma, for the cost of services provided to Medicaid eligibles, Oklahoma claimed the costs under title XIX. Oklahoma then billed third party health insurance carriers that had been identified as potentially liable for the cost of the services provided to Medicaid eligibles. Tr. at 21; Oklahoma Ex. 2 (Affidavit of Lisa Gifford). (8) (9) Oklahoma's recovery rate on such third party billings was approximately 3% of the total spent for the services. Id.; Oklahoma Br. dated 9/26/03, at 8-9. According to Oklahoma, this recovery rate --

> is consistent with the results of a survey that OHCA conducted in April 2001 of over 1000 insurance companies and other health plans included in OHCA's third party liability database. The State received approximately 101 responses which indicated that most would not cover or pay for school-based services in any circumstance. See Ex. 4 (June 26, 2002 letter from Mike Fogarty). The remaining insurance companies indicated that they might pay for school-based services, but only if certain specific circumstances existed or if there was physician intervention. See id.

Oklahoma Br. dated 9/26/03, at 6-7. In the case of services provided to students who were not Medicaid eligible, no attempt was made to set a fee schedule, identify and bill potentially liable third parties, or bill the students or their families. CMS Response to Order to Develop Record at 7. (10)

The Office of the Inspector General (OIG) conducted an audit of EPSDT services reimbursed by Oklahoma's Medicaid program to determine whether school districts in Oklahoma violated what it characterized as CMS's "long-standing 'free care' policy" by billing Medicaid for services that were

provided free to other students. (11) OIG found that Medicaid was improperly billed for services provided to 97 of a sample of 100 Medicaid-eligible students because the services were provided free to students who were not eligible for Medicaid. OIG found that services to the three remaining Medicaid eligibles were exempt from the "free care rule" because those individuals were children with disabilities who had an IEP or IFSP under the IDEA. OIG estimated that the Oklahoma schools received $1,902,390 FFP for services provided in violation of "CMS policy" in state fiscal year 2000. Oklahoma Ex. 5 (Office of Inspector General Audit of Oklahoma Medicaid School-Based Services Provided Free to Other Students and Not Exempt Under The Individuals With Disabilities Education Act). (12)

Summary of Parties' Arguments

CMS disallowed the claims in question on the ground that-

> FFP is not available for "free care" under the Medicaid program. Free care is defined as any care furnished by a provider who generally does not charge Non-Medicaid clients or bill their insurers.

Oklahoma Ex. 8 (letter from Farris to Fogarty dated 3/27/03) at 2. According to the disallowance letter, the only exception is "for Medicaid-covered services provided under the Individuals with Disabilities Education Act (IDEA) in an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)." Id. The disallowance letter further states that the statutory basis for the "free care policy" is section 1902(a)(17)(B) of the Social Security Act. Before the Board, CMS stated that "even if the Board were to reject CMS' argument that section 1902(a)(17)(B) provided statutory authority for its free care policy, CMS submits that the free care policy comports with the requirements under the Act and regulations and is a reasonable and permissible construction of the Act." CMS Br. in Support of Disallowance at 9. CMS suggested that the "free care policy" can be inferred from two statutory exceptions to the principle that Medicaid is the payor of last resort. CMS Response to Order to Develop Record at 5-6; CMS Reply to Petitioner's Supplemental Br. at 3-4. (13) CMS contended, moreover, that in California Dept. of Health Services, DAB No. 1285 (1991), the Board "accepted the free care policy as a reasonable construction of the Act." CMS Br. in Support of Disallowance at 9. According to CMS, the Guide, which had not been issued at the time of the Board's decision, merely clarifies the longstanding policy in section 5340 of the State Medicaid Manual which the Board upheld in its decision. CMS acknowledged that the "free care policy" is "non-binding" since it "is not expressly set forth in statute." CMS Reply to Petitioner's Supplemental Br. at 5; see also CMS Br. in Support of Disallowance at 9; Tr. at 7. CMS contended, however, that, as a reasonable agency interpretation, the "free care policy" is entitled to deference since Oklahoma received timely notice of it through the Technical Assistance Guide. CMS Br. in Support of Disallowance at 10, citing Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984); CMS Reply to Petitioner's Supplemental Br. at 4, citing Louisiana Department of Health and Hospitals, DAB No. 1772 (2001).

On appeal, Oklahoma took the position that the standard the Board should apply in determining whether to defer to provisions in agency manuals such as the Guide is whether the agency's interpretation is reasonable and has "the power to persuade" rather than simply whether the interpretation is reasonable. Oklahoma Supplemental Br. at 4, citing United States v. Mead Corp., 533 U.S. 218, 228 (2001). In Oklahoma's view, this standard was not met here. First, Oklahoma argued that there is no statutory basis for the requirement that, as a condition of FFP for services provided under title XIX, a provider bill the non-Medicaid population for the same services. Oklahoma Br. at 9. Oklahoma also observed that the Board had previously found that the regulations implementing section 1902(a)(17)(B) of the Act preclude an interpretation of that section as authorizing such a requirement. Id., citing California at 15. Oklahoma further argued that the application of the Guide's free care principle to EPSDT services is inconsistent with congressional intent to reduce the administrative burdens placed on EPSDT providers. Finally,

Oklahoma argued in effect that, even if it were proper to accord deference to this principle, Oklahoma was entitled to a waiver under the circumstances of this case.

ANALYSIS

The parties framed the issue in this case as whether the Guide's free care principle is a reasonable (or reasonable and persuasive) interpretation of the Act. In general, the Board has held that, where a statute or regulation is subject to more than one interpretation, the HHS operating division's interpretation is entitled to deference as long as the interpretation is reasonable and the grantee had adequate notice of that interpretation or, in the absence of notice, did not reasonably rely on its own contrary interpretation. See Alaska Dept. of Social and Health Services, DAB No. 1919, at 14 (2004), citing Louisiana Department of Health and Hospitals and Community Action Agency of Franklin County, DAB No. 1581 (1996). (14)

As discussed in sections A - C below, however, the Guide's free care principle is not an interpretation of language in any provision of title XIX. Since there is no statutory or indeed regulatory provision of which this principle can be considered a plausible interpretation, it is not entitled to the deference generally accorded an agency's reasonable interpretation. Moreover, as CMS acknowledged, this principle is not a binding rule since it is not specifically authorized by the Act. (15) Furthermore, as discussed in section D below, even if the Guide's free care principle were entitled to deference or were binding, CMS's refusal to waive it would under the circumstances of this case be arbitrary and capricious. Accordingly, CMS may not properly disallow Oklahoma's claim based on Oklahoma's failure to comply with this principle.

A. Neither section 1902(a)(17)(B) of the Act nor the regulations implementing that provision contemplate much less authorize the Guide's free care principle.

It is undisputed that the Act and regulations expressly require as a condition of FFP under title XIX that a provider seek reimbursement from potentially liable third parties only for the cost of any covered services provided to Medicaid eligibles. CMS conceded that there is no express requirement in the Act that, as a condition of FFP, the provider seek reimbursement from potentially liable third parties for the cost of the same services provided to non-Medicaid eligibles. CMS also did not point to any such requirement in the regulations. Although the Act and regulations are devoid of any provision that on its face could be read as imposing the latter requirement, CMS took the position that this requirement can somehow be derived from section 1902(a)(17)(B). CMS's disallowance letter states that-

> [t]his section requires Medicaid to take into account all other resources available to the client. Services provided without charge are considered an available resource and consequently would not qualify for Medicaid reimbursement.

Oklahoma Ex. 8, at 2. Similarly, CMS explained in its briefing that "[s]ince care that is free to the community (both Medicaid and non-Medicaid recipients) can be considered an available resource, CMS has adopted a longstanding policy that payment should not be made for such care." CMS Response to Order to Develop Record at 5.

In California Dept. of Health Services, however, the Board rejected a similar assertion by the Health Care Financing Administration (HCFA). HCFA asserted there that section 1902(a)(17)(B) provided statutory authority for the application of the policy in section 5340 of the State Medicaid Manual -- that services available without charge to all individuals in the community may not be reimbursed by Medicaid -- to a

claim for targeted case management (TCM) services provided at state expense to all developmentally disabled individuals. The Board stated in pertinent part as follows:

> Under section 1902(a)(17)(B), the Secretary has substantive authority to prescribe standards for determining "income" and "resources" for determining Medicaid eligibility and the extent of medical assistance. The Secretary has exercised this authority repeatedly by promulgating regulations concerning what constitutes "income" or "resources." . . . [T]reating state-funded services as a "resource" in this case appears to be inconsistent with specific standards promulgated by the Secretary concerning what constitutes a "resource" under section 1902(a)(17)(B).

Id. at 28-29. The Board then explained that "[t]he Secretary has prescribed income and resource standards in various sections of the Code of Federal Regulations for the different categories of Medicaid recipients," and concluded that "the Secretary has not defined 'resources' to include receipt of state-funded services." Id. at 29. The Board cited as an example the definition of "resources" in the regulations relevant to individuals who are eligible for Medicaid by virtue of their eligibility for Supplemental Security Income (SSI). These regulations, which are still in effect, state that "resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance." 20 C.F.R. 416.1201. (16) The Board stated that "[t]hat definition, which conceptually focuses on assets or property, would not encompass receipt of medical or social services." Id. at n.21. Although the Board noted that this definition was promulgated for purposes of eligibility determination rather than for determining the "extent of medical assistance" in the post-eligibility process, the Board stated that-

> HCFA has not cited any regulation or other authority which changes the definition of "resource" in the post-eligibility process. Therefore, the only definitions in effect do not encompass the receipt of state-funded medical services.

Id. at 30. The Board further stated:

> We recognize the Secretary's broad power to adopt separate post-eligibility definitions. The problem here is that HCFA has not identified any credible source in which the Secretary has defined the receipt of state-funded services as a "resource" and such a definition is contrary to the only existing definitions of "resources" promulgated.

Id. at n.22.

Thus, the Board concluded in California that, in light of the implementing regulations already promulgated by the Secretary, section 1902(a)(17)(B) could not be read as providing implicit authority for the State Medicaid Manual provision from which CMS claims the Guide's free care principle is derived. In the proceedings in the instant appeal, the Board asked CMS to comment on whether the analysis summarized above is still valid. Letter to parties dated 4/5/04, at 2. In response, CMS asserted that section 1902(a)(17)(B) "remains a viable basis" for the Guide's free care principle because of the Secretary's "broad discretion" to interpret the statute in this manner. Tr. at 8. CMS also noted that after California was issued, CMS "promulgated another publication of the free care policy in the technical assistance guide." Id. at 9. CMS misses the point of the Board's holding in California, however. The Board found that, irrespective of the discretion the Secretary may have to interpret the term "resources," the Secretary had published a regulatory definition of that term that clearly did not include state-funded services. Thus, the Secretary had exercised his discretion to interpret section 1902(a)(17)(B) in a way that does not provide authority for the Guide's free care principle. In the period since California was issued, the Secretary has not amended the regulatory definition of "resources" or promulgated a regulation defining this term differently for purposes of determining the extent of medical assistance. Even if the Guide

purported to define the term "resources" (which it does not), it cannot supersede the regulatory definition of "resources." Thus, we see no basis for reaching a different conclusion than in California on this issue.

Furthermore, even if receipt of state-funded services did qualify as a "resource" within the meaning of section 1902(a)(17)(B), it is unclear how that would provide authority for the requirement in the Guide's free care principle to seek third-party reimbursement for the cost of services to non-Medicaid eligibles since section 1902(a)(17)(B) applies only to eligibility for and extent of medical assistance "under the plan," i.e., furnished to Medicaid eligibles in accordance with the state Medicaid plan. In response to the Board's question on this point, CMS stated that "a provider that is offering free services" is "implicitly included" in the definition of "third party" in the third-party liability regulations at 42 C.F.R. 433.136. Tr. at 10-11. This appears to be an attempt to bring this case within the scope of the third-party liability provisions by characterizing the school districts, which offered free services here, as third parties that are liable for the cost of the services. However, there is nothing in the Act, the regulations, or the State Medicaid Manual that implies that a school district offering free health services would be considered a liable third party. Indeed, by saying that Medicaid funds may be available for community health services and by listing examples of liable third parties that do not include government entities like school districts, the State Medicaid Manual implies to the contrary. Moreover, CMS did not specifically allege that the school districts here had a legal obligation to provide these services free of charge to all students. (17)

Accordingly, we conclude section 1902(a)(17)(B) does not provide specific authority for the Guide's free care principle.

B. The Board's prior decision did not uphold the free care principle applied here as a reasonable interpretation of the Act.

CMS argued that the Board in California had "accepted" the free care principle applied here as a reasonable interpretation of the Act. According to CMS, the free care principle in the Guide is merely a clarification of the State Medicaid Manual policy that was accepted by the Board in California. CMS Reply to Petitioner's Supplemental Br. at 7. As explained below, however, CMS's reliance on California is misplaced since, although the Guide similarly states that it merely summarizes existing law and policy, the Guide imposes requirements that go beyond the State Medicaid Manual provision at issue.

We note preliminarily that California did not find that the State Medicaid Manual constituted independent legal authority for the disallowance. Instead, the Board relied on section 8435 of Public Law No. 100-647, which states in part that the Secretary is not required to make payment for TCM services which are provided "without charge," as authority for the disallowance in that case and considered the State Medicaid Manual solely because it contained the only extant definition of the term "without charge."

Moreover, with respect to that definition, the Board stated that "the plain language . . . authorizes FFP for services which are provided to everyone in the community as long as third party reimbursement is sought." California at 12. The Board specifically rejected HCFA's assertion "that the State would have to show that its providers sought third party reimbursement for all recipients of TCM services and not just for Medicaid recipients, stating: "We see no obvious federal interest in whether a state seeks such reimbursement for non-Medicaid individuals." California at 20, n.12. In contrast, the Guide expressly requires a state to seek payment or third-party reimbursement for non-Medicaid eligibles as well as Medicaid eligibles. (18) (19) Thus, the free care principle that CMS now seeks to apply here goes beyond what the Board sanctioned in California. (20)

Moreover, Oklahoma's actions here were consistent with what California held section 5430 of the State Medicaid Manual requires. The most significant requirement 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." It is undisputed that Oklahoma complied with the applicable third-party liability provisions. The State Medicaid Manual also includes a requirement for a fee schedule. There is no indication in the record that the schools had a fee schedule for the EPSDT services; however, this requirement pertains to "services provided by other agencies or programs financed by Federal and State funds," and thus does not apply here. (21) In any event, the purpose of this requirement is presumably to ensure that the charges to Medicaid are not overstated or arbitrary. See California at 13, n.8. CMS never asserted that the amounts charged to Medicaid for the services in question here were unreasonable. Nothing in California suggests that the additional requirements that CMS sought to impose in the Guide are warranted.

C. The Guide's free care principle cannot be inferred from the principle that Medicaid is the payor of last resort.

CMS asserted that the free care principle in the Technical Assistance Guide "comports with the basic tenet that Medicaid should be the payor of last resort." CMS Br. in Support of Disallowance at 12; see also id. at 3. In CMS's view, if Congress had intended that Medicaid be the primary payor for EPSDT services that are provided without charge, it would have expressly provided for this as it did in section 1903(c) of the Act for services included in an IAP or IFSP established pursuant to IDEA or in section 1902(a)(11)(B) of the Act for services offered by or through the state title V agency. CMS argued that "[a]bsent such a provision, the free care policy is within the scope of the Secretary's general interpretive and administrative authority." CMS Response to Order to Develop Record at 6. In effect, CMS asked that the Board infer authority for the Guide's free care principle from the fact that there is no provision applicable to EPSDT services that is comparable to section 1903(c) or section 1902(a)(11)(B).

CMS's argument is not persuasive. While the principle that Medicaid is the payor of last resort is well-established, this principle originates from the third-party liability requirements in section 1902(a)(25) of the Act. See, e.g., Commonwealth of Massachusetts v. HHS, 816 F.2d 796, 803 (1st Cir. (1987)) ("[t]he concept of payor of last resort in the Medicaid program comes from the Medicaid Act's requirement that the state administering agency 'ascertain the legal liabilities of third parties to pay for care and services (available under the [Medicaid] plan) . . . ." Emphasis added. Indeed, when Congress amended the Act in 1985 to strengthen section 1902(a)(25), the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1 (emphasis added). As the quoted language indicates, the third-party liability requirements apply only to services provided to Medicaid eligibles. Thus, the provisions in sections 1903(c) and 1902(a)(11)(B) making Medicaid the primary payor for certain types of services simply exempt providers of these services from the third-party liability requirements of the Act and regulations. (22) Accordingly, we see no basis for inferring statutory authority for the Guide's free care principle from the existence of these two provisions. (23)

Furthermore, Oklahoma argued persuasively that section 1902(a)(25)(E) justifies an exception for EPSDT services similar to the alleged exceptions for IDEA and title V services. Oklahoma Br. dated 9/26/03, at

15-16. Section 1902(a)(25)(E) permits a state to use Medicaid funds to pay for EPSDT services before seeking reimbursement from potentially liable third parties, in contrast to the normal rule permitting payment only after the provider has sought reimbursement from potentially liable third parties. The impetus for permitting this "pay and chase" method for obtaining Medicaid reimbursement for EPSDT services was Congress' concern "that the administrative burdens associated with third party liability collection efforts not discourage participation in the Medicaid program by physicians and other providers of preventive pediatric and prenatal care, since the beneficiaries in need of such services already have difficulty finding quality providers in many communities." H.R. Conf. Rep. No. 99-453, at 544 (1985). Conditioning Medicaid funds for EPSDT services provided by a school on the school's seeking payment or third-party reimbursement for those services it provided to non-Medicaid eligibles would add rather than remove barriers to the provision of EPSDT services, contrary to congressional intent. Thus, even if authority for the Guide's free care principle can be inferred from sections 1903(c) and 1902(a)(11)(B) of the Act, section 1902(A)(25)(E) justifies an exception for EPSDT services. (24)

D. Even if the Guide's free care principle were entitled to deference as an interpretive rule or were properly promulgated and therefore binding, CMS's refusal to grant a waiver would under the circumstances of this case be arbitrary and capricious.

It is undisputed that Oklahoma schools did not set a fee schedule for EPSDT services provided to non-Medicaid eligibles, collect information on third parties potentially liable for the cost of these services, or bill liable third parties for these services. (As noted earlier, CMS stated that it would not require that students' families be billed for these services.) Oklahoma argued, however, that its low recovery rate for third-party reimbursement for the cost of services to Medicaid eligibles and the results of the survey showing that most Oklahoma insurers will not pay for school-based services had "satisfied any concern that [Oklahoma] is paying for Medicaid services provided to non-Medicaid children 'without charge.'" Oklahoma Br. dated 9/26/03, at 14. Oklahoma stated specifically that-

> [o]n average, a non-IAP student in the Medicaid program accesses only 2.24 services a year, costing a total of $ 95. See Pallotta Aff. at 2 (Ex. 1). Given the minimal value of each claim, and the very low recovery rate, requiring school districts to identify and submit bills to third party insurers for all students before they can submit them to Medicaid would be an exercise in futility costing far more than it could ever produce in reimbursement.

Id. In effect, this constitutes a request for a waiver of the Guide's free care principle on the ground that the schools would not have netted any funds even if they had followed the steps set out in the Guide to establish that EPSDT services were not provided to all students without charge.

CMS took the position that a waiver was not warranted here. However, we conclude that, even if the Guide's free care principle were entitled to deference or were binding, CMS's refusal to grant a waiver in this case would be arbitrary and capricious, for the following reasons:

- CMS asserted that since Oklahoma's survey was conducted in April 2001, "its survey findings are not applicable to its failure to seek third party reimbursement during state fiscal year 2000." CMS Br. in Support of Disallowance at 16. However, CMS did not point to any specific factors that would make the survey findings unreliable as an indication of what the prior year's results would have been. Moreover, CMS did not dispute Oklahoma's conclusion that efforts to obtain third-party reimbursement for the cost of EPSDT services provided to non-Medicaid eligibles would generally have been unavailing. Thus, enforcing the Guide's free care principle in this case would not appear to serve any purpose.

- CMS appeared to maintain that no waiver was appropriate because the schools had ample notice, through the State Medicaid Manual and the Technical Assistance Guide, of the steps they could take to ensure that the EPSDT services would not be considered to be free of charge. Tr. at 15-16. As noted above, however, the provision in the Guide goes beyond that in the State Medicaid Manual, and Oklahoma complied with the Manual. Moreover, that the schools could have complied with the Guide's free care principle does not mean that they should be compelled to follow it if it does not serve any purpose.
- CMS acknowledged that "there is no specific statutory or regulatory provision precluding a waiver" of its free care principle. Tr. at 15. CMS nevertheless took the position that no waiver was appropriate here because "historically waivers have been mandated by Congress or by the agency in its regulations." Id. at 16. Since the Guide's free care principle itself is not articulated in any statute or regulation, however, there could be no statutory or regulatory provision authorizing a waiver. CMS also noted that Congress has already provided a "statutory exemption for certain services such as title V and [IDEA] from the [payor] of last resort principle." Tr. at 16. As discussed earlier, however, these alleged exemptions pertain to the third-party liability requirements, not to the Guide's free care principle.
- CMS has already said that it will disregard one of the criteria in the Guide for establishing that EPSDT services are not provided "without charge," i.e., that schools must bill all beneficiaries. Thus, CMS clearly believes that it has discretion to grant a waiver.
- If a state documents that certain activities required to meet the third-party liability requirements are not cost effective, the state may obtain a waiver of those requirements. See section 1902(a)(25)(A) of the Act; 42 C.F.R. 433.138(l). It would be inconsistent with these provisions to deny a waiver, under similar circumstances, of any requirement to seek third-party reimbursement for the cost of services provided to non-Medicaid eligibles.
- CMS stated that Oklahoma had not requested a written waiver from CMS. CMS Br. in Support of Disallowance at 16. However, CMS did not point to any requirements as to the form or timing of a request for a waiver of the Guide's free care principle and apparently waived one of its requirements without any request by a state.

In light of the foregoing factors, we conclude that CMS's refusal to grant a waiver in this case is arbitrary and capricious, an abuse of discretion or otherwise not in accordance with the law. This is the standard of review that a court would use under the Administrative Procedure Act, when ruling on a challenge to informal agency action. 5 U.S.C. 706. This highly deferential standard mandates judicial affirmance if a rational basis for the agency's decision is presented, even though a court might otherwise disagree. Environmental Defense Fund v. Costle, 657 F.2d 275, 283 (D.C. Cir. 1981). In this instance, however, CMS has not presented a rational basis for its decision to deny a waiver.

Conclusion

For the reasons explained in detail above, we reverse the disallowance in full.

JUDGE

Judith A. Ballard

Cecilia Sparks Ford

Donald F. Garrett

Presiding Board Member

FOOTNOTES

1. CMS stated that this "does not require the school to continue to [bill] an insurer which has indicated that it does not pay for the service." CMS Reply to Petitioner's Supplemental Br. at 5; see also id. at 7.

2. The version of this section of the State Medicaid Manual supplied by the parties is dated "04-95" and is identified as "Rev. 10;" however, a prior version is dated "04-90" and is identified as "Rev. 3."

3. Our citations to the Guide use the pagination in a complete copy of the Guide that CMS downloaded from its Website and submitted to the Board on 4/5/04.

4. Section 1903(c) provides:

> Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.

5. Section 1902(a)(11)(B) provides in pertinent part that the state Medicaid plan must--

> provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V, . . . (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1903 . . . .

6. The Health Care Financing Administration was renamed the Centers for Medicare & Medicaid Services (CMS). See 66 Fed. Reg. 35,437 (July 5, 2001).

7. Oklahoma asserted that the services in question here included services provided by registered nurses or licensed practical nurses; counseling services provided by professional counselors, licensed social workers and family therapists; and therapy services such as occupational therapy, physical therapy, and speech therapy. Tr. at 20. These individuals were presumably either employees or contractors of the schools or school districts.

8. The Guide contemplates an arrangement where the state agency submits Medicaid claims on behalf of a school that is enrolled as a provider, stating that "[b]illing for Medicaid reimbursement sometimes requires more administrative work than schools have the time and personnel to invest. As a result, schools as providers sometimes share the billing requirements with LEAs or with the state Medicaid agency . . . ." At 39.

9. CMS's initial brief stated that Oklahoma did not seek third-party reimbursement for Medicaid eligibles who received EPSDT services. CMS Br. in Support of Disallowance 12-13. CMS later acknowledged, however, that this was not the case. CMS Response to Order to Develop Record at 6.

10. CMS did not specifically allege that the schools did not bill the students or their families for the services. However, CMS stated during the proceedings before the Board that "CMS would not require the schools to bill families of students," although if they did, "that would certainly be an indicator to CMS that those services were not provided free of charge." Tr. at 15.

11. OIG indicated that the "policy" was based on section 1902(a)(17) of the Act, and also cited the State Medicaid Manual and Dallas Regional Medical Services Letter No. 92-105.

12. Although the OIG audit report referred generally to "school-based services" or "school-based health services," both parties appeared to assume that all the services in question were EPSDT services.

13. However, CMS conceded that the "free care policy" did not follow from the language in section 1905(a) of the Act defining "medical assistance" as "payment of part or all of the cost" of covered "care and services," since there is no "specification as to whether the 'cost' is the amount for which the Medicaid recipient would otherwise be liable, the amount the State or local agency actually pays, or the cost to the end provider." CMS Response to Order to Develop Record at 6.

14. An extended discussion of how the Board analyzes disallowance cases where an agency asserts that its interpretation of statutory language is controlling can be found in Alaska Dept. of Social and Health Services, at 14-16. As that discussion indicates, the standard the Board applies in such a situation is for all practical purposes the same standard that Oklahoma maintained is applicable here.

15. CMS's position is consistent with the requirement of the Administrative Procedure Act that a legislative rule be promulgated through notice and comment rulemaking in order to be binding. 5 U.S.C. 553(b) and (c). Section 553(a)(2) provides an exception for matters relating to grants; however, HHS has chosen to abide generally by the provisions of section 553, notwithstanding the grants exception. 36 Fed. Reg. 2532 (1971). Accordingly, an agency statement of policy that is not specifically authorized by the Act or its implementing regulations is not binding unless promulgated in accordance with section 553.

The Secretary may promulgate rules in accordance with section 553 pursuant to the general authority in section 1102 of the Act to issue regulations for any program under the Act or his general authority in section 1902(a)(4) of the Act to prescribe State plan requirements.

16. The other regulatory definitions of "resources" cited in California no longer appear at their original locations.

17. Thus, this situation is distinguishable from the situation where states are obligated to provide services under title V or IDEA. The existence of that obligation explains why specific statutory exceptions are necessary to make Medicaid the primary payor for services under title V and IDEA.

18. CMS asserted that the Guide's free care principle reflects the "federal interest in ensuring that Medicaid is the payor of last resort, except when expressly mandated by statute." CMS Reply to Petitioner's Supplemental Br. at 6. However, the principle that Medicaid is the payor of last resort has no bearing on the Guide's free care principle since, as discussed below, the latter principle refers only to third-party liability for the cost of services to Medicaid eligibles.

19. It is clear from other parts of the decision as well that the Board viewed section 8435, in conjunction with the definition of "without charge" in the State Medicaid Manual, as requiring a state to seek third party reimbursement only for services to Medicaid eligibles. See, e.g., California at 15 (examining third-party liability provisions in the Act and regulations to determine whether the provider rather than the state must seek third-party reimbursement).

20. CMS asserted that "[e]ven if it is determined that the Guide's definition is a modification of the [State Medicaid Manual] definition of free care, CMS is not prohibited from modifying its definition." CMS Reply to Petitioner's Supplemental Br. at 7. CMS quoted the Board's statement in California that the decision did not "preclude HCFA from modifying its definition and providing notice to the states . . . ." California at 19. However, the quoted statement refers to the Board's determination that the Manual's definition of "without charge" did not require that there be either an obligation to pay on the part of the individuals receiving the services or unimpaired recourse against all type of third parties. This does not suggest that CMS could impose a new requirement for seeking third-party reimbursement for the cost of services to non-Medicaid eligibles merely by giving notice of a modification of section 5340 of the State Medicaid Manual.

21. This limitation indicates that the requirement is designed to address the issue of potential cost-shifting among grant programs.

22. CMS maintained here that section 1903(c) does not exempt a provider from the third-party liability requirements, but only from the free care principle. Tr. at 14; see also Dallas Regional Medical Services Letter No. 90-19, at 2. However, the Guide states that section 1903(c) "permits an exception to the TPL

[third-party liability] requirements in that, for Medicaid-covered services listed on a Medicaid eligible child's IEP/IFSP, Medicaid will pay primary to IDEA." At 47. The Guide further states that section 1903(c) "does not provide any exemption from pursuing OTHER liable third party payers, such as private insurance." Id. (emphasis in original); see also CMS Br. in Support of Disallowance at 13.

23. Not only is the logic of making such an inference flawed, but applying the Guide's free care principle based on such an inference would arguably run contrary to the Supreme Court's holding in Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, at 17 (1981) that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."

24. Ironically, the Guide discusses application of the free care principle only to EPSDT or school-based health services. CMS was unable to point to any document that called for the application of this principle to Medicaid services generally except Dallas Regional Medical Services Letter No. 90-19. Tr. at 15.