DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD# 14-006

Re: Medicaid Payment for Services Provided without Charge (Free Care)

December 15, 2014

Dear State Medicaid Director:

This letter addresses Medicaid payment for services covered under a state's Medicaid plan to an eligible Medicaid beneficiary that are available without charge to the beneficiary (including services that are available without charge to the community at large, or "free care"). We are issuing this guidance to ensure that Medicaid payment is allowed for any covered services for Medicaid-eligible beneficiaries when delivered by Medicaid-qualified providers. In particular, we intend to remove any ambiguity about the application of a "free care" policy.

Historically, the Centers for Medicare & Medicaid Services (CMS) guidance on "free care" was that Medicaid payment was generally not allowable for services that were available without charge to the beneficiary, with some statutory and some policy exceptions.[1] This policy was expressed in a number of guidance documents, including the prior CMS guidance "1997 Medicaid and School Health: A Technical Assistance Guide, and the 2003 Medicaid School-Based Administrative Claiming Guide (School-Based Administrative Claiming Guide)." The free care policy was challenged and the Departmental Appeals Board (DAB), in Decision No. 1924 (2004), reconsidered in Ruling 2005-1 (2005), concluded that this policy was not an interpretation of either the Medicaid statute or existing regulations.

In light of the DAB ruling, CMS is withdrawing its prior guidance on the "free care" policy as expressed in the School-Based Administrative Claiming Guide and other CMS guidance. As indicated by the DAB, the free care policy as previously applied effectively prevented the use of Medicaid funds to pay for covered services furnished to Medicaid eligible beneficiaries when the provider did not bill the beneficiary or any other individuals for the services. The goal of this new guidance is to facilitate and improve access to quality healthcare services and improve the health of communities.

[1] Exceptions included services provided under the Maternal and Child Health Services Block Grant program under Title V of the Social Security Act, covered under the Special Supplemental Nutrition Program for Women, Infants and Children, and provided as part of an Individualized Education Program or Individualized Family Service Plan under the Individuals with Disabilities Education Act.

Under this guidance, Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, Federal Financial Participation (FFP) is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met.

As is the case more generally, FFP for Medicaid payments is available only when all of the following elements are satisfied:

- The individual is a Medicaid beneficiary.
- The service is a covered Medicaid service, provided in accordance with the approved state plan methodologies, including coverage under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit provided to children.
- The provider is a Medicaid-participating provider and meets all federal and/or state provider qualification requirements.
- The state plan contains a payment methodology for determining rates that are consistent with efficiency, economy and quality of care.
- Third party liability (TPL) requirements are met.
- Medicaid payment does not duplicate other specific payments for the same service.
- The state and provider maintain auditable documentation to support claims for FFP.
- The state conducts appropriate financial oversight of provider billing practices.
- All other program requirements (statutory, regulatory, policy) for the service, payment, and associated claiming are met.

Third Party Liability (TPL) Provisions

The Medicaid statute at section 1902(a)(25) of the Social Security Act (the Act) requires that states take all reasonable measures to ascertain and pursue claims for payment of health care items and services against legally liable third parties. Regulations at 42 Code of Federal Regulations (CFR) 433 subpart D describe the TPL provisions for the Medicaid program. In general, Medicaid beneficiaries are required to cooperate with the state Medicaid program in identifying available third party resources and assigning their rights to third party payments to the Medicaid program. Providers, in turn, are generally required to bill legally liable third parties prior to billing Medicaid, and bill Medicaid only the difference between the third party's payment liability and Medicaid's payment rate established in the Medicaid state plan (although there are some regulatory exceptions permitting Medicaid to pay providers in full and separately pursue TPL).

We clarify here that CMS does not view public agencies or programs that are carrying out general responsibilities to ensure access to needed health care, such as schools, public health agencies, and child protective services agencies, as legally liable third parties at the federal level for purposes of Medicaid reimbursement, except to the extent of liability that is more specific in nature, such as a tort claim or employer responsibility for employee health benefits, or when legal liability is specified by state law. A third party is defined in CMS regulations at 42 CFR 433.136 as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a state plan." While the term "entities or programs" includes schools and similar agencies, typically these entities have general responsibilities to ensure that their students or clients obtain necessary services. This general responsibility to ensure access to needed care does not necessarily mean that these entities or programs have legal liability for payment for services when there are other available payers, such as Medicaid (even though their general responsibility may be supported by authority to make payment for such services). This clarification is consistent with how CMS has historically viewed the role of public agencies and the flexibility of states to use a variety of state and local agencies to ensure that individuals receive needed services, including Medicaid services. Since state laws may vary on this subject, we suggest that states review their own legal framework to determine whether such agencies or programs are required by state law to pay for services when there are other available payers.

Under this guidance, we also would not consider schools to be legally liable third parties to the extent that they are acting to ensure that students receive needed medical services to access a free appropriate public education consistent with section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794.

This guidance does not create any exception to requirements to pursue TPL from legally liable third parties, such as private insurance plans or negligent tort-feasors, but it allows states to determine that public agencies with general responsibilities to ensure health and welfare are not considered legally liable third parties. Nor does this guidance create an exception to legal liability arising from public agency responsibilities under state or federal laws other than general responsibilities for the health and welfare of the population served. For example, a public agency or program would still be legally liable for costs resulting from improper or negligent actions by employees during the performance of assigned duties.

We also note that, even if a state determines that schools or providers of Individuals with Disabilities Education Act (IDEA) services generally are legally liable third parties, the Medicaid statute contains an exception at section 1903(c) of the Act, which requires that Medicaid serve as the primary payer to schools and providers of services in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the IDEA. Likewise, IDEA sections 612(e) and 640(c), codified in 20 U.S.C. 1412(e) and 1440(c), provide that nothing in the IDEA permits a state to reduce medical or other assistance available, or to alter eligibility, under Titles V (relating to maternal and child health) and XIX of the Social

Security Act (relating to Medicaid for infants and toddlers with disabilities and to the provision of a free appropriate public education to children with disabilities) in the state.

If you have any questions regarding the information in this letter, please contact Ms. Barbara Coulter Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

/s/

Cindy Mann
Director

cc:

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