Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

California Department of Health Care Services
Docket No. A-10-94
Decision No. 2373
March 30, 2011

DECISION

The California Department of Health Care Services (CDHCS) appeals a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $12,337,493 in Federal Financial Participation (FFP) in Medicaid expenditures for the period April 1, 2003 through September 30, 2004. The disallowed expenditures were for services provided to individuals whom CDHCS had originally determined were Medicaid eligible based on their receipt of supplemental security income (SSI) payments from the Social Security Administration (SSA), but whom SSA later found ineligible for SSI. Under federal regulations, FFP is available in services to such individuals only for limited time periods following a state's receipt of notice from SSA that they are ineligible for SSI, unless the state determines they are eligible for Medicaid on some other basis. CDHCS, however, continued to claim FFP for expenditures beyond the applicable time limits, even though CDHCS had not made any new eligibility determinations and the individuals were ultimately determined to be ineligible for Medicaid. CDHCS argues that it is entitled to an exception in the regulations permitting FFP for payments made pursuant to a court order. In the alternative, CDHCS argues that CMS actually or implicitly waived the time limits for determining eligibility.

For the reasons explained below, we sustain the disallowance.

Legal Background

Individuals who are eligible to receive SSI benefits from SSA are automatically eligible for Medicaid. Social Security Act (Act) § 1902(a)(10)(A)(i)(I); 42 C.F.R. § 435.120.[1] If SSA notifies a state Medicaid agency that a Medicaid recipient has been determined ineligible for SSI, the state agency "must take prompt action to determine eligibility after

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_ Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

receiving the SSA notice." 42 C.F.R. § 435.1003(b). Section 435.1003 provides FFP in Medicaid expenditures for limited time periods following receipt of notice from SSA:

> (a) If the Social Security Administration (SSA) notifies an agency that a recipient has been determined ineligible for SSI, FFP is available in Medicaid expenditures for services to the recipient as follows:
> (1) If the agency receives the SSA notice by the 10th day of the month, FFP is available under this section only through the end of the month unless the recipient requests a hearing under subpart E, part 431 of this subchapter.
> (2) If the agency receives the SSA notice after the 10th day of the month, FFP is available only through the end of the following month, unless the recipient requests a hearing under subpart E, part 431 of this subchapter
> (3) If a recipient requests a hearing, FFP is available as specified in subpart E, part 431 of this subchapter.

42 C.F.R. § 435.1003.[2]

The regulations at 42 C.F.R. part 431, subpart E, "Fair Hearings for Applicants and Recipients," authorize FFP in a state's costs of providing fair hearings for Medicaid applicants and recipients, and also, as relevant here, in the following expenditures:

> (b) Payments made—
> (1) To carry out hearing decisions; and
> (2) For services provided within the scope of the Federal Medicaid program and made under a court order.
> (c) Payments made to take corrective action prior to a hearing;
> (d) Payments made to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order[.]

42 C.F.R. § 431.250.

Once individuals have been found eligible for Medicaid, states must "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible," and states may receive FFP "in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided . . . ." 42 C.F.R. §§ 435.930(b); 435.1002(b).

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[2] Subpart E of part 431 provides FFP "in expenditures for . . . Payments for services continued pending a hearing decision[.]" 42 C.F.R. § 431.250(a). CDHCS has not cited section 431.250(a) or asserted that the disallowed expenditures were for payments for services continued pending a hearing.

Case Background

CDHCS made the disallowed Medicaid payments for services provided to individuals who had become ineligible for Medicaid when they lost their SSI eligibility. They were subjects of a state lawsuit, *Celia Craig et al. v. Diana Bontá, California Department of Health Services*, Case No. CPF-02-500688 (Cal. Sup. Ct.). S*ee* CDHCS Exs. 7-11. As relevant here, the suit alleged that CDHCS failed to comply with a California law requiring counties to "promptly redetermine eligibility" for Medicaid upon receipt of "information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits" (Medi-Cal is California's Medicaid program) and setting procedures for redetermining eligibility.[3] CDHCS Ex. 12 (Cal. Welf. & Inst. Code § 14005.37); CDHCS Br. at 2. The state law requires counties to "make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary." CDHCS Ex. 12. According to CDHCS, the *Craig* court held that this law "applied to all beneficiaries, including those who lost SSI eligibility." CDHCS Br. at 2. The court "ordered California to continue Medicaid coverage for recipients whose SSI-linked Medicaid eligibility was discontinued after June 30, 2002 until such time as the individual's Medicaid eligibility on another basis was determined," unless the reason for loss of SSI was death or incarceration, and "further ordered California to develop a process to ensure that SSI-linked Medicaid recipients were afforded redetermination hearings prior to termination and required the State to submit its plan for approval by the Court within 120 days" of the court's June 24, 2002 order. CMS Br. at 3, *citing* CDHCS Exs. 7 (*Craig* Temporary Order); 8 (Implementation Plan); 10 (Order Approving Implementation Plan).

CDHCS submitted its implementation plan in December 2002, and the *Craig* court approved it on April 7, 2003. CDHCS Exs. 10 (*Craig* Order); 11 (*Craig* Judgment and Writ).[4] By judgment and writ issued in April 2004, the *Craig* court prohibited CDHCS "from failing or refusing to provide a redetermination" of Medicaid eligibility pursuant to the requirements of the state law "for all Medi-Cal beneficiaries losing SSI as the basis for Medi-Cal eligibility" and "from terminating Medi-Cal eligibility for beneficiaries losing SSI until the redetermination process required" by the state law "has been completed as set forth in the approved implementation plan." CDHCS Ex. 11 (*Craig* Judgment at 3, *see also* Writ at 1-2). The court also ordered CDHCS "to withdraw the administrative hearing decision" for one of the named plaintiffs, "to enter a new Decision consistent with the orders of this Court and to retroactively restore petitioner Lee's Medi-

[3] *Celia Craig et al. v. Diana Bontá, California Department of Health Services*, Case No. CPF-02-500688 (Cal. Sup. Ct.). *See* CDHCS Exs. 7-11.

[4] We refer collectively to the *Craig* orders, the *Craig* judgment and writ, and the CDHCS Implementation Plan, as the "*Craig* order."

Cal eligibility for any months which may have been affected by the previous Decision." *Id*.

CMS determined that during the disallowance period CDHCS "failed to take such prompt [redetermination] action, continued to make payments for services to such beneficiaries, and then claimed FFP in payments that were made beyond the regulatory time limits established by . . . 42 C.F.R. § 435.1003(a) for services to persons later determined to have been ineligible for Medicaid at the time the services were furnished." CMS Disallowance Notice (July 8, 2010). CDHCS does not dispute that the beneficiaries for whom CDHCS made the disallowed Medicaid payments were found upon redetermination to have been ineligible for Medicaid. *See* CDHCS Br. at 3 (disallowance "reflects payments made for beneficiaries who were found not to otherwise qualify for Medicaid services").[5]

Analysis

1. **Section 431.250 does not entitle CDHCS to FFP in Medicaid payments for the *Craig* beneficiaries whom CDHCS did not determine to be Medicaid-ineligible until after the time limits specified in section 435.1003.**

    a. *The disallowed payments were not made to carry out hearing decisions under 42 C.F.R. § 431.250(b)(1).*

CDHCS argues that it is entitled to FFP in its Medicaid expenditures on behalf of ineligible *Craig* beneficiaries beyond the time limits for redetermining their eligibility imposed by section 435.1003(a) because section 431.250 "provides that FFP is available to implement fair hearing decisions and provide services within the scope of Medicaid pursuant to court orders" and "to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order." CDHCS Br. at 5, *citing* 42 C.F.R. § 431.250(b), (d). CDHCS argues that *Craig* "is indisputably a proceeding that is contemplated by 42 [C.F.R. §] 431.250," and more specifically that –

> [t]he lawsuit clearly involved eligibility of a class, however, it also pertained to the eligibility of the class representatives in their individual capacity. The Judgment and Writ clearly demonstrate that the litigation pertained to the fair hearing decision for Petitioner [CK] Lee. In both the Judgment and Writ, the Respondent (Appellant) was ordered to withdraw

[5] Prior to taking the disallowance, CMS informed CDHCS that, "[c]onsistent with" 42 C.F.R. § 435.1003(a), (b), "FFP will be allowed for expenditures made on behalf of any recipients who are found eligible under the court- ordered implementation plan" but "is available to those individuals who are not found eligible, only to the extent allowed by 42 CFR 435.1003." CMS Ex. 1, at 1 (CMS letter to CDHCS, Jan. 30, 2004).

> the administrative decision regarding Lee's eligibility and Appellant was further ordered to re-determine the eligibility of Lee and the class of Craig beneficiaries in accordance with the Implementation Plan which had been approved and incorporated into the Court's Order. At issue was eligibility for services within the scope of Medicaid. Further, the court retained jurisdiction to monitor the execution of the Plan/Order.

CCHS Br. at 5.

Paragraph (b)(1) of section 431.250 makes FFP available for payments "[t]o carry out hearing decisions." Despite CDHCS's assertion that the *Craig* litigation pertained to a fair hearing decision, there is no indication that, in order "[t]o carry out hearing decisions," CDHCS was required to make payments for the ineligible *Craig* beneficiaries beyond the deadline for redetermining their eligibility. CDHCS has not submitted any fair hearing decisions and concedes it was ordered by the *Craig* court to withdraw the administrative decision regarding the named petitioner. CDHCS Br. at 5; *see* CDHCS Ex. 11, at 3 (*Craig* Judgment). Thus, CDHCS has not shown that it was entitled to FFP in payments to ineligible individuals beyond the deadline for conducting redeterminations.

b. The disallowed payments were not made pursuant to court order under 42 C.F.R. § 431.250(b)(2).

As to the other provisions of section 431.250(b), the Board has long recognized that "[t]he only basis for federal participation in costs which would not otherwise be allowable Medicaid costs is 42 C.F.R. § 431.250(b), which authorizes FFP in payment 'for services provided within the scope of the Federal Medicaid program and made under a court order'" or to carry out hearing decisions. *California Dept. of Health Services*, DAB No. 1139, at 7 (1990).[6]

Paragraph (b)(2) of section 431.250 presents "a two-prong test for the allowability of FFP for medical services. The services must be 'within the scope of . . . Medicaid . . . and made under a court order.'" *Texas Dept. of Human Services*, DAB No. 1344, at 14 (1992), *quoting Illinois Dept. of Public Aid*, DAB No. 1320 (1992). "Thus, the mere fact that the court ordered the payment of the funds in issue is not enough to qualify the expenditures for federal reimbursement." *Texas* at 14. As to the first prong, the preamble to this provision when published in its current codification states that–

[6] Paragraph (d) of section 431.250 merely extends the effect of paragraph (b) with respect to "individuals in the same situation" as those "directly affected" by the relevant hearing decision or court order. It and paragraph (b)(1) were not at issue in DAB No. 1139.

> even when there is a court order against a State to provide services beyond the limits of the program, FFP is not available when there are **other regulatory provisions which impose limitations [such as separate time limits or limitations on types of services] upon the receipt of Federal funds**.

45 Fed. Reg. 24,878 (Apr. 11, 1980) (brackets in original, emphasis added), *cited, e.g., in California* at 8, n.5; *Texas* at 13. A federal court of appeals that considered this preamble language stated:

> Clearly, then, the regulation provides for federal funds to be furnished where a court has ordered a state to provide Medicaid benefits that **would have been eligible for federal funds had the state, in implementing its federally approved program, provided those funds on its own initiative**, and not where a court has ordered a state to pay benefits on the basis of an interpretation that Title XIX requires such payments despite the unavailability of federal funds.

Georgia v. Heckler, 768 F.2d 1293, 1298 (11th Cir. 1985) (emphasis added).

There is no indication here that CDHCS would have been eligible for federal funds in the payments made beyond the redetermination deadlines had it provided those payments "on its own initiative" in the absence of any court order. Indeed, while section 435.1003(a) provides FFP for only limited periods pending redeterminations of eligibility of former SSI recipients, section 435.930(b) of 42 C.F.R. requires states to "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible," with no exceptions for instances where the state did not find them ineligible within the redetermination deadlines. Thus, the federal regulations anticipate that a state that fails to meet the redetermination deadlines in section 435.1003(a) will nonetheless be required to make payments on behalf of such individuals for services otherwise covered by Medicaid even though FFP is not available in those payments.

The Board, citing the above preamble language that the *Georgia* court addressed, concluded in *California*, DAB No. 1139, that the requirement in the regulation that the services the state funds under court order be provided "within the scope" of the Medicaid program "'was intended to, and does set limits on the availability of FFP pursuant to the court's order in such situations . . . these limits are drawn from regulatory requirements which are not the subject of the court's order (as opposed to those which may be affected)'." *California* at 7-8, *quoting Ohio Dept. of Public Welfare*, DAB No. 173, at 11 (1981). The Board has thus read this regulation "as providing limited exceptions to program limitations to the extent the exceptions are the subject of the court order, while retaining other program limitations." *Illinois* at 9-10 (1992), *citing California*.

Under these analyses, the disallowed payments CDHCS made under the *Craig* order were not for services provided "within the scope" of the Medicaid program as required to qualify for the exception for court-ordered payments in section 431.250(b)(2). There is no indication that the redetermination deadlines in section 435.1003(a) with which CDHCS admittedly failed to comply were "the subject of" the court's order. *California*; *Illinois*. CDHCS points to no language in the *Craig* order referencing the federal redetermination deadlines or indicating that the litigation resulted from the state's failure to comply with section 435.1003(a). Instead, the litigation was brought about by CDHCS's failure to afford former SSI recipients the full process for redetermining their Medicaid eligibility that state law required CDHCS to conduct upon receipt of "information about changes in [their] circumstances that may affect eligibility for" Medicaid. CDHCS Ex. 12 (Cal. Welf. & Inst. Code § 14005.37). Section 435.1003(a) was thus among the "other regulatory provisions which impose limitations **. . .** upon the receipt of Federal funds" that the *Craig* court did not address. 45 Fed. Reg. 24,878.

In essence, the *Craig* order required CDHCS to comply with the requirements of state law with respect to Medicaid recipients whom SSA had found to be no longer eligible for SSI. CDHCS has cited no provision in the Medicaid law or regulations permitting a state to receive FFP in unallowable payments on the ground that they were required by state law. CDHCS has also not alleged that it incorporated the requirements of its state law or the *Craig* order into its approved state Medicaid plan, which would have been a prerequisite to CDHCS claiming FFP in Medicaid payments made to carry out those requirements. *See, e.g., Maine Dept. of Health and Human Services*, DAB No. 2292, at 10 (2009) ("A State's expenditures are eligible for federal Medicaid reimbursement only if they are made in accordance with the state plan."), *aff'd, Maine Dep't of Human Servs. v. U.S. Dep't of Health and Human Servs.*, No. 1:10-cv-00077-JAW, 2011 WL 680198 (D.Me. Feb. 25, 2011).

The court of appeals in *Georgia* further stated that the preamble to section 431.250 "noted that the regulation 'concerns [federal funds] for expenditures in services for individuals who are successful in their appeal' from a denial of benefits." 768 F.2d at 1298 (brackets in original), *quoting* 45 Fed. Reg. 24,878. There is no indication here that ineligible *Craig* plaintiffs for whom the disallowed payments were made (or others "in the same situation," 42 C.F.R. § 431.250(d)) were successful in appeals from denials of benefits. CDHCS does not identify any finding in the *Craig* order that the individuals who received the services for which FFP was disallowed were in fact Medicaid eligible. The *Craig* order instead followed upon CDHCS's failure to provide those ineligible recipients the process required by state law.

c. CDHCS's failure to comply with the state redetermination law further renders 42 C.F.R. § 431.250(b)(2) inapplicable.

Further evidence that CDHCS is not entitled to the benefit of section 431.250(b) comes from the record showing that CDHCS failed to follow the state redetermination law. The Board, in considering 45 C.F.R. § 205.10(b), a parallel regulation that was adopted for Medicaid as section 431.250(b), explained that the provision authorizing FFP in court-ordered assistance payments was–

> a recognition that FFP should be made available in the situation where a State, ***through no fault of its own***, is forced to pay for costs which would not normally meet program requirements. . . . A court order, however, acts to overcome the program limitations and to make FFP available, so long as payments are otherwise within the scope of the program.

Illinois Dept. of Public Aid, DAB No. 1320, at 9 (1992), *citing Louisiana Dept. of Health and Human Resources*, DAB No. 188, at 8 (1981) (emphasis added).[7]

CDHCS was not required to make Medicaid payments for ineligible recipients beyond the deadline for redetermining their eligibility through no fault of its own. The record here indicates, on the contrary, that CDHCS knowingly denied former SSI recipients the full redetermination process that the state law required. CDHCS apparently considered the state law's requirement for an "ex parte review" prior to contacting the beneficiary unnecessary to apply to recipients losing SSI eligibility, on the ground that information relevant to their eligibility was likely to be maintained by SSA rather than by California counties**.** *See* CDHCS Ex. 5, at 6-7 (CDHCS letter to CMS, Dec. 24, 2003, stating that the redetermination process required by the *Craig* order "includes an *ex parte* review of each beneficiary's file, even if such *ex parte* review is futile . . . [t]he county has no existing Medi-Cal file to use for an *ex parte* determination"); Ex. 8, at 2 (Implementation Plan, stating that the determination of SSI eligibility "is made at the SSA federal level, which means that in most instances the counties will not have access to the individual's files or other necessary information when doing a Medi-Cal only eligibility determination after the person is discontinued from SSI"). CDHCS does not explain, however, why it could not have done a timely ex parte review of whatever information was available, nor does CDHCS claim it reasonably interpreted the state redetermination law as exempting former SSI eligibles. CDHCS's failure to comply with its redetermination process shows that CDHCS was not without fault and renders the provisions of section 205.10(b) inapplicable to those untimely payments. Its deliberate disregard of the state

[7] The *Georgia* court described section 431.250 as "a parallel regulation" to 45 C.F.R. § 205.10(b) "with nearly identical wording, that was to apply solely to Medicaid," 768 F.2d at 1298; *see* 44 Fed. Reg. 17,926 (Derivation Table) (Mar. 23, 1979).

redetermination law should not shield CDHCS from the financial consequences of its failure to redetermine eligibility within the time frames set in the federal regulation.

In any event, CDHCS concedes that "[e]ligibility for the Craig beneficiaries was re-determined according to the procedures specified by the Implementation Plan, however, not within the timelines contained in the Plan."[8] CDHCS Br. at 3. Even if section 431.250(b) applied to relieve CDHCS from the redetermination deadlines for receiving FFP, and we conclude that it does not, it is not clear that it would apply to payments CDHCS made that were not in compliance with the timeframes in the implementation plan, which was incorporated into the *Craig* order. CDHCS did not state what portion of the disallowed payments were made beyond the timelines in the implementation plan and did not explain why payments not in compliance with the terms of a court order may be considered payments "made under a court order" for purposes of section 431.250(b)(2).

As the disallowed payments do not fall within the exceptions in section 431.250(b), CDHCS is not entitled to FFP under paragraph (d) of the regulation, which extends the exception to payments made "to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected" by the decision or order.

Finally, CDHCS argues that the disallowance should be reversed because it allegedly did not claim FFP that it says "should be available to, not only fully execute the Implementation Plan approved by the Craig court for the Craig beneficiaries, but to conduct re-determinations for any and all Medicaid beneficiaries found to be ineligible for SSI." CDHCS Br. at 5-6. As CDHCS has identified no disallowance of such costs, much less alleged that it has claimed any such costs, there is no reviewable dispute before us about whether FFP is available for such purposes. *See* 45 C.F.R. part 16, App. A, ¶ B(a) (Board reviews "final written decisions" in mandatory grant programs, including disallowances under title XIX of the Act (Medicaid)); 45 C.F.R. § 16.3(b) (before the Board will take an appeal, the appellant "must have received a final written decision").

[8] CDHCS states that "[t]he Disallowance reflects payments made for beneficiaries who were found not to otherwise qualify for Medicaid services after a 60 day period for non-disabled beneficiaries and a 90 day period for disabled beneficiaries." CDHCS Br. at 3. CDHCS points to no provision of the *Craig* order or the Implementation Plan, and we can find none, requiring that CDHCS wait for those periods of time before redetermining eligibility. We note that the CMS April 7, 2000 letter to State Medicaid Directors that CDHCS cites in support of its waiver argument, which we address below, reports that "States that have developed reinstatement procedures have typically reinstated individuals and families [pending eligibility redeterminations] for a period of 60 or 90 days." CDHCS Ex. 1, at 3.

2. CMS did not waive the requirements of 42 C.F.R. § 435.1003(a), and there is no basis to find an implied waiver.

CDHCS also argues that CMS waived the redetermination time limits in an April 7, 2000 State Medicaid Directors Letter (SMDL), pursuant to the authority in 42 C.F.R. § 435.1003(c). Section 435.1003(c) states:

> When a change in Federal law affects the eligibility of substantial numbers of Medicaid recipients, the Secretary may waive the otherwise applicable FFP requirements and redetermination time limits of this section, in order to provide a reasonable time to complete such redeterminations. The Secretary will designate an additional amount of time beyond that allowed under paragraphs (a) and (b) of this section, within which FFP will be available, to perform large numbers of redeterminations arising from a change in Federal law.

The April 7, 2000 letter gave states 120 days or more to redetermine the Medicaid eligibility of former recipients who had been improperly terminated as a result of changes to Federal law that caused the "delinkage of Medicaid from cash assistance" and directed states to, among other things, reinstate recipients who had been wrongfully terminated. CDHCS Ex. 1, at 1. States were instructed to conduct an ex parte review prior to asking the recipient to provide information to establish continued eligibility. *Id*. at 1-3. CMS thereafter issued guidance in the form of questions and answers (Q&A), titled "Questions About the April 7, 2000 Letter to State Medicaid Directors." CDHCS Exs. 2-4.

CDHCS does not dispute that, as CMS states, the SMDL "focused primarily on the sweeping changes to Federal law . . . which together eliminated the automatic linkage between cash assistance to families and children and Medicaid and also affected the eligibility of children who were receiving SSI benefits, individuals receiving SSI disability benefits based on a finding of alcoholism and drug addiction, and non-U.S. citizens." CMS Br, at 6-7, *citing* CDHCS Ex 1, at 1; s*ee* CDHCS Br. at 6 (changes in SSI eligibility addressed by the SMDL "were contained in the Personal Responsibility and Work Opportunity Act of 1996 . . . and Section 4913 [of] the Balanced Budget Act of 1997"). CDHCS does not allege that any of the referenced statutory changes were the subject of or enforced by the *Craig* order, which instead resulted from CDHCS's failure to comply with its state law in redetermining the eligibility of former SSI recipients.

CDHCS argues nonetheless that "CMS extended [the] provisions of the SMD Letter to the situation at issue in this appeal." CDHCS Br. at 8. In particular, CDHCS cites CMS's response to "Question 34" in the Q&A guidance, asking "[w]ill States have to review closures for other categories of Medicaid, like adult SSI, and reinstate any eligible individuals?" CMS Ex. 3, at 5. CMS responded "No," but advised that states "have a continuing obligation to provide Medicaid to all eligible persons who have not been

properly determined ineligible for Medicaid. If States do identify other groups of beneficiaries who have been improperly terminated, reinstatement would be the proper action to take." *Id*. Based on this advice, CDHCS argues that "it is clear that CMS waived the prompt action requirements and extended the time in which FFP was available to 120 days for groups identified by States as being improperly terminated from Medicaid without a re-determination." CDHCS Br. at 8. CDHCS also cites a letter from its Deputy Director of Medical Care Services to CMS asserting that the state redetermination law was enacted "largely in response" to the April 7, 2000 SMDL. CDHCS Ex. 5, at 8 (CDHCS letter to CMS, Dec. 24, 2003), *cited in* CDHCS Br. at 8.

As CDHCS acknowledges, its assertion that the Q&A guidance extended the waiver beyond those groups affected by the changes in federal law is contrary to the plain terms of the Q&A guidance, which stated that a review of case closures was not required for categories of Medicaid recipients other than those affected by the changes in the federal law. CDHCS Br. at 8; CDHCS Ex. 3, at 5. Nothing in the guidance indicates that the waiver extended to situations not affected by the federal legal changes. No such inference may reasonably be drawn given that the federal regulations recognize that a state may be required to make Medicaid payments for services otherwise covered by Medicaid provided to recipients pending the state's redetermination of their eligibility, even though the state may not receive FFP in those payments beyond the redetermination deadlines in section 435.1003(a).

CDHCS also has not demonstrated that the state law was enacted in response to the SMDL, or why that conclusion would be reasonable. The SMDL and Q&A guidance make clear that the redetermination procedures the SMDL required, and for which it granted the waiver, applied with respect to recipients whose Medicaid benefits were "improperly terminated" upon the termination of the other benefits. *See, e.g.*, CDHCS Ex. 1, at 2 (SMDL); Ex. 3, at 3 (Q&A guidance). CDHCS has not shown why the state would reasonably conclude that these procedures applied to *all* redeterminations conducted following receipt of "information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits" as its state law requires. CDHCS Ex. 12 (Cal. Welf. & Inst. Code § 14005.37). Had CDHCS on the basis of the guidance elected to apply the redetermination procedures in its state law that the *Craig* order enforced, it could have incorporated those procedures into its state Medicaid plan and sought CMS approval.

CDHCS also argues that the Board "should find an implied waiver (i.e., that CMS was unreasonable to withhold a waiver in this circumstance)" because the redetermination process mandated by the SMDL "simply cannot be done within the time allotted by the section 435.1003." CDHCS Br. at 8-9. As we discussed above, the SMDL did not apply to the untimely redeterminations at issue here, and cannot reasonably be read as the basis of the state law addressing all redeterminations conducted following receipt of information that could affect eligibility.

We also disagree with CDHCS's claim that the Board is authorized to find an implied waiver because "the laws and regulations provide for a waiver." CDHCS Reply Br. at 1. To the contrary, the waiver regulation limits the waiver authority to circumstances not present here ("a change in Federal law" affecting the eligibility of substantial numbers of Medicaid recipients). 42 C.F.R. § 435.1003(c). For that reason, the Board decision CDHCS cites as recognizing Board authority to require waivers of CMS policy, *Oklahoma Heath Care Authority*, DAB Decision No. 1924 (2004), is not applicable. CDHCS takes out of context the Board's statement there that "[e]ven 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." *Oklahoma* at 2, *cited at* CDHCS Reply Br. at 1. The "principle" that the Board referenced was "not based on any language in the Act or regulations" and a refusal by CMS to waive that principle "would be inconsistent" with regulations that did permit waiver of applicable regulatory requirements. *Oklahoma* at 2, 22. *Oklahoma* did not hold that the Board had authority to mandate that CMS grant waivers under circumstances where denial would be consistent with applicable law. Here, declining to grant a waiver is in fact consistent with the waiver regulation, which authorizes waivers only in limited circumstances not present here.

Conclusion

For the reasons stated above, we sustain the disallowance.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member