Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Virginia Department of Medical Assistance
Docket No. A-08-73
Decision No. 2222

DATE: December 31, 2008

DECISION

The Virginia Department of Medical Assistance (Virginia) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $3,948,352 in federal financial participation (FFP) that Virginia claimed as "medical assistance" under title XIX of the Social Security Act (Act). CMS based the disallowance on an Office of the Inspector General (OIG) audit of Virginia's claims for the period July 1, 1997 through June 30, 2001. CMS determined that Virginia improperly claimed FFP in physician, pharmacy, outpatient hospital and clinic, inpatient acute care, community mental health, and other services provided to children who resided in "institutions for mental diseases" (IMDs).

The Act excludes from the definition of "medical assistance" any payment for services to an individual who is under age 65 and is in an IMD. We refer to this as the "IMD exclusion." The Act and regulations provide for an exception to the IMD exclusion for "inpatient psychiatric services for individuals under age 21," but CMS determined that FFP is not available under that exception for the services at issue. CMS determined that, at a minimum, to claim for "inpatient psychiatric services for individuals under age 21," Virginia had to document that the claimed costs were for services provided in and by the IMDs, but that Virginia had not done so.

On appeal, Virginia challenges CMS's determination that the exception applies only to "inpatient psychiatric services." Virginia argues that the exception makes FFP available for all services provided to children residing in IMDs. Virginia also relies on the fact that its Medicaid State Plan allows Virginia

to reimburse residential treatment facilities for "inpatient psychiatric services" using a per diem rate that excludes the costs of professional services. Virginia says this shows it lacked effective notice that FFP is not available for such professional services if they are not provided in and by an IMD. Alternatively, Virginia relies on the results of its analysis of claims data, asking us to draw various alternative inferences from the analysis and to reduce the disallowance amount accordingly.

For the reasons first summarized and then explained more fully below, we uphold the disallowance, although CMS may reduce the disallowance amount if it accepts the latest data analysis presented by Virginia, either by itself or as supplemented by further information.

Summary of our decision

Virginia acknowledges that this Board upheld CMS's position on the scope of FFP available for services to children in IMDs in New York State Dept. of Health, DAB No. 2066 (2007), but asks us to reconsider that decision. The Board's major reasons for upholding CMS's position in that case were:

- CMS's reading of the Act is based on the plain wording of the IMD exclusion and of the exception for "inpatient psychiatric hospital services for individuals under age 21."

- The Act and the regulations clearly indicate that the exception makes FFP available only for inpatient services provided by a qualifying IMD.

- The legislative history of the IMD exclusion and its exception are consistent with CMS's reading of the statutory language.

- Since at least 1994, CMS policy issuances have clearly set out CMS's reading that the exception does not make FFP available for services provided outside of the qualifying IMD by other providers.

- While the expectation is that an IMD that qualifies for the exception will provide care and services to meet the child's medical needs, that does not mean that FFP is available for medical services provided by other hospital or non-hospital providers outside of the IMD.

Virginia offers no persuasive reason for us to reconsider this analysis, or to determine that Virginia lacked notice of CMS's reading.

Virginia's alternative arguments raise a factual issue – which, if any, of the claimed services are allowable under the Virginia State Plan as payment for "inpatient psychiatric services for individuals under age 21." As discussed below, Virginia's evidence indicates that some of the claims may be allowable, but falls far short of establishing which particular claims were allowable. Contrary to what Virginia suggests, its State Plan provision excluding payment for "professional services" from the per diem rates for residential treatment facilities refers only to reimbursement for professional services in those facilities provided by participating providers. This plan provision does not imply that all professional services provided to facility residents qualify as inpatient psychiatric services, no matter where they are provided or by whom. Moreover, the plan provision was not effective until 2000 and does not apply to IMDs that are not residential treatment facilities. Yet, Virginia's claims system lacked any controls to ensure that non-IMD claims were not for services for which the IMDs had already been reimbursed through their per diem rates. Virginia's summary analysis of the claims data does not address this concern.

Virginia provided during this appeal a revised data analysis that indicates that some of the services at issue here were psychiatric services and/or that they were inpatient services. CMS reasonably rejected this analysis as insufficient to meet Virginia's burden to show what claims were allowable. This analysis does not establish which, if any, services were provided by a qualifying IMD as part of its inpatient psychiatric services. Virginia recently submitted another analysis to show that some of the claims were submitted by IMDs. CMS has not yet had an opportunity to review that data. Thus, our decision would not preclude a reduction in the disallowance amount if CMS accepts that data as showing which of the services were provided by a qualifying IMD. CMS may, of course, require supplementary information from Virginia to ensure that the IMDs did not already receive reimbursement for these services through the IMDs' per diem rates.

Below, we first set out the legal and factual background to this case. We then provide an analysis of first Virginia's legal arguments and then its alternative factual arguments.

Legal Background

Title XIX of the Act establishes the Medicaid program, in which the federal government and the states jointly share in the cost of providing health care to low-income persons and families.[1] Each state operates its own Medicaid program in accordance with broad federal requirements and the terms of its Medicaid state plan.

Section 1903(a)(1) of the Act makes FFP available on a quarterly basis (at a rate called the "Federal medical assistance percentage") for amounts expended "as medical assistance under the State plan . . . ." The term "medical assistance" is defined in section 1905(a) of the Act. That section begins by defining the term to mean payments for "the following care and services" if they meet certain conditions and are provided to specified eligible individuals, and then lists various categories of services that either must or may be covered under a State Medicaid plan. Some of the service categories for inpatient services include the parenthetical "(other than services in an institution for mental diseases)."[2] Also, the list includes "inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases." Act § 1905(a)(14). After the list of services, the definition of "medical assistance" contains the following language:

> [E]xcept as otherwise provided in paragraph (16), such term does not include–
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> * * *
>
> (B) any such payments with respect to care or services for any individual who has not attained 65 years of age

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[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

[2] The term "institution for mental diseases" is defined in subsection 1905(i) of the Act to mean "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

> and who is a patient in an institution for mental diseases.

(Emphasis added.)

Paragraph (16) identifies (as one of the categories of service for which payment qualifies as "medical assistance") "inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h)."

Subsection (h)(1) of section 1905 states:

> For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only–
>
> (A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital . . . or in another inpatient setting that the Secretary has specified in regulations;
> (B) inpatient services which, in the case of any individual (i) involve active treatment . . . , and (ii) a team . . . has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and
> (C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22; . . .

(Emphasis added.) Subsection (h)(2) provides, essentially, that states must maintain efforts prior to 1971 to fund either such services or outpatient services to eligible mentally ill children from non-federal funds.

The general IMD exclusion in section 1905(a) of the Act is implemented by regulations that address limitations on funding for "[i]nstitutionalized individuals." Specifically, section 435.1008 of 42 C.F.R. provides:

> (a) FFP is not available in expenditures for services provided to–
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> * * *
>
> (2) Individuals under age 65 who are patients in any institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

See, also, §§ 436.1004; 441.13(a). The phrase "[i]n an institution" refers to "an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements." 42 C.F.R. § 435.1009.

Section 440.160 defines "[i]npatient psychiatric services for individuals under age 21" to mean services that–

> (a) Are provided under the direction of a physician;
> (b) Are provided by –
> (1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
> (2) A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.
> (c) Meet the requirements in § 441.151 of this subchapter.

(Emphasis added.) Section 441.151 contains general requirements for inpatient psychiatric services for individuals under age 21. Other provisions in subpart D of part 441 of 42 C.F.R. explain other requirements from section 1905(h) of the Act, such as the requirements regarding the need for services on an inpatient basis and for active treatment, as well as the maintenance of effort requirement. "Active treatment" is defined to mean "implementation of a professionally developed and supervised individual plan of care," and the plan of care must be based on a "diagnostic evaluation of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation . . . ." 42 C.F.R. §§ 441.154, 441.155 (emphasis added).

Factual Background

The OIG conducted a review "to determine if controls were in place to preclude [Virginia] from claiming Federal financial

participation (FFP) under the Medicaid program for all medical services, except inpatient psychiatric services, provided to residents of institutions for mental diseases (IMDs) under the age of 21." VA Ex. 19, Executive Summary at i. The reviewers determined that Virginia improperly claimed FFP for medical services provided to IMD residents under the age of 21 "because it did not have controls in place to preclude FFP from being claimed for medical services provided to IMD residents under the age of 21." Id. The review also found that the Commonwealth did not have adequate procedures to identify all Medicaid-eligible patients in the IMDs. According to the reviewers, this resulted in 119,922 improper claims out of the 132,135 claims reviewed for the audit period (July 1, 1997 through June 30, 2001). Id. The auditors identified the services as inpatient acute care, or physician, pharmacy, outpatient hospital and clinic, or other medical services. Id. at 4.

Based on the audit report, CMS disallowed $3,948,532 in FFP in the claims identified by the auditors as improper. CMS determined that the "only exception to the IMD exclusion is the inpatient psychiatric hospital coverage authorized by paragraph [1905(a)(16)] for individuals under age 21." VA Ex. 23, at 2nd unnumbered page. CMS concluded that, "[t]o claim for 'inpatient psychiatric services for individuals under the age of 21,' [Virginia] must document, at a minimum, that the costs are psychiatric hospital services provided in and by an IMD," but that Virginia had not done that. Id. CMS found that "[s]ome of the services challenged were clearly provided outside the IMD - approximately $800,000 in outpatient hospital costs and $17,000 in inpatient acute care costs that were furnished in other facilities." Id. at unnumbered pages 2-3. For the remaining costs, CMS found that Virginia "has not demonstrated where the services were provided." Id. Finally, CMS found:

> Even if the challenged services were provided in and by an IMD, [Virginia] has not documented that payment for the services is consistent with the payment methodology established in its state plan in psychiatric services. According to the Virginia state plan, the per diem rate for this benefit "shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services." While the physician services are services that are thus excluded from the per diem rate, neither the State plan nor any documented State policy or procedure establish that these physician services are a component of inpatient psychiatric hospital services.

Id.

Analysis

On appeal, Virginia does not deny that it has the burden of establishing that its Medicaid claims are allowable. Virginia asks the Board, however, to reconsider its decision in New York, upholding CMS's position on the scope of FFP available for services to children in IMDs. According to Virginia, it believes that "neither the statute nor any regulation compels the Board's holding in that case," that the relevant statutory language is ambiguous, and that "CMS's interpretation is unreasonable in light of the statute's context, the regulatory history, and the therapeutic consequences of not covering the full range of medically necessary services for children with mental illness. VA Br. at 1-2. Virginia acknowledges that the Board decided in New York that CMS policy issuances in 1994 put states on notice of CMS's policy. Virginia argues, however, that those issuances were not sufficient to put Virginia on notice and that Virginia reasonably relied on its interpretation of the statute to the contrary. Virginia alternatively argues that its data analysis, identifying which claims were for psychiatric services and/or for services provided in an inpatient setting, provides a basis for reducing the disallowance amount.

Below, we first discuss Virginia's legal arguments. We then discuss Virginia's data analysis.

1. The statutory language is not ambiguous.

Virginia argues that "both statute and regulation are ambiguous" and that the "CMS policy – while technically plausible – is an unreasonable interpretation that disregards legislative history, regulatory background, and therapeutic practice." VA Br. at 5. "While the IMD exclusion does make clear that federal funding is not available for IMD services furnished to IMD residents under age 65," Virginia contends, "nothing in the language of Section 1905(a) clearly indicates that federal funding is unavailable for *other* Medicaid services to IMD residents." Id. (italics in original). According to Virginia, the "general exclusion of FFP for 'care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases' could refer either to the care or services provided in an IMD, or to all services listed in Section 1905(a)." Id. Virginia argues that the "former, more narrow reading is supported by the exclusion's placement in the list of reimbursable Medicaid services, rather than in the eligibility section" and "is consistent with the fact that the three

institutional services included in section 1905(a) – inpatient hospital services, skilled nursing facility services, and services provided in intermediate care facilities – are expressly limited to settings other than IMDs." Id. at 5-6 (italics in original), citing Act §§ 1905(a)(1), (a)(4)(A), and (a)(15).

These arguments are not persuasive, for the following reasons. First, the general IMD exclusion provides broadly that the term "medical assistance" (for which FFP is available) does not include "any such payment" for services provided to an individual who is under age 65 and in an IMD. In other words, it qualifies the part of section 1905(a) defining "medical assistance" as payment of part or all of the costs of the listed services when provided to eligible individuals. Virginia's narrow reading ignores the effect of the reference to any such payment, which clearly is not limited to payments for institutional services, as Virginia suggests.

Second, the fact that the parenthetical phrase "other than in an IMD" appears in the coverage description for institutional services such as inpatient hospital services means that the general IMD exclusion language would be superfluous if Congress intended to exclude from "medical assistance" only the institutional services provided in an IMD. Thus, the existence of these parenthetical phrases in section 1905(a) does not support Virginia's reading.

Contrary to what Virginia asserts, moreover, there is no separate "eligibility section," and the IMD exclusion is not part of the list of services. Instead, section 1905(a) addresses both who may be eligible under Medicaid and what services may be covered. The general IMD exclusion language follows the list of services and refers back to the lead-in language of the section, defining "medical assistance" as "payment of part or all of the cost of the following care or services" when other specified conditions are met, including the eligibility of the individual to whom the care or services are provided.

As the Board noted in New York, moreover, Congress created the exception not only by adding paragraph (16) to section 1905(a) but by adding the phrase "except as otherwise provided in paragraph (16)" before the general IMD exclusion and after the list of services. Pub. L. No. 92-603 (1972 Amendments). Paragraph (16) itself provides for only one category of Medicaid service – inpatient psychiatric hospital services for individuals under age 21 as defined in subsection (h). That subsection in turn defines those services to mean "only" those inpatient services that are provided under the direction of a physician in

a qualifying institution and meet other specified requirements. Virginia points to nothing in the statutory language of the exception or in paragraph (16) from which it logically follows that the exception was intended to make FFP available for all services to children in IMDs, no matter who provides the services or where they are provided.

In sum, the statutory language is unambiguous both with respect to the scope of the general IMD exclusion and with respect to the scope of the exception.

2. The legislative history is consistent with CMS's reading of the statute.

Virginia argues that "there is nothing in the legislative history of the exclusion that required CMS to interpret it as precluding FFP for all services." VA Br. at 6. Virginia characterizes the Board's decision in New York as recognizing that "Congress enacted the IMD exclusion because it wanted to ensure that States continued to fund inpatient psychiatric treatment, which had been a traditional state responsibility." Id. According to Virginia, however, this fact "does not answer whether non-psychiatric medical services provided to inpatients must necessarily also be considered a State-only responsibility." Id. Virginia points to legislative history of the Medicaid statute which Virginia says "suggests that Congress affirmatively sought to encourage the provision of medical services to individuals with mental illness, in order to promote more positive outcomes." Id. For example, Virginia points out that Congress required any state seeking federal reimbursement for IMD services for the aged to comply with the standards at sections 1902(a)(20) and (21) of the Act, including that the state assure that the institutional care of the patient "is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, [and] that he will be given appropriate medical treatment within the institution." Id. at 6-7, quoting section 1902(a)(20)(B) of the Act.

In light of this history, Virginia argues that --

> one would expect some explanation from Congress if, in 1972, it intended to provide coverage for inpatient psychiatric coverage for children, as it had for those over 65, but not to cover other necessary medical services. Yet there is not even a glimmer of such an explanation in the statute or legislative history.

Id. at 7. Virginia asserts instead that–

> the history confirms that Congress was concerned with ensuring therapeutic results. The provision was necessary, Congress stated, because "the nation cannot make a more compassionate or better investment in medicaid than this effort to restore mentally ill children to a point where they may very well be capable of rejoining and contributing to society as active and constructive citizens." S. Rep. No. 92-1230, at 281 (1972)(attached as Ex. 4). The 1972 legislation accordingly provided that FFP would be available only after "an independent review team consisting of medical and other personnel qualified to make such determination" had determined that the active care and treatment to be provided can reasonably be expected to result in significant improvement in the mental condition of such individual leading to the eventual discharge from the institution." H.R. Rep. No. 92-1605, at 65 (1972)(Conf. Rep.)(attached as Ex. 5).

Id. at 7-8. Virginia argues further that there was no need for Congress to specify that medical care would be a key component of inpatient psychiatric hospital services for individuals under age 21 because Congress had previously enacted the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit in 1967. Id. at 8, citing Social Security Amendments of 1967, Pub. L. No. 90-248, § 302 (1968), VA Ex. 3. Virginia speculates that CMS's position and the New York decision "turn on the fact that Congress used different language to create the exception to the IMD exclusion for the under-21s than it did for the over-65s." Id. According to Virginia, this difference "is meaningless if (as appears to be the case) Congress did not interpret the IMD exclusion as excluding other types of services and intended its 1972 legislation to complete the package of services available to children, not to provide them only with inpatient psychiatric services at the expense of all other necessary care." Id.

These arguments have no merit. Virginia's reliance on the legislative history of the exclusion to determine congressional intent is misplaced, given the plain language of the statute, discussed above. Even if the statute were ambiguous and even if nothing in the legislative history required CMS to interpret the exclusion as precluding FFP for all services (and we accept neither premise), that is irrelevant. Virginia has pointed to nothing in the legislative history that directly conflicts with CMS's reading of the statute.

The legislative history of the IMD exclusion does not, as Virginia suggests, refer to the "States' traditional responsibility" as extending only to psychiatric treatment. Instead, it mentions public and private mental hospitals and states that "long-term care in such hospitals had traditionally been accepted as a responsibility of the State." S. Rep. No 44, 89th Cong. 1st Sess. (1965); VA Ex. 1. Congress later defined an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Act § 1905(i)(emphasis added). Even before this clarifying amendment, moreover, Congress took steps indicating it viewed the states' traditional responsibility as encompassing all services for institutionalized individuals, not just the psychiatric treatment. From its inception, section 1905(a) has also excluded from the definition of "medical assistance" any payment for services provided by a public institution, other than a medical institution. The separate IMD exclusion for individuals under age 65 was needed since state mental hospitals could be considered "medical institutions" despite their public nature. Thus, Congress did not view the states' traditional responsibility as being narrowly limited to psychiatric treatment (to the exclusion of needed medical services).

In light of the statutory purpose of the IMD exclusion, it makes sense to apply it not just to payment for services provided in IMDs but to any payment for services that are provided to individuals in IMDs who are under age 65 and are not the services that are specifically excepted from the exclusion. Otherwise, a state could (at least in part) avoid its traditional responsibility for care of institutionalized individuals simply by sending them outside of the institution to get the services.

Neither CMS's reading of the statute nor the Board's analysis in New York suggests that, unlike the aged receiving IMD services under section 1905(a)(14) of the Act, children in IMDs should not receive services to meet their medical needs. To the contrary, the statute and regulations set out above make clear that, to qualify for the exception, a child had to be receiving "active treatment," under the direction of a physician, based on a plan of care developed by an interdisciplinary team after assessment of the child's needs, including the child's medical needs. Virginia is correct that, unlike the requirements for IMD services for the aged in sections 1902(a)(20) and (a)(21) of the Act, the statutory definition of "inpatient psychiatric services for individuals under age 21" does not explicitly refer to "medical services." Yet, Congress clearly expected that children

who qualify for the exception would get whatever care and treatment they needed, and the definition of "active treatment" in the regulations as including services under a plan of care to meet assessed medical needs is a longstanding one. See 41 Fed. Reg. 2198, 2199 (Jan. 14, 1976)(45 C.F.R. § 249.10(b)(16)(iv)).

Contrary to what Virginia suggests, the issue here is not whether the children should receive the medical services they need, but whether FFP is available for those services. If medical and other services are provided on an inpatient basis by the IMD in which the child resides and meet the other requirements for "inpatient psychiatric services for individuals under age 21" in the statute and regulations, FFP is available. Otherwise, the services are Virginia's responsibility.

We also note that CMS's conclusion that the hospital or other facility in which the child is receiving inpatient psychiatric services should also be providing services to meet the children's medical needs is supported by Virginia's own evidence. Specifically, the declaration by Virginia's Mental Health Policy Analyst (who is a board certified psychiatric mental health clinical nurse specialist) attests that "[i]t is well accepted in the mental health field that if a psychiatric patient's physical needs are untreated, his or her mental illness cannot be effectively treated"; that "[m]any psychiatric disorders have their origins in medical disorders"; that "[t]o properly evaluate and treat a newly admitted patient, inpatient psychiatric facilities must order appropriate medical tests designed to determine whether the patient's symptoms have an underlying physical cause"; and that the "administration of medication to persons with mental illness requires active medical monitoring." Declaration (Decl.) of Catherine K. Hancock, RN, PMHCNS, BC, at ¶¶ 3-6, VA Ex. 25; see also, VA Ex. 25, Attachment (Att.) B (inpatient care may be justified if "the individual suffers one or more complicating concurrent medical disorders which the family is not effectively addressing"). Since such medical services are integral to assessing and meeting the child's needs, they are certainly part of the "active treatment" the statute and regulations contemplated would be provided by qualifying IMDs.

In light of the statutory language and history as a whole, the fact that the legislative history of the exception does not specifically mention medical services simply does not have the significance Virginia says it has.

Moreover, as the Board discussed in New York, at 10-11, the legislative history of the exception to the IMD exclusion is consistent with CMS's reading that the exception was created only

for a particular category of service. For example, while the Senate Report on the bill that became the 1972 Amendments to the Act refers to "Medicare Coverage of Mentally Ill Children," it also states that the "committee bill would authorize coverage of inpatient care in mental institutions for medicaid eligibles under age 21, provided that the care consists of a program of active treatment, that it is provided in an accredited medical institution, and that the State maintains its own level of fiscal expenditures for the care of the mentally ill under 21." S. Rep. No. 1230, 92d Cong. 2d Sess., 57 (emphasis added); see also H.R. Rep. No. 1605, 92d Cong, 2d Sess., at 65 (referring to "the institutional care and services authorized under the Senate amendment"). In other words, Congress viewed itself as authorizing only limited coverage of institutional care and services for individuals under age 21 provided in and by qualifying IMDs, not as authorizing coverage of Medicaid services provided by other types of providers to such children.

In sum, Virginia's arguments do not persuade us that Congress intended to fund all services to children in IMDs, no matter who provides those services or where they are provided. Instead, Congress intended to fund only services that meet the requirements for inpatient psychiatric services to individuals under age 21, including those psychiatric, medical, and other services provided by a qualifying IMD on an inpatient basis under a plan of care for active treatment.

3. Prior regulations do not represent a contemporaneous interpretation of the exception that was later changed.

Virginia argues that "CMS's contemporaneous regulations after the 1972 amendment was enacted support the interpretation of the statute that as long as children are receiving inpatient psychiatric services (as defined by the statute), they are not subject to the IMD exclusion." VA Br. at 9. Specifically, Virginia relies on 45 C.F.R. § 248.4(b)(2)(1974)(VA Exhibit 6). That section provided:

> Federal financial participation is not available for care or services provided to any individual . . . who is under age 65 and a patient in an institution for . . . mental diseases (see exception in paragraph (b)(1)(i) of this section for individuals under age 22). *See* § 248.60.

The exception in paragraph (b)(1) provided that "[e]xcept for the exclusion in paragraph (b)(2), and subject to the provisions of paragraphs (b)(3) and (4) of this section and of Part 250 of this

chapter," FFP is available in "payments for medical care and services provided under the State plan to any financially eligible individual who is . . . [u]nder the age of 21 (or under the age of 22 and receiving inpatient psychiatric hospital services pursuant to § 249.10(b)(16) of this chapter)." Virginia notes that this provision was eliminated as part of the redesignation of Medicaid regulations in 1978 (which had previously been recodified in 42 C.F.R. Part 448), but asserts that "the surviving regulation" at 42 C.F.R. § 435.1009(a)(2) "continues to suggest that FFP is available for *all* services provided to individuals under age 22 in an IMD as long as they are "receiving inpatient psychiatric services." VA Br. at 9-10.

This argument has no merit. First, the provision on which Virginia relies is an eligibility provision which simply recognizes that the broad ineligibility that results from the IMD exclusion does not apply to children receiving inpatient psychiatric services authorized under section 1905(a)(16) of the Act. It is silent on whether, once a child is receiving those services, FFP is available for other services as well. Second, the provision on which Virginia relies was part of the implementation of different provisions of the 1972 Amendments - those establishing the Supplemental Security Income Program in title XIV of the Act. See 39 Fed. Reg. 9517 (Mar. 11, 1974).

The regulation implementing section 1905(a)(16) of the Act was first codified at 45 C.F.R. § 249.10 in 1976. The preamble to the rulemaking initially adopting this regulation described the statutory provision at section 1905(a)(16) as "specifying that States may provide inpatient psychiatric services for individuals under age 21, as an optional item of medical care in their State Medicaid plans . . . ." 41 Fed. Reg. at 2198 (emphasis added). The preamble also states that "reimbursement to States for providing inpatient psychiatric services to patients under 21 is contingent on meeting maintenance of effort requirements . . . ." Id. The "limitations" provision in the original section 249.10(c) contained the following language, similar to that on which Virginia relies:

> Federal financial participation in expenditures for medical and remedial care and services listed in paragraph (b) of this section is not available with respect to any individual . . . who has not attained 65 years of age and who is a patient in an institution for . . . mental diseases (except for an individual under age 22 who is receiving inpatient psychiatric facility services pursuant to paragraph (b)(16) of this section).

Id. at 2199. Nothing in the relevant preamble, however, indicates that the 1972 Amendments that enacted the exception were viewed as broadly authorizing FFP for all Medicaid services provided to children receiving inpatient psychiatric services or that the Secretary viewed the regulatory wording of the limit on FFP in section 249.10(c) as interpreting the scope of the exception.[3] In other words, this language addresses when no FFP is available for institutionalized individuals, but does not specify the scope of FFP available for services to children who are institutionalized in qualifying IMDs.

We also note that, at the time this language was drafted, the exception was being interpreted as applying only to services provided by "inpatient psychiatric hospitals." 40 Fed. Reg. 13,142 (Mar. 24, 1975)(proposed § 249.10(b)(16)). It was not until the final rule in 1976 that, in response to comments, this Department determined to interpret the phrase "inpatient psychiatric hospital services" to include such services in accredited facilities that were not hospitals. 41 Fed. Reg. at 2198.[4] The final rule made this change to recognize "the efforts many facilities have made to provide inpatient psychiatric care to individuals under age 21 in an environment consistent with current health care delivery practices" and legislative intent. Id. Nothing in the rulemaking implementing this change, however, indicates that by allowing non-hospital facilities to qualify to provide "inpatient psychiatric services," the Medicaid program was permitting states to claim FFP for medical services provided outside these facilities. Moreover, as noted above, the same regulation required that an active treatment plan be based on an assessment that included the child's medical needs. Also, to qualify, a facility had to provide the services under the direction of a physician. As early as 1976, the *Medical Assistance Manual* explained this requirement by stating that a physician "is the appropriate individual to direct the total

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[3] Virginia notes that 45 C.F.R. §§ 248.4(b)(2) and 248.60 were recodified at 42 C.F.R. § 435.1009, after first being recodified as 42 C.F.R. §§ 448.4(b)(2) and 448.60 and then being recodified as 42 C.F.R. § 435.1008. VA Br. at 9, n. 3, and materials cited therein. Virginia is correct, therefore, that it was not section 249.10(c) that became section 435.1008. Section 249.10(c) was recodified as 42 C.F.R. § 449.10(c) and then as section 441.13, which uses parallel language.

[4] Congress effectively ratified this interpretation when it added to 1905(h)(1)(A) the phrase "or in another inpatient setting that the Secretary has specified in regulations."

health care of patients in a psychiatric facility" and "has the necessary authority to take responsibility and make emergency medical decisions affecting patients." VA Ex. 8.

In New York, this Board gave several additional reasons why, even if the regulatory wording on which New York relied (and Virginia relies) could be read as implying that FFP is available in expenditures for all services for individuals under age 22 who are receiving inpatient psychiatric services, New York could not reasonably rely on that implication as interpreting the scope of the exception. First, the statute (and other regulatory provisions) clearly define what services qualify under section 1905(a)(16), defining them as inpatient services that are provided by an accredited psychiatric hospital, hospital program, or other facility.

Second, prior to 1985, the Medicaid regulations provided FFP for noninstitutional services provided to an otherwise Medicaid-eligible individual during the month in which the individual was admitted to an IMD. In amending the regulations to delete this provision in 1985, CMS explained that it had provided this FFP for reasons of administrative convenience, but had determined that its regulation was inconsistent with the statutory exclusion. Thus, the preamble to this rulemaking said the amendment was bringing the "regulations into conformance with the Medicaid statute by clarifying that no [FFP] is available for any services furnished to certain institutionalized individuals." 50 Fed. Reg. 13,196 (Apr. 3, 1985). The preamble also described this clarification as meaning that "the exclusion in the statute and regulations applies to both services provided by the institution and to services rendered by other Medicaid providers to institutionalized individuals in the types of facilities specified by the law." Id. The preamble also states that the "only legal exceptions to the preclusion of FFP for . . . patients in institutions for mental diseases . . . are those which are specified in the law at section 1905(a) of the Act." Id. The preamble to the notice of proposed rulemaking for this amendment stated: "Section 1905(a) . . . prohibits Federal payments for services provided to . . . individuals under age 65 who are patients in an institution for mental diseases . . . except for inpatient psychiatric services received by individuals under age 22." 48 Fed. Reg. 13,446 (March 31, 1983); see also 59 Fed. Reg. 59,624 (Nov. 17, 1994); 63 Fed. Reg. 64,195 (Nov. 19, 1998).

In sum, the history and context of the regulatory wording on which Virginia relies indicates that it was intended only to recognize that the exception existed. The provision was not

intended as an interpretation that the exception made FFP available for all Medicaid services for children receiving inpatient psychiatric services, no matter who provides the services or where they are provided.

4. Virginia had timely, actual notice of how CMS read the statute.

In New York, the Board found that New York had actual notice of how CMS reads the exception from a *State Medicaid Manual provision* issued 1994 that states:

> The IMD exclusion is in 1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21.

State Medicaid Manual, § 4390.A.2.(emphasis added).

Virginia acknowledges that the Board found in New York that the *State Medicaid Manual* provision put states on notice of CMS's reading.[5] Virginia argues, however, that this provision did did not provide "sufficient" (or "effective") notice to Virginia because it was published more than 20 years after the statutory exception was enacted and is inconsistent with other provisions of the *State Medicaid Manual* and because Virginia had to meet the requirements of the EPSDT program. Virginia also says that every state audited by the OIG failed to understand and apply the exception to the IMD exclusion and was "taken by surprise" with the OIG's position during the audit. VA Br. at 2, 14.

These arguments have no merit. The *State Medicaid Manual* provision from 1994 is consistent with many earlier statements

[5] In New York, the Board also found that New York had notice through a 1994 memorandum from the Director of the Medicaid Bureau to the Regional Administrator for New York that specifically states that "FFP is not available for other Medicaid services provided to individuals under age 21 while they are patients in IMDs, even though they may have temporarily left the facility to receive medical services." New York at 13. Virginia points out that there is no evidence that this memorandum was ever provided to it.

about the scope of the exception in the regulatory preambles cited above. Indeed, as CMS points out here, the same wording appeared in section 4390 of the *State Medicaid Manual* as early as 1986. CMS Ex. 3. Thus, it is a not a belated reading of the statute, as Virginia suggests.

The other provisions of the *State Medicaid Manual* which Virginia says are inconsistent have to do with calculating the costs of a waiver of Medicaid requirements under section 1915 of the Act. They are general provisions that were not intended to provide guidance about scope of the IMD exclusion or the scope of the exception. See VA Exs. 11 and 12. Virginia could not reasonably rely on them and provided no evidence that it did in fact rely on them as establishing what FFP is available for services to children who reside in IMDs.

With respect to Virginia's claim that CMS's position conflicts with EPSDT requirements, we rejected a similar argument in New York. New York at 24-25. As CMS points out, moreover, the Director of the Medicaid Bureau issued a policy statement in 1991 (well before the disallowance period) that said that the "fact that a need for the services was determined through an EPSDT screen would not provide a basis for paying for services for which we otherwise could not pay because of the IMD exclusion." CMS Ex. 4.

Finally, in response to Virginia's argument that the audited states were surprised, CMS points out that audits like the ones in Virginia were conducted in only seven states, and that officials in four of them either acknowledged that it was improper for outside medical providers to claim for services provided to children in IMDs or agreed that the only service to children in IMDs for which FFP could be claimed was inpatient psychiatric services. See CMS Ex. 5, at 4 and App. C; CMS Ex. 6, at 6-7; CMS Ex. 7, at App.; CMS Ex. 8, at App. B. Virginia provided nothing to rebut CMS's assertions, which are supported by the cited documents.

5. Virginia did not show it reasonably relied on its own interpretation when claiming FFP for the services at issue.

Virginia also argues that it relied on CMS's approval of its State Plan provision for reimbursement of residential treatment facilities, which allows it to pay a per diem rate that excludes professional services. Virginia submitted a declaration by Victoria Simmons, who was a Regulatory Coordinator for Virginia from 1986 to 2004. VA Ex. 27. Ms. Simmons states that she was

involved in the submission of State Plan Amendments (SPAs) 99-11, 01-01, 02-06, and 03-03, and has consulted with other knowledgeable staff. Id. at ¶ 3. She says that, in her experience, CMS often raised questions when a State Plan section was being amended. Id. at ¶ 5. She also says that the files for the referenced SPAs "contain no documentation of any communication from CMS representatives stating that there was a CMS policy prohibiting FFP in the cost of medical services provided to children in IMDs" nor "any documentation of CMS communications stating that the reimbursement methodology might make it more difficult for [Virginia] to receive FFP in payments for the professional services component of Residential Psychiatric Treatment Services." Id. at ¶ 6. Ms. Simmons states her belief, based on her experience and knowledge of Virginia's practices, that "Virginia would have implemented a different reimbursement methodology for Residential Psychiatric Treatment Services if CMS representatives had informed us that professional services to children in IMDs had to be reimbursed as part of the rate for inpatient psychiatric treatment services." Id. at ¶ 8.

Virginia submitted parts of its State Plan provisions describing the payment methodology for "[i]npatient psychiatric services in residential treatment facilities (under EPSDT)" effective January 1, 2000 and approved on February 3, 2000 and November 13, 2001. VA Exs. 16 and 17. (The provision at Virginia Exhibit 18 was not approved until March 5, 2004, after the end of the disallowance period.) Each of the relevant provisions states:

> Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by the participating providers, under the terms and payment methodology described below.
>
> A. Methodology. Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.

VA Exs. 16 and 17 (emphasis added).

In our view, the language excluding professional services has to be read in the context of the lead-in language, which shows that

it is addressing services provided "in" the residential treatment facilities and implies that it means services provided by those facilities, consistent with the federal regulations. We also note that Virginia did not submit to us copies of the State Plan reimbursement provisions in effect for residential treatment facilities prior to January 1, 2000, the provisions it did submit are incomplete and do not include the terms for payment, and Virginia did not include State plan provisions addressing reimbursement of providers of inpatient psychiatric services in psychiatric hospitals or other facilities that are not residential treatment facilities. Yet, the audit covered all IMDs in Virginia, including public and private hospitals as well as residential treatment facilities. VA Ex. 19, Appendix A.

As CMS points out, moreover, it is not surprising that, in the context of reviewing the State Plan provisions for residential treatment facilities, CMS would not have provided the warning Virginia says it would have expected. Whether professional services provided in IMDs are allowable does not depend on whether they were included in the per diem rate or billed separately, but on whether they are "inpatient psychiatric services" meeting federal requirements.

Finally, Virginia has provided no evidence to show that it in fact had and relied on an interpretation that FFP is available for services not qualifying as inpatient psychiatric services under the federal regulations. From the audit report findings, it appears instead that Virginia simply had no controls or procedures to preclude payments for services separately billed for children in IMDs, even if they were for services that were included in the per diem rates or were not for professional services provided in and by IMDs that could be separately billed under the State Plan. VA Ex. 19, at 3.

6. Virginia's data analysis submitted with its reply brief is insufficient to show which, if any, of the disallowed claims were allowable.

Virginia's alternative arguments in support of its position that the disallowance amount should be reduced raise an issue of fact regarding which, if any, of the claimed services are allowable under the Virginia State Plan as payment for "inpatient psychiatric services for individuals under age 21." To support reduction of the disallowance amount, Virginia first relied on a declaration of William J. Lessard, Jr., Director of Provider Reimbursement for Virginia, explaining why he thought the disallowance calculations were wrong and why the amount should be reduced by the amount of services his staff had determined were

psychiatric services. VA Ex. 26. After CMS had responded, Virginia withdrew this declaration and substituted a revised declaration by Mr. Lessard. VA Ex. 29. In this declaration, Mr. Lessard explains how he had asked his staff to analyze the claims data from the auditors and other data based on various codes associated with the claims. Attachment A to this declaration is a summary chart, based on this data analysis, which breaks down the disallowed amounts into four service categories (professional, pharmacy, outpatient hospital/clinic, and others), identifies amounts that the data analysis classified as "psychiatric" or "non-psychiatric" for each category, and, for the category "professional services," further identifies the amounts as inpatient or non-inpatient services. Mr. Lessard's revised declaration explains that his staff determined whether a professional service was provided "in an inpatient setting" by determining from state claim files whether the place of service (POS) code was Code 21. VA Ex. 29, at ¶ 9.

Attachments to the revised Lessard declaration include the code descriptors for the procedure and diagnosis codes Virginia used to classify services as "psychiatric" or "non-psychiatric" and a chart showing how Virginia classified the medications associated with the pharmacy claims as "psychiatric" or "non-psychiatric." VA Ex. 29, Atts. B-D. Virginia did not submit a descriptor for POS Code 21. In addition to relying on Code 21 as showing that some professional services were provided on an inpatient basis, Mr. Lessard states: "I believe that all of the pharmacy claims ($979,624) would have been provided in the inpatient setting." Id. at ¶ 9.

Based on Mr. Lessard's revised declaration, Virginia's reply brief offers three alternatives for reducing the disallowance amount:

> 1) Allow all of the amounts Virginia's data analysis identified as psychiatric services and disallow only the $1,567,045 the analysis identified as non-psychiatric services;
>
> 2) Allow all of the amounts Virginia's data analysis identified as services provided in an inpatient setting through use of place of service Code 21, plus the amounts for pharmacy services, and disallow only the remaining $1,625,862; or
>
> 3) Allow all of the amounts identified as both psychiatric and as inpatient claims, plus the amount for

> pharmacy services and disallow only the remaining $2,245,764.

Reply Br. at 13.

Since Virginia provided new evidence with its reply brief, the Board provided CMS an opportunity to respond. CMS's surreply notes, among other things, that it did not have data through which it could verify Virginia's classification of claims based on the place of service code used. With its surreply, CMS presented documentation, based on information provided by Virginia during the audit, that shows what costs might have been included in the per diem rates for both residential treatment facilities and other facilities providing inpatient psychiatric services. CMS Exs. 9, 10.

We decline to reduce the disallowance amount based on the revised Lessard declaration and the associated data analysis. While this information indicates that some of the claims may be allowable, it falls far short of establishing that any particular claims are allowable, for the following reasons.

First, contrary to what Virginia suggests, the relevant State Plan provisions excluding payment for "professional services" from the per diem rate for residential treatment facilities does not broadly cover <u>any</u> professional services, so long as they are psychiatric services. Instead, as noted above, the provisions authorize payment only for "inpatient psychiatric services <u>in</u> residential treatment facilities provided by participating providers." VA Exs. 15-17. Moreover, what information we have regarding the rate-setting for psychiatric hospitals suggests that the per diem rates may have included reimbursement for professional services and did include reimbursement for pharmacy services. CMS Exs. 9, 10; VA Ex. 25, Att. A (rate for free-standing inpatient psychiatric hospitals is an "all-inclusive rate" except that the "psychiatric and professional component may be billed separately").

Second, it is not enough that Virginia has shown that some of the services at issue here were <u>psychiatric</u> services. In order to meet its burden to show that these claims were allowable, Virginia had to show that the services were <u>provided by</u> the facility as part of its inpatient psychiatric services. It is not reasonable to infer merely from the fact that some of the claims had diagnosis or other codes that led Virginia to classify them as "psychiatric" that those claims were part of the inpatient psychiatric services provided by the IMDs. Indeed, some of the claims classified as "psychiatric" were for service

categories (such as outpatient hospital or clinic services) which clearly would not be part of the inpatient psychiatric services provided by the IMDs. Moreover, given that Virginia had no controls to determine whether claims related to children in IMDs were allowable, it is possible that service providers who were regularly providing psychiatric services to children before they were admitted to the IMDs simply continued to submit claims.

With respect to Virginia's analysis regarding the setting in which the services were provided, the Board asked Virginia to provide the descriptor for POS Code 21 that Virginia used to classify some claims as "inpatient" claims. Virginia responded by informing the Board that this code is defined at the CMS web site as a "facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions." VA 12/23/08 letter (emphasis added). Virginia admits that "CMS also has distinct codes for psychiatric inpatient services" but asserts that "in Virginia's case, it appears that when the Department of Medical Assistance Services switched over to a new MMIS in 2003, all inpatient claims were coded as POS 21, even payments to IMDs." Id. This information appears to indicate that claims submitted during the disallowance period - July 1, 1997 through June 30, 2001 - with POS Code 21 would not have been provided by an IMD, but in an non-psychiatric inpatient setting. Even if the system change in 2003 change affected the claims at issue retroactively, however, use of POS Code 21 on the claims would not necessarily mean that the place of service was an IMD, rather than an acute care (non-psychiatric) hospital. Since some of the disallowed claims were for acute care hospital services, it is possible that other claimed services were provided in such hospitals rather than by the IMDs in which the children were institutionalized. Virginia's analysis based on the POS code thus does not show which, if any, of these claims are allowable as part of the inpatient psychiatric services provided by the IMDs.

We also note that Virginia asks us to allow $979,624 in pharmacy claims solely on the basis of Mr. Lessard's belief that they were inpatient services. Mr. Lessard states no reason for that belief. As CMS points out, moreover, during the disallowance period, pharmacy services provided by residential treatment facilities were not always treated as "professional services" excluded from the per diem rates, and pharmacy services provided by psychiatric hospitals were included in the per diem rates. See, e.g. CMS Exs. 9, 10. Thus, even if the pharmacy services were provided on an inpatient basis, these separate claims for

pharmacy services could duplicate payments already made through the IMDs' per diem rates.

Virginia's third alternative proposed reduction in the disallowance amount has the same flaws. Even Virginia's analysis identifying what claims were for professional psychiatric services with POS Code 21 ($945,153 in claims) is flawed, because, as discussed above, that code could have been used for claims by acute care hospitals and because costs of some of these services may have already been reimbursed through the IMDs' per diem rates.

7. Virginia's new alternative analysis indicates that some of the claims were submitted by IMDs, but CMS may request more information to ensure allowability of the claims.

After CMS had submitted a surreply to address Mr. Lessard's revised declaration, Virginia sought and was granted an opportunity to supplement that declaration. VA Ex. 30. The supplementary declaration was prepared in response to CMS's contention that, even if services were provided in an IMD, they might not have been provided by the IMD. To determine what services were provided by IMDs, Mr. Lessard asked his staff "to determine how many of the disallowed claims were paid to providers with the same tax identification numbers" as IMDs. Id. at ¶ 2. According to the supplemental declaration, the resulting analysis "shows that $658,984 were paid to providers with the same tax identification numbers as IMDs" and that "[o]f this amount, $527,672 were for professional services and the remainder was for other services." Id. at ¶ 3. Thus, Mr. Lessard concludes, "*at least* $658,954 of the amount in dispute (approximately 16 percent of the $3,948,532) were for professional and other services provided *by* the IMD, even though they were billed separately." Id. (italics in original).

CMS has not yet had a chance to respond to this most recent analysis to determine whether CMS considers it sufficient, either by itself or with some additional information, to establish that some of the claims are allowable. Thus, our decision would not preclude CMS from reducing the disallowance amount. While this information seems to address CMS's concern about whether the services were provided by the IMDs, it does not clearly address CMS's concern about whether the separately billed services (particularly those that are not professional services) were covered by the per diem rates. Thus, CMS could reasonably determine that the documentation is still inadequate.

Conclusion

For the reasons stated above, we uphold the disallowance. Our decision does not, however, preclude CMS from allowing some of the claims if it determines that the most recent analysis by Virginia, either with or without supplemental information, is adequate.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member