Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Kansas Health Policy Authority DATE: June 23, 2009
Docket No. A-09-35
Decision No. 2255

DECISION

The Kansas Health Policy Authority (Kansas) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $3,883,143 in federal financial participation (FFP) that Kansas claimed as "medical assistance" under the Medicaid program for quarters ending September 30, 2007 through June 30, 2008. "Medical assistance" is defined generally for Medicaid purposes to exclude services to individuals who are residents of institutions for mental diseases (IMDs) and are under the age of 65, but the statute provides an exception for "inpatient psychiatric hospital services to individuals under age 21." Implementing regulations make FFP available for "inpatient psychiatric facility services for individuals under age 21" provided in and by qualifying facilities as part of "active treatment" of the residents under a plan of care. CMS determined that Kansas was submitting FFP claims for health care services provided to IMD residents that did not qualify for the exception. The IMDs at issue were private psychiatric residential treatment facilities (PRTFs) that qualified to provide inpatient psychiatric facility services, but CMS determined that the health care services at issue were not part of those inpatient services.

Kansas argues that CMS approved a State plan provision permitting Kansas to make "add-on" payments to PRTFs (over and above the facilities' per diem rates) to cover the costs of the health care services at issue. Kansas also argues more generally that FFP should be available for payment for all Medicaid services provided to PRTF residents.

For the reasons stated below, we uphold the disallowance. The Board has previously held that the statutory exception to the IMD exclusion is available only for services, provided in and by a qualifying facility, meeting the statutory and regulatory requirements for "inpatient psychiatric facility services" and that states are responsible for other medical services for IMD residents. The Board has recognized that the fact that medical services are not reimbursed through a facility's per diem rate does not necessarily mean that they are not inpatient psychiatric facility services provided by the facility. Here, however, the approved Kansas State plan does not authorize any add-on payment to a PRTF for the "other health care services" at issue. Instead, the State plan defines "other health care" as services provided by "outside medical providers" and treats the costs of such services as "non-reimbursable & non-resident related expense items." The per diem rate, on the other hand, is intended to reimburse PRTFs for their resident-related costs incurred in providing services according to applicable state and federal laws, and quality and safety standards.

Given these State plan provisions and the absence of any evidence from Kansas that these services were nonetheless considered to be part of the inpatient psychiatric facility services provided by the PRTFs, CMS reasonably determined that FFP is not available. Kansas has the burden of documenting the allowability of its Medicaid claims and has not met that burden here.

Legal Background

Title XIX of the Social Security Act (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.

[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.

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)." After the list of services, the definition of "medical assistance" contains the following language:

> [E]xcept as otherwise provided in paragraph (16), <u>such term does not include</u>–
>
> * * *
>
> (B) <u>any such payments</u> with respect to 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.

(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 <u>provided in an institution</u> (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 "Institutionalized individuals." Specifically, section 435.1009 of 42 C.F.R. provides:

> (a) FFP is not available in expenditures for services provided to–
>
> * * *
>
> (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.
>
> * * *
>
> (c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

<u>See also</u> §§ 436.1005; 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. § 435.1010.

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 <u>provided by</u> –

> (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 Services for Children and Families, 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.

"Active treatment" means implementation of an individual plan of care, meeting specified requirements. 42 C.F.R. § 441.154. The plan must be "based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation." 42 C.F.R. § 441.155(b)(2). The plan must be "developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility." 42 C.F.R. § 441.156(a).

Factual Background

During 2006, Kansas submitted a Medicaid State Plan Amendment (Transmittal 06-09) that addressed the reimbursement methodology for private PRTFs. The actual language proposed by Kansas is not in the record. A letter to Kansas dated September 27, 2006 from a member of the CMS National Institutional Reimbursement Team indicates that the proposed reimbursement formula included a component for "a per diem add-on intended to reimburse facilities for the cost of 'health care services' which must be incurred by facilities for their residents." KS Ex. 1, at 2. For this purpose, the proposal defined "health care services" as "all medically necessary health care services covered by Medicaid excluding mental health and substance abuse treatment services (which are already included in the base reimbursement rate)." Id. The CMS letter noted that the "latest draft submitted by the State (on September 21, 2006) proposed to calculate a revised per diem add-on amount each quarter based on what the Kansas Medicaid program would have paid for actual 'health care services' claims from a preceding quarter." Id. The CMS letter stated that CMS was still evaluating the proposal and needed further information to assist in that evaluation, specifically, information "describing the nature of these 'health care services', the expected frequency/cost of the services, who the provider of the services will be, and how the facilities will arrange and pay for the services." Id. CMS also noted that there may be other methodologies to adequately reimburse the PRTF providers for the costs of these services and offered to work with Kansas to identify such methodologies.

Kansas asserts, and CMS does not deny, that there were "extensive discussions" between it and CMS about Transmittal 06-09. KS Br. at 2. Kansas says that, due to the typical nature of PRTFs in Kansas, it was "concerned over the need for providing additional medical and health services to individuals under the age of 22 years, particularly when such services were triggered by medical reviews and screenings." Id. Kansas does not, however, provide any evidence about specifically what it discussed with CMS or what information it provided in response to CMS's request for more information.

What the record does contain is Transmittal 06-09 and State Plan Amendment documents as approved by CMS with an effective date of July 1, 2007, as well as a May 2007 Transmittal (07-04) that superseded Transmittal 06-09, with the same effective date, July 1, 2007.

The approval of Transmittal 06-09 included approval of a 2-page Attachment 3.1A #16 (describing PRTF services), pages 38-41 of Attachment 4.19-A (a narrative explanation of the methods and standards for establishing reimbursement rates for PRTFs), and Attachments 1 and 2 to Attachment 4.19-A (consisting of 21 pages of instructions for completing the PRTF Financial and Statistical Report and 12 pages of the Report form). KS Ex. 2; CMS Exs. 1, 2, and 4.

At the end of Attachment 3.1-A is a paragraph labeled "Limitations." The version approved with Transmittal 06-09 reads:

> All Medicaid services furnished to individuals residing in a PRTF are considered content of the service. Federal financial participation is not available in expenditures for any other service to a PRTF resident. An individual under age 22 who has been receiving this service is

> considered a resident of the PRTF until he is conditionally released or, if earlier, the date he reaches age 22.

CMS Ex. 1, at 2. The version as revised through Transmittal 07-04 deleted the first two sentences of this paragraph.

The approved rate-setting method called for first determining average per diem costs for all PRTFs for administrative, property, and treatment cost centers, based on allowable historic costs for these cost centers adjusted by an inflation factor and divided by the total number of reported allowable resident days for all PRTFs. The averages of these three cost centers were then to be summed, resulting in the "base reimbursement rate" for PRTFs for these cost centers. The "base reimbursement rate" for these cost centers was then to be adjusted based on the "acuity indices" of the residents in each facility. CMS Ex. 2, at 2. Each resident was to be assigned a "severity index score" based on a uniform assessment. Id. at 3. The process for computing the severity index included factors for "Neuropsychiatric Disturbances" (symptoms of psychiatric disorders with a known neurological base) and "Medically Intense Needs" (biologically based medical needs that complicate psychiatric treatment). KS Reply Br. at 3. After the base reimbursement rate was adjusted for a facility's acuity index, the facility's per diem rates for facility operating and room, board, and support cost centers were to be added, resulting in the facility's rate (effective January 1, of each year). CMS Ex. 2, at 2.

The instructions for completing the Financial and Statistical Report state that the purpose of the report is "to obtain the resident-related costs incurred by [PRTFs] in providing services according to state and federal laws, and quality and safety standards." CMS Ex. 2, at 5. The definitions section of the instructions distinguishes costs related to resident care ("necessary and proper costs, arising from arm's-length transactions in accordance with general accounting rules, that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities") and costs not related to resident care ("costs that are not appropriate, necessary, or proper in developing and maintaining the PRTF operation and activities"). Id. at 7. The definitions state that the latter costs "shall not be allowed in computing reimbursable costs." Id.

The instructions for "Other Health Care Costs" state:

> These are medically necessary services provided by outside medical providers to meet the needs of individual residents. Examples include: pharmaceuticals, laboratory tests, physician visits, etc.

The Report form contains a schedule for "Non-Reimbursable & Non-Resident Related Expense Items." "Other Health Care" is included as an item on this schedule. CMS Ex. 4 (page 7 of the 12-page form).

CMS subsequently performed a financial management review that identified claims made by Kansas for costs of other health care services for children who were residents in PRTFs. CMS disallowed the federal share of the costs.

On appeal, Kansas argues that CMS's position that FFP is available only for inpatient psychiatric services is too narrow. Kansas argues, based on the structure of section 1905(a) of the Act, that Congress intended to fund all covered Medicaid services for children in PRTFs. Kansas further argues that it is required to provide all covered services to children who need them, pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements of the Act. Kansas also argues that CMS's position is inconsistent with CMS instructions for demonstration grants under the Deficit Reduction Act of 2005.

In addition, Kansas relies on the statement in the CMS letter of September 2006 and the original "Limitations" language in the approved State Plan Amendment to argue that it reasonably thought that Kansas had approval to make "add-on" payments to cover the other health care services at issue here.

Analysis

I. CMS is correct regarding the scope of the general IMD exclusion and its exception.

A. This Board has previously upheld CMS's reading based on the plain language of the Medicaid statute and other factors.

As CMS's brief makes clear, CMS's position is that the plain language of the exception makes FFP available only for services that are "inpatient psychiatric hospital services for individuals under age 21 as defined in subsection (h)" of the Act and meet the regulatory requirements for such services – that is, are services provided in and by a qualifying psychiatric facility meeting specified requirements. CMS Br. at 5.

Previous Board decisions have upheld CMS's position on the scope of FFP available for services to children in IMDs. New York State Dept. of Health, DAB No. 2066 (2007); Virginia Dept. of Medical Assistance, DAB No. 2222 (2008); Texas Health and Human Services Commission, DAB No. 2237 (2009). The Board's major reasons for upholding CMS's position in those cases 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."

- While section 1905(a) of the Act defines the term "medical assistance" as meaning payment for the listed covered services, it goes on to say that the term does not include "any such payments" for any individual under age 65 who is a patient in an IMD "except as otherwise provided in paragraph (16)." That paragraph in turn provides for payment only for "inpatient psychiatric hospital services for individuals under age 21" as defined in subsection 1905(h) of the Act.

- Subsection 1905(h) defines "inpatient psychiatric hospital services for individuals under age 21" to include "only" certain inpatient services provided in a qualifying psychiatric hospital (or distinct part thereof) or other qualifying inpatient setting. The implementing regulations define the term to include only inpatient services provided by a qualifying hospital, hospital program, or facility. Thus, the Act and the regulations do indicate that the exception makes FFP available only for services provided in and by the qualifying IMD.

- The statute and legislative history confirm that Congress intended to exclude payment for all services, including medical services, provided to individuals under age 65 institutionalized in IMDs because the states had traditionally been responsible for such services. Neither the statute nor its legislative history suggest that, in creating the exception to that exclusion, Congress intended to assume responsibility for all Medicaid services provided to children institutionalized in qualifying IMDs, no matter who provided them. Indeed, the exception was narrowly tailored to ensure that the covered inpatient psychiatric services would promote active treatment in a setting meeting federal standards. The legislative history of the exception is consistent with CMS's reading of the statutory language to mean that Congress intended for Medicaid to assume responsibility only for the category of services defined in subsection 1905(h).

- CMS policy issuances have for over ten years clearly set out CMS's interpretation that the exception does not make FFP available for noninstitutional 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.

Kansas acknowledges that the Board has previously upheld CMS on this issue, and we incorporate into this decision our full analysis from our prior decisions. We next turn to the arguments Kansas made about why that analysis is wrong.

B. Kansas's argument based on the structure of section 1905(a) has no merit.

Kansas contends that the CMS position is based only on the language found in subsections 1905(a)(16) and 1905(h) and does not examine the entirety of subsection (a). Kansas argues that the structure of section 1905(a) indicates three things: first, it provides a definition of medical assistance; second, it identifies 13 categories of potentially eligible persons (including eligible youth under the age of 21); and third, it identifies 28 enumerated services for payment. KS Br. at 9. The critical point, according to Kansas, is that the list of services is joined by the conjunction "and." Kansas argues that use of the conjunction "and" means that "payment of part or all enumerated services [is] available to eligible youth under the age of 21." Id. Thus, Kansas argues, while CMS may contend that payments under section 1905(a)(16) and 1905(h) cover only inpatient psychiatric care for individuals under age 21 in PRTFs, "the language does not specifically preclude coverage for services that are noted in one of the other enumerated services." Id. at 10. Instead, Kansas argues, any designated service used by an eligible individual qualifies as "medical assistance," and FFP is available under 45 C.F.R. § 435.1007.

CMS's reading of the statute is not, however, based only on subsections 1905(a)(16) and 1905(h). Instead, as indicated above, CMS's reading is based on the language in subsection 1905(a) following the list of services and providing that, except as provided in paragraph (16), such "term" does not include "any such payments" with respect to care or services for any individual under age 65 who is a patient in an IMD. The term referred to in this general IMD exclusion is clearly the term "medical assistance" – which is defined by the section as a whole, not just the first part, as Kansas contends. That the list in subsection 1905(a) includes medical services in addition to "inpatient psychiatric hospital services for individuals under age 21" does not matter since any payments for such medical services are excluded from the definition of "medical assistance" when they are provided to IMD residents under age 65. "Medical assistance" does include "inpatient psychiatric facility services for individuals under age 21" even though those individuals are under age 65 and are in IMDs. Contrary to what Kansas argues in its reply brief, however, that service category is not undefined, but is limited to the services described in the statute at subsection 1905(h) and in the implementing regulations.

Moreover, Kansas's reliance on 42 C.F.R. § 435.1007 is misplaced. That section provides that "FFP is available in expenditures for covered services provided to categorically needy recipients, medically needy recipients, and qualified Medicare beneficiaries, <u>subject to the restrictions contained in subpart K of this part</u> . . . ." (Emphasis added.) The restrictions in subpart K include the provisions in section 435.1009, regarding "institutionalized individuals, which state that FFP is <u>not</u> available for individuals under age 65 who are patients in an IMD "unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 . . . ."

Kansas is also mistaken in relying on the fact that Iowa allows PRTFs to bill separately for services such as prescription drugs, eyeglasses, and physician's services. The Iowa manual provision quoted by Kansas in its reply brief (at note 2) indicates that those services, while billed separately by the PRTFs, were nonetheless considered part of the inpatient psychiatric services provided by the PRTFs. As discussed below, Kansas provides no evidence that the health care services at issue here were part of the inpatient services provided by Kansas PRTFs, nor does it point to any comparable provision in its State Plan or manuals allowing PRTFs to bill Medicaid separately for such services.

C. Kansas's reliance on EPSDT cases is misplaced.

Kansas also argues that section 1905(r) of the Act requires a state to cover necessary services to treat or cure conditions discovered during an EPSDT screening of a child, even if the service is not specifically identified in the State Plan as a covered service. Kansas relies on the following quote from the Fifth Circuit's decision in S.D. v Hood, 391 F.3d 581 (5th Cir. 2004):

> Accordingly, every Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a) [section 1905(a) of the Act]. ***See Collins v. Hamilton***, 349 F.3d 371, 376, n.8 (7th Cir. 2003)("a state's discretion to exclude services deemed 'medically necessary' . . . has been circumscribed by the express mandate of the statute"); ***Pittman by Pope v. Sec'y, Fla. Dep't of Health & Rehab.***, 998 F.2d 887, 892 (11th Cir. 1993)(1989 amendment adding § 1396d(r)(5) took away any discretion state might have had to exclude organ transplants from the treatment available to individuals under age twenty-one); ***Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.***, 293 F.3d 723, 725-26 (8th Cir. 2002)(state must provide EPSDT coverage for "early intervention day treatment" as part of § 1396d(a)(13)'s "rehabilitative services" category because program was structured to ameliorate conditions and strengthen skills children learn in therapy); ***Pereira v. Kozlowski***, 996 F.2d 723, 725-26 (4th Cir. 1993)("[i]n section 1396d(r)(5), the Congress imposed upon the states, as a condition of their participation in the Medicaid program, the obligation to provide children under the age of twenty-one all necessary services, including transplants.")

Kansas notes that, in Collins v. Hamilton, Indiana had attempted to deny access to a PRTF for a youth screened under EPSDT. The Seventh Circuit found that a PRTF was qualified to provide inpatient psychiatric services and that Indiana was required to fund the cost of placement in a PRTF if it is deemed necessary by an EPSDT screening. According to Kansas, services under EPSDT are a mandated and covered service under section 1905(a)(4)(B) and, under section 1905(r)(5), if a service is determined to be necessary for a child, the state must provide it and FFP is available for the service.

Other states have made similar arguments, and we have rejected them. Section 1905(r) defines EPSDT services for purposes of section 1905(a)(4)(B) to include certain specified services, as well as "[s]uch other necessary health care, diagnostic services, treatment, and other measures <u>described in section 1905(a)</u> to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (Emphasis added.) As the Fifth Circuit recognized, the legislative history of section 1905(r) indicates that Congress intended that states cover every type of necessary health care or service that is "allowable" under section 1905(a). <u>See</u> 391 F.3d at 581 (discussing legislative history).

Thus, a 1991 policy statement issued by the Director of CMS's Medicaid Bureau stated 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 Br. at 2.

We see no conflict between CMS's reading of the scope of the IMD exclusion and the provision in subsection (r), requiring states to provide services for which the need is determined by an EPSDT screen "whether or not such services are covered under the State plan." The list of services in subsection 1905(a) includes some services that are considered mandatory and some that are considered optional. Specifically, a Medicaid state plan must include "at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a)" for the categorically needy and other specified services for the medically needy (if eligible under the state plan). Act, § 1902(a)(10); <u>see</u> 42 C.F.R. §§ 440.210, 440.220, 440.225. Generally, FFP is available for payments for services only if they are expended as "medical assistance under the State plan." Act, § 1903(a)(1). Thus, the clear purpose of subsection (r) is to provide for some EPSDT services that otherwise would not be available under a state's Medicaid program because they are optional services that are described in section 1905(a), but are not covered in the relevant state plan. Kansas points to no support in the legislative history of the EPSDT provisions or elsewhere for interpreting this language to mean that Medicaid must separately pay for all needed services even if the child is in an IMD.

None of the cases on the EPSDT provisions cited by the Fifth Circuit addressed whether FFP is available for services provided to a child who resides in an IMD by a provider other than the IMD.

In its reply brief, Kansas asserts, however, that the CMS position leads to complications in the Medicaid system. To illustrate these complications, Kansas gives the example of a child "who is diagnosed with a brain tumor found during an EPSDT screen due to developmental language delay, who is in foster care, who had had a substance abuse history, and who is aggressive and violent with other individuals." KS Reply Br. at 8. Kansas posits that, if the child were placed in a PRTF, CMS would deny FFP for all other services except for "inpatient psychiatric services," but Kansas would be bound by the EPSDT provisions to cover all other necessary health care (and, if it did not, would likely be sued). In that case, Kansas asserts it would be better to seek inpatient hospitalization or some other form of care, so the state would likely "game" the system by doing so. KS Reply Br. at 8. Kansas also queries what the appropriate analysis would be if the brain tumor found during the EPSDT screen was also the neuropsychiatric basis for the aggression and whether the resulting treatment for the tumor could be classified as "inpatient psychiatric services" since it would "assist in the resolution of the aggression." Id.

This argument reflects a fundamental misunderstanding of CMS's position. CMS does not argue that only "psychiatric" services are covered for children in PRTFs or other IMDs. Instead, CMS recognizes that "[i]f 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." CMS Br. at 10. Moreover, CMS approved the Kansas method for reimbursing PRTFs, which takes into account, as part of the severity index that justifies a higher per diem rate for a facility, factors such as neuropsychiatric disturbances and medically intense needs. Kansas does not explain why higher payments where such factors are present would not be sufficient to cover any costs a facility incurs in meeting the medical needs of a child with a brain tumor residing in the facility.

If, however, a PRTF cannot provide medical services to meet the needs of a child such as the child with the brain tumor described by Kansas, placement in a hospital that could meet those needs would be appropriate, and not simply "gaming the system" as Kansas contends.

Moreover, if a state chooses to place the child in a PRTF and to meet the child's medical needs through services of other providers, the fact that the state may have to cover the costs of those services does not render CMS's position here unreasonable. As discussed above, the legislative history of the IMD exclusion indicates that Congress considered care of individuals in IMDs to be a traditional state responsibility. While Congress later agreed to an exception for "inpatient psychiatric facility services to individuals under age 21," Congress did not agree to assume the states' responsibility for other services provided to IMD residents under age 65 by other providers. A state would still be better off if it receives FFP for PRTF services that qualify for the exception than if the child were placed in an IMD not qualifying for the exception. Thus, we see no merit to the argument by Kansas that CMS's position will lead to disuse of PRTFs and placement of children in more restrictive environments.

D. The instructions used to determine cost-effectiveness for demonstration grants under the Deficit Reduction Act are not a basis for reversing the disallowance.

Section 6063 of the Deficit Reduction Act of 2005, Public Law No. 109-171, authorized grants for demonstration projects, modeled after waivers involving Home and Community Based Services (HCBS) under section 1915(c) of the Act and providing for HCBS services as an alternative to placement in a PRTF. Section 6063(c)(2) required "budget neutrality," that is, that the aggregate payments made for the demonstration projects do not exceed what would have been paid if the demonstration projects had not been implemented. In an "Invitation to Apply for FY 2007 Demonstration Project Grant CFDA 93.789" issued July 2006 (Invitation), CMS explained the components of this calculation, citing the regulation at 42 C.F.R. § 441.303(f)(1). That section applies to HCBS waivers and describes the information a state must provide to support its assurance under section 441.302(f) that the "actual total expenditures for home and community-based and other Medicaid services under the waiver . . . will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver," in a hospital, nursing facility, or intermediate care facility for the mentally retarded. Section 441.303(f)(1) sets out an equation (D+D’ $\leq$ G+G’) and defines each component of the equation. Essentially, D is the cost for HBCS, G is the cost for care in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and D’ and G’ are the cost of other Medicaid services. On page 41 of the Invitation, CMS stated:

> For purposes of the equation, the prime factors (D’ and G’) include the average per capita cost of all State plan services and expanded [EPSDT] services (when the services cover children) that have been utilized but not accounted for in other formula values.

KS Br. at 13. Kansas argues that this “instruction clearly provides for additional costs to be included in any determination of budget neutrality” and that this “implies that those costs can be included in the demonstration project since they would also be expected to occur in the regular program administration.” Id. According to Kansas (which applied for demonstration project approval), this “seems to contradict CMS’ present stance on evaluating costs in a PRTF situation as being limited to inpatient psychiatric care” since other services “are meant to be included.” Id.

The equation and the instruction in the invitation can be read to be consistent with CMS’s position here, however. The equation as set out in the regulation compares expenditures under an HCBS waiver with Medicaid expenditures for services in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and those services do not include services in an IMD. 42 C.F.R. §§ 440.10, 440.40, 440.150, 435.1010. While PRTFs are IMDs, section 6063 specifies that, for purposes of a demonstration project under that section, a PRTF “shall be deemed to be a facility specified in section 1915(c)” of the Act, that is, a hospital, nursing facility, or intermediate care facility for the mentally retarded. Thus, the fact that CMS adopted the same formula for children in PRTFs, and apparently expected states to include costs of “other Medicaid services” for those children, does not necessarily imply that CMS considered those costs ordinarily to be allowable Medicaid expenditures.

In any event, the factor G’ is defined as “the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.” 42 C.F.R. 441.303(f)(1)(emphasis added). Thus, when applied to expenditures for individuals institutionalized in PRTFs, it could be read as not including costs of services not provided by the PRTF, for which federal Medicaid funding is not available.

Even if CMS permitted Kansas to include in the G' factor in its application for a demonstration project grant the costs of medical services not provided by PRTFs (which Kansas did not specifically allege), Kansas points to nothing in the demonstration project instructions or elsewhere indicating that CMS intended such an action to constitute an interpretation by CMS of the IMD exclusion and exception. As CMS points out, the equation goes only to the authority for a waiver and does not supersede the statutory and regulatory language excluding from the definition of "medical assistance" any payments for services provided to IMD residents under age 65 that do not qualify as "inpatient psychiatric facility services for individuals under age 21."

II. Kansas did not show that its approved State Plan Amendment can reasonably be read to allow "add-on" payments to PRTFs to cover the costs of other health care services.

Kansas points out that the September 2006 letter from CMS regarding the State Plan Amendment (SPA) Kansas proposed refers to an "added per diem component in the PRTF reimbursement for 'health care services' . . . ." KS Br. at 2, citing KS Ex. 1, at 2. Kansas asserts that it engaged in extensive discussions with CMS about the proposal and that, due to the typical nature of PRTFs in Kansas, Kansas was concerned about "the need for providing additional medical and health services to individuals under the age of 22, particularly when such services were triggered by medical reviews and screenings." Id. at 1-2. Kansas also points out that the "Limitations" section of the SPA, as originally approved, included the following sentences:

> All Medicaid services furnished to individuals residing in a PRTF are considered content of service. Federal financial participation is not available in expenditures for any other service to a PRTF resident.

KS. Ex. 2. According to Kansas, it "believed that the per diem additional cost for 'health care services' was still authorized for reimbursement in the PRTF reimbursement formula." KS Br. at 3.

This Board has set out a framework for analyzing issues about how to interpret a state plan provision in which a state sets out its method for reimbursing particular providers. South Dakota Dept. of Social Services, DAB No. 934 (1988). Generally, the Board gives deference to a state's interpretation of its own state plan, so long as that interpretation is an official interpretation and is reasonable in light of the language of the plan as a whole and the applicable federal requirements. Missouri Dept. of Social Services, DAB No. 1412 (1993). Thus, in Texas, DAB No. 2237, supra, the Board adopted Texas's reasonable reading of its plan as authorizing separate payments to physicians and other practitioners to cover part of the costs of inpatient psychiatric facility services. However, the Board has also held that states must follow the methods and standards set out in their state plans, and may not change their plans unilaterally. New Hampshire Dept. of Health and Human Services, DAB No. 1862 (2003); California Dept. of Health Services, DAB No. 1474 (1994); California Dept. of Health Services, DAB No. 1007 (1989).

Here, while there is evidence that the reimbursement method originally proposed by Kansas included an "add-on" payment for other health care services, that evidence also shows that CMS raised questions about the proposal. More important, Kansas points to nothing in the plan language as approved that could reasonably be interpreted as providing for such an "add-on" payment. Instead, as CMS points out, the approved reimbursement methodology treats the costs of other health care services as non-resident related, non-reimbursable costs. Even if Kansas intended this to mean merely that the costs of the services were not reimbursable as part of the per diem rate, this treatment is significant, given the absence of any language in the plan providing for an additional payment on top of the per diem rate.

We also find it significant that the definition of "health care services" as approved was different from the proposed definition. The September 2006 letter indicates that Kansas proposed to define such services as "all medically necessary health care services covered by Medicaid excluding mental health and substance abuse treatment services which were included in a base rate for the facility" and that CMS understood this to mean costs "incurred by the facilities for their residents." KS Ex. 1, at 2. The definitions approved refer to "other health care costs" as "medically necessary services provided by outside medical providers to meet the needs of individual residents." CMS Ex. 2, at 16 (emphasis added). The CMS letter indicates that, in evaluating the proposal for an add-on payment, CMS considered it important to know who would provide the services.

In its reply brief, Kansas suggests that CMS miscasts the purpose of the expense reporting process, which is limited to expenses incurred by the facility. KS Reply at 2. The purpose statement on which Kansas relies, however, does not support a conclusion that Kansas intended to reimburse PRTFs for non-resident related costs of other health care services. That statement says: "The purpose of this report is to obtain the resident-related costs incurred by [PRTFs] in providing services according to applicable state and federal laws, and quality and safety standards." CMS Ex. 2, at 5. It does not state any intent to also pay PRTFs for costs they (or other providers) incur for services that the report treats as non-resident related and non-reimbursable.

Moreover, contrary to what Kansas suggests, the approved reimbursement methodology could be viewed as addressing the concern Kansas had about meeting children's medical needs. That methodology includes not only a formula for calculating a base rate for a facility but also a formula for making adjustments based on a severity index that would reflect medical conditions requiring more intense treatment. Thus, the approved methodology appears to contemplate the provision of at least some services by a PRTF beyond mental health and substance abuse treatment. This is consistent with the "active treatment" provisions for "inpatient psychiatric facility services for individuals under age 21" discussed above, which require a plan of care based on an assessment of the child's needs, including the child's medical needs.

Kansas's reliance on the language in the "Limitations" section of the SPA as originally approved is misplaced. First, stating that "all Medicaid services" are part of the "content of service" does not necessarily imply that an add-on payment will be made for services not covered by a facility's per diem rate. Instead, it could mean that PRTFs were required to provide any medically necessary services as part of the resident-related treatment reimbursed through the per diem rate. Second, to the extent health care services are provided to a child in an IMD by a provider other than an IMD, they are not Medicaid covered services. Third, and most important, this language never went into effect since it was superseded by the provision in Transmittal 07-04 eliminating the two sentences on which Kansas relies. If Kansas thought this superseding amendment somehow was inconsistent with its intent to provide for an add-on payment to reimburse PRTFs for the services at issue, Kansas could have treated this change as effectively disapproving the proposed amendment and appealed it. Kansas seeks to fault CMS for not being clear about the effect of the superseding provision, but Kansas cannot reasonably accept such an amendment to its plan without timely protest, and then rely on the language as it existed prior to amendment as a basis for submitting Medicaid claims.

Finally, while Kansas makes assertions regarding its belief that it had CMS approval for making "add-on" payments to cover the costs of the services at issue, Kansas provides absolutely no evidence to show that it in fact had such a belief, much less to show that such a belief would be reasonable in light of the discussions between Kansas and CMS and the plan language ultimately approved. Nor did Kansas present any evidence to show that health care services provided by outside medical providers could reasonably be considered part of the "inpatient psychiatric facility services" provided in and by the PRTFs.

States seeking Medicaid funding must maintain "records to assure that claims for Federal funds are in accord with applicable Federal requirements." 42 C.F.R. § 433.32. Based on this or similar provisions, the Board has long held that states have the burden of demonstrating the allowability of the costs for which they claim federal grant funds. See, e.g., New York State Dept. of Social Services, DAB No. 204, at 5 (1981). Kansas failed to meet that burden here.

Conclusion

For the reasons stated above, we uphold the disallowance of $3,883,143 in FFP that Kansas claimed for other health care services for quarters ending September 30, 2007 through June 30, 2008.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member