Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Texas Health and Human Services Commission
Docket Nos. A-07-32
Decision No. 2237

DATE: April 1, 2009

DECISION

The Texas Health and Human Services Commission (Texas or HHSC) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $1,290,047 in federal financial participation (FFP) that Texas claimed as "medical assistance" under the Medicaid program from September 1, 1997 through August 31, 2000. "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." CMS determined that Texas was submitting FFP claims for medical services, provided to IMD residents under the age of 21, that did not qualify for the exception because the services were rendered by providers outside of IMDs in which the children resided.

Texas raises several legal challenges to CMS's position that FFP is available under Medicaid only for services provided in and by a facility that qualifies to provide "inpatient psychiatric services to individuals under the age of 21." Texas recognizes, however, that the Board has previously rejected similar arguments. Further, Texas admits that some of its claims are for services that it cannot show were provided as part of the inpatient psychiatric facility services the children were receiving. With its initial brief, however, Texas presented evidence, based on a sample of the claims at issue, which it says shows that some of the claimed professional services were inpatient psychiatric services provided by the IMDs and were therefore allowable. In response, CMS questioned whether this evidence was sufficient and also whether reimbursement for such claims would duplicate payments made to the IMDs, arguing that the per diem rate for the IMD services was an all-inclusive rate.

For the reasons stated below, we reject the general legal challenges that Texas raises to CMS's position regarding the IMD

exclusion. Thus, we uphold the disallowance of FFP for services for which Texas concedes it has no documentation to establish that they were provided at the IMDs in which the children resided.[1] With respect to the remaining sample claims, we conclude that the evidence Texas presented shows that all but nine of the sample claims were for evaluation and management, psychiatric, or clinical psychologist services provided on an inpatient basis in the IMDs in which the children resided. The fact that the claims were submitted by the professionals, rather than the IMDs, does not mean the IMDs could not also reasonably be considered to have provided the services under the Medicaid regulations. Texas was permitted, under the applicable, approved State plan provision and under a waiver that CMS approved, to pay for professional services provided as part of these inpatient psychiatric hospital services separately from the per diem rate paid to the hospital. Nothing in the Medicaid regulations or CMS guidance precluded such payment being made directly to the professionals. Texas also showed that, contrary to what CMS asserted, the per diem rates paid to the IMDs were not all-inclusive rates that covered the cost of the professional services. CMS has provided no evidentiary support for its argument that Texas made duplicate payments for the services.

Accordingly, we uphold the disallowance in part and reverse it in part, in an amount to be determined, consistent with our decision below.

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.[2] Each state operates its own Medicaid program in accordance with broad federal requirements and the terms of its Medicaid state plan.

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[1] Texas estimated the amount related to these claims to be $722,248.79. As we discuss below, however, the amounts related to allowable and unallowable claims must be recalculated pursuant to our decision.

[2] 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)."[3] 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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> * * *
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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 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-
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> (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

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[3] 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."

> 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 435.1008 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 any 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.

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.

"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. 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 (emphasis added). The team must include, as a minimum, a Board-eligible or Board-certified psychiatrist; a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or has been certified by the state or by the state psychological association. Id.

Case Background

The Office of the Inspector General (OIG) of the federal Department of Health and Human Services conducted an audit to determine whether Texas had controls in place to prevent it from

claiming FFP under Medicaid for "medical services, except inpatient psychiatric services, provided to [IMD] residents under the age of 21." TX Ex. 1, Executive Summary. The auditors found that the Medicaid Management Information System operated by the National Heritage Insurance Company (which was the Texas administrative contractor at the time) did not have edits or mechanisms "to detect and prevent FFP from being claimed for IMD residents under the age of 21." Id.

The auditors examined claims for services during the period September 1, 1997 through August 31, 2000. The auditors focused on 27 private and 10 State-operated psychiatric hospitals, obtaining lists of the Medicaid-eligible residents under the age of 21 admitted to the hospitals during the audit period. The auditors "used computer programming to match the residents' IMD admission and discharge dates to the Medicaid payments to identify payments for services that were provided during the time the individual was a resident of the IMD, and thus unallowable for FFP." Id. at 2. The audit report states: "Any claims for inpatient psychiatric services were then removed, as they are allowable for IMD residents under the age of 21." Id. The auditors found that Texas had improperly claimed $1,290,047 in FFP.

Based on the audit report, CMS disallowed $1,290,047 in FFP for payments that CMS described as claims for "outpatient hospital, physician, laboratory, pharmacy, and transportation services rendered by providers outside of the psychiatric facility." TX Ex. 2, at 1. CMS based the disallowance on its reading of the IMD exclusion and its exception, and the implementing regulations. CMS reads those provisions to mean that FFP is available for services provided to a Medicaid recipient under the age of 21 who resides in an IMD (and has not been unconditionally released) only if those services qualify as "inpatient psychiatric facility services for individuals under the age of 21" as defined in section 440.160. In other words, CMS reads the statute and regulations to mean that FFP is not available for services to individuals under the age of 21 who reside in IMDs unless the services are provided in and by a qualifying IMD.

Texas appealed the CMS determination. After a stay in which the parties tried unsuccessfully to resolve the case, the Board set a briefing schedule. CMS's brief raised for the first time an issue regarding whether the IMDs received an "all-inclusive" reimbursement rate. Texas objected to this in its reply brief. The Board then set procedures to ensure that Texas had an adequate opportunity to supplement its reply and evidence to address the new issue, and the parties jointly requested further

extensions of time. Texas then presented further evidence and argument to show that its approved State plan and federal and State regulations permitted it to separately reimburse professionals for services provided as part of inpatient psychiatric services, and that the costs of those services were not included in the IMDs' per diem rates. CMS filed a surreply and Texas filed a response.

Analysis

Below, we first address the arguments Texas made about the legal premises for the disallowance. We then discuss the evidence Texas submitted to show that some of the claims disallowed were not, as CMS asserts, for services provided outside of the IMDs in which the children resided, but instead were for services that are allowable inpatient psychiatric hospital services. Finally, we address CMS's argument that the IMDs were paid an all-inclusive rate.

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.

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). 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.

Texas 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 Texas made about why we should reconsider our prior analysis and explain below why those arguments are not persuasive.

B. Texas' reliance on the legislative history of the exception is misplaced.

Texas submits that the intent of the 1972 Amendments creating the exception to the IMD exclusion for individuals under the age of 21 (and in some instances up to 22) "was to clarify that the state could provide those individuals with psychiatric hospital services in addition to, rather than in lieu of, the other medical services already provided to that population." TX Br. at 8-9. According to Texas, the legislative history of the exception indicates that Congress intended to add funding for inpatient care of mentally ill children, and no mention was made of eliminating benefits for which these children were already eligible. TX Br. at 9-10, citing and quoting from H.R. Conf. Rep. 1605, 92nd Cong. 2nd Sess. (1972); 118 Cong. Rec. 32472, 32477; S. Rep. No. 1230, 92nd Cong. 2nd Sess. (1972).

This argument misstates the status of children such as those at issue here prior to the 1972 Amendments. Under the general IMD exclusion, the status of children institutionalized in an IMD such as a psychiatric hospital was that no FFP was available under Medicaid for any services provided to the children. For those children, the general IMD exclusion had the effect of excluding from the term "medical assistance" any payment for services to the institutionalized children, whether they were provided inside or outside of the hospital.

Thus, the statements in the legislative history of the 1972 Amendments do not support the position taken by Texas, much less override the plain language of the statute regarding what services Congress intended to cover.

C. CMS's position does not conflict with the provisions of the Act requiring the EPSDT Program.

Texas also argues, as did New York, that coverage of the services at issue is required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program is established by paragraph 1905(a)(4)(B) of the Act, which includes in the list of services in the definition of "medical assistance" the following: "Early and Periodic Screening, Diagnostic, and Treatment Services (as defined in subsection (r) for individuals who are eligible under the plan and are under the age of 21)."

Texas argues that the "CMS interpretation that the Medicaid Act does not cover medical services provided outside the IMD during the time the individual is a resident of the IMD is in direct conflict with the intent of the EPSDT requirements of the federal

Medicaid statute, particularly the 1989 amendments to that statute." TX Br. at 16. Texas points out that, in 1989, Congress "expanded EPSDT benefits to require states participating in the Medicaid program to provide coverage for all Medicaid screening, diagnostic, and treatment services to individuals under the age of 21, whether or not those services are covered services under the state Medicaid program for adult beneficiaries." Id., citing Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403. Specifically, Congress amended subsection 1905(r)(5) of the Act to define EPSDT services to include specified screening services, vision services, dental services, hearing services, and "other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Act, § 1905(r)(5) (emphasis added). According to Texas, the last clause in this amended section requires states to cover all medically necessary services for any condition "if the service is within the section 1905(a) list of services that may be funded under the federal Medicaid statute." TX Br. at 17, citing Katie A. v. Los Angeles County, 481 F.3d 1150, 1154 (9th Cir. 2007) and cases cited therein.

Texas further argues that CMS's interpretation "that psychiatric or medical care provided during the time a child under the age of 21 is a resident in an IMD is not a covered service for which the state is entitled to FFP is contrary to the intent of Congress" in enacting provisions that "require the state to provide inpatient psychiatric hospital services in addition to any other services listed in [section 1905(a) when medically necessary." TX Br. at 20. Texas also argues that Congress clearly considered both mental health and medical care to be components of its 1989 expansion of EPSDT benefits. Id., citing 135 Cong. Rec. S 6900 (daily ed. June 19, 1989)("This bill requires states to offer EPSDT services whenever doctors suspect medical or mental health problems. It also requires prompt treatment once a condition has been diagnosed.).

There are two fundamental flaws with the legal arguments Texas makes. First, Texas does not accurately state the CMS position. CMS does not take the position that psychiatric or medical care provided while a child is an IMD resident is never a covered service. Instead, CMS's position is that FFP is available only when such care and services fall within the exception to the IMD exclusion - that is, only when they are part of inpatient psychiatric facility services for individuals under age 21 that meet the statutory and regulatory requirements for such services.

Second, Texas misreads the reference to section 1905(a) in section 1905(r) as being a reference to the "list" of services in section 1905(a). Instead, the reference is to "measures described" in section 1905(a) "whether or not such services are covered under the state plan." Act, § 1905(r).

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); see 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 the phrase in subsection (r) is to provide for some EPSDT services that otherwise would not be covered because they are optional services, not covered in the relevant state plan. Texas points to no support in the legislative history or elsewhere for interpreting this language as meaning that a state must provide services even if federal participation in expenditures for those services is precluded because the child is in an IMD.

Katie A. and the related cases cited by Texas are not directly on point. Moreover, as Texas acknowledges, what those cases said was that "states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable" under section 1905(a). Id. Thus, section 1905(r) triggers a requirement for a state to provide a service only if section 1905(a) allows it. As noted above, the general IMD exclusion in section 1905(a) provides that, "except as otherwise provided in paragraph (16)," the term "medical assistance" does not include "any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient" in an IMD. The phrase "any such payments" refers back to the payments previously defined as payments considered to be "medical assistance" - that is, payments for the listed care and services, including EPSDT services.[4] Nothing in the cited

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[4] In New York, we also noted that, in Medicaid State

(continued...)

decisions suggests that Medicaid must cover services for which FFP would not be allowable as "medical assistance" under section 1905(a).

Texas also seeks to distinguish New York on the facts, pointing to the Board's statements in that decision that "New York's argument assumes that the services for which payment were disallowed were EPSDT services" and that "New York did not, however, provide any evidence to support this assertion." TX Br. at 17, citing New York at 50. Texas asserts that "all of the disallowed claims are for individuals under the age of 21 and for EPSDT services." Id. Texas points out that the 1989 legislation expanded the EPSDT Program to provide for interperiodic screens and that CMS guidance treats any encounter with a health care professional acting within the scope of practice to be an EPSDT screen. Id. at 18. Texas also argues that, in accordance with Medicaid requirements, children are not hospitalized without a determination by a health care professional that hospitalization is required and that states are required by the EPSDT provisions to provide services if, during the child's hospital stay, a health care professional determines that either psychiatric or non-psychiatric medical care is needed, and the services are listed in section 1905(a), whether or not the state otherwise offers these services. Id. at 19. Texas argues that all of the disallowed services except transportation services were provided by health care professionals acting within the scope of practice, and, thus, the services were EPSDT services. Id. at 20. With respect to the transportation services, Texas argues that CMS's State Medicaid Manual requires it to provide necessary transportation and that the OIG audit did not question the necessity of the transportation claims at issue.

These arguments have no merit. First, Texas erroneously assumes that, if New York had established the factual predicate for its argument, it would have prevailed. The Board concluded in that

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[4](...continued)
Operations Letter 91-36, the CMS Regional Administrator for the New York region informed New York, in response to questions about whether FFP is available for services to children in IMDs, 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 and the only exception to the exclusion is the psych under 21 benefit." New York at 14-15. CMS submitted that letter as CMS Exhibit 3 here, but does not assert that Texas had notice of that letter.

decision, however, that the legal predicate for the argument had no merit. New York at 25-27. Second, Texas did not establish as a matter of fact that all of the services at issue were EPSDT services.

We recognize that a medical necessity determination must be made before a child may receive inpatient psychiatric facility services under Medicaid. 42 C.F.R. § 441.151(a)(4). Also, for a child residing in a qualifying IMD, the IMD had to ensure that the child's needs were evaluated prior to or shortly after admission and periodically thereafter while the child was a resident and to provide services to meet the child's needs (including medical needs), as determined by the interdisciplinary team. Thus, Texas would be obligated to provide those services under the EPSDT Program, whether or not the Texas State Plan covered inpatient psychiatric facility services for individuals under age 21.

With respect to any claims for outpatient services for such a child, however, the mere fact that health care professionals submitted the claims does not establish either that Texas had to pay for the services as a required EPSDT periodic or other screen or that the services were medically necessary. Texas has not explained why the required evaluations and services to be provided by the IMD would not be sufficient to meet the EPSDT requirements while the child was a resident. Moreover, since the children were residing in the IMDs at the time the services were allegedly provided, separate outpatient claims for services such as transportation are inherently questionable. In any event, Texas did not provide any evidence to support its assertion that the outpatient services constituted required, periodic EPSDT screens or were for services that had been determined by a screen to be medically necessary.

In sum, Texas' reliance on the EPSDT requirements is misplaced.

D. The IMD exclusion does not impermissibly discriminate against individuals on the basis of disability.

Texas argues that the "CMS position that states participating in the Medicaid program are required to provide EPSDT-eligible individuals all medical services listed in [section 1905(a)], unless those individuals have an emotional disturbance or mental illness so serious that they require admission to an institution for mental diseases, constitutes discrimination on the basis of disability and is inconsistent with the requirements imposed on the states by *section 504 of the Rehabilitation Act of 1973, as amended*, 29 U.S.C. §794, and the *Americans with Disabilities Act*

(ADA), 42 U.S.C. § 12101, et seq." TX Br. at 22 (italics in original). According to Texas, "CMS's position that EPSDT eligibles can get outpatient health care only if they do not have a mental health problem severe enough to warrant institutionalization screens out individuals with more severe mental disabilities." Id. Texas concludes that "[s]uch criteria deny individuals with serious mental disabilities Equal Protection of the law in violation of the Due Process Clause of the 5th Amendment to the United States Constitution." Id.

This argument again misstates CMS's position and the effect of the general IMD exclusion. The issue here is not whether the children receive the services they need, but whether FFP is available for services provided outside the IMDs in which they reside. If a child is institutionalized in an IMD, FFP is available only if the services the child receives meet the statutory and regulatory requirements to qualify for the exception to the exclusion in section 1905(a)(16). The reason for the funding distinction is that services in an IMD were traditionally the responsibility of the states. Contrary to what Texas argues, the distinction is not on the basis of the severity of the mental disease.

Similar arguments about the IMD exclusion were rejected by the Board many years ago, based on the Supreme Court decision in Schweiker v. Wilson, 450 U.S. 221 (1980). New York State Dept. of Social Services, DAB No. 1577, at 11 (1996). In Schweiker, the Supreme Court held that a statutory provision making Supplemental Security Income benefits unavailable to IMD residents who were not receiving Medicaid "made a distinction not between the mentally ill and a group composed of non-mentally ill, but between residents in public institutions receiving Medicaid funds and . . . residents in such institutions not receiving Medicaid funds." 450 U.S. at 232. Similarly, the IMD exclusion does not distinguish individuals on the basis of their mental illness (or its severity), but instead prohibits FFP in certain services provided to individuals by reason of their institutional status, age, and the nature of the services.

II. The evidence submitted by Texas establishes that, contrary to what CMS asserts, some of the claims at issue were for services provided on an inpatient basis by professionals who were permitted to bill for the services.

A. Texas showed that the factual premises on which the disallowance was based were ill-founded.

CMS found that the services at issue were provided outside of the

IMDs in which the children resided, by providers other than the IMDs. The audit report, on which CMS based this finding, said that any claims for inpatient psychiatric services were removed. TX Ex. 1, at 2. A declaration of one of the auditors indicates that the auditors thought that all of the disallowed claims were for outpatient services based on-

- the fact that the claims were not submitted by the IMDs;
- the auditors' understanding of what they had received from Texas and its claims processing contractor; and
- their understanding that the internal control number (ICN) for each claim indicated it was for services provided on an outpatient basis.

CMS Ex. 1 (Declaration of Claire Huerta).

On appeal, Texas presented evidence and argument to show that the mere fact that the claims were not submitted by the IMDs did not definitively show that the services were not part of the inpatient services provided by the IMDs.

With respect to who may bill for Medicaid services, Texas points to the Medicaid regulation at 42 C.F.R. § 447.10, entitled "Prohibition against reassignment of provider claims." That regulation provides:

> (a) *Basis and purpose.* This section implements section 1902(a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or recipient, except in specified circumstances.
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> (b) *Definitions.* For purposes of this section:
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> *Facility* means an institution that furnishes health care services to inpatients.
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> * * *
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> (d) Payment may be made only-
> (1) To the provider; or
> (2) To the recipient . . .; or
> (3) In accordance with paragraphs (e), (f), and (g) of this section.
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> * * *
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> (g) *Individual practitioners.* Payment may be made to-

> (1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;
> (2) The facility in which the service is provided if the practitioner has a contract under which the facility submits the claim; or
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> * * *

(Emphasis added.) Texas argues that this regulation "specifically allows" individual practitioners to bill for the services they provide in a facility such as an inpatient psychiatric hospital. Texas argues that not only is it Medicare practice to have such practitioners bill directly for their inpatient services, but that the Texas Occupations Code prohibits private psychiatric hospitals from employing physicians (as the corporate practice of medicine) and that direct billing by the physicians is common practice.[5] To show that, in fact, individual practitioners such as physicians and clinical psychologists were permitted in Texas to bill directly for their services provided on an inpatient basis, Texas submitted affidavits and documentation (such as its provider reimbursement manuals). See, e.g., TX Supp. Exs. 15-18.

Texas also points to the requirement at 42 C.F.R. § 441.156, which provides that the individual plan of care for a child receiving inpatient psychiatric facility services "must be developed by an interdisciplinary team of physicians or other personnel who are employed by, or provide services to patients in, the facility." (Emphasis added.)

In response, CMS concedes that, under the Texas system of reimbursement, Texas "pays IMDs and physicians separately for inpatient psychiatric services provided at the IMD." CMS Response Br. at 2. CMS points out, however, that the regulations define inpatient psychiatric services for individuals under age 21 to include only services provided by a qualifying hospital, program, or facility, and that those services must involve implementation of plans of care developed by physicians and other personnel who have "the specified licenses, credentials, and experience to enable them to assess the patients' requirements

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[5] Texas also argued that direct billing by practitioners was required as of 1996 by the Health Insurance Portability and Accountability Act (HIPAA). In response to questions from the Board about when HIPAA requirements were implemented, however, Texas withdrew this argument. TX Supp. Reply at 19.

and render appropriate services." Id. at 3-5. CMS concludes from this that the provision at section 441.156 does "not authorize payment for services to non-IMD providers or override the statutory and regulatory restrictions which limit this benefit to qualified services provided in and by an IMD." Id. at 5.

CMS is correct that the regulations (if not the statute) require that active treatment pursuant to a plan of care be provided by the facility as well as in the facility. As Texas points out, however, CMS is confusing the issue of services for which FFP is available, with the question of who may bill for those services. There is no finding or evidence here that the physicians, psychiatrists, or clinical psychologists who submitted claims for services they furnished on an inpatient basis did not have the requisite qualifications and credentials or that they were not implementing the child's plan of care. Moreover, while section 441.156 does not specifically authorize payment to "non-IMD providers," the reference to non-employees who provide services in the facility indicates that CMS was aware that qualified personnel might be considered as "providing" services that are part of the active treatment the facility has the responsibility to provide to its residents, even if the professionals are not facility employees. While CMS asserts that Congress intended the payments to be made to the IMD, CMS cites to no support for this assertion and concedes that it has issued no policy guidance requiring that a facility bill for all inpatient services it provides. CMS Surreply at 10.[6]

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[6] We note that CMS did recently clarify that, for purposes of calculating a hospital-specific limit for disproportionate share hospital payments, costs a hospital incurs for professional services may be included in calculating the hospital's uncompensated care costs only if the state plan defines inpatient or outpatient hospital services to include the services and the hospital bills for those services. 73 Fed. Reg. 77,904 (Dec. 19, 2008). In so doing, CMS recognized that states have the flexibility to treat professional services as part of hospital services under Medicaid, even though Medicare reasonable cost principles treat only certain costs for professionals as allowable for rate-setting purposes. Id. Similarly, CMS has apparently recognized that states have flexibility to include professional services as part of "inpatient psychiatric facility services for individuals under age 21." Texas asserted, and CMS does not deny, that CMS has approved rates for this category of services that include the costs of professional services.

CMS says that the private hospitals were not prohibited by state or federal law from billing for the practitioners' services but that Texas has chosen to let the individual practitioners bill directly. Id. at 9. CMS argues that the Texas Occupations Code on which Texas relies does not clearly limit employment of physicians to state hospitals. CMS does not directly deny the assertion by Texas that section 447.10(g) specifically allows the individual practitioners to bill directly, but describes that section as meaning that individual practitioners may receive payment "either through (1) the employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer; or (2) the facility in which the services is [sic] provided if the practitioner has a contract under which the facility submits the claim." Id. at 8.

We agree with CMS that neither the Texas Occupations Code nor section 447.10 prohibits a hospital from ever billing on behalf of a practitioner who provides services in the hospital as part of its inpatient services. Texas has clearly overstated its case. On the other hand, the plain language of section 447.10 clearly restricts the situations in which a provider facility may bill for individual practitioner services to situations where the practitioner is a facility employee whose employment contract provides for such billing or where the practitioner has a contract with the facility permitting it to bill. The regulation thus treats an individual practitioner as a "provider" of facility services for purposes of billing, and permits the practitioner to bill for the professional component of the facility services, unless the practitioner has agreed to let the facility bill.

Moreover, even if direct billing by the practitioner is considered a choice - made either by the facility and practitioner together or by a state - rather than a requirement, that does not change the import of the practice. Since services provided by a practitioner as part of inpatient psychiatric hospital services may be billed by the practitioner who furnished the services, the fact that a service is billed by the practitioner does not by itself establish that the service is not part of the inpatient services provided by the IMD.

CMS provided no evidence to support a general finding that all of the claims at issue were for services provided outside the IMDs by non-IMD providers other than the auditor's declaration regarding her understanding of the claims provided by Texas for audit review and her understanding that the ICNs assigned to the claims indicated they were for outpatient services.

With respect to the ICNs, Texas submitted an affidavit from Diane Broadhurst, an experienced claims processor, averring that, while the ICNs for claims from a hospital (submitted on a CMS UB-40/1350 form) would indicate whether the service was an inpatient or outpatient service, the ICNs assigned to claims for professional services (on CMS 1500 claims forms) would not. Reply Br. Ex. A. We find this statement to be credible, given her experience and given CMS's failure to further address this issue despite an opportunity to do so. CMS did not provide any basis on which we could determine that the ICNs for the CMS 1500 claims forms at issue indicate that the services were for outpatient services.

In any event, as we discuss below, to rebut the audit findings, Texas presented evidence that in fact some of the relevant claims forms contain place of service codes and other information that shows that the claimed services were provided in the IMDs in which the children resided. Thus, the auditor's understanding that all of the claims disallowed were for services provided outside the IMDs was clearly erroneous.

B. Texas presented convincing, reliable evidence that some (but not all) of the disallowed claims were for allowable inpatient psychiatric services.

Texas asserts that--

- the auditors did not remove from the disallowed claims all claims for allowable inpatient psychiatric services;

- the audit workpapers did not contain sufficient claims detail for anyone to determine what type of service was provided or where it was provided, so Texas obtained more detailed claims data; and

- the analysis/evidence of a random, statistical sample of the detailed claims documentation shows that 48.7% of the disallowed claims for medical services were for psychiatric-related services or inpatient medical evaluation and management services provided by physicians or clinical psychologists at the IMD in which the child resided and that 44.0479% of the managed care services (which Texas later clarified meant primary care physician management services) were for such services provided at the IMD in which the child resided.

To support the reliability of its sampling methodology and the conclusions Texas reached based on its analysis of the sample

claims documentation, Texas submitted with its appeal brief the following:

- copies of paper or electronic claims forms for the sample claims (TX Ex. 11); and
- affidavits explaining the bases for the analysis and conclusions reached and the sampling method used (with supporting attachments) (TX Exs. 6-8).

Exhibit 6 is an affidavit by Diane Broadhurst, who is Unit Lead in the Claims Administrator Contract Management section of the Medicaid/CHIP Division, HHSC, and was formerly employed by the National Heritage Insurance Company (NHIC), which processed claims for Texas during the relevant period. She attests that she is familiar with the Texas claims processing system, that she requested copies of the paper or electronic claims forms containing details such as the place of service, the service(s) actually rendered (by procedure code), the provider that rendered the service (by provider number), and the paid amount per claim, per detail. She also supervised Policy Analyst Rhonda Reed in her review and analysis of disallowed claims. Ms. Broadhurst attests that the analysis showed that a large percentage of the disallowed claims were claims for professional inpatient services and that further analysis of professional inpatient services claims revealed that the claims were for professional inpatient services actually rendered onsite at the IMD. Ms. Broadhurst attests that "based on my extensive knowledge and expertise of claims filing requirements particularly as it relates to the Texas Medicaid Program[,] I agree with the methodology [Ms. Reed] used in her analysis and with the resulting findings." TX. Ex. 6, at 2nd page.

Exhibit 7 is the affidavit of Rhonda Reed, who describes herself as currently responsible for analyzing and implementing claims processing policies and for ensuring contractor compliance. She has been in her current position for only 17 months but has worked for 16 years with HHSC. She attests that she worked with the claims administrator to retrieve detailed information related to the disallowed claims. She explains that, using information obtained from the audit workpapers, the current Texas claims administrator was able to pull up the claims details shown in Texas Exhibit 5, based on which she was able to determine that many of the professional services were actually rendered on-site at the IMD in which the client was a resident. TX Ex. 7, 2nd page.

Ms. Reed further explains in her affidavit that, since not all of the claims detail contained a provider name or number for the

facility, she requested copies of the original claims images for the claims. For the claims processed by former contractor NHIC, they had to use "a labor-intensive and manual process" to retrieve and print images, so she decided to request a statistically valid random sample. Id. In response, the HHSC Strategic Decision Support returned lists that constituted statistically valid random samples of the claims, attached as Exhibits 9 (medical services) and 10 (managed care claims). Exhibit 11 contains copies of the actual paper claims that were mailed in by the provider or the electronic claim images that were submitted electronically. Ms. Reed used place of service codes to determine whether services were rendered on an inpatient basis; standard procedure (CPT) codes to validate that the codes were either for psychiatric/counseling services or medical evaluation and management services that are commonly used by psychiatrists to bill for the services they render to patients; and the name and address of the facility where services were rendered to determine whether the services were rendered at the IMD in which the client was a resident. Based on these data elements, Ms. Reed attests, she determined if the services "were actually rendered at the IMD" and "if the services being rendered were for the professional components that were for services that ranged from Psychological and/or psychiatric Services to Evaluation and Management Services as defined by CPT." Id. at 3d page. She then created the Excel spreadsheet at Texas Exhibit 12. She determined that of the 577 medical services claims reviewed, at least 48.7% of the claims were rendered at the IMD for valid psychiatric related services, and that of the 252 managed care claims reviewed, at least 44.0479% were rendered at the IMD for valid psychiatric related services. Id. at 4th page.

Exhibit 8 is the affidavit of Monica Smoot, who has a masters degree in psychology with a subspecialty in statistics and 11 years of experience. Ms. Smoot explains why she chose the sample sizes she did (in order to get a 95% confidence level) and what statistical software package she used to generate the random samples. She affirms that the computer package generated the lists of sample claims at Texas Exhibits 9 and 10.

Texas requested an opportunity to submit claims forms for all of the claims if the Board decided that the sample documentation is not sufficient.[7]

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[7] Texas also said that because the audit was based on claims data that is old (from 9/97 to 8/2000), Texas was not able to obtain all of the claims forms. Texas said that, if the Board

(continued...)

In response, CMS did not challenge the statistical methods Texas used to choose the sample on a random basis and to determine sample size. We find the methods to be valid, based on the record before us. CMS also did not submit any evidence to dispute the accuracy of the information on the claims forms or their authenticity.

CMS points out that Texas in effect has conceded that, for some of the sample claims, Texas has no documentation to show that they were for inpatient services provided in the IMD in which the child resided. We agree and uphold the part of the disallowance related to such claims on that basis.

On the other hand, CMS concedes that some of the sample claims forms have information showing as the place of service the IMD in which the identified Medicaid child resided. CMS Br. at 13. CMS suggests, however, that only the paper, non-electronic claims forms identify the place where the services were rendered and the identity of the billing provider. This is incorrect. Not only do the electronic claims copies in Texas Exhibit 11 contain inpatient place of service codes, but many of them also specifically identify the IMD in which the child resided as the "facility provider" (as distinct from the "billing provider" or "referring provider"). As Ms. Reed explained in her affidavit, the electronic claims show place of service under the column heading "PS" and in a box for "FAC PROV NUMBER" and "NAME." TX Ex. 7, at 3rd page.[8]

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[7](...continued)
were to consider the percentage of claims disallowed in error based on the number of claims files that were located, then the Board could find that approximately 58.6% of the disallowed medical services claims were for services provided in the IMD. We decline to make any such finding. Texas provided no evidence based on which we could determine that claims for which Texas could not locate any documentation would have been for inpatient psychiatric services in the same percentage as the claims for which Texas could locate documentation.

[8] CMS complained that several of the claims forms it received were "too illegible to read." CMS Br. at 15, n. 5. In reply, Texas offered to provide legible copies, and CMS did not reiterate this complaint. The electronic forms submitted to us are sufficiently clear to allow us to ascertain the critical information, when read with the other information in the record.

Even with respect to the paper claims that CMS concedes show the pertinent IMD as the place of service (in Box #32) and the billing provider (in Box #33), CMS argues that the claims data submitted by Texas do not demonstrate that those services provided in an IMD were provided by the IMD because -

- the billing physicians are not listed on the OIG list of IMD providers; and
- Texas has not presented any evidence that the billing physicians have a provider agreement with Texas to provide IMD services pursuant to the Texas Administrative Code.

CMS Br. at 13-14, citing 25 TAC § 419.373(5). In reply, Texas points out that the Texas Administrative Code provision cited by CMS (TAC § 419.373) applies only to IMD services to individuals over age 65. Texas also points out that, in any event, the terms "IMD" and "IMD provider" in that provision refer only to the facility or hospital, not to the professionals/practitioners who provide services in the facility or hospital. Texas provided evidence that shows that it permits a practitioner to bill for his/her services provided as part of a facility's inpatient services if the practitioner is "enrolled" in the Texas Medicaid program. TX Reply Br. Ex. B, at 2nd page. In response, CMS points to nothing in federal or state regulations or policies that would require a physician or clinical psychologist to separately qualify as an IMD and to have an IMD provider agreement with a state in order to evaluate or treat patients in an IMD and to bill for those services.[9]

Thus, we reject CMS's position that the fact that the "billing providers" shown on the claims forms were not IMDs with IMD

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[9] For purposes of a Medicaid fee-for-service program generally, the term "provider" means "any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency." 42 C.F.R. § 400.3; *compare* § 400.2 (Medicare definition of "provider.") Not all Medicaid providers are required, however, to have the type of "provider agreement" that facilities are required to have under 42 C.F.R. Part 489, since the term "provider" is defined more narrowly for that purpose and does not include individual practitioners. We also note that, unlike the definition of "inpatient psychiatric hospital services" for purposes of Medicare, the Medicaid definition of "inpatient psychiatric hospital services for children under age 21" does not specifically exclude the professional services of physicians and clinical psychologists. *Compare* Act § 1861 with Act § 1905(h).

provider agreements undercuts the evidence presented by Texas to show that the claims were, in fact, for inpatient psychiatric services provided by the IMDs in which the children were residing.

CMS does, in response to the evidence Texas presented, argue that some of the sample claims Texas said were provided in an IMD were "clearly improper" because they were provided outside the IMD by non-IMD providers. CMS Br. at 14. Specifically, CMS raises questions about nine of the paper claims, indicating that these are just examples of similar claims. For these claims, CMS lists the information in Box #32 (Place of Service) and Box #33 (Billing Provider). Id. at 15. CMS says that, since Box #32 on each of these claims "does not list an IMD provider that was included on the OIG's list of IMD providers," CMS properly disallowed these claims. Id. at 16.

In reply, Texas submitted a second affidavit from Diane Broadhurst as Exhibit A to the reply brief. In this affidavit, Ms. Broadhurst discusses the CMS examples of services it said were provided outside the facility, and explains why Texas staff determined these were valid claims for inpatient psychiatric services. She says it is a common practice for inpatient facilities to have relationships with either physician, psychiatry, or other health professional groups that come into the facility to provide medical, behavioral health, or other professional treatment to the patients, and that the group then bills using as place of service either code 51 (inpatient psychiatric facility) or code 21 (inpatient hospital), either of which is acceptable on the claim. TX Reply Br. Ex. A, at 5th unnumbered page. With its supplemental reply, Texas also submitted Instructions from the Texas Medicaid Provider Procedures Manuals from 1997-2000, which contain information such as billing instructions, model claims forms, and code information. TX Supplemental (Supp.) Exs. 15-18.

The first six examples given by CMS in its response brief are from claims forms that appear in Texas Exhibit 11a, at pages 12, 18, 21, 25, 28, and 37. With respect to these examples, Ms. Broadhurst explains that--

> both the billing and facility providers are listed in blocks 33 and 32 as SW Psychiatric Physicians at 8535 Tom Slick Dr., San Antonio, Texas 78229-3363. In researching this psychiatric physicians group it was determined that they are directly affiliated with Southwest Mental Health Center (SMHC), an IMD located at 8535 Tom Slick Dr., San Antonio, Texas 78229-3363. SW

> Psychiatric Physicians group provides both inpatient and outpatient care at SMHC (IMD facility). While the claims forms for examples 1 through 6 of [CMS's] table do not show SMHC as the facility provider in block 32, block 24(b) does show a place of service code of 51 (Inpatient psychiatric facility). Based on the documented claims data and the fact that the psychiatric group and the IMD are located at the same address, it is apparent that the services were rendered at the IMD (SMHC).

Id. at 6th unnumbered page. We examined these claims forms and the related information from the auditors in Texas Exhibit 5, at 455, 448, 434, 428, 324, and 413. The comparison shows that, for each of these claims, Southwest Mental Health Center was the IMD in which the child resided, and the admission and discharge dates for the child correspond to the period identified on the claims forms as "hospitalization dates related to current services." In addition, the "type of service" and procedure codes used (99232 and 99233) on the claims forms indicate "subsequent daily hospital care." See, e.g., TX Supp. Ex. 15, at page 33-5. Thus, based on the record as a whole, we find that Texas adequately documented that these sample claims qualify as claims for services provided in and by the IMD.

On the other hand, we agree with CMS that documentation that is comparable to that for the claims CMS gives as examples 7 through 9 is not adequate to support the allowability of the claims, even considered with the supporting affidavits.

For CMS example 7 (from Texas Exhibit 11d, at 836), Ms. Broadhurst justifies a conclusion that the services were for inpatient psychiatric services by explaining that-

> the billing provider is Psychiatric Affiliates of Texas in block 33 and the facility provider in block 32 is Med-Forest Springs at 1120 Cypress Station, Houston. The claims shows a POS code of 3, which is a valid inpatient facility POS code for paper claims. The address 1120 Cypress Station, Houston is Intracare North Hospital, an identified Texas IMD. An assumption can be made that the services were rendered at the IMD and the biller entered the wrong facility name.

TX Reply Br., Ex. A, at 6th to 7th pages. For CMS examples 8 and 9, Ms. Broadhurst states that--

> the billing provider is listed as Primary Medicine

> Clinics in block 33, with Drs. Timothy Sharma and Wayne Keller as the performing physicians, who are psychiatrists. Primary Medicine Clinics is also listed as the facility provider in block 32, with a POS code of 21 in block 24(b). In block 17(a) of both claim forms, the name of the referring provider is listed as either Intracare North Hospital or Intracare Med Ctr Hosp. It is a common billing error for filers to reverse the placement of the facility and referring providers, which is most likely the case in these two examples.

Id. at at 7th page. Ms. Broadhurst attests that there is a "reasonable certainty that these services were rendered onsite at the IMD and are valid claims for the professional behavioral health services rendered to the IMD residents." Id.

We first note that examples 7-9 in CMS's brief are for managed care claims which Texas did not include in the list of the 111 managed care sample claims its analysis found were for inpatient psychiatric services rendered in the IMD in which the child resided. TX Ex. 12b, information for ICNs 204400175216033 (Med-Forest Springs), 204400143325045 (Primary Medicine Clinics, and 2044001433253038 (Primary Medicine Clinics).[10] On the other hand, similar claims documentation was submitted for some sample claims that were included in the 111 sample managed care claims Texas asserts were allowable. Specifically, documentation for one paper claim (with ICN 204400220374058) shows Med Forest Springs as the place of service in Box #32 and Psychiatric Associates as the billing provider in Box #33. TX Ex. 11e, at 989. Similarly, the documents for eight sample electronic claims show Intracare as the referring provider and Primary Medicine Clinics as the facility provider. TX Ex. 11e, at 997, 999, 1001, 1003, 1005, 1009, 1025, 1031.[11] Also, the place of service code

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[10] The documents related to the 111 claims for which the Texas summary shows "yes" in the column labeled "Rendered in IMD" are in Texas Exhibit 11e, rather than in Exhibit 11d. Apparently, CMS did not realize this because the Reed Affidavit mistakenly says they are in Exhibit 11d. See TX Ex. 7.

[11] We note that the paper claim form at page 1048 of Texas Exhibit 11e also has Primary Medicine Clinics in Box 32, but it clearly was attached to the form at page 1047, which has the same ICN, 394400111681054, and shows Intracare Hospital, with its correct address, as the place of service. Moreover, both forms have 12/09/99 to 12/21/99 as the "hospitalization dates related

(continued...)

for these claims is 21, which could be used for inpatient hospital services other than services in the IMD in which the child resided. Id. While it may be true, as Ms. Broadhurst attests, that the flaws in the documentation were simply the result of common billing errors, we decline to make that assumption for these claims. The analysis she and Ms. Reed performed treated some similar claims documentation as not sufficient to show that the services were rendered in an IMD. TX Ex. 12b (lines referring to Med Forest Springs or Primary Medicine Clinics, with a "no" in the relevant column). The affidavits provide no explanation for treating these similar claims differently.

For all of the other sample claims, however, we find that the documentation and evidence submitted by Texas, including place of service codes and procedure codes that indicate the claims were for inpatient psychiatric, psychotherapy, or evaluation and management services, adequate to rebut the audit findings that the services were provided outside the IMD by providers other than the IMD in which the child resided.

In sum, we uphold the disallowance related to claims for which Texas concedes its analysis did not show the claims were for inpatient services. For nine of the 111 sample managed care claims Texas identified as inpatient psychiatric services, we find the evidence inadequate to show that the services were allowable. For the remaining sample claims, we find that Texas has submitted adequate evidence to support its analysis, and that CMS has provided no persuasive reason for rejecting that evidence.

III. CMS's argument that payments for the professionals' inpatient services would duplicate payments to the IMDs because Texas used an "all inclusive" per diem rate to reimburse the IMDs for their services is unfounded.

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[11](...continued)
to current services." This period corresponds to the dates of admission to and discharge from Intracare for the child at issue (Medicaid #510734869). TX Ex. 5, Managed Care Claims Tab at 58. The procedure code is 99233 (subsequent hospital care) for each service date between 12/10/99 and 12/20/99, and 99239 (hospital discharge day management) for 12/21/99, the day the child was discharged from Intracare. TX. Ex. 11e, at 1047-1048. Thus, we find this documentation adequate to show the claims on the form were for the inpatient psychiatric hospital services Intracare provided to the child.

In its response brief, CMS raised for the first time a question about whether separate payments to professionals providing services in the IMDs would duplicate payments already made to the facilities. CMS cites to provisions of chapters 355 and 419 of the Texas Administrative Code regarding the reimbursement methodology for "IMD services." CMS Response Br. at 7. CMS acknowledges that the criteria and methodology in these provisions deal with "services to individuals aged 65 and older," but asserts that the provisions are "relevant and provide guidance to a provider's eligibility for reimbursement" for services to individuals aged 21 and younger. Id. Based on the cited provisions of the Texas Administrative Code, CMS argues that the payments were not consistent with the Texas reimbursement methodology, which provides that the per diem rate is "inclusive of all costs" so that, to the extent a billing physician seeks reimbursement for IMD services, he must "submit costs to an IMD provider for inclusion in the IMD's Medicare cost report." Id. at 17.

After Texas objected in its reply brief to CMS raising this new issue, the Board set further procedures. Texas was given an opportunity to supplement its reply and exhibits, followed by a CMS surreply and a final Texas response. The evidence Texas presented shows persuasively that there is no merit to CMS's new assertion.

A. Texas presented persuasive evidence that the IMDs' per diem rates did not include the costs of professional services.

The evidence shows that Texas had two approved reimbursement methodologies for inpatient psychiatric hospitals during the audit period. The first was the State Plan methodology under the following provision, which has been in effect since 1992:

> EPSDT DIAGNOSTIC AND TREATMENT SERVICES NOT OTHERWISE COVERED UNDER THE STATE PLAN
>
> Inpatient psychiatric hospital services furnished to EPSDT recipients. The psychiatric hospital must be accredited by the Joint Commission on Accreditation of Healthcare Operations (JCAHO). The single state agency or its designee reimburses psychiatric hospitals using Medicare principles of reasonable cost reimbursement found at 42 CFR 413, but without applying the Tax Equity and Fiscal Responsibility Act (TEFRA) rate of increase limits. The single state agency or its designee establishes interim payment rates. . . .

> Except for payment as described in this attachment for inpatient hospital services, payment for authorized medically necessary services required to diagnose and treat a condition found on EPSDT medical screening will be based on existing Medicare and Medicaid reimbursement methodologies.

TX Supp. Ex. 1. As Texas explains, the Medicare hospital prospective payment system did not at the time apply to psychiatric hospitals or units, and the reasonable cost reimbursement methodology applied only to payments to the hospital for services covered by Part A since Medicare reimburses for professional services under Part B. TX Supp. Br. at 9-10. The evidence supporting this includes the Medicare Provider Reimbursement Manual and an affidavit by Richard Bledsoe. TX Supp. Exs. 4 and 9.

The Medicare manual distinguishes between services a professional provides to a hospital that benefit the general population of the hospital or are emergency services (which are called "provider services" for purposes of reasonable cost reimbursement) and services the professional provides to individual patients (called "professional services") that are not considered an allowable cost for purposes of determining a hospital's per diem reimbursement rate. According to the Bledsoe Affidavit, since CMS approved Texas using the Medicare methodology, Medicaid IMDs in Texas were required to use CMS-approved Medicare software for their cost reports. TX Supp. Ex. 9, at 2. The software automatically excludes the cost of the professional component from the allowable costs used in setting the per diem rate. Id. at 3-4. The IMDs also were required to follow instructions that provided for excluding such costs. Id. at 2-3. Attachments to the Bledsoe Affidavit include the instructions and the IMDs' cost reports showing adjustments for professional services costs. These cost reports each contain Worksheet A-8-2, which identifies the professional services costs, if any, to be excluded from the IMDs' costs used for rate-setting.

The second reimbursement methodology was under a selective contracting program called the LoneSTAR Waiver. Texas negotiated with IMDs in the largest metropolitan areas for per diem rates that were paid on a prospective basis (i.e., not subject to adjustment based on actual costs). Texas explains that, since the starting point for these negotiations was based on the hospital's latest audited cost report (and the resulting per diem value), the negotiated reimbursement rates necessarily excluded the costs associated with professional services. TX Supp. Br. at 14, citing Affidavit of Richard Peters, TX Supp. Ex. 8.

Texas also submitted further support for its assertions, including an affidavit by Kevin Nolting, Director of Hospital Reimbursement for HHSC, and formerly Chief Financial Officer of the Texas Department of Mental Health and Mental Retardation. TX Reply Br. Ex. B. Attached to this affidavit is an example of a Medicare cost report for the Austin State Hospital (with instructions), showing "typical" adjustments to exclude from the calculation of the inpatient per diem rate costs associated with services provided to individual patients by professionals such as psychologists, psychiatrists, and general physicians.

B. CMS presented no evidence to support a finding that Texas was paying an "all-inclusive" rate to the IMDs, and its arguments about the evidence Texas presented have no merit.

CMS submitted no evidence to support its assertion that Texas was paying an "all-inclusive" per diem rate for inpatient psychiatric hospital services for children during the disallowance period. Instead, CMS tries to undercut the evidence Texas submitted, by raising questions based on the evidence presented by Texas. None of these arguments has merit.

First, CMS questions whether the quoted State Plan provision in fact applied to the services at issue. CMS claims in effect that it cannot tell if the quoted provision applies because Texas has not provided evidence that the services at issue were EPSDT services. As Texas points out, however, the audit found the services were provided to individuals under age 21, and a prerequisite for claims for inpatient psychiatric facility services for individuals under age 21 is that they be medically necessary. Also, CMS's own State Medicaid Manual (at 4390) requires a state to provide inpatient psychiatric services for individuals under age 21 as EPSDT services if they are determined to be medically necessary (even if the State plan does not cover such services). Texas would need a plan provision specifically establishing a reimbursement method for inpatient psychiatric services required by the EPSDT Program if the Texas State Plan did not opt to cover such services generally. Documents related to the State Plan provision on which Texas relies show that, at the time it was submitted, CMS questioned why Texas was not submitting an amendment to cover the services, but only a reimbursement provision, acknowledging that the reason for this might be that the services were being provided only as an EPSDT benefit. TX Supp. Ex. 2.

CMS states no reason for not crediting all of the evidence Texas submitted showing that, in fact, it was using the Medicare

reasonable cost methodology to calculate the relevant per diem rates for IMDs not in the LoneSTAR program. As noted above, CMS acknowledges that the Texas Administrative Code provisions on which its argument relies apply to services to individuals aged 65 and older. Moreover, CMS cites to no other State Plan provision applying to inpatient psychiatric hospital services during the disallowance period. CMS argues merely that the Texas Administrative Code provision Texas cites as the applicable one (section 8063(w)) was not effective until 2008. CMS Surreply at 9, citing CMS Ex. 4. Yet, the version of this provision that CMS submitted is clearly the version that Texas amended to adopt a prospective reimbursement system, not the version that was in effect during the disallowance period. CMS Ex. 4. Texas explains that CMS approved its new system in 2008. TX Response to Surreply at 4.

CMS also asserts that--

> Texas also did not inform CMS through its State Plan that Texas intended to claim FFP for payments made to individuals or entities other than inpatient psychiatric facilities or programs. Clearly, Texas did not place CMS on notice that IMDs were going to "out source" the integral part of the IMD coverage for reimbursement of FFP purposes namely, inpatient psychiatric services which involve active treatment of the patients' mental health condition.

CMS Surreply at 7. CMS should have known that professional services would be reimbursed separately from the per diem rate, however, since the State Plan provision in question adopted a CMS rate-setting methodology that specifically excludes the costs of professional services from the rate calculation. The State Plan provision also refers to other approved reimbursement methods, and, as discussed above, Texas presented evidence that shows it consistently interpreted its plan to allow physicians or their billing groups to bill separately for Medicaid inpatient services using those methods.

CMS appears to have misread a statement in the Nolting Affidavit, moreover. In explaining the Medicare reasonable cost reimbursement methodology, Mr. Nolting states that the "per diem only covers what would be described by a layperson as 'room and board.'" TX Reply Br., Ex. A, at 4th page. CMS read this to mean that, in fact, only room and board was covered by the rates, arguing that such a system is inconsistent with the active treatment requirement. The only costs Mr. Nolting mentions as being excluded from the rate calculations, however, are the costs

of "professionals such as psychologists, psychiatrists and general physicians." Id. at 3rd page. In any event, notwithstanding Mr. Nolting's statement about how a layperson would describe the costs covered by the per diem rate, the cost reports submitted by Texas (and the manual provisions on CMS's own Medicare reasonable cost methodology) show that the per diem rate covered the hospital routine care costs, such as nursing services, not just room and board. This evidence is stronger and more reliable evidence about what the rates included than the ambiguous statement in the affidavit. Thus, we reject CMS's arguments that are based on the erroneous premise that Texas was paying only for custodial care, contrary to the regulations.

CMS further argues that Texas represented that payments under the LoneSTAR contracting program would be "a cost-effective means of providing *a full range of certain inpatient services* to the requested Medicaid population." CMS Surreply at 5 (emphasis in original), citing TX Supp. Ex. 11, at 1-2. CMS says that the Texas Legislature directed the HHSC to ensure that providers receiving contracts meet the needs of Medicaid recipients. Id., citing TX Ex. 11, at 2-3. According to CMS, any payments to physicians made in addition to the contracted per diem rates "were made contrary to the Legislature's directive to ensure that providers receiving contracts met the needs of Medicaid recipients who, in this case, were residents of IMDs" and "were also contrary to the Program's objective to be a cost-effective means of providing a full range of inpatient psychiatric services to IMD residents." Id. at 6. Thus, CMS argues, it properly disallowed the payments for additional physician costs.

These arguments have no merit. Texas could achieve the objective of reducing costs while providing needed services by negotiating per diem rates for the IMDs lower than the rates it otherwise would have paid (both of which excluded costs of "professional services"). Indeed, in describing the cost savings due to reductions in payment rates, the document Texas submitted regarding this program compares payment rates not affected by the waiver with the negotiated prospective rates paid under the LoneSTAR program. TX Supp. Ex. 11, at 28; App. A (CMS approval letter of March 10, 1995, referring to contracts negotiated using rates other than cost-related reimbursement). The document also provides that in order to assure access to care, Texas will require contractors to agree "to grant admitting and clinical privileges to all qualified practitioners who apply for such privileges for purposes of treating Medicaid patients and who meet the reasonable professional standards and criteria established" by the inpatient psychiatric facility. Id. at 37. This suggests that Texas anticipated (and CMS was aware) that

some of the treatment in the facilities would be by professionals who had "privileges" at the facilities, but were not facility employees.

IV. The disallowance amount should be recalculated.

Since we find that Texas has fully rebutted the CMS finding that all of the services were provided outside the IMDs by non-IMD providers, as well as CMS's assertion that payments for these services would duplicate the per diem rates paid to the IMDs, we reverse the disallowance in part. Specifically, we reverse the disallowance with respect to:

- "medical claims" represented by the 281 sample claims in Texas Exhibit 11a for which we have found the documentation adequate; and

- managed care/primary care physician management claims represented by the 102 (111 - 9) sample claims in Texas Exhibit 11e for which we have found the documentation adequate.

We note that, while Texas presented evidence that it used statistical sampling methods to determine an appropriate sample size and to generate a random sample, that evidence does not show that Texas used statistically accepted methods to extrapolate the results of the sample to the relevant universes of claims at issue. TX Exs. 7-8. It appears that Texas simply calculated a percentage for each type of claim by dividing the number of sample claims that its analysis found to be for inpatient psychiatric services by the total number of sample claims of that type and then applied each of those percentages to the corresponding disallowance amounts. What is at issue, however, is not the number of claims that are allowable, but the amount of payments allowable for FFP. The amount allowable for each service category represented by the amounts for the allowed sample claims for that category (and the FFP amounts by which the disallowance should be reduced) must therefore be recalculated. The parties may apply a valid statistical methodology to extrapolate the results of the sample to the universe of claims for each category, or any other reasonable method to which the parties agree, consistent with our decision.

Conclusion

For the reasons stated above, we uphold the disallowance in part and reverse it in part, in an amount to be determined consistent with our decision.

Leslie A. Sussan

Constance B. Tobias

Judith A. Ballard
Presiding Board Member