PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D29

PROVIDER –
St. Anthony Hospital

Provider No.:
37-0037

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

ON REMAND

Cost Reporting Period Ended –
December 31, 2006

CASE NO.
14-2968

INDEX

ISSUE STATEMENT

Should Medicaid days attributable to child and adolescent patients who received services in three of the Provider's inpatient behavioral health units licensed as psychiatric residential treatment facilities ("PRTFs"), namely ACCENTS (Unit 1929), Human Restorations (Unit 1930), and the Positive Outcomes (Unit 4519), during fiscal year ending December 31, 2006 ("FY 2006") be included in the Medicaid fraction of the Provider's Medicare disproportionate share hospital ("DSH") payment.[1]

DECISION

After considering Medicare law, regulations and guidance, testimony and arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") has compared the level of care generally provided during FY 2006 to the patients of St. Anthony Hospital's ("St. Anthony" or "Provider") in its hospital-based Units 1929, 1930, and 4519 to acute care psychiatric services provided in a general Inpatient Prospective Payment System ("IPPS") hospital, as directed on remand by the Administrator. The Board finds that the level of care generally provided in these PRTF units during FY 2006 was not equivalent to the acute care psychiatric services provided in a general IPPS hospital and was not generally payable under IPPS. Accordingly, the Medicare Contractor properly excluded the PRTF patient days at issue from the Medicaid fraction of St. Anthony's Medicare DSH payment for FY 2006.

INTRODUCTION

St. Anthony is a 685-bed acute care hospital located in Oklahoma City, Oklahoma. During the time period at issue, St. Anthony's designated Medicare contractor[2] was TrailBlazer which was succeeded by Novitas Solutions, Inc. The Board will refer to both entities collectively as the "Medicare Contractor."

St. Anthony operates six separate hospital-based units that provide inpatient psychiatric care to children and adolescents under the age of 21. Two of these units are licensed as psychiatric acute care units by the Oklahoma Medicaid Program ("OMP"). The Medicare Contractor conducted an audit of the patient days from the psychiatric units and included the days from the two certified acute care units in the Medicare DSH calculation while excluding the patient days from the other four psychiatric units.[3]

The four units, whose patient days were excluded from the DSH calculation, are licensed as residential treatment centers ("RTCs") and participate in the OMP as hospital-based PRTFs.[4] Following a medical review, the Medicare Contractor determined that one of the PRTFs met the

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[1] Transcript ("Tr.") at 5-6 (Mar. 30, 2015). As the hearing was held over the course of four days, March 30-31, 2015 and May 27-28, 2015, the Board will refer to the transcript for each day by its date. Further, the Board notes that all exhibits cited in this decision reference the general series of exhibits submitted by the Provider and the Medicare Contractor, not the set of exhibits that the parties submitted solely in connection with the Provider's objection to the admissibility of the testimony of Dr. Baer.

[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[3] *See* Okla. Admin. Code § 317:30-5-95 (copy included at Provider Exhibit P-7); Tr. at 355 (Mar. 30, 2015).

[4] Tr. at 150-152 (May 28, 2015); Provider Exhibits P-13 at 1, P-62; Medicare Contractor Exhibit I-10 at 3.

acute care standard of care and included inpatient days from that unit in the Medicare DSH calculation.[5] However, the medical review confirmed that the inpatient days for patients in three remaining PRTF's (the ACCENTS Unit, the Human Restoration Unit, and the Positive Outcomes Unit, collectively referred to as the "Three Disputed Units" or "Units") did *not* meet the level of care generally payable under IPPS. As such, the patient days from the Three Disputed Units were *not* included in the Medicare DSH calculation and are at issue in this case.

St. Anthony timely appealed the Medicare Contractor's determination as it related to the Three Disputed Units and met the jurisdictional requirements for a hearing before the Board. Accordingly, the Board held a hearing on March 30-31, 2015, and May 27-28, 2015. Mark D. Polston, Esq., and Daniel J. Hettich, Esq., of King & Spalding, LLP, represented St. Anthony and Brendan G. Stuhan, Esq., and Robin M. Sanders, Esq., of the Blue Cross and Blue Shield Association represented the Medicare Contractor.

The Board issued a decision, dated December 29, 2017, wherein a Board majority found that the patient days at issue for the Three Disputed Units should be included in the Medicaid fraction of the DSH payment calculation for FY 2006 because the patient days for the Three Disputed Units met the Medicare requirements for acute level of care. As a consequence, the Board majority reversed the Medicare Contractor's decision and remanded to the Medicare Contractor with directions to include these patient days in the Medicaid fraction of St. Anthony's DSH payment calculation for FY 2006.[6]

Following the Board's decision, the Medicare Contractor and the Centers for Medicare and Medicaid Services ("CMS") submitted comments to the CMS' Administrator requesting that the Board's majority decision be reversed.[7] The Provider also submitted comments, requesting that the Administrator decline review and allow the Board's majority decision to stand.[8] The parties were notified of the Administrator's intention to review the Board's majority decision and received subsequent comments from St. Anthony.[9] The Governor of the State of Oklahoma, the U.S. Congressional delegation from the State of Oklahoma and other members of the community submitted letters in support of the Provider's position.[10]

On March 6, 2018, CMS' Administrator issued an Order that vacated the Board's majority decision and remanded this case to the Board "for further review and, as the Board finds appropriate, further briefing by the parties . . . to determine whether the services generally provided in the [Three Disputed Units] were services generally payable under IPPS."[11] On April 6, 2018, the Board issued an Order that reopened this case and directed the parties to submit their briefs addressing the issues raised by the CMS Administrator's Order within 60 days of the

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[5] Since the PRTF that the Medicare Contractor determined met an acute level of care was *not* part of the Board appeal, the Board did *not* review (and makes no findings on) the Medicare Contractor's determination to include days associated with that PRTF unit in the DSH calculation.
[6] *St. Anthony Hosp. v. Novitas Solutions, Inc.*, PRRB Dec. 2018-D12 (Dec. 29, 2017).
[7] *St. Anthony Hosp. v. Novitas Solutions, Inc*., Adm'r Dec. at 1 (Mar. 6, 2018), *vacating and remanding* PRRB Dec. No. 2018-D12 (Dec. 29, 2017) (hereinafter "*St. Anthony* Adm'r Dec.").
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.* at 18.

Board's Order. Having received the supplemental briefs with additional exhibits from both parties, this matter (per the Administrator's Order) is now ripe for decision by the Board.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program generally pays hospitals a fixed, predetermined rate for each inpatient discharge based on the patient's diagnosis-related group ("DRG").[12] In addition to the DRG payment, the IPPS adjusts a hospital's payment based on various hospital-specific factors, one of which is the Medicare DSH adjustment[13] at issue in this appeal. The DSH adjustment is a proxy measurement that is intended to represent the number of low-income patients that a hospital serves[14] as measured in "patient days."[15] The DSH adjustment is calculated by adding two fractions, generally referred to as the Medicare fraction and the Medicaid fraction.[16] Specifically, this appeal involves a dispute over the number of patient days to be included in the numerator of the Medicaid fraction.

St. Anthony maintains that, until 2008 when an onsite audit of St. Anthony's FY 2006 cost report was conducted, the Medicare Contractor had allowed the patient days from the Three Disputed Units to be included in the Medicaid fraction used in St. Anthony's DSH calculation.[17] Following the 2008 onsite audit, the Medicare Contractor disallowed patient days from the four of the six psychiatric units from being included in St. Anthony's Medicaid DSH fraction on the basis that the care provided in those units did not meet the criteria for acute care.[18] At the direction of CMS, the Medicare Contractor conducted a medical review of all of the Six Psychiatric Units and prepared a report of its findings (the "TrailBlazer Report") to validate the audit results.[19]

The Medicare Contractor conducted the CMS-directed medical review through the examination of patient days for thirty (30) inpatient stay records from the Six Psychiatric Units. There is no indication in the Trailblazer Report (or elsewhere in the record) as to how the sample was structured (*e.g.*, stratification) and selected and whether sample was statistically valid (*i.e.*, a representative sample).[20] Of the 30 inpatient stays sampled, only 17 pertained to the Three Disputed Units.[21] The review only related to certain portions of those patient's inpatient stay and used the InterQual Behavioral Health Child and Adolescent Acute Care screening criteria ("InterQual Criteria") to analyze those portions.[22] The InterQual Criteria were used to determine, for each patient day reviewed:

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[12] 42 U.S.C. § 1395ww(d)(2)-(3). *See also* 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[13] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[14] *Id.*
[15] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] *Id. See also Metropolitan Hosp. v. U.S. Dept. of Health and Human Servs.,* 712 F.3d 248, 251 (6th Cir. 2013).
[17] Provider's Position Paper at 11; Tr. at 95-96 (May 28, 2015). The record is unclear about the full nature and extent of the onsite audit that the Medicare Contractor conducted.
[18] *See* Exhibit I-19; Exhibit I-10 at 3.
[19] Exhibit I-10 at 4.
[20] *See, e.g.,* Tr. at 487-492 (Mar. 31, 2015); Medicare Contractor Exhibit I-10. The 17-patient sample consists of 3 patients from the ACCENTS Unit, 7 patients from the Human Restorations Unit, and 5 patients from the Positive Outcomes Unit; however, only portions of the medical record were reviewed for these 17 patients. *See id.*
[21] *See supra* note 20.
[22] *See generally* Ex. I-10.

(1) Whether the severity of the patient's illness required an acute level of care; and

(2) Whether the patient received the intensity of services required for an acute level of care.[23]

Generally, each patient record was reviewed under the InterQual Criteria for the first day of the patient admission, for continued stay days beginning on the day after the DRG length of stay (plus five days) for 10 consecutive days and, if a patient remained admitted on day 61, for an additional five days.[24] Based on the InterQual Criteria, the Medicare Contractor concluded that three of St. Anthony's psychiatric units (the Children's Unit, the Adolescent Unit, and the Children's RTC Unit) met the criteria for acute care.[25] The medical review validated the audit results for the Three Disputed Units concluding that they did not satisfy the acute care requirements for IPPS because less than 50 percent of the patient days sampled met the acute inpatient admission criteria.[26]

On February 13, 2014, the Medicare Contractor issued to St. Anthony the FY 2006 Notice of Program Reimbursement ("NPR") and assessed St. Anthony with an overpayment of $5,535,004.[27]

Within the instant appeal, the parties dispute the application of the regulation at 42 C.F.R. § 412.106(a)(1)(ii) (2006) as it relates to the meaning of the term "acute care services" and whether the patient days associated with the Three Disputed Units should be included in the Medicaid fraction of the DSH calculation.

As part of the initial proceedings and hearings held in 2015, St Anthony contended that patients in the Three Disputed Units were acutely ill and had diagnoses that squarely fit within the DRGs payable under IPPS.[28] As part of this contention, St. Anthony argued that the Medicare program covers inpatient psychiatric care (regardless of length of stay) and that the intensity of services furnished in the Three Disputed Units (*e.g.*, nature of care, frequency of physician visits and levels of staffing)[29] qualifies as acute inpatient care in the psychiatric community. In support of its position, St. Anthony presented the testimony of the medical directors from the Three Disputed Units (Drs. Holloway and Bell)[30] and two medical experts on adolescent and psychiatry and psychiatric levels of care (Drs. Kaminski and Divincenzo).[31] Finally, St. Anthony recognized that the OMP designated the Units as PRTFs but claimed that this designation was irrelevant and can be ignored[32] and suggested that the PRTF designation was only necessary for state Medicaid "reimbursement purposes."[33]

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[23] *Id.* at 5.
[24] *Id.* A full description of the review process is set forth in the Trailblazer report.
[25] Medicare Contractor's Position Paper at 18.
[26] Ex. I-10 at 11.
[27] Exhibits P-1, P-2, P-4.
[28] Provider's Position Paper at 16, 39; Provider Exhibit P-28; Provider's Updated Post-Hearing Brief at 9-35.
[29] Provider's Position Paper at 40-42; Provider's Updated Post-Hearing Brief at 24-27.
[30] Dr. Holloway was the medical director of the ACCENTS and the Human Restoration Units and Dr. Bell was medical director of the Positive Outcomes Unit (as well as another unit known as the Adolescent Unit that is not at issue in this appeal). Tr. at 23 (Mar. 30, 2015); Tr. at 5 (Mar. 31, 2015).
[31] Tr. at 156-57 (Mar. 31, 2015); Tr. at 210 (May 27, 2015).
[32] Provider's Updated Post-Hearing Brief at 36-45.
[33] *See, e.g.* Tr. at 26-28 (Mar. 30, 2015).

In contrast, as part of the initial proceedings and hearings held in 2015, the Medicare Contractor argued that the care provided in the Three Disputed Units did not meet the standard for "acute care" as defined by the Secretary, *i.e*., "necessary treatment of a disease or injury for only a short period of time in which a patient is treated for a brief but severe episode of illness."[34] In support of its positions, the Medicare Contractor referred to the following facts to suggest that the patients of the Three Disputed Units did not receive the type of care provided in an acute care setting:

- Some patients were placed on a waiting list until a bed became available in the relevant unit;
- Some patients had passes to leave the relevant unit; and
- The patients had significant recreational and educational activities during their stays.[35]

Finally, the Medicare Contractor argued that St. Anthony's registration of the Three Disputed Units as PRTFs in the OMP belies the claim that these units provide acute care.[36] The Medicare Contractor states that St. Anthony "self-designated" its Psychiatric Units as PRTFs which, under Oklahoma law, do not provide acute care services. In support of its position, the Medicare Contractor presented the testimony of a medical expert in Medicare coverage and psychiatry (Dr. Baer).[37]

The Board issued a decision, dated December 29, 2017, wherein a Board majority found that the patient days at issue for the Three Disputed Units should be included in the Medicaid fraction of the DSH payment calculation for FY 2006. As a consequence, the Board majority reversed the Medicare Contractor's decision and remanded to the Medicare Contractor with directions to include these patient days in the Medicaid fraction of St. Anthony's DSH payment calculation for FY 2006.[38]

On March 6, 2018, CMS' Administrator issued a decision that made the following findings:

> In sum, the Board [majority] was incorrect in finding the services provided [in the Three Disputed Units] were the same regardless of whether the benefit was provided *in the* ***psychiatric hospital*** *or PRTF*. In addition, in equating the services provided under a PRTF as being the same as those services provided *in a (****non-IPPS****) section 1861(f) hospital*, the Board's finding does not provide support for inclusion of these days in this case. The focus should be on the level of care generally provided in the PRTF compared to *acute care psychiatric services provided in a general IPPS (short term) hospital*. In addition, not addressed by the parties is the impact if any of the PRTF as identified as an IMD [*i.e.*, institution for mental diseases] at 59 Fed[.] Reg. 59624, in light of, *inter alia*, the statutory definition of a hospital under section 1861(e), the definition of a[] section 1886(d)

[34] Medicare Contractor's Final Position Paper, at 13-14 (emphasis omitted).
[35] *Id.* at 14-15.
[36] *Id.* at 17.
[37] Tr. at 384 (Mar. 31, 2015).
[38] *St. Anthony Hosp. v. Novitas Solutions, Inc.*, PRRB Dec. 2018-D12 (Dec. 29, 2017).

> hospital and the exclusion as of IMD services as inpatient hospital services under section 1905 of the [Social Security] Act.[39]

Accordingly, the Administrator *vacated* the Board's majority decision and remanded this case to the Board "for further review and, as the Board finds appropriate, further briefing by the parties . . . to determine whether the services generally provided in the [Three Disputed Units] were services generally payable under IPPS."[40]

On remand, St. Anthony first argues that the relatively long lengths of stay in the Three Disputed Units during FY 2006 should not alter the Board's prior determination that the services furnished in these Units "meet the definition of acute care services that would be paid under the hospital prospective payment system." In support of this position, St. Anthony maintains that there can be no categorical exclusion of long lengths of stay from DSH and that any comparison to lengths of stay associated with single a DRG admission is misleading since it fails to account for readmissions over a spell of illness. Similarly, St. Anthony maintains that the vacated Board majority decision[41] already properly determined that the type of care provided in Medicare-excluded psychiatric units during FY 2006 is comparable to the type of care provided in short-term acute care units.

Second, St. Anthony argues that, during FY 2006, the Three Disputed Units met the Medicare standards for non-excluded units. In support of this position, St. Anthony asserts that active treatment for psychiatric care does not vary by exclusion status. In addition, St. Anthony maintains that the care furnished in the Three Disputed Units during FY 2006 met the statutory and regulatory requirements for inpatient services because it met the non-excluded unit standards relating to admission, continued stays, and medical records.

Finally, St. Anthony argues that the vacated Board majority decision was correct that the PRTF payment is not determinative as to whether the disputed unites "provide acute care services." In support of this position, St. Anthony maintains that a service cannot be presumed to be non-acute merely because it was billed at the PRTF rate and that St. Anthony and the Three Disputed Units are a subsection (d) hospital under any definition.

In contrast, the Medicare Contractor argues on remand that the level of care in Three Disputed Units does not come close to the level of care of a patient with a psychiatric diagnosis properly admitted to a general IPPS paid short-term acute care bed. The Medicare Contractor further maintains that the PRTFs are by definition a nonhospital setting as demonstrated by the following excerpt from the proposed rule published on November 17, 1994: "A PRTF is a community based facility that provides a less medically intensive program of treatment than a psychiatric hospital or a psychiatric unit of a general hospital."[42]

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[39] *St. Anthony* Adm'r Dec. at 18 (emphasis in original).
[40] *Id.*
[41] *I.e.*, the original Board majority decision issued on December 29, 2017 that the Administrator vacated on March 6, 2018.
[42] MAC Brief and Response to Notice of Reopening and Board Order at 11-12 (July 18, 2018) (quoting 59 Fed. Reg. 59624, 59627 (Nov. 17, 1994)).

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

As directed on remand, the Board "determine[d] whether the services generally provided in the [Three Disputed Units] were services generally payable under IPPS" by comparing "the level of care generally provided in the [Three Disputed Units] to acute care psychiatric services provided in a general IPPS (short term) hospital."[43] Further, as directed on remand, the Board assessed "the impact if any of the PRTF, as identified as an IMD [*i.e.*, institution for mental diseases] at 59 Fed Reg. 59624, in light of, *inter alia*, the statutory definition of a hospital under section 1861(e), the definition of an section 1886(d) hospital and the exclusion as of IMD services as inpatient hospital services under section 1905 of the Act."[44] In conjunction with the Remand Order and an analysis of the record, the Board has determined that the vacated Board majority decision was incorrect and, as set forth below, reverses certain findings made in that *vacated* decision.

A. The General Level of Care Provider in PRTFs Is Not Comparable to Acute Care Provider in an IPPS Short-Term Acute Care Hospital.

Analysis of this appeal must begin around what the term "acute care" means in the following excerpt from 42 C.F.R. § 412.106 (2006) entitled "Special treatment: Hospitals that serve a disproportionate share of low-income patients":

> (a) *General considerations*. (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
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> * * *
>
> (ii) For purposes of this section, the number of patient days in a hospital i**ncludes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system** and excludes patient days associated with –
>
> (A) Beds in excluded distinct part hospital units;
>
> * * *
>
> (C) Beds in a unit or ward that is not occupied **to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system** at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month); . . .[45]

During 2006, the time period relevant to this appeal, the Board has identified no other statute, regulation or Medicare program guidance in effect that specifically defined the term "acute care."

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[43] *St. Anthony* Adm'r Dec. at 18.
[44] *Id.*
[45] (Emphasis added.)

As such, the Board turns to the guidance provided by the Secretary when 42 C.F.R. § 412.106 was promulgated through the final rule published on August 1, 2003 (the "2003 Final Rule").[46] In its discussion of the 2003 Final Rule, the Secretary confirmed that it was revising § 412.106(a)(1)(ii), in part, as a result of its disagreement with the decision of the Ninth Circuit Court of Appeals in *Alhambra Hosp. v. Thompson* ("*Alhambra*").[47] In *Alhambra*, the provider operated units that were licensed in California as skilled nursing facility ("SNF") beds but were not similarly certified by Medicare. The California Medicaid Program classified the units as "subacute" care units that provided less intensive care than acute care units, but more intensive skilled nursing care than is typically provided in a SNF.[48] The Secretary addressed *Alhambra* court's ruling in the preamble to the 2003 Final Rule as follows:

> As noted previously, a recent decision in the Ninth Circuit Court of Appeals (*Alhambra v. Thompson*) ruled that days attributable to groups of beds that are not separately certified as distinct part beds (that is, nonacute care beds in which care provided is generally at a level below the level of routine inpatient acute care), but are adjacent to or in an acute care ''area,'' are included in the ''areas of the hospital that are subject to the prospective payment system'' and should be counted in calculating the Medicare DSH patient percentage.
>
> In light of the Ninth Circuit decision that our rules were not sufficiently clear to permit exclusion of bed days based on the area where the care is provided, in the May 19, 2003 proposed rule, we proposed to revise our regulations to be more specific. Therefore, we proposed to clarify that beds and patient days are excluded from the calculations at § 412.105(b) and § 412.106(a)(1)(ii) ***if the nature of the care provided in the unit or ward is inconsistent with what is typically furnished to acute care patients***, *regardless of whether these units or wards are separately certified or are located in the same general area of the hospital as a unit or ward used to provide an acute level of care*. Although the intensity of care may vary within a particular unit, such that some patients may be acute patients while others are nonacute, [we] believe that a patient-by-patient, day-by-day review of whether the care received would be paid under the IPPS would be unduly burdensome. Therefore, we believe it is more practical to apply this principle (that is, that we should consider only the inpatient days to which the IPPS applies) by using a proxy measure that is based upon the location at which the services were furnished.
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> In particular, we proposed to revise our regulations to clarify that the beds and *patient days attributable to a* ***nonacute*** *care unit or ward should not be included in the calculations at § 412.105(b) and § 412.106(a)(1)(ii)*, ***even if the unit is not separately certified by Medicare as a distinct-part unit*** and even if the unit or ward is

[46] 68 Fed. Reg. 45346, 45417 (Aug. 1, 2003).
[47] 259 F.3d 1071 (9th Cir. 2001); 68 Fed. Reg. at 45417.
[48] 259 F.3d at 1073.

> within the same general location of the hospital as areas that are subject to the IPPS (that is, a unit that provides an IPPS level of care is on the same floor of the hospital as a subacute care unit that does not provide an IPPS level of care).[49]

The Secretary disagreed with the *Alhambra* Court's ruling because it was contrary to longstanding policy and confirmed that the intent of the revisions to the regulation was to ensure that the regulation clearly reflected that policy:

> *Comment*: Several commenters objected to our proposal and indicated that we were attempting to codify the Secretary's litigation position in Alhambra and administratively overrule the Ninth Circuit's decision in that case. . . .
>
> *Response*: We disagree that our proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. . . .
>
> We also do not believe that by placing our longstanding interpretation of our rules in regulations we are unlawfully overruling or nullifying the decision by the Ninth Circuit in *Alhambra Hospital v. Thompson*, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit decision focused on an interpretation of CMS' previous regulation at § 412.106(a)(1)(ii)—**not on an interpretation of the statute**. . . . Although we respectfully disagree with the Ninth Circuits [*sic*] interpretation of the existing regulations, we are nonetheless amending them, through notice and comment rulemaking **to ensure that going forward** the regulations clearly reflect our longstanding position. Therefore, we do not agree with the commenter's assertion that our proposed policy is an illegal attempt to administratively overrule the Ninth Circuit's decision in Alhambra. Therefore, going forward, we plan to apply the clarified regulation to hospitals in all U.S. jurisdictions, including hospitals in the Ninth Circuit.[50]

Accordingly, when determining whether a hospital unit provides a level of care that would generally be payable under IPPS the proper focus must be on the level and type of care generally provided in the unit as a whole rather than a day-by-day or patient-by-patient review without regard to whether the Medicare program separately certifies the unit.[51]

Furthermore, based on the Secretary's discussion of its longstanding policy in the preamble to the 2003 Final Rule, the classification of a provider unit by a state Medicaid program may not be dispositive, but is certainly relevant, to determining the level of care provided in that unit. The classification of a provider unit, by its very nature, reflects the type of care generally furnished in that unit. In this case, each of the Three Disputed Units participated in the OMP as a hospital-

[49] 68 Fed. Reg. at 45417 (emphasis added beyond the 9th Circuit decision name).
[50] *Id.* at 45418.
[51] *Id.*

based PRTF. Similar to the California Medicaid Program classification of the hospital unit as sub-acute in *Alhambra*, the classification of the Three Disputed Units as PRTFs is relevant, notwithstanding the fact that the Medicare program did not specifically certify either the sub-acute units in *Alhambra* or the PRTFs in this case. Based on the Secretary's position in *Alhambra* and the Secretary's affirmation of its longstanding policy in the preamble to the 2003 Final Rule, it is clear that the Medicaid classification of a unit has relevance when determining the level of care generally provided in that unit. As such, it is necessary to examine the OMP classification of the Three Disputed Units as PRTFs and how this relates to the determination of the level of care generally provided in those units.

The Board recognizes that the vacated Board majority decision found that "[f]ederal law allows PRTFs to provide an acute level of inpatient psychiatric care to individuals under 21 years of age."[52] However, as set forth below, the Board finds that the vacated Board majority decision failed to fully consider the HHS Medicaid regulations and guidance governing PRTFs and their relationship to the OMP regulations governing PRTFs. As a result, the Board finds that the Board's vacated decision erred in making this finding. Rather, the Board agrees with the Administrator and finds that PRTFs are ***not*** the equivalent of a hospital and, by federal regulation (as well as OMP regulation), are not designed to provide an acute level of care.

First, it important to acknowledge that the Medicare program neither recognizes nor certifies distinct hospital units (or facilities) as PRTFs. Rather, as recognized by the parties,[53] PRTFs are a Medicaid program creation in general, similar to nursing facilities ("NFs") and intermediate care facilities for the mentally retarded ("ICF/MRs").[54] Both the HHS regulations governing State Medicaid programs and the Medicare Claims Processing Manual recognize that PRTFs, such as the Three Disputed Units, may be located in a hospital but are not recognized (nor formally excluded) by the Medicare program from IPPS pursuant to 42 C.F.R. § 412.25.[55]

At the outset, the Board notes that, contrary to St. Anthony's suggestion, PRTFs are not simply a payment mechanism but are subject to accreditation and State inspection to confirm that they meet the relevant PRTF conditions of participation in OMP as a PRTF.[56] Further, it is clear that these PRTF standards and conditions of participation are designed to address the nature and level

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[52] PRRB Dec. No. 2018-D12 at 14.
[53] *See, e.g.,* Provider's Post Hearing Brief at 36-39.
[54] *See* Medicare Benefits Policy Manual, CMS Pub. No. 100-07 ("MBPM"), § 1000B (as revised May 21, 2004) (stating "[i]n general, the only types of institutions participating ***solely*** in Medicaid are NFs, Psychiatric Residential Treatment Facilities (PRTF), and Intermediate Care Facilities for the Mentally Retarded (ICF/MR)" (emphasis added)); One-time Notification, CMS Pub. No. 100-20, Transmittal No. 80 (May 7, 2004) (stating that manual revisions had been made "to assign . . . provider numbers for a new Medicaid provider, Psychiatric Residential Treatment Facilities (PRTF)").
[55] *See* 42 C.F.R § 483.352 defining "Psychiatric Residential Treatment Facility" as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting." *See also* Medicare Claims Processing Manual, CMS Pub. No. 100-04, § 10.5 which specifies that the place of service ("POS") codes used on claims for PRTFs is POS code 56 which specifies that a PRTF is either "a facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment."
[56] *See* Okla. Admin. Code §§ 317:30-5-95(d)-(e), 317:30-5-95.40, 317:30-5-95.42.

of the care furnished in the PRTF as illustrated by the medical necessity criteria for admission to a PRTF *as well as* for ***continued*** stay in a PRTF.[57]

The OMP amended the definitions of PRTF, acute care, and residential treatment services in its administrative code in June 2006. Notably, the underlying administrative code setting the standards for furnishing psychiatric acute care versus residential treatment services did not change, making the amended definitions applicable to all of 2006, the year at issue in this appeal. Under the amended definitions, the OMP defines a PRTF as a "non-hospital"[58] or "facility **other than a hospital**"[59] that provides "***non-acute*** inpatient facility care for recipients who have a behavioral health disorder and need 24-hour supervision and specialized interventions."[60] Moreover, PRTFs are defined to specifically include both freestanding and hospital-based PRTFs – such as the Three Disputed units.[61]

The use of the term "non-hospital" in the OMP PRTF definition appears to mirror the Secretary's regulation at 42 C.F.R § 483.352 defining "Psychiatric Residential Treatment Facility" as "a facility ***other than a hospital*****,** that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting."[62] This regulation was promulgated as part of the interim final rule published on January 22, 2001 and the preamble confirms that PRTFs are not hospitals (*i.e*., do not provide an acute level of care):

> This interim final rule with comment period establishes a definition of a ''psychiatric residential treatment facility'' *that is* ***not*** *a hospital* and that may furnish covered Medicaid inpatient psychiatric services for individuals under age 21. This rule also sets forth a Condition of Participation (CoP) that psychiatric residential treatment facilities *that are* ***not*** *hospitals* must meet to provide, or to continue to provide, the Medicaid inpatient psychiatric services benefit to individuals under age 21.
>
> ***
>
> The Medicaid program makes Federal funding available for State expenditures under an approved State Medicaid plan for inpatient psychiatric services for eligible individuals under 21 years of age in hospital and nonhospital settings. ***Nonhospital settings***, *which we are defining as psychiatric residential treatment facilities (facilities)*, are rapidly replacing hospitals in treating children and adolescents with psychiatric disorders. *These facilities are generally* ***a less restrictive alternative*** *to a hospital for treating*

[57] *See id*. at § 317:30-5-95.29-.30.
[58] *Id*. at § 317:30-5-95(d).
[59] *Id*. at § 317:30-5-95(b)(4) (emphasis added).
[60] *Id.* at § 317:30-5-95(a) (emphasis added).
[61] *Id.* at § 317:30-5-95(c) (defining PRTF and describing PRTFs as both hospital-based and freestanding).
[62] (Emphasis added.)

> *children and adolescents whose **illnesses are less acute** but who still require a residential environment*.[63]

As referenced in the preamble to the 2001 interim final rule, the Secretary first proposed regulations defining PRTFs as "nonhospitals" in 1994 but never finalized those regulations.[64] The following excerpt from the 1994 proposed rule sheds additional light on how Medicaid coverage of PRTF services for those under 21 years of age are excepted from the Medicaid "IMD" exclusion and how PRTFs provide a level of care less than an inpatient hospital setting:

> Under section 1905(a) of the Act, Medicaid payment is generally not available for any services provided to individuals under age 65 who are patients in "institutions for mental diseases" (IMDs). This statutory preclusion of Medicaid payment is commonly known as the "IMD exclusion." The term "IMD", as defined in section 1905(i) of the Act, includes hospitals, *nursing facilitie*s, *or other institution*s of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.
>
> The psychiatric 21 benefit, at section 1905(a)(16) of the Act, is the *only statutory exception to the IMD exclusion*. The psychiatric 2l benefit is optional, and it is currently covered under 41 State plans.
>
> * * *
>
> We propose to revise existing regulations to establish a definition of the term "psychiatric residential treatment facility" (PRTF) and conditions of participation for this type of facility. A PRTF is a community-based facility that *provides **a less medically intensive program of treatment** than a psychiatric hospital or a psychiatric unit of a general hospital*.
>
> * * *
>
> *PRTFs would provide a type of care that is **distinctly different** from the care provided by **acute** care facilities* and therefore a PRTF that is affiliated with a participating psychiatric hospital or general hospital would need to obtain ***separate PRTF certification*** in addition to its

[63] 66 Fed. Reg. 7148, 7148 (Jan. 22, 2001).

[64] *See id.* at 7148 (stating: "On November 17, 1994, we published in the Federal Register (56 FR 59624) proposed regulations to establish standards for ***nonhospital*** psychiatric residential treatment facilities, to be contained in a new subpart F of 42 CFR part 483." (emphasis added)). *See also* 59 Fed. Reg. 59624, (Nov. 17, 1994) (stating: "We propose to revise existing regulations to establish a definition of the term "psychiatric residential treatment facility" (PRTF) and conditions of participation for this type of facility. A PRTF is a community-based facility that *provides **a less medically intensive program of treatment** than a psychiatric hospital or a psychiatric unit of a general hospital*." (emphasis added)).

> hospital certification. The setting(s) that a State chooses to use for the psychiatric 2l benefit would be indicated in its State plan.
>
> * * *
>
> Currently operating residential treatment facilities include a wide range of providers, from facilities that provide care similar to that provided in psychiatric hospitals to facilities that are more similar to group homes. In addition, many residential treatment facilities are part of multi-service mental health organizations which also provide a range of outpatient services. A number of States have developed or are in the process of developing licensure requirements for these facilities.
>
> Treatment in residential treatment facilities generally costs less per day than treatment in a psychiatric hospital, but because *the length of stay in residential facilities is generally longer*, treatment in a residential facility is not always less expensive for the total inpatient stay. Rates for residential treatment facility services now range from approximately $140 to $420 per day, including professional fees.[65]

The categorization of all PRTFs as a "nonhospital" would also suggest that, per the following excerpt from the definition of hospital at 42 U.S.C. § 1395x(e), a PRTF would *not* qualify as a hospital:

> Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)).[66]

Thus, the Board concludes based on the Secretary's PRTF policy published in the Federal Register and the OMP regulations that a psychiatric unit enrolled as a "PRTF" generally provides "***non-acute inpatient facility care.***"[67]

Further, the Secretary's PRTF policy and the OMP Regulations lead to that conclusion that PRTF services are *not* of the type that are "generally payable under the prospective payment system" because they are "non-acute."[68] Further, examining the OMP regulations in conjunction

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[65] 59 Fed. Reg. 59624, 59625-27 (Nov. 17, 1994) (emphasis added).

[66] This conclusion is reinforced by the fact that institutions for mental diseases ("IMDs") are generally excluded from benefits (including, but not limited to, inpatient hospital services) under the *Medicaid* program in 42 U.S.C. § 1396d.

[67] *See also* 66 Fed. Reg. 3148, 3153 (Jan. 12, 2001) (stating: "The [upper payment limit] regulations at § 447.272 govern payments to inpatient 'hospitals and long term care facilities,' which includes, nursing facilities, and intermediate care facilities for the mentally retarded. Residential treatment facilities are *a **separate** **type** of institutional provider*, which may furnish inpatient psychiatric services to individuals under 21. Therefore, payments to these residential treatment facilities are governed by [Medicaid] regulations at § 447.325, 'Other inpatient and outpatient facility services; Upper Limits of Payment.'" (emphasis added)). *See also id.* at 3171.

[68] St. Anthony confirmed that the Medicare program has not paid for any services furnished in the Three Disputed Units. *See* Tr. at 124-28 (May 28, 2015).

with the *Alhambra* discussion in the 2003 Final Rule preamble, the unavoidable conclusion is that the patient days associated with the Three Disputed Units are not to be included in the calculations at 42 C.F.R. § 412.106(a)(1)(ii).

The relevance of the St. Anthony's OMP participation as a PRTF to the issue posted on remand is reinforced by the fact that, during the fiscal year at issue, virtually ***all*** of the patient days in the Three Disputed Units (99.92 percent) were Medicaid patients[69] and, as a result, ***each*** such patient necessarily underwent an OMP *prior authorization process* to confirm admission to the PRTF setting was the appropriate level of medical care. In this regard, the OMP requires PRTFs to obtain prior authorization from the OMP before admitting Medicaid patients to determine "if the recipient meets *the medical necessity criteria*" for PRTF services[70] as well as periodic re-authorizations for extension of *continued* medical necessity. By definition, the OMP pre-authorization and extension process "will [only] approve lengths of stay using the current . . . ***medical necessity*** *criteria* and following the current inpatient provider manual approved by [OMP]."[71] The OMP process is designed to determine the appropriate level of medical care both *prior to* admission *and* during certain intervals after admission when re-authorization is required.[72] Further, St. Anthony's witness's testimony during the hearing confirmed that ***all*** of the days at issue in the Three Disputed Units received prior authorization from the OMP as PRTF services ***and*** were claimed *and* paid on a *per diem* basis ***as PRTF*** services.[73] In other words, in considering prior authorization *for the patient days at issue in this case*, the OMP applied its medical necessity criteria for both acute psychiatric care and psychiatric residential treatment services;[74] and (2) following that process, found the patients qualified for authorization of PRTF services in one of the Three Disputed Units. Thus, unlike the Provider's expert witnesses, the OMP did review the medical necessity of virtually all of the patient days at issue *on a prior authorization basis* (both prior to admission *and* following admission to periodically extend authorization) and found that PRTF services rather than acute care services was an appropriate level of care.

Similarly, to the extent the child receiving Medicaid was transferring from an inpatient acute care unit to the PRTF, the OMP was necessarily finding that a phase of medical care had ended

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[69] Exhibit I-19 at 2 (Medicare Contractor worksheet entitled "St. Anthony Hospital Statistical Summary 12/31/2006 Wkst S – Input" showing the ACCENTS Unit with 67 discharges for 10,861 total patient days of which 10,861 days were Medicaid (*i.e.*, 100 percent Medicaid), the Human Restoration Unit with 97 discharges for 12,424 total patient days of which 12,399 (*i.e.*, 99.8 percent Medicaid) and the Positive Outcomes Unit with 54 discharges for 8433 total patient days of which 8434 [*sic* 8433] were Medicaid (*i.e.*, 100 percent Medicaid). Accordingly, the patient days at issue for Three Disputed Units, in the aggregate, were 99.92 percent Medicaid, *i.e.*, 100 x ((10,861 + 12,399 + 8434) / (10,861 + 12,424 + 8434)).

[70] Okla. Admin. Code § 317:30-5-95.31(a) (emphasis added). *See also* 42 C.F.R. § 456.1; 42 U.S.C. § 1396a(a)(26).

[71] *Id*. at § 317:30-5-95.24(3) (emphasis added). *See also* Okla. Admin. Code § 317:30-5-95.31.

[72] "All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay." Okla. Admin. Code § 317:30-5-95.24(3). "Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited *to the approved length of stay*. The Agent designated by the [Oklahoma Health Care Authority] will approve lengths of stay ***using*** the current OHCA Behavioral Health ***medical necessity criteria*** and following the current inpatient provider manual approved by the OHCA." Okla. Admin. Code § 317:30-5-95.24(3) (emphasis added).

[73] *See* Tr. at 161-166 (May 28, 2015). *See also id.* at 155-156.

[74] Indeed, since the average length of stay in the Three Disputed Units was more than 4 months (*see infra* note 96), the Board notes that "[r]equests for the continued stay of a child who has been . . . in a [PRTF] for 3 months ***will require a review of all treatment documentation*** completed by the [Oklahoma Health Care Authority's] designated agent to determine efficacy of treatment." Okla. Admin. Code § 317:30-5-95.31(b).

(*i.e.*, acute inpatient psychiatric services) and a new one was beginning (*i.e.*, PRTF services). In this regard, contrary to St. Anthony's allegation, there are material differences between the OMP standards for acute psychiatric care and PRTF care such as:

- Psychiatric acute care is for "*short-term* intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders"[75] while PRTF services are "nonacute care"[76] and "longer-term."[77] This is borne out in the rules governing plans of care where a patient's individual plan of care in an acute psychiatric setting must be reviewed every 7 days while those in a PRTF setting must be reviewed every 14 days.[78]

- The criteria for admission differs where the acute psychiatric care standards focuses on whether the behaviors of the patient "present an imminent life threatening emergency" ***within the last 48 hours*** (*e.g.*, specifically described suicide attempts or suicide intent within the past 48 hours)[79] while the PRTF standard focuses on whether the "[p]atient demonstrates escalating pattern of self injurious or assaultive behaviors" (*e.g.*, suicidal ideation or threat).[80]

- The staff supervision level is different where 24-hour nursing/medical supervision is required in an acute psychiatric care setting[81] while only 24-hour observation and treatment for PRTF care.[82]

- The minimum number of "individual treatment provided by the physician" is different where a minimum 3 treatments per week is required for acute psychiatric care versus a minimum of one treatment per week is required for PRTF care.[83]

Accordingly, the Board finds that the combination of the Three Disputed Units being enrolled and accredited as PRTF and virtually all of the stays at issue being specifically medically reviewed by OMP, and then authorized for *and* paid as PRTF services, necessarily addresses the nature of the care provided and demonstrates that that care did not rise to an acute level of care.[84]

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[75] Okla. Admin. Code § 317:30-5-95.22(b)(1) (emphasis added).
[76] *Id*. at § 317:30-5-95(a).
[77] *Id*. at § 317:30-5-95.22(b)(7).
[78] *Id.* at § 317:30-5-95.33(b)(7).
[79] *Id.* at § 317:30-5-95.25(5).
[80] Okla. Admin. Code § 317:30-5-95.29(5).
[81] *Id*. at § 317:30-5-95.25(6).
[82] *Id.* at § 317:30-5-95.29(6).
[83] *Id.* at § 317:30-5-95.34(c)(1).
[84] The Board's finding is supported by the opinion of Medicare Contractor's medical expert. *See* Exhibit I-20 at 2-3 (written opinion of Dr. Baer); Tr. at 394 (Mar. 31, 2015) (Dr. Baer testifying that "Acutely suicidal, acute suicide attempt, this is what the Oklahoma statute [*sic* regulation] requires that if you look at those two criteria, they're

B. Additional Bases Supporting the Board's Decision

Although the Board's review could stop here, further analysis provides additional support for the conclusion that the Three Disputed Units do not provide "acute care" pursuant to 42 C.F.R. § 412.106(a)(1)(ii).

1. IPPS is generally short-term while, in contrast, residential treatment services such those in a PRTF are inherently long-term.

The OMP defined "acute care" as "care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and ***short-term*** intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders."[85] In contrast, "Residential treatment services" are defined as "[p]sychiatric services that are designed to serve children who need ***longer-term***, more intensive treatment, and a more highly structured environment than they can receive in family and other community-based alternatives to hospitalization."[86] Thus, at the top, one thing that differentiates "residential treatment services" from "acute care" is the fact that "residential treatment services" are "longer-term" treatment while "acute care" is "short-term" treatment.

These definitions also make other clear distinctions between the OMP definitions of "acute care" and "residential treatment." Per these OMP definitions, the location of "acute care" services provided must be in a "psychiatric unit" or "psychiatric hospital" versus "residential treatment services" which must be "not community-based."[87] Acute care services must include "medical management and monitoring" while residential treatment services require "psychiatric services" with little or no medical involvement. However, the most telling distinction under these OMP definitions is that "acute care" services are limited to "short-term intensive treatment and stabilization" while "residential treatment" services consist of "longer-term" treatment in a highly structured environment.[88]

In addition, the OMP definition of "acute care" parallels the guidance provided by CMS and Congress when describing the type of services generally payable under IPPS. When Congress adopted IPPS in 1983, healthcare facilities that did not provide short-term acute care services (*e.g.* long-term care hospitals, psychiatric hospitals, cancer hospitals and children's hospitals) were excluded from IPPS[89] because, as noted in the legislative history, "[t]he DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays."[90] When

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practically identical. In order to be in an RTC you've got to have suicidal ideation. You've got to have a history of violence, this kind of thing. For the inpatient criteria you have to have a suicide attempt or something like that in the last 48 hours. All right. That's acute. And so those patients get this higher level, more intensive level of care on St. Anthony's inpatient unit, and when that is dealt with they can be transferred, discharged, whatever their particular needs are."). *See also* Tr. at 418-19 (Mar. 31, 2015).

[85] Okla. Admin. Code § 317:30-5-95.22(b)(1) (emphasis added).

[86] Okla. Admin. Code § 317:30-5-95.22(b)(7) (emphasis added).

[87] Okla. Admin. Code §§ 317:30-5-95.22(b)(1), 317:30-5-95.22(b)(7).

[88] *Id.*

[89] *See id.*; 42 U.S.C. § 1395ww(d)(1)(B); 42 C.F.R. §§ 412.20(b), 412.20(e), 412.23; 67 Fed. Reg. 55954, 55957 (Aug. 30, 2002).

[90] H.R. Rep. No. 98-25, p. 1 at 141 (1983) (accompanying H.R. 1900 which became Pub. L. No 98-21, 97 Stat. 65 (1983)) (excerpt included at Exhibit I-14) (explaining that the proposed exemptions and exceptions to IPPS: "Psychiatric, Long-Term Care, Rehabilitation and Children's Hospitals. Such hospitals would be specifically

CMS (then known as the Health Care Financing Authority ("HCFA")) implemented IPPS in 1983, it recognized that "[t]he standardized amounts [payable under IPPS] are based on expenditures in short-term general hospitals"[91] and that long term care hospitals, psychiatric, cancer and children's hospitals were excluded because they were "[o]rganized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities."[92] Even the *Alhambra* court recognized that IPPS is generally "[n]ot used to reimburse hospitals for long-term care."[93]

Similarly, in the regulation providing an overview of IPPS, the Secretary describes IPPS as "[p]ayment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (*generally, short-term, acute-care hospitals*) is made on the basis of prospectively determined rates and applied on a per discharge basis."[94] Further, when the Secretary issued regulations to implement IPPS, the Secretary established a policy whereunder certain transfers to another hospital would not be considered a discharge and, as a result, potentially would not receive full payment under IPPS. In setting this policy, the Secretary exempted transfers from an IPPS hospital to a hospital excluded from IPPS because the care being received at the excluded hospital is "distinctly" different:

> When patients are transferred to hospitals or units excluded from [IPPS] (e.g., psychiatric, rehabilitation, children's hospitals), the transfers will be considered discharges and the full prospective payment [under IPPS] will be made to the transferring hospital. Hospitals and units excluded from [IPPS] are organized for treatment of conditions ***distinctly*** *unlike* treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities would not be the same services obtained in transferring hospitals (i.e., paid under [IPPS]) and payment to both facilities would be appropriate.[95]

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exempted from your Committee's prospective payment bill. The DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays").

[91] 48 Fed. Reg. 39595, 39782 (Sept. 1, 1983).

[92] *Id.* at 39760. *See also* 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (restating 1983 discussion) (excerpt include at Medicare Contractor Exhibit I-16); 67 Fed. Reg. 55954, 55957 (Aug. 30, 2002) (explaining that Congress had excluded these hospitals from IPPS because they "typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system").

[93] 259 F.3d 1071 (9th Cir. 2001)

[94] 42 C.F.R. § 412.1(a) (2006) (originally located at 42 C.F.R. § 405.470(a)(1) as adopted in 1983 at 48 Fed. Reg. at 39817) (emphasis added).

[95] 48 Fed. Reg. 39752, 39759-60 (Sept. 1, 1983) (interim final rule) (excerpt included at Exhibit I-15). *See also* 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (IPPS final rule that finalized the IPPS interim final rules published on Sep. 1, 1983) (stating that the reason for treating transfers from IPPS hospital to excluded hospitals differently from transfers between IPPS hospitals "is due to the ***difference*** *in the types of treatment* furnished in the two classes of facilities. As we stated in the interim final rule, we believe that hospitals and units excluded from [IPPS] are organized for treatment of conditions ***distinctly*** *unlike* treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities *would* ***not*** *be the same* services obtained in transferring hospitals (that is, paid under [IPPS]), and payment to both facilities would be appropriate, with the transferring hospital paid at the full DRG prospective payment rate." (emphasis added)). S*ee also id.* at 237 ("[t]he criteria that define psychiatric units that are excluded from prospective payment were established to identify existing units that provide care that is so similar to the care provided in psychiatric hospitals and is ***so unlike*** the acute care provided elsewhere in the hospital, as to warrant exclusion." (emphasis added)).

Notwithstanding these descriptions of IPPS, there unfortunately is no definitive guidance limiting IPPS to short-term care or to specific lengths of stay despite the guidance from Congress and CMS describing IPPS as intended only for short-term care.

Here, during FY 2006, the Three Disputed Units had an average length of stay of *over 4 months*[96] and the primary discharge diagnoses from the Disputed Units are the diagnoses associated with DRG 426, 428, 430, 431 and 432.[97] As noted by the Administrator, these 4+-month lengths of stay are much longer than the average IPPS length of stay for IPPS hospitals (5 days)[98] and the minimum average length of stay needed to qualify as a long term acute care hospital (greater than 25 days).[99] Further, in the context of IPPS, they would clearly be outliers[100] since they are much longer than the mean lengths of stay for IPPS hospitals for DRGs 426, 428, 430, 431, and 432 as published in FY 2006 IPPS Final Rule:

DRG	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
426	Depressive neuroses	0.4656	3.0	4.1
428	Disorders of personality & Impulse control	0.6981	4.6	7.3
430	Psychoses	0.6483	5.8	7.9
431	Childhood mental disorders	0.5178	4.0	5.9
432	Other mental disorder diagnoses	0.6282	2.9	4.3[101]

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Indeed, these 4+-month lengths of stay are even much longer than even the average lengths of stay for DRGs 426, 428, 430, 431 and 432 under the *long term care* prospective payment system ("LTC-PPS") ***for long-term care hospitals*** as published in the FY 2006 IPPS Final Rule:

LTC-DRG	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
426	Depressive neuroses	0.4113	20.7	17.3
428	Disorder of Personality & Impulse control	0.4499	19.0	15.8
430	Psychoses	0.4330	24.2	20.2
431	Childhood mental disorders	0.4499	19.0	15.8

[96] *See* Exhibit I-19 (showing that, for 2006, the ACCENTS Unit had 67 patients with an average length of stay 162 days, the Human Restoration Unit had 97 patients with an average length of stay of 128 days, and the Positive Outcome Unit had 54 patients for an average length of stay of 156 days).

[97] Exhibit P-28 at 5.

[98] *St. Anthony* Adm'r Dec. at 13 n.24 (citing to publicly available information).

[99] 42 C.F.R. § 412.23(e).

[100] If these stays were covered and payable under IPPS, they would undoubtedly exceed the threshold for cost outliers under 42 C.F.R. § 412.84 given the extraordinary length of the stays and the allged volume of underlying services. This is reinforced by the fact that, until FY 1998, the Medicare program previously adjusted DRG payments for ***day*** outliers (as opposed to cost outliers) and, under the policy *in effect 1997*, the IPPS ***day*** outlier threshold for DRGs 426, 428, 430, 431, and 432 could be no greater than 27.7, 28.9, 30.5, 29.5, and 27.7. *See* 62 Fed. Reg.45966, 46040, 46087 (Aug 29, 1997) (establishing the day outlier threshold for 1997 as "geometric mean length of stay for each DRG plus the ***lesser of*** 24 days or 3.0 standard deviations" (emphasis added) and reporting for 1997 the relevant geometric mean length of stay for DRGs 426, 428, 430, 431, and 432 as 3.7, 4.9, 6.5, 5.5, and 3.7 respectively).

[101] 70 Fed. Reg. 47278, 47629 (Table 5 entitled "List of Diagnosis-Related Groups, Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay") (Aug. 12, 2005).

432	Other mental disorder diagnoses	0.5837	21.3	17.8[102]

Further, as previously discussed, these 4+-month lengths of stay are consistent with the OMP's licensing of the Three Disputed Units as PRTFs[103] and fit within the OMP distinction between acute care services (short-term treatment) and residential treatment or care services (longer-term treatment). Indeed, the Secretary has noted that DRG payments under IPPS are not designed to account for the types of care in LTCHs, psychiatric hospitals, or other excluded hospitals/units:

> The acute care hospital inpatient prospective payment system [IPPS] is a system of average-based payments that assumes that some patient stays will consume more resources than the typical stay, while others will demand fewer resources. Therefore, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the acute care hospital inpatient prospective payment system [IPPS]. In a report to Congress, "Hospital Prospective Payment for Medicare (1982)," the Department of Health and Human Services stated that the "467 DRGs were *not* ***designed*** *to account for these types of treatment* found in the four classes of excluded hospitals, and noted that "including these hospitals will result in criticism and their application to these hospitals would be inaccurate and unfair."
>
> The Congress excluded these hospitals from the acute care hospital inpatient prospective payment system [IPPS] because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. . . . Therefore, these hospitals could be ***systemically*** *underpaid* if the same DRG system were applied to them.[104]

While the length of stay is not dispositive, the available guidance on length of stay supports the conclusion that the Three Disputed Units were organized for treatment of conditions "distinctly unlike" treatment encountered in short-term acute care facilities and that IPPS was "not designed to account" for the types of treatment provided in the Three Disputed Units such that they would be "systemically underpaid" if all services in the Three Disputed Unit were paid under IPPS.[105]

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[102] *Id.* at 47687-88 (Table 11 entitled "FY 2006 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay"). Similarly, Dr. Baer written opinion states: "As a [Contractor Medical Director] who reviewed many acute psychiatric inpatient stays for the Medicare population, I would very rarely have allowed acute inpatient lengths of stay in excess of 100 days. Except for extremely rare cases, such a patient could not be deemed acute, and there were other, less intensive treatment settings for such patients to be transferred, such as residential settings, where they could have 24-hour monitoring and have their chronically severe psychiatric symptoms treated." Exhibit I-20 at 2. *See also* Tr. at 472-73 (Mar. 31, 2015).

[103] Exhibit I-19 (documenting that, for FY 2006, the average length of stay was 162 days for the ACCENTS Unit, 128 days for the Human Restoration Unit, and 156 days for the Positive Outcomes Unit)

[104] 67 Fed. Reg. 55954, 55957 (Aug.30, 2002) (emphasis added).

[105] The Provider cites to the decision of the U.S. Court of Appeals for the Sixth Circuit in *Metropolitan Hosp. v. Dep't of Health & Human Servs*. ("*Metropolitan*"), 712 F.3d 248 (6th Cir. 2013), to support its contention that "there can be no categorical exclusion of long lengths of stay from DSH." However, it is unclear whether this case could be applicable to the instant appeal because the *Metropolitan* litigation arose due to the Board's grant of expedited judicial review ("EJR") on the legal question *posed by that provider* (*see* 702 F. Supp. 2d 808, 819 (W.D.

Accordingly, the Board finds that above discussion on length of stay supports the fining that the services provided in the Three Disputed Units were not of the type of care generally payable under IPPS.[106]

2. *The Provider's Medical Experts Testimony Was Given in Context of Long-Term Inpatient Psychiatric Settings Rather Than Short-Term Acute Care Hospitals.*

The Board notes that the testimony of one of the medical experts presented by St. Anthony focused on comparing the Three Disputed Units to care furnished in psychiatric hospitals or extended care facilities rather than in "traditional" short-term acute care hospitals.[107] Specifically, Dr. DiVincenzo concludes in his declaration:

> It is my professional opinion held to a reasonable degree of medical and psychiatric certainty, that the patient's [*sic*] receiving treatment within the [Three Disputed Units], were patients suffering from acute symptoms in the context of one or more major psychiatric diagnoses, and received ***extended*** *acute care services within* ***long-term*** *inpatient psychiatric hospital settings*, evidenced by the intensity of services received as documented in their respective medical records.[108]

Mi. 2010)) and that legal issue (as certified for EJR by the Board) did *not* encompass the issue currently before the Board. Regardless, the lengths of stay at issue in *Metropolitan* may have been moot and/or irrelevant since: (1) most of the Medicare exhausted days at issue in *Metropolitan* could not be counted in the Medicare fraction "because very few of the patients were entitled to SSI" (*see* 712 F.3d at 254); and (2) it is unclear whether the "hospital unit" in *Metropolitan* that would be subject to the analysis in 42 C.F.R. § 412.106(a)(1)(ii) is the exclusively the Assisted Breathing Center and whether that "hospital unit" ***only*** "provide[d inpatient] care to ventilator-dependent patients that is generally unavailable in nursing homes" (*see id.* at 253).

[106] The fact that the beds in the Three Disputed Units were "licensed" by the Oklahoma Department of Human Services as acute care beds (*see* Exhibit P-61 that includes "Hospital Designation of Licensed Beds") does not have bearing on the issue in this case because it is unclear how, or by what method or standard, the State uses in making that licensing designation and how that licensing has any relevance to enrollment and accreditation of the Three Disputed Units as PRTFs by OMP (much less the care provided therein). As noted in the FY 2005 IPPS Final Rule: "individual states determine the number of licensed beds for hospitals. There is no consistent method from State to State on the requirements or standards for determining these licensed beds. Lack of a consistent method or standard for establishing the number of licensed beds could unfairly disadvantage hospitals in some states, and benefit hospitals in others; the inconsistency among States in bed-licensing methods or standards makes licensed beds an unreliable representation of a hospital's number of available beds." 69 Fed. Reg. 48916, 49096 (Aug. 11, 2004).

Similarly, the Board recognizes that St. Anthony alleges that "St. Anthony's provider agreement with the State of Oklahoma for [the Three Disputed Units] specifically allows for the provision of services beyond those that are reimbursable under the residential treatment facility payment model." Provider's Updated Post-Hearing Brief at 39 (citing Exhibit P-60 at 3). However, St. Anthony ignores the fact that that OMP requires PRTFs to obtain *prior authorization* before admitting Medicaid patients to determine "if the recipient meets *the medical necessity criteria*" for PRTF services[106] as well as periodic prior authorization for extension of continued medical necessity. Okla. Admin. Code § 317:30-5-95.31(a) (emphasis added). As virtually all of the patient stays during FY 2006 were for Medicaid patients (99.92 percent, *see supra* note 69), it is clear that OMP reviewed medical necessity and determined that the appropriate level of care was PRTF care (as opposed to, for example, acute psychiatric care per Okla. Admin. Code § 317:30-5-95.25).

[107] Tr. at 217 (May 27, 2015).

[108] Exhibit P-41 at ¶ 2 (Decl. of Dr. DiVincenzo dated Nov. 30, 2014) (emphasis added). *See also* Exhibit P-46 at ¶ 7 (Supp. Decl. of Dr. DiVincenzo dated Feb. 1, 2015) (stating that each of the Three Disputed Units "were providing

In contrast, Dr. Kaminski only testified that, in his opinion, the Three Disputed Units provided care consistent with an "inpatient adolescent acute care psychiatric unit" without indicating the setting such as a short term acute care hospital versus a psychiatric hospital.[109] As a result, the Board finds neither testimony provides much assistance to the Board in addressing the Administrator's directive for the Board to "[f]ocus . . . on the level of care generally provided in the PRTF compared to *acute care psychiatric services* ***provided in a general IPPS (short term) hospital***."[110]

3. The Evidence in the Record Regarding the Care Provided in 3 Disputed Units Is Insufficient to Support a Finding That Any of Those Units Provided Care Typically Furnished To Acute Care Patients.

When examining the evidence before the Board to determine the intensity of services provided in the Three Disputed Units, it becomes clear that there is insufficient evidence to establish that the the nature of the care provided in the 3 Disputed Units is consistent with what is typically furnished to acute care patients.[111] Although much of the testimony and documentary evidence presented in this appeal focused on the "inpatient" nature of the care, individual patient diagnoses and the Trailblazer Report, this evidence fails to establish that the care provided in the Three Disputed Units rises to an "acute" level of care. Simply being a hospital "inpatient" does not mean that the patient is receiving "acute care" services, as the facts of *Alhambra* reveal.[112] Similarly, Dr. Willis Holloway, Medical Director of two of the Three Disputed Units, testified that an "acute" diagnosis does not necessarily mean the level of care provided in response to that diagnosis rises to the "acute care" level.[113]

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that each of the Three Disputed Units "were providing extended acute care services." (emphasis added)). *See also* Tr. at 109 (Mar. 30, 2015) (In responding to questions about the type of population in the ACCENTS Unit, Dr. Holloway testified: "Well, for sure, there are some additional challenges because one of the benefits in any treatment setting is that there is no substitute for, you know, good cognitive function. And because these patients oftentimes don't have good cognitive function, and they also often don't have good socialization skills as well, so these are things that make the treatment process much more difficult, and it's much more arduous. And so there are things that we have to do to work with this population that perhaps we wouldn't have to do with other populations. And for this reason, sometimes it takes longer to resolve some of these acute issues that the patient presents with."); Tr. at 63-64 (Mar. 31, 2015) (Dr. Bell stated the following in describing why the lengths of stay in Positive Outcomes Unit are so long (9 to 12 months): "Most of my kids, many times all of my kids on the unit have been sexually abused, so it's like they're repeating what happened to themselves. It's behavior that's learned, so treating a sexual offender is a very long complicated process because of the danger to the community. We have to teach them a new way of thinking, a new way of learning, a new way of interacting. They have to incorporate it, and we -- then we spend a great deal of time practicing.").

[109] Tr. at 167-68, 215, 222-23, 247, 265 (Mar. 31, 2015).

[110] (Emphasis added.)

[111] *See* 68 Fed. Reg. 45346, 45417 (August 1, 2003).

[112] *Alhambra* addressed the inclusion of patient days from "subacute" care units in the DSH calculation. 259 F.2d at 1073. *See also* PRM 15-1 § 2201.1 (an "inpatient" is a "person who has been admitted to a hospital or skilled nursing facility for bed occupancy to receive inpatient hospital or skilled nursing services.")

[113] Tr. at 413-414 (Mar. 30, 2015) (Q: "So acuity of episode by itself, knowing . . . is an acute episode doesn't tell you in and of itself the level of care. . . ." A: "No, it doesn't."). *See also* Tr. at 144-147 (May 27, 2015) (testimony from Dr. Baer confirming that the diagnosis itself is not dispositive of the level of care furnished). For example, not all patients who are diagnosed with pneumonia need to be admitted to a hospital for an acute level of care. Similarly, a patient may be very ill as reflected by an "acute" diagnosis or episode of illness; however, an "acute" diagnosis or episode of illness is not synonymous with "acute care" as highlighted by the fact that a patient could have an "acute" ingrown toe nail and the care needed would not rise to the level of acute care.

Finally, the numerous questions surrounding validity of the Trailblazer Report (including the underlying sample and methodology used to review that sample) call into question its evidentiary value.[114] Some of the unanswered questions surrounding the Trailblazer Report are:

- Was the sample patient size a statistically valid representative sample?[115]
- Whether review of partial medical records was representative of the care provided to the sample patients?
- Whether the medical review inappropriately focused on individual patient care versus unit wide care level?
- Was the Trailblazer Report the basis of the MAC's determination or confirmation of the MAC's audit determinations?

Similarly, the Board continues to question the value of the InterQual criteria used by the Medicare Contractor to review the sample.[116] InterQual guidelines are widely used by the hospital industry to determine whether an *individual patient should be admitted* to the hospital and whether the hospital is likely to get paid for the inpatient stay.[117] However, they are not generally used to determine whether a particular hospital unit or facility ***provides*** an acute level of care.[118] These same concerns necessarily persist with the opinions of St. Anthony's medical experts because they based their opinion, in large part, on a patient-by-patient review of the sample which, in turn, provided context for their review of any other documents and testimony.[119]

Another clue to the level of care provided in the Three Disputed Units is the difference between the OMP standards for acute psychiatric care and residential treatment services in a PRTF. Not surprisingly, the OMP requires a lower, less intense, level of care in a PRTF than in an acute

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[114] Some of the questions surrounding the Trailblazer Report were: Was the sample patient size a statistically valid representative sample? Whether review of partial medical records was representative of the care provided to the sample patients? Whether the medical review inappropriately focused on individual patient care versus unit wide care level? Was the Trailblazer Report the basis of the MAC's determination or confirmation of the MAC's audit determinations?

[115] Indeed, St. Anthony entered, as Exhibit P-44, the declaration of consultant experienced in "extrapolation of clinical reviews based on medical record samples." Exhibit P-44 at ¶ 2. The consultant questioned, in part, the validity of the sampling and extrapolation used in the TrailBlazer Report. *Id.* at ¶¶ 6, 11-12, 14-15.

[116] The Board's vacated decision raised these questions and concerns regarding the Medicare Contractor's use of the InterQual criteria. PRRB Dec. No. 2018-D12 at 8.

[117] *Alexander v. Cochran*, No. CV11-1703, 2017 WL 522944 (D. Conn. 2017) following remand from U.S. Court of Appeals in *Barrows v. Burwell*, 777 F.3d 106 (2d Cir. 2015). *See also* Exhibit I-20 (Dr. Baer's expert opinion stating "[o]f note, InterQual criteria generally focuses on severity of illness, not acuity of illness, therefore patients at their baseline may meet InterQual criteria even though their illness is not in the acute stage").

[118] CMS does not require hospitals to use these guidelines, maintaining that it is the treating physician who determines whether a patient should be admitted and the length of a patient's stay in a facility. *See* Medicare Benefit Policy Manual ("MBPM"), Ch. 1, § 10 at 7 (*available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf).

[119] Exhibit P-41 at ¶¶ 9-10 (Decl. of Dr. DiVincinzo); Tr. at 183 (Mar. 31, 2015) (Dr. Kaminsky correcting his declaration confirming he reviewed the patient records for 15 of 17 patients included in the Trailblazer sample). St. Anthony entered as Exhibit P-44 the declaration of consultant experienced in statistical sampling and the consultant's criticism of the small sample size is also applicable to the review conducted by St. Anthony's two medical experts of that same sample.

psychiatric unit.[120] Despite being aware of this lower standard of care and the differences from acute care standards, St. Anthony opted to enroll the Three Disputed Units as PRTFs,[121] hold them out to the public as PRTFs[122] and drafted the Scopes of Care consistent with the state regulatory standards for PRTFs.[123] In fact, the Scopes of Care for ACCENTS and the Human Restoration Unit explicitly state that admission "[d]oes not require an acute care setting. . . ."[124] Although St. Anthony argues that these representations were to inform patients and their parents as to how the PRTF services would be reimbursed, it seems more likely that St. Anthony was describing the level of care to be provided. This conclusion is supported by the facts that (1) the scopes of care mirror the OMP's "[m]edical necessity criteria for admission" to a PRTF;[125] and, (2) the OMP requires PRTFs to obtain prior authorization before admitting Medicaid patients to determine "[i]f the recipient meets the medical necessity criteria."[126]

The OMP subjects PRTFs to less intensive "active treatment" requirements than those for acute psychiatric care.[127] The Board heard hours of testimony about the Three Disputed Units regarding: how severe the patients' conditions were, how heavily staffed the units were and how thorough the care was that was provided. Some of the evidence suggests that the Three Disputed Units, at times, may have provided more therapy than the OMP regulations required for PRTF services; however, there is insufficient evidence to determine the degree and frequency more therapy care than required under the OMP regulations for PRTFs, was provided.[128] Similarly, although testimony was received regarding the frequency the physicians were present on the Three Disputed Units, there is a stark difference between being present on the unit and documented therapeutic "[i]ndividual ***treatment*** provided by the physician."[129] Furthermore,

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[120] Okla Admin. Code §317:30-5-95.34(c). A PRTF is required to provide fewer physician visits, less time in individual therapy, process group therapy and expressive group therapy per week than an acute unit.
[121] Which, incidentally, resulted in significantly higher reimbursement by the OMP. *See* Exhibit P-3 at 158; Exhibit I-19 at 1.
[122] *See* Exhibit P-10 at 24 (Accents Unit Handbook and answers question of "what is residential treatment level?", in part, by stating that it "[d]oes not require an acute care setting or crisis stabilization, but is not stable enough to be discharge [*sic*] to home.").
[123] *See, e.g.,* Exhibit P-9 at 3 (stating in the admissions criteria for the ACCENTS Unit that the referral "[d]oes not require an acute care setting or crisis stabilization, but is not stable enough to be discharged home"); Provider Exhibit P-11 (emphasis added) (stating in the admissions criteria for the Human Restoration Unit that the referral "[d]oes not require an acute care setting, but cannot be maintained in a less restrictive setting for treatment of medical or psychiatric symptoms"); Tr. at 324-325 (Mar. 30, 2015) (confirming the Exhibit P-9 materials were intended for anyone making referrals to the Accents Program).
[124] Exhibits P-9 at 3 and P-11 at 4.
[125] Okla. Admin. Code § 317:30-5-95.29.
[126] *Id.* at § 317:30-5-95.31(a).
[127] The Medicare Contractor's medical expert included at Exhibit I-23 an example of a local coverage determination ("LCD") covering psychiatric inpatient hospitalization in effect near the time at issue. The Board notes and that the LCD's medical necessity standards for Medicare coverage are close to those for OMP's acute psychiatric care at Okla. Admin. Code § 317:3-5-95.25. *See also* Tr. at 373-85 (Mar. 31, 2015) (Dr. Baer discussing this LCD).
[128] For example, while acute care requires three physician visits per week, residential treatment requires just one visit per week. Similarly, acute care requires 24-hour *supervision*, but residential treatment only requires 24-hour *observation*. Tr. 140-142 (Mar. 30, 2015; Exhibits P-26-A, P-26-B, P-26-C.
[129] Okla. Admin. Code § 317:30-5-95.34(c)(1) (emphasis added). *See also* Tr. at 407 (Mar. 31, 2015). Further, Dr. Baer explains that, in order for a physician visit to be counted, it must be documented in the patient record because "[i]t's a communication thing. So if a physician has an interaction with a patient, and it's either therapeutically, psychotherapeutically meaningful or having to do with, you know, medicine or precautions or whatever it might be, you've got to document that so [*sic* as] that's the methodology by why [sic which] he informs the staff." *Id.* at 416-17.

OMP regulations require 24-hour medical/nursing supervision for acute care services while PRTF regulations only require 24-hour observation.

Finally, the Board recognizes the "active treatment" standards for inpatient psychiatric services set forth in the Medicare Benefits Policy Manual ("MBPM"), Ch. 2, § 30.2.3 only require one physician visit per week. However, those MBPM standards are ***not*** relevant because they pertain to inpatient psychiatric hospitals and facilities ("IPF") paid under the IPF inpatient prospective payment system.[130] As such, those standards do not appear to be *directly* applicable to psychiatric care furnished *in short-term acute care hospitals paid under the IPPS*.

Regardless, the Board has concerns about whether the one physician per week being furnished in the Three Disputed Units would be sufficient for an acute level of care furnished in a short-term acute care hospital. In this regard, the Board notes that Dr. Baer opined that the weekly physician visits in the Three Disputed Units allowed for only "minimal" physician interaction with the patients as the weekly physician visit was on average *only 10 minutes*.[131] Further, consistent with the OMP requirements, Dr. Baer presented testimony that the "active treatment" standard used by the Medicare program and other third party payers was at least 3 physician visits per week but as high as 5 physician visits per week and that a visit by a physician extender (*e.g.*, nurse practitioner) does not count as a physician visit.[132] Indeed, consistent with this standard of care and in contrast with the Three Disputed Units, St. Anthony's two psychiatric acute care units do furnish physician visits 5 times per week.[133] The Board recognizes that St. Anthony has claimed that *undocumented*, impromptu physician interaction and observation occurred with patients by physicians on staff and that they should be counted as physician treatment; however, these interactions are ***not*** part of the patient's *treatment* record and, as a consequence, the nature and extent of those alleged interactions/observations is unknown.[134] Accordingly, the Board declines to give any weight to that claim.

Even if the medical expert testimony offered by St. Anthony was accepted at face value and the care in the patient sample taken from the Three Disputed Units were, in fact, found to meet the OMP level of care for acute psychiatric services 24-hours a day, seven days a week, it would still be insufficient because that testimony was based in large part on the sample and, again, it is unclear whether this sample was a *representative* sample (*i.e.*, a statistically valid sample such that it was representative of the care generally provided in the Three Disputed Units).[135] Regardless, as discussed below, a thoughtful examination of the record before the Board, including other evidence not considered in the vacated Board's decision, demonstrates that

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[130] MPBM, Ch. 2, §§ 10.1-10.3.
[131] Tr. at 407 (Mar. 31, 2015). *See also id.* at 412 (testifying that "[y]ou can't see somebody once a week if you're going to have that intensive inpatient acute treatment and figure out what's going on with the patient").
[132] *See* Tr. at 414-15; 478-79; 497 (Mar. 31, 2015). *See also* Exhibit I-23.
[133] *See* Tr. at 412 (Mar. 31, 2015).
[134] Dr. Baer explained that, in order for a physician visit to be counted, it must be documented in the patient record because "[i]t's a communication thing. So if a physician has an interaction with a patient, and it's either therapeutically, psychotherapeutically meaningful or having to do with, you know, medicine or precautions or whatever it might be, you've got to document that so [*sic* as] that's the methodology by why [sic which] he informs the staff." *Id.* at 416-17. This concern is highlighted in the fact that Patient 44 had a 100-day length of stay but there were only 10 pages of physician notes. *See* Exhibit P-51; Tr at 343-45 (Mar. 31, 2015).
[135] *See supra* notes 20, 21 and accompanying text. Note that the Board's vacated decision questioned the validity of the sample and its evidentiary value. PRRB Dec. No. 2018-D12 at 8. *See also id.* at 22-23 (dissenting opinion).

medical expert testimony is not reliable and has no value *for purposes of the standards that the Board is directed to apply on remand*. Indeed, the Board's vacated decision failed to address this other evidence and, as a result, the Board reaches different findings, *on remand*, once this other evidence is considered.[136]

As discussed above, both the OMP "active treatment" requirements and Medicare guidance require that psychiatric acute care is *only* for those patients whose admission is required for "active treatment" of an intensity that can be provided appropriately *only* in the inpatient hospital setting. "Active treatment" includes physician services, therapy services, medication, and physician meetings with the treatment team members.[137] Furthermore, the OMP criteria governing the medical necessity of acute care specify that "*[w]ithin the past 48 hours,* the behaviors of the patient present an imminent life threatening emergency."[138] Utilizing this background information, there are several additional indicators that the Three Disputed Units do not furnish acute care services as would generally be payable under IPPS.

1. ***Wait Lists*** – The existence of wait list[s] for admission to the Three Disputed Units is inconsistent with the conclusion that the Three Disputed Units provided acute psychiatric care which is medically necessary under the Oklahoma Medicaid criteria *only* if "[w]ithin the past 48 hours, the behaviors of the patient present with an imminent life threatening emergency."[139] It strains the limits of credibility to claim that a patient who has exhibited imminent life threatening behaviors *within the past 48 hours*, could safely be placed on a waiting list for admission to one of the Three Disputed Units. St. Anthony's argues that a portion of patients on the wait list were temporarily admitted to acute care units (including St. Anthony's own acute care units) until a bed became available in one of the Three Disputed Units. In those instances where a patient on the wait list was admitted to an acute care unit *for treatment*, it is unclear if the life-threatening behaviors warranting such an admission would continue (as opposed to being stabilized from the care received), particularly if that admission lasted more than 48 prior to transfer to one of the Three Disputed Units. No evidence or testimony was presented demonstrating that behaviors meeting the OMP criteria were exhibited by all (or any) of the patients at the point in time they were admitted to the Three Disputed Units from the wait lists. As such, the mere existence of a wait list for admission to the Three Disputed Units is contrary to the claim that acute care services were being provided in those units.[140]

2. ***Transfers from acute care facilities*** – A similar conclusion must be reached with regard to the admission of patients being transferred from acute care facilities. This is a significant factor since the records indicates that 10 of the 17 patients included in the TrailBlazer sample for the Three Disputed Units were transferred into one of these units

[136] In PRRB Dec. No. 2018-D12, the Board majority did not address wait lists, transfers, passes to leave the facilities, and the medical review findings made in the OMP prior authorization process.
[137] MBPM, Ch. 2, § 30.2.3.
[138] Okla. Admin. Code § 317:30-5-95.25(5) (emphasis added).
[139] *Id.* at § 317:30-5-95.25(5) (emphasis added).
[140] *See also* Tr. at 451 (Mar. 31, 2015) (testimony from Dr. Baer testifying that wait lists are incongruous with a need for acute care because patients admitted into an acute care unit must present with an emergent crisis).

from an acute care unit.[141] Again, no evidence was presented that the patients exhibited imminent life-threatening behaviors within 48 hours of being admitted to the Three Disputed Units (*i.e.*, within 48 hours of being transferred from an acute care unit to the Three Disputed Units). As such, the conclusion must be reached that acute care services were not being provided in the Three Disputed Units as would generally be payable under IPPS.[142] Similarly, the fact that the diagnosis for a patient being admitted to a PRTF upon transfer from a psychiatric acute care unit is the same diagnosis that the patient had while he/she was in a psychiatric unit does not mean that the patient *continues* to need an acute level of care in the PRTF as highlighted by the fact that the Oklahoma Medicaid medical necessity criteria for psychiatric care facilities and PRTFs have the *same* universe of qualifying diagnoses yet provide treatment at different

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[141] The 5-patient sample taken from the ACCENTS Unit involved 3 patients that appeared to have been transferred *from acute care units* – Patient 37 as a transfer from Integris (Ex. P57-A at 46; Ex. P-27 at 31-32); Patient 40 as a transfer from Tulsa Regional Hospital (Ex. P-57-D at 7); and Patient 41 as a transfer from a St. Anthony acute care unit (Ex. P-57-E at 14, 17; Exhibit P-27 at 28) where the patient had an 18-day stay (Ex. P-27 at 28).

Similarly, the 5-patient sample taken from the Positive Outcomes Unit involved 2 patients that appear to have been transferred *from acute care units*: Patient 43 transferred from Willow View Hospital (Ex. P-59-B at 6; Ex. P-27 at 36); Patient 45 transferred from the St. Anthony Adolescent Care Unit (Ex. P-59-D at 5, 32, 33, 35; Ex. P-27 at 30). Further, Patient 42 had a lengthy stay in detention prior to being admitted to St. Anthony's for events that appear to have occurred prior to those institutional stays. Specifically, Patient 42 appears to have had a 4-month stay in detention related to rape charges involving a sister prior to being admitted to the Positive Outcomes Unit in connection with issues surrounding that alleged rape-related events (Ex. P-59-A at 5, 11, 33; Ex. P-27 at 36).

Similarly, all of the patients in the 7-patient sample taken from the Human Restorations Unit appear to have been transferred from acute care units or other residential treatment facilities: Patient 47 had an 8-month stay in the St. Anthony Child and Adolescent PRTF (also known as 29W) before being transferred to the Human Restorations Unit apparently related to threatening behavior to peers and staff in the St. Anthony's Child and Adolescent PRTF (Ex. P-58-A at 1, 22, 27); Patient 48 was transferred from the St. Anthony Adolescent Care Unit (also known as 39S) to Human Restorations Unit "for long term tx" (Ex. P-58-B at 34) due to "increasing depression as well as suicidal ideation" (Ex. P-58-B at 5; Ex. P-27 at 33); Patient 49 was initially admitted to the St. Anthony Adolescent Care Unit for increased depression and suicidal ideation prior to being transferred to the Human Restorations Unit (Exhibit P-58-C at 1, 6, 7, 24; Ex. P-27 at 27); Patient 50 was initially admitted to the St. Anthony Adolescent Care Unit for 9 days prior to being transferred to the Human Restorations Unit (Exhibit P-58-D at 1, 6; Exhibit P-27 at 29); Patient 51 was initially admitted to the St. Anthony Adolescent Care Unit for 4 days for anger issues and threats to hurt himself or others prior to being transferred to the Human Restorations Unit (Ex. P-58-E at 22, 24, 25, 43; Ex. P-27 at 28); Patient 52 was transferred from a local RTC that was closing to the Human Restorations Unit (Exhibit P-58-F at 6, 9; Ex. P-27 at 33); Patient 53 was admitted to a peripheral hospital (Norman Regional Hospital) for drug overdose before being transferred to the St. Anthony adolescent acute care unit for a 7-day day and then transferred again to the Human Restorations Unit (Ex. P-58-G at 6, 9; Ex. P-27 at 29).

[142] *See, e.g.*, Tr. at 392-93 (Mar. 31, 2015) (Dr. Baer testifying that "Dr. Bell gave a very good example of how this works and how it works at St. Anthony's in that he talked about sexual offenders, your male sexual offender in the community who was discovered. Did he go to the Positive Outcomes unit? No. He went to the acute adolescent inpatient unit for intensive care of the suicidality because he'd just had a recent attempt. And then once that was quieted down and the crisis had passed, he was transferred to the Positive Outcomes unit for treatment of his underlying illness. So he had an acute episode. He's in crisis. That crisis is quelled with treatment, talking about why that initial ten days or whatever it may have been is different than Positive Outcomes."); Tr. at 73-75 (In response to question what goes into a recommendation of extended acute care versus the regular inpatient hospital acute care, Dr. DiVincenzo testified that "Well, it's – obviously, you would not be referred directly to an extended acute care admission having not been already in a regular hospital acute stay. So you'd have to be there, and you're usually there for a durable period of time, unable to be discharged because of acuity. And what goes into it as an agreement from all the disciplines involved and the physician's recommendation based upon review of the history that his patient's appropriate."). This is also consistent with the fact that patients appear to be transferred into the Three Disputed Units for long term or extended care. *See, e.g.*, Exhibit P-58-B at 34 (Patient 48 transferred to Human Restorations Unit for "longer term tx"); Exhibit P-58-G at 1 (Patient 53 "transferred to the longer term [Human Restorations] unit").

levels.[143] Finally, as discussed previously, all of these transfers would have gone through prior authorization to determine if a transfer was medically appropriate to warrant a change in the level of care from an acute level of care to a PRTF level of care.

3. ***Passes to Leave the Facility*** – As part of the treatment regime, patients of the Three Disputed Units were granted passes to leave the facility for time periods ranging from 2 hours to overnight, without staff supervision.[144] It is unclear how unsupervised community passes are consistent with an acute level of care. Although the ACCENTS and Human Restorations Units Medical Director testified that a patient's "acute episode" may wax and wane, and that passes would be provided only during a waning period,[145] he did not explain how such passes were part of a course of treatment *in an acute care setting*. Furthermore, an "acute episode" does not necessarily equate to a need for acute psychiatric care. The granting of unsupervised community passes suggests that the patients were not receiving, nor did they require, acute care during these periods contradicting the claim that the Three Disputed Units were providing acute care services, as would generally be payable under IPPS for short-term acute care hospitals. At a minimum, passes to leave the facility would appear congruent with the long-term nature of the care provided.

4. ***Prior authorization of residential treatment services under Medicaid*** – By definition, the OMP prior authorization and extension process "will [only] approve lengths of stay using the current . . . medical necessity criteria and following the current inpatient provider manual approved by [OMP]."[146] The OMP medical review process is designed to determine the appropriate level of care both *prior to admission* and during certain intervals after admission when re-authorization is required.[147] St. Anthony's witness's testimony during the hearing confirmed that ***all*** of the days at issue in the Three Disputed Units received prior authorization from the OMP and were claimed and paid on a *per diem* basis ***as PRTF*** services.[148] Thus, for the patient days at issue in this case (including those associated with patients who were on a wait list or were transferred), the OMP applied its medical necessity criteria for both acute psychiatric care and residential treatment services. Universally, the OMP concluded that the patients in the Three Disputed Units qualified for psychiatric residential treatment services, which is different from and does not rise to the level of care as would generally be payable under IPPS.

5. ***Total Admission Days*** – Attached to "Provider's Supplemental Briefing Following Remand by CMS Administrator" is a Declaration from Peter Dressel, Senior Managing Director in the Forensic & Litigation Group at FTI Consulting.[149] The purpose of Mr.

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[143] *Compare* OAC § 317:30-5-95.25(1) (medical necessity criteria for psychiatric acute care) *with* OAC § 317:30-5-95.29(1) (medical necessity criteria for PRTF care).
[144] Tr. at 240-243 (Mar. 30, 2015); Tr. at 67, 74-77 (Mar. 31, 2015).
[145] Tr. at 281-282 (Mar. 30, 2015). Similarly, the medical director for the Positives Outcomes Unit testified that they would not give a pass for a patient if there were a danger to the community. *See* Tr. at 99 (Mar. 31, 2015).
[146] Okla. Admin. Code § 317:30-5-95.24(3). *See also* Okla. Admin. Code § 317:30-5-95.31.
[147] A provider can appeal prior and re-authorization decisions as explained at Okla. Amin. Code § 317:30-5-95.31(d). *See also* 42 C.F.R. § 456.1.
[148] *See* Tr. at 164-166 (May 28, 2015). *See also id.* at 155-156; *supra* note 74 (quoting OMP provision requiring review of ***all*** *treatment documentation* at the 3-month mark as part of the re-authorization process).
[149] *See* Ex. P-66.

Dressel's Declaration was to address the CMS Administrator's reference to acute care IPPS hospital average lengths of stay equaling, approximately, 5 days.[150] Based on the testimony of both parties, the average length of stay in the Three Disputed Units ranges from 128 to 162 days.[151] Mr. Dressel, utilizing publicly available cost report data, calculated the total number of days billed to Medicare for each of the DRGs (426, 430 and 432) which were referenced by the Administrator as representative of the patients in the Three Disputed Units.[152] Mr. Dressel concludes that Medicare patients with more than 25 days of utilization under these three DRGs represented a significant portion of the total patient days billed to Medicare. Although his analysis is interesting, it does not support a finding that the care generally provided in the Three Disputed Units rises to the level of care as would generally be payable under IPPS. First, as Mr. Dressel explained in his Declaration, the sample population he used consisted of patients who were discharged and readmitted, likely having several relatively short lengths of stay.[153] This pattern would be indicative of a patient being readmitted as a result of multiple acute episodes and being discharged when the underlying acute episode ends. In other words, the patients in Mr. Dressel's sample patient population are strikingly *dissimilar* to the patients of the Three Disputed Unit who are admitted and remained patients for extended periods of time. Second, comparing Medicare patients who have *total* ***annual*** utilization of greater than 25 days to the patients in the Three Disputed Units whose average stays *start* at 128 days does not support the conclusion that acute care services were being provided in the Three Disputed Units. Finally, the average stay for the patients identified by DRG 326, 340 and 342 in Mr. Dressel's Declaration is 9.87 days which is ***13 to 18 times less than the average stay*** for patients in the Three Disputed Units.[154] In essence, Mr. Dressel's analysis is interesting but compares two completely

[150] *See* Order of the Administrator at 13 and n. 24 (Dec. 29, 2017).
[151] Tr. at 323 (Mar. 31, 2015).
[152] *See* Order of the Administrator at 14 and n. 26 (Dec. 29, 2017).
[153] Ex. P-66 at 3.
[154] This average was calculated using the highest value of each range of days and 75 days for the 46+ range. The following chart demonstrates the calculation of average number of days per patient:

Medicare Patient Days for DRGs 426, 430 and 432 Combined		
Days	Patients	Max Total
5	29,263	146,315
10	19,794	197,940
15	7,207	108,105
20	2,781	55,620
25	1,311	32,775
30	729	21,870
35	361	12,635
40	219	8,760
45	150	6,750
75	295	22,125
Total	62,110	612,895
	Average =	9.87

different patient populations with different utilization histories and, ultimately, is comparing apples to oranges. As such, the Board gives his analysis no weight.

In summary, although the Board believes that the Three Disputed Units are essential to the psychiatric care being provided to the children and adolescents of Oklahoma (and beyond), the evidence before the Board is simply inadequate to find that the services provided rose to a level generally payable under IPPS. As such, the Board must find that the Three Disputed Units did not provide services at a level generally payable under IPPS.

DECISION

After considering Medicare law, regulations and guidance, testimony and arguments presented, and the evidence admitted, the Board has compared the level of care generally provided during FY 2006 to the patients of the Three Disputed Units to acute care psychiatric services provided in a general IPPS hospital, as directed on remand by the Administrator. The Board finds that the level of care generally provided in these PRTF units during FY 2006 were not equivalent to the acute care psychiatric services provided in a general IPPS hospital and were not generally payable under IPPS. Accordingly, the Medicare Contractor properly excluded the PRTF patient days at issue from the Medicaid fraction of the St. Anthony's Medicare DSH payment for FY 2006.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq. (*joining & concurring*)

For the Board:

9/19/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

CONCURRING OPINION

While I agree with, and join, the Decision of the Board, I feel bound to file this Concurring Opinion to call attention to the parties' failure to adequately supplement the record following the Administrator's remand of this appeal, putting the Board in a difficult position.

The Administrator directed the Board to, "focus . . . on the level of care generally provided in the PRTF compared to *acute care psychiatric services provided in a general IPPS (short term) hospital*."[1] With this focus in mind, the Board was directed to "determine whether the services generally provided in the disputed units were services generally payable under IPPS. . . ."[2] The Board's challenge was the dearth of relevant, reliable evidence or testimony, presented by the parties that would, or could, lead to an answer to this question.

As explained in more detail in the Opinion and Decision of the Board, the Trailblazer Report used the questionable InterQual Criteria based on a sample size of *less than 7%* of the total patient population.[3] Both of Provider's expert witnesses *and* the Medicare Contractor's expert witness based their testimony, primarily, on this inadequate sample. Their reliance on this problematic data set for their testimony leads me to question the reliability, and therefore usefulness, of their conclusions.

As also explained in the Opinion and Decision of the Board, the Provider assigned IPPS DRGs to the care delivered in the Units.[4] Because they were not used for payment of the services provided, there is no evidence of the DRGs accuracy. Evidence and testimony were also presented regarding the average length of stay in the Units[5] and that it does not reflect (or is not relevant to determining) a level of care that is generally provided in an IPPS hospital. However, comparing that average length of stay to the mean length of stay associated with the Provider assigned IPPS DRGs, is an unreliable and invalid means of determining the level of care provided in the Units.[6]

In sum, the parties to this appeal have failed to provide the evidence, or testimony, needed to determine whether the services provided in the Units were services generally payable under IPPS. However, despite the dearth of evidence, the Board has reached the correct decision because the law is clear that a PRTF does not provide the level of care or services generally payable under IPPS.

9/19/2022

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: Robert A. Evarts -A

[1] *St. Anthony* Adm'r Dec. at 18 (italics in original).
[2] *Id.* at 13.
[3] *See,* Discussion of the Trailblazer Report in Board Decision at 22 – 23. *See also,* Tr. at 487-492; Medicare Contractor Exhibit I-10. The 17-patient sample consists of 3 patients from the ACCENTS Unit, 7 patients from the Human Restorations Unit, and 5 patients from the Positive Outcomes Unit; however, only portions of the medical record were reviewed for these 17 patients.
[4] *See,* Exhibit P-28 at 5. The primary discharge diagnoses from the Disputed Units are associated with DRGs 426, 428, 430, 431 and 432.[4]
[5] *See* Exhibit I-19 (showing that, for 2006, the ACCENTS Unit had 67 patients with an average length of stay 162 days, the Human Restoration Unit had 97 patients with an average length of stay of 128 days, and the Positive Outcome Unit had 54 patients for an average length of stay of 156 days).
[6] *See also,* Discussion of DRGs in Board Decision at 17 – 18.