PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2023-D05

PROVIDERS-
Integris Health 2007 DSH Inpatient
Behavior Health Days CIRP Group

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
June 21, 2016

Cost Reporting Period – 2007

CASE NO. 15-3079GC

CONTENTS

Issue Statement

Whether to include Medicaid days of children and adolescents for the hospital's inpatient behavioral health departments in the Medicaid fraction of the Medicare disproportionate share hospital ("DSH") calculation for fiscal year ("FY") 2007 for each of the participants in this common issue related party ("CIRP") group.[1]

Decision

After considering Medicare law, regulations and guidance, testimony and arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") makes the following findings regarding the two participants in this CIRP group, Integris Health Baptist Medical ("Baptist") and Integris Bass Baptist Health Center ("Bass"):

1. During FY 2007, Baptist operated five (5) child and adolescent psychiatric units in a hospital department known as Integris Mental Health Spencer ("Spencer") and, similarly, Bass operated three (3) child and adolescent psychiatric units in a hospital department known as Integris Meadowlake ("Meadowlake");

2. For FY 2007, the level of care that Spencer and Meadowlake generally furnished in their respective child/adolescent psychiatric units, *as a whole*, was a psychiatric residential treatment facility ("PRTF") level of care;

3. The furnished PRTF level of care was not equivalent to the psychiatric acute care services provided in a short-term acute care hospital subject to the inpatient prospective payment system ("IPPS") and, thus, is not generally payable under the IPPS;

4. The Medicare Contractor *properly* excluded all of the days associated with the units at Spencer (both days for psychiatric acute care and PRTF care) from the Medicaid fraction used in Baptist's DSH calculation for FY 2007; and

5. The Medicare Contractor *improperly* excluded only the PRTF care days associated with the units at Meadowlake from the Medicaid fraction used in Bass's DSH calculation for FY 2007.

Accordingly, the Board remands this case to the Medicare Contractor and instructs it to exclude all days (both psychiatric acute care and PRTF care days) associated with the units at Meadowlake from the numerator and denominator of the Medicaid fraction of Bass's DSH adjustment calculation for FY 2007.

Introduction

This CIRP group is comprised of the following 2 participants (collectively the "Providers") which are both located in Oklahoma and commonly owned by Integris Health:

[1] Transcript ("Tr.") at 5-6 (June 21, 2016).

1. Baptist which operates a child/adolescent psychiatric department referred to as Spencer; and

2. Bass which operates a child/adolescent psychiatric department referred to as Meadowlake.

The Medicare contractor[2] currently assigned to the Providers is Novitas Solutions, Inc. ("Novitas"). Novitas succeeded Trailblazer Health Enterprises ("Trailblazer") as the designated Medicare contractor for Baptist and Bass on October 29, 2012 and, similarly, Trailblazer succeeded Chisholm Administrative Services ("Chisholm") on March 1, 2008.[3] The Board will refer to Novitas, Trailblazer, and Chisolm collectively as the "Medicare Contractor."

During FY 2007, Baptist operated five (5) child and adolescent psychiatric units in a hospital department referred to as Spencer.[4] Similarly, during FY 2007, Bass operated three (3) child and adolescent psychiatric units in a hospital department referred to as Meadowlake.[5] During FY 2007, both Baptist and Bass participated in the Oklahoma Medicaid Program ("OMP") as providers of both: (1) psychiatric acute care to patients under 18 years old; and (2) PRTF care (also referred to as residential treatment center ("RTC") care) to patients under 18 years old.[6]

Baptist's days, statistics, costs and charges, reported on Line 10.04 (labeled "Residential Treatment Centers") and Line 10.05 (labeled "Children's Psych") were reclassified by the Medicare Contractor to Lines 14.00 and 14.01, which are lines on the cost report used for subproviders. All of the reclassified days occurred at Spencer and the Medicare Contractor reclassified them because it determined that the underlying care did not rise to the level of acute care.[7] Since subprovider days are not included in the DSH calculation, this resulted in 32,922 Medicaid days[8] and the total days of 34,021[9] being excluded from the numerator and denominator, respectively, of the DSH Medicaid fraction and in a reduction in Baptist's FY 2007 DSH percentage from 20.88[10] percent to 6.31.[11] The excluded Spencer days consisted of ***all*** days of care furnished at Spencer, whether identified as for acute care or PRTF care.[12] This adjustment, *combined with other adjustments*, resulted in a settlement of ($11,358,904) for Baptist's FY 2007.[13] Baptist estimates the impact of excluding these Spencer days to be approximately $11.4 million.[14]

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[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 and relevant.
[3] Medicare Contractor's Final Position Paper, 6 (Mar. 30, 2016) ("Medicare Contractor's FPP").
[4] Tr. at 43-44; Exhibit P-11.
[5] Tr. at 44; Exhibits P-14, P-37.
[6] *See infra* notes 32-44 and accompanying text.
[7] Exhibit P-23.
[8] Exhibit P-25 at 275-276. Medicaid days on Line 14 of 31,887 plus Medicaid days on Line 14.01 of 1,035 = 32,922.
[9] Exhibit P-25 at 276. Total days on line 14 of 32,434 plus total days on line 14.01 of 1,587 equal 34,021.
[10] Exhibits P-25, P-26. It is noted that the *beginning* percentage on the Medicare Contractor's adjustment on Exhibit P-25, Audit Adjustment No. 47 does not tie to the provider's estimated DSH impact on Exhibit P- 26. The beginning percentage on Exhibit P-25 is 20.88 as compared to 20.89 on Exhibit P-26.
[11] *Id.* It is noted that the final DSH percentage on the Medicare Contractors adjustment on Exhibit P-25, Audit Adjustment No.47 does not tie to the provider's estimated impact on Exhibit P-26. The beginning percentage on Exhibit P-25 is 6.31 as compared to 6.08 on Exhibit P-26.
[12] *See* Exhibit P-45 at ¶ 9.
[13] Exhibit P-26.
[14] Exhibit P-7 (showing estimated impact of $11,417,370); Exhibit P-26 (showing estimated impact of $11,358,904).

Similarly, Bass's days statistics, costs and charges, reported on Line 1, entitled "Adults and Pediatrics" were reclassified by the Medicare Contractor to Line 14.01, entitled "Subprovider."[15] All of the reclassified days occurred at Meadowlake and the Medicare Contractor reclassified them because it determined that the underlying care did not rise to the level of acute care.[16] The reclassification of these days resulted in 12,336 Medicaid days and the total days of 14,518[17] being excluded from the numerator and denominator, respectively, of the DSH Medicaid fraction and a resultant reduction in Bass's FY 2007 DSH percentage from 40.25[18] percent to 22.54.[19] However, unlike Baptist, the days excluded from Bass only pertained to residential care (*i.e.,* days associated with acute care remain in the numerator of Medicaid fraction for Bass's FY 2007 DSH calculation). This adjustment combined with other adjustments resulted in a settlement of ($2,289,240) for Bass's FY 2007.[20] Bass estimates the impact of excluding these Meadowlake days to be approximately $2.3 million.[21]

Integris timely appealed the Medicare Contractor's determinations for Baptist and Bass to form this CIRP group and has met the jurisdictional requirements for a hearing before the Board. Accordingly, the Board held a hearing on June 21, 2016. Integris was represented by Stephanie A. Webster, Esq., and the Medicare Contractor was represented by Edward Lau, Esq. and Scott Berends, Esq. of Federal Specialized Services.

Statement of Facts and Relevant Law

A. Background on Baptist and Bass

As noted above, during FY 2007, Baptist operated 5 child and adolescent psychiatric units in a hospital department referred to as Spencer and these 5 units were located by themselves in a building about 15 minutes driving-time away from the main campus (*i.e*., without any other hospital units).[22] For most of FY 2007, Spencer had 102[23] inpatient beds and these beds broke out across the 5 units as follows:

- 2 units, each consisting of 15 beds which were used to treat children 5-12 years old;
- 2 units, each consisting of 15 beds which were used to treat adolescents between 13-17 years old with traditional psychiatric illnesses; and

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[15] Exhibit P-20.
[16] Exhibits P-14, P-28.
[17] Exhibit P-20 at 251.
[18] Exhibit P-20; Exhibit P-29. It is noted that the *beginning* percentage on the Medicare Contractor's adjustment on Exhibit P-20, Audit Adjustment No. 31 does not tie to the provider's estimated DSH impact on Exhibit P-29. The beginning percentage on Exhibit P-20 is 40.25 as compared to 40.32 percent on Exhibit P-29.
[19] *Id.* It is noted that the final DSH percentage on the Medicare Contractors adjustment on Exhibit P-20, Audit Adjustment No. 31 does not tie to the provider's final estimated percentage on Exhibit P-29. The beginning percentage on Exhibit P-20 is 22.54 as compared to 22.86 on Exhibit P-29.
[20] Exhibit P-29.
[21] Exhibits P-7, Exhibit P-29 (both showing estimated impact of $2,289,240).
[22] Exhibit P-11; Exhibit P-12 at 53, 57 (showing no other licensed beds located at the Baptist Spencer address); Exhibit P-36A at 360 (stating that Spencer "is also approximately a 15 minute drive from the main hospital campus.").
[23] *See* Provider's Final Position Paper, 15 (Feb. 29, 2016) ("Provider's FPP"); *but see* Exhibit 12 at 57, dated Nov. 24, 2006 showing 118 licensed unit beds under 18.

- 1 unit consisting of 42 beds which were used in a sexual trauma and abuse recovery ("STAR") program that treats children between 5-14 years old who have exhibited sexually aggressive behaviors.[24]

Spencer inpatient days were predominately for PRTF care (roughly 95 percent of the total days[25]) and were predominantly *paid* by Medicaid (about 97 percent of the total days[26]).

Similarly, during FY 2007, Bass operated 3 child and adolescent psychiatric units in a hospital department referred to as Meadowlake and these 3 units were located by themselves in a building 1.6 miles travel distance from the main campus (*i.e.*, without any other hospital units).[27] In FY 2007, Meadowlake had 50 inpatient beds[28] and these beds broke out as follows across the 3 units:

- 1 unit consisting of 20 beds which were used to treat 5-12 year old children;

- 1 unit consisting of 10 beds which were used to treat adolescents ages 13-17 with traditional psychiatric illnesses; and

- 1 unit consisting of 20 beds which were used to treat adolescents between 13-17 years of age with both development disabilities and emotional disorders.[29]

Meadowlake inpatient days were predominately for PTRF care (roughly 98 percent of the total days[30]) and were predominantly *paid* by Medicaid (about 84 percent of the total days for FY 2007[31]).

During FY 2007, it is clear that Spencer and Meadowlake each participated in the OMP as providers of both psychiatric acute care ("Acute Care") *and* PRTF care in a hospital-based PRTF for patients under 18 years old as demonstrated by the following facts:

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[24] Providers' Post-Hearing Brief, 23 (Sept. 9, 2016); Tr. at 43-44. *See* Exhibit P-36A at 364 for the description of the type of behavioral disorders treated in the children unit (children under 5-12), the Adolescent unit (Adolescent ages 12-17) and the Star unit (treating sexually aggressive behaviors for ages 5-14).

[25] 32,434 PRTF days / 34,021 total days = 95 percent rounded. Exhibit P-8 at 27-28, Exhibit P-25 at 276 (showing that, during FY 2007, Spencer had 34,021 total days of care (32,434+1,587) of which 32,434 were for residential care days and 1,587 were for acute psychiatric care).

[26] Exhibits P-8 at 27, P-25 at 276. Medicaid days of 32,922 (31,887 + 1,035) divided by total days of 34,021 (32,434 + 1,587) = 97 percent rounded. Exhibit P-45 at ¶ 7 clarifies that Medicaid *paid* for 32,159 days of the total 33,065 days at Spencer which is also 97 percent.

[27] Exhibit P-14; Exhibit P-15 at 63 (showing no other licensed beds at the Meadowlake address); Exhibit P-37A at 388 (stating Meadowlake "is separated from the main hospital campus with a travel distance of 1.6 miles.").

[28] Exhibit P-15 at 63.

[29] Providers' Post-Hearing Brief at 24; Tr. at 44.

[30] 14,518 PRTF days / 14,827 total days = 98 percent rounded. Exhibit P-20 (showing that, during FY 2007, Meadowlake had 14,827 days of which 14,518 were for residential care or PRTF days and 309 were for psychiatric acute care).

[31] Exhibit P-20. Medicaid days of (12,336 + 157) divided by total days of (14,518 + 309) is 84 percent rounded. Exhibit P-45 at ¶ 7 states that all of the Medicaid eligible days for Meadowlake were paid days. The Board recognizes that there is a conflict between Exhibit-45 showing only 12,493 Medicaid eligible days from Meadowlake being included in the DSH calculation and the statement in Exhibit P-45 that there were 15,056 Medicaid eligible days (that were all paid days) included in the DSH calculation for FY 2007. That said, the Board has placed the emphasis on the fact that all of the Medicaid eligible days were paid days per the statement in Exhibit P-45.

1. The Oklahoma Healthcare Authority ("OHCA"), which oversees the OMP, required Spencer and Meadowlake to each maintain separate provider agreements/provider numbers for Acute Care and for PRTF care.[32]

2. All beds at Spencer and Meadowlake were ***dually licensed*** as Acute Care and PRTF beds.[33]

3. Spencer and Meadowlake are each listed in OMP materials as a "residential treatment center" or "RTC."[34] Integris compares the services provided by Spencer and Meadowlake to the services delivered by St. Anthony Hospital ("St. Anthony")[35] which is another Oklahoma hospital that operates a hospital-based PRTF as noted in PRRB Dec. Nos. 2018-D12 and 2022-D29[36] and also listed in OMP materials as an RTC.[37]

4. In support of its position that the RTC days at issue are acute care days, Integris cites to the October 2, 2008 letter from OHCA at Exhibit P-1. However, the OHCA letter does *not* refer to RTC days but rather refers to "days of patients in a hospital-based psychiatric residential treatment facility (PRTF)."[38]

5. In further support of its position that the days at issue are acute care days, Integris has also cited to the OMP DSH calculation and has included instructions for what inpatient days are included in that calculation. However, these instructions do not refer to RTC days but rather to PRTF days: "[a]lso included [in the computation of Medicaid inpatient days] are rehabilitation, newborn, swing bed and <u>on-site</u> Psychiatric Residential Treatment Facility (PRTF) days. They do not include . . . PRTF days rendered in separately licensed certified, ***off-site*** PRTF . . . ."[39]

6. Okla. Admin. Code § 317:30-5-95(d) (2007) defines a PRTF as follows:

> A PRTF is any non-hospital facility with a provider agreement with OHCA to provide the inpatient services benefit to Medicaid eligible individuals under the age of 21. To enroll as a hospital-based or freestanding PRTF, the provider must be appropriately state licensed pursuant to Title 10 O.S. § 402 and approved by the OHCA to provide services to individuals under 21.

7. Okla. Admin. Code § 317:30-5-95.22(a) (2007) explains that the services provided in acute hospitals, free-standing hospitals and PRTFs must meet the requirements of Okla.

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[32] Tr. at 99-100; Exhibit P-45 at ¶ 10; Providers' Post-Hearing Brief at 21-22.
[33] Tr. at 45-47; Provider's Post-Hearing Brief at 20 (with citations to the record).
[34] Exhibit I-3 at 1; Exhibit P-40 at 394 (note Spencer is referred to as Integris Willowview at Spencer).
[35] *See, e.g.*, Post-Hearing Brief at 30-31, 59; Tr. at 40, 143-45, 149; Exhibit P-45 at ¶ 9. *See also* Exhibit P-3 (referring to "OK RTC – NPR Process," "RTC issue," and "RTC days" when discussing the disallowance of RTC days at Oklahoma hospitals, including, but not limited to, Baptist, Bass, and St. Anthony).
[36] *St. Antony Hospital v. Novitas Solutions, Inc.*, PRRB Dec. 2022-D29 (Sept. 19, 2022), *on remand from* Admin'r Dec. (Mar. 6, 2018), *vacating* PRRB Dec. No. 2018-D12 (Dec. 29, 2017).
[37] Exhibit I-3 at 1; Exhibit P-40 at 394.
[38] Exhibit P-1.
[39] Exhibit P-6-at 20 (underline emphasis added and bold and italics emphasis in original).

Admin. Code §§ 317:30-5-95.25 through 317:30-5-95.30 to be covered. In subsection (b), it provides the following definitions in pertinent part:

> (1) "Acute care" means 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.
>
> (7) "Residential Treatment services" means psychiatric 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.

8. Okla. Admin. Code § 317:30-5-95.29 (2007) defines the medical necessity criteria for admission and specifies the "terms and conditions" that qualify for "*psychiatric residential treatment facility* [*i.e.*, PRTF] admissions."[40] These are the same criteria that Spencer and Meadowlake specify their RTC admissions must meet.[41] This is the only section that deals with initial admissions for under-21 psychiatric residential treatment.

9. 95 percent or more of the care days at Spencer and Meadowlake were for under-18 RTC services while the remaining 5 percent or less of care days were for under-18 psychiatric acute care services.[42]

10. During FY 2007, both Spencer and Meadowlake provided services almost exclusively to Medicaid beneficiaries where Medicaid was the primary payor (97 percent and 100 percent respectively[43]).

11. During the hearing, Spencer and Meadowlake were referred to as PRTFs and RTCs interchangeably without correction by Integris' witness or representative.[44]

Thus, it is clear that the beds in the units at Spencer and Meadowlake are operated separately from the rest of the applicable hospital and provide both:

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[40] (Emphasis added.)
[41] Compare Okla. Admin. Code § 317:30-5-95.29 to the admissions standards for residential care for Baptist Spencer at Exhibit P-36A at 352-53. *See also* Providers' Post-Hearing Brief at 18 (citing to Okla. Admin. Code § 317-30-5-95.29 as the standards by which Baptist Spencer and Meadowlake admits under-18 patients for psychiatric residential care); *id.* at 21 (stating that "[t]he Providers have admission criteria for each unit that mirrors the medical necessity criteria as described in the Oklahoma Administrative Code for facilities that provide inpatient psychiatric hospital services to children and adolescents.").
[42] *See supra* notes 26, 31 and accompanying text.
[43] *See* Exhibit P-45 at ¶ 7 (Affidavit of the Integris' witness, Ms. Allen); Tr. at 129-30, 140-41, 148. The Affidavit also confirms that the remaining 3 percent of days for Baptist Spencer were associated with patient who were Medicaid eligible but had other insurance that was the primary payor. Exhibit P-45 at ¶ 7. *See also infra* note 213 and accompanying text (discussing the fact that no patients at Spencer and Meadowlake were Medicare patients).
[44] *See, e.g.*, Tr. at 66, 85-86, 95-100, 106-107 (references to PRTFs); Tr. at 61, 66, 118-20, 151-52 (references to residential treatment centers or RTCs).

1. Under-18 psychiatric acute care that is billed to the OMP using a unique provider number and paid by the OMP on a diagnosis-related group ("DRG") basis; and

2. Under-18 PRTF care that is billed to the OMP using a unique provider number (*i.e.*, separate from acute care) and paid by the OMP on a per diem basis.

B. The DSH Adjustment Under the IPPS

The Medicare program generally pays hospitals a fixed, predetermined rate for each inpatient discharge based on the patient's DRG.[45] 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[46] at issue in this appeal. The DSH adjustment is a proxy measurement, intended to represent the number of low-income patients that a hospital serves[47] as measured in "patient days."[48] The DSH adjustment is calculated by adding two fractions, generally referred to as the Medicare fraction and the Medicaid fraction.[49]

This appeal involves a dispute over the number of patient days to be included in the numerator and denominator of the Medicaid fraction as used in the DSH calculation. The regulation governing what "days" are included in the DSH adjustment calculation is located 42 C.F.R § 412.106(a)(1)(ii) (2007) which states:

> (ii) For purposes of this section, the number of patient days in a hospital includes 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;
>
> (B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts;
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> (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

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[45] 42 U.S.C. § 1395ww(d)(2)-(3). *See also* 42 C.F.R. Part 412.
[46] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[47] *Id.*
[48] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[49] *Id. See also Metropolitan Hosp. v. U.S. Dept. of Health & Human Servs.,* 712 F.3d 248, 251 (6th Cir. 2013).

> months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month); and
>
> (D) Beds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days.

The Medicare Contractor found that the Spencer and Meadowlake days were not eligible to be counted in either the numerator or denominator of the DSH Medicaid fraction pursuant to the above regulation.[50] Baptist and Bass challenge the Medicare Contractor's removal of the Spencer and Meadowlake days from the numerator and denominator of their respective Medicaid fraction when calculating their respective DSH adjustment.

C. Summary of Integris' Position[51]

This dispute revolves around 42 C.F.R § 412.106(a)(1)(ii) (2007), and the meaning of the phrase "acute care generally payable under the prospective payment system" as used therein. Integris argues that the care provided at Spencer and Meadowlake for both the acute care and PRTF patients rise to the level of acute care and must be counted in the DSH Medicaid fraction.[52] In support of this assertion, Integris included as Exhibit P-1 a letter sent by the Chief Executive Officer ("CEO") of OHCA to the CMS-Regional Administrator for CMS Region V.[53] The letter opens by opining that OHCA "*believes* that days of patients in a hospital-based psychiatric residential treatment facility (PRTF) are *acute care days* that should be *included in the hospital's Medicare DSH calculation*."[54]

To add credence to this letter, Integris claims that staffing levels in the Spencer and Meadowlake Units are based on the number of beds occupied in the unit and not based on the number of beds occupied for acute care versus PRTF care.[55] Integris asserts in its Post-Hearing Brief that the Medicare Contractor has conceded that the difference between the acute and PRTF care levels is purely a ***reimbursement*** distinction by the State and is not an indication of acuity of care.[56] Furthermore, Integris asserts that Spencer and Meadowlake have "self-designated" their beds as available to furnish care reimbursable as both acute care and PRTF[57] and that "all of that care is

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[50] *See supra* notes 7-21 and accompanying text.
[51] The summary here is based on large part on the Providers' Post-Hearing Brief. Subsequently, the Provider filed two supplemental filings on August 10, 2018 (following the Administrator's March 6, 2018 remand decision in the *St. Anthony* case) and on October 28, 2022 (following the Board's issuance of PRRB Dec. No. 2022-D29 based on that *St. Anthony* remand). These filings did not materially alter or shift Integris' position.
[52] Provider's FPP at 1-2.
[53] Tr. at 51.
[54] Exhibit P-1 (emphasis added.)
[55] Providers' Post-Hearing Brief at 17; Tr. at 110.
[56] Providers' Post-Hearing Brief at 49 (citing Medicare Contractor's FPP at 9; Exhibit P-3).
[57] *Id.* at 51.

furnished under the federal Medicaid benefit for acute inpatient hospital services for patients under the age of 21."[58]

Integris takes issue with the Medicare Contractor's assertion that the fact that Spencer and Meadowlake provide educational services is an indication that they are not providing acute care services.[59] Integris notes that the Medicare Contractor cites no authority to support this claim, and that other acute care facilities that treat children and adolescents, such as children's hospitals, provide similar educational services.[60] Accordingly, Integris asserts that OMP classifications between acute and PRTF services should not determine whether the PRTF days should be included in the Medicaid fraction of the DSH calculation. Rather, the focus should be on the nature of the care provided.[61] In this regard, Integris takes issue with the Medicare Contractor's treatment of PRTF days as non-acute care based on a site visit that did not include "any medical review."[62]

The 2001 Ninth Circuit decision in *Alhambra Hosp. v. Thompson* ("*Alhambra*")[63] examined 42 C.F.R. § 412.106(a)(1)(ii). The Ninth Circuit concluded, based on the plain meaning of that regulation, 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 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.[64]

Following the *Alhambra* decision, the Secretary *revised* 42 C.F.R. § 412.106(a)(1)(ii) to clarify that only "**acute** care services generally payable under the prospective payment system"[65] are to be included in the Medicaid DSH fraction. Integris contends that the units at Spencer and Meadowlake provide acute care services to *all* the patients and, as a result, the Medicaid days for *all* patients in these units should be included in their respective the Medicaid DSH fraction.

In addition, Integris asserts that the 2003 revised regulation must be interpreted in accordance with the DSH statutory provisions at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The pertinent statutory text looks to the patient days of hospitals subject to IPPS (*i.e.*, subsection (d) hospitals[66]) for a cost reporting

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[58] *Id. See also id.* at 2 (quoting 42 U.S.C. § 1396d(a)(16) as providing the Medicaid benefit of "inpatient psychiatric hospital services for individuals under age of 21").
[59] *Id.* at 49.
[60] *Id.* at 50.
[61] *Id.* at 51.
[62] *Id.* at 48.
[63] 259 F.3d 1071 (9th Cir. 2001).
[64] *See* 68 Fed. Reg. 45346, 45417 (Aug. 1, 2003).
[65] *Id.* at 45470; Providers' Post-Hearing Brief at 43.
[66] Pursuant to 42 U.S.C. § 1395ww(d)(1)(A), "subsection (d) hospital[s]" are subject to IPPS and a "subsection (d) hospital" is defined in § 1395ww(d)(1)(A) as a hospital other than:

- a psychiatric hospital;
- a rehabilitation hospital;
- a children's hospital (*i.e.*, a hospital whose inpatients are predominately individuals under 18 years of age);

period. Integris contends that nothing in the text, design or legislative history of the DSH statutory provisions permits CMS to carve out any of the inpatient days related to counting days in the Medicaid and SSI fraction except for days associated with patients that meet one of the exception clauses in § 412.106(a)(1)(ii)(A) to (D).[67] Integris contends that the term "section (d) hospital" as defined in the statue[68] refers to a general acute care hospital and excludes only those parts of a hospital that are certified as a distinct part (exempt) psychiatric or rehabilitation hospital.[69]

Based upon the primary diagnosis associated with each of the Spencer and Meadowlake days at issue (*i.e.*, the days excluded from the numerator and denominator of the Medicaid fraction by that the Medicare Contractor), Integris contends that, had the patients underlying these days been eligible for Medicare Part A, then all of the days would have been paid by Medicare using the DRG assigned to the relevant primary diagnosis.[70] In support of this contention, Integris included a listing of psychiatric inpatient stays covered, and paid, by Medicare Part A where the patient stay occurred in the main medical-surgical section of the hospital and the discharge diagnosis underlying the DRG assigned to and billed for those stays is the same as the primary diagnosis for the days at issue in this case.[71]

Integris takes issue with the Medicare Contractor's claim that the PRTF days for the units at Spencer and Meadowlake should not be included in the DSH Medicaid fraction because the average length of stay in those units is greater than a 25-day average length of stay.[72] Integris notes that, even after the 2003 revisions, 42 C.F.R. § 412.106(a)(1)(ii) does not refer to the length of stay[73] and asserts that "the Medicare Contractor [improperly] attempted to import into the DSH statue a standard of no more than 25-day average length of stay for a hospital unit to be included in the DSH calculation."[74] Integris notes that neither § 412.106(a)(1)(ii) nor the remaining regulations governing DSH payments contain such a standard/requirement. Integris recognizes that 42 C.F.R. § 412.1(a) implements 42 U.S.C. §§ 1395ww(d) and (g) but contends that the prefatory language in § 412.1(a)(1) that IPPS hospitals are "generally, short term acute-care hospitals" in no way indicates that some stays may not be longer than the hospital's average (*e.g.*, no greater than a 25 day average) or "that some departments of a hospital may not furnish services to patients who have longer lengths of stay than the average patient in other departments of the hospital."[75] Integris

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- a long-term care hospital (*i.e.*, a hospital with an average length of stay greater than 25 days);
- cancer hospitals;
- a hospital outside the 50 states, the District of Columbia or Puerto Rico;
- a hospital paid under certain special provisions (*e.g.*, a Veterans Administration hospital or a hospital reimbursed pursuant to a demonstration project) and
- psychiatric and rehabilitation distinct part units of the hospital.

See also 42 C.F.R. §§ 412.23, 412.25; 42 C.F.R. § 412.1(a)(1)(I) (stating that the hospitals subject to IPPS are, "generally, short-term, acute-care hospitals").

[67] Providers' Post-Hearing Brief at 34

[68] *See supra* note 66 and accompanying text.

[69] Providers' Post-Hearing Brief at 63.

[70] *Id.* at 36.

[71] *See* Exhibit P-21. Integris' witness confirmed the psychiatric acute care furnished to the Medicare patients listed in Exhibit P-21 was furnished in the medical surgical areas of Bass and Baptist and not in either Spencer or Meadowlake. Tr. at 52-56.

[72] Providers' Post-Hearing Brief at 42.

[73] *Id.* at 43.

[74] *Id.* at 42.

[75] *Id.* at 45.

maintains that the use of the word "generally" in § 412.1(a)(1) implies that exceptions apply and that there may be certain departments of the hospital that may exceed the Medicare Contractor's proposed average 25-day standard.[76] Integris notes that, for FY 2007, the average length of stay for Baptist and Bass, including stays at Spencer and Meadowlake, was 6.47 for Baptist and 6.88 for Bass.[77]

Integris also takes issue with the position of Medicare Contractor that Spencer and Meadowlake are more related to specialty hospitals that are excluded from IPPS due to their longer lengths of stay such as Long Term Care Hospitals ("LTCHs") which are required to have a minimum 25-day average length of stay.[78] Integris essentially agrees with the Medicare Contractor that the specialty hospitals provide care that is "more complex and not adequately accounted for in the IPPS DRG structure."[79] Integris counters the Medicare Contractor's position by contending that, as a result, "there is no debate that these excluded hospitals, including [LTCHs], all provide services that are acute in nature."[80]

Based on the historical inclusion of Spencer and Meadowlake days in the numerator and denominator of the Medicaid fraction for Baptist and Bass, Integris maintains that the Medicare Contractor's position in this case is a *new* interpretation of § 412.106(a)(1)(ii) that cannot be applied without going through notice and comment rulemaking.[81] Specifically, Integris *claims* that:

1. For nearly a decade prior to the FY 2007 cost reporting period, Spencer and Meadowlake included the total and Medicaid days for children and adolescent units in the DSH calculation.[82]

2. This practice began with FY 1999 after it contacted the then-designated Medicare contractor, Chisholm, and received *verbal* approval from Chisholm to do this.[83]

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[76] *Id.*
[77] *Id.* at 47.
[78] *Id.* at 46.
[79] *Id.* (citations omitted)
[80] *Id.* at 46-47 (citation omitted).
[81] *Id.* at 56.
[82] Providers' Post-Hearing Brief at 24; Exhibits P-16 – P-19; Tr. at 36. Exhibits P-16 through P-19 document the settlement of the cost reports prior to 2006 and, during the hearing (Tr. at 36), Integris' witness testified that Chisholm allowed the days since FY 1999. Exhibit P-16 has final settled cost reports for Baptist for FYs 1999 to 2006. A review of this Exhibit shows that the child and adolescent psychiatric units were included on line 10.04 and 10.05, which are not subprovider lines, and would be included in the Medicaid fraction. However, the Board notes that subprovider beds and days were reported on the subprovider Lines 14 up until FY 2001 and, for FY 2002, the days were no longer reported on Line 14. For Bass, the days related to the psychiatric units that provided children and adolescent care were reported in Adults and Pediatrics. The Board notes that two subprovider units were reported on Line 14 and for FY 2002 only one unit was reported on Line 14. It is unclear why this psychiatric unit was no longer reported on Line 14.
[83] Providers' Post-Hearing Brief at 24; Tr. at 36, 105. However, Integris did not receive any written confirmation of the alleged approval from Chisolm. At the time of the hearing, Integris' witness was the Reimbursement Director at Integris, who had been in that role since roughly 2001 and started at Integris in 1992 as a Reimbursement Specialist. It is unclear if the witness directed the inquiry or was present to hear firsthand the alleged guidance from Chisholm, or when the inquiry was made as the witness referred to the inquiry being made about the FY 1999 cost report some unspecified time before filing. Further, the witness did not identify who at Chisholm (whether by name or position) allegedly gave the guidance, or give any particulars regarding the nature and context for the claimed approval/guidance. As a result, the Board questions this claim and the extent to which Integris could rely on it and declines to give it any weight.

3. The days at issue were part of the DSH reimbursement allowed by Chisholm for FY 1999 to 2006,[84] and it was not until May 2015 that TrailBlazers, based on the FY 2007 audit, sent an NPR that removed the Spencer and Meadowlake days at issue from inclusion in the DSH Medicaid fraction.[85]

Integris states that, when doing their financial planning, they assumed based on this history that these days were allowable. However, since the FY 2007 audit, Integris has experienced a reduction in force and has had to discontinue service lines while undergoing an ongoing review of expenses.[86] Accordingly, Integris states that, where a previous interpretation of a regulation is reasonable and otherwise permissible, it cannot be applied retroactively to penalize a party who did not have fair notice.[87]

Finally, Integris presents two different positions on why it would be arbitrary and capricious to exclude the Spencer and Meadowlake days from Baptist and Bass's respective DSH Medicaid fractions. First, Integris alleges that the days at issue are similar to Medicaid newborn days which are included in the DSH Medicaid fraction:

> [E]ven if the[se units] did not provide inpatient hospital services that are payable under the IPPS (and they did), it would be arbitrary and capricious to exclude the Medicaid-covered services furnished in these units while including other Medicaid-covered services furnished in another hospital-area, the healthy newborn nursery, that does not provide inpatient hospital services payable under the IPPS. Medicaid-covered patient days in a healthy newborn nursery are included in the DSH calculation precisely because they are Medicaid-covered patient days. The same reason would apply with equal force for counting the Medicaid-covered patient days in the Hospitals' behavioral health units.[88]

Similarly, Integris mentions the disparate treatment of the acute care and PRTF days between Spencer and Meadowlake as well as at other Oklahoma hospitals. For Baptist, all of the acute and PRTF days at Spencer were disallowed, whereas at Bass the Meadowlake acute days were allowed while the Meadowlake PRTF days were disallowed.[89] Integris also points to another Oklahoma hospital, St. Anthony, and contends that the Medicare Contractor's determinations here with Spencer and Meadowlake are also inconsistent with the Medicare Contractor's determination for St. Anthony that was at issue in a case before the Board[90] (ultimately resulting in PRRB Dec. No. 2022-D29[91]).

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[84] Exhibits P-16, P-17.
[85] Providers' Post-Hearing Brief at 29; Tr. at 42.
[86] Tr. at 37-41.
[87] Providers' Post-Hearing Brief at 33.
[88] *Id.* at 33-34. *See also id.* at 61.
[89] Tr. at 42, 102.
[90] Providers' Post-Hearing Brief at 59. *See also id.* at 34; Exhibit P-44 at 473; Exhibit P-45 at ¶ 9.
[91] *See supra* note 36.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Pursuant to 42 C.F.R § 412.106(a)(1)(ii) (2007):

> [P]atient days in a hospital includes ***only*** those days attributable to units . . . of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with— . . . . (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)[.][92]

Set forth below is the Board's application of this regulation to determine whether the acute care and PRTF patient days rise to the level of acute care services generally payable under IPPS.

A. The focus for determining whether a "unit" generally provides acute care services generally payable under IPPS is on the level and type of care provided in the unit as a whole.

Analysis of this appeal must begin with the meaning of the term "acute care" in the applicable regulatory framework. The inquiry starts with 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.
>
> * * *
>
> (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

[92] (Emphasis added).

> from the determination of available bed days during the current month); . . . .[93]

During 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."

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").[94] 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 in *Alhambra*[95] regarding the Ninth Circuit's interpretation of that regulation.[96] 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.[97] In the following excerpt from the preamble to 2003 Final Rule, the Secretary addressed the *Alhambra* court's ruling in the preamble to the 2003 Final Rule and clarified his policy on counting days in § 412.106(a)(1)(ii):

> 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

[93] (Emphasis added.)
[94] 68 Fed. Reg. 45346, 45417 (Aug. 1, 2003).
[95] 259 F.3d 1071 (9th Cir. 2001).
[96] 68 Fed. Reg. at 45417.
[97] 259 F.3d at 1073.

> 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*.
>
> 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 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).
>
> Exceptions to *this policy to use* ***the level of care generally provided in a unit*** or ward ***as proxy*** *for the level of care provided to a particular patient on a particular day* are outpatient observation bed days and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit.
>
> ****
>
> The proposed policy is not intended to focus on the level or type of care provided to individual patients in a unit, *but rather on the level and type of care* ***provided in the unit as a whole***. For example, the bed days for a patient participating in an experimental procedure that is not covered under the IPPS should be counted as long as the patient is treated in a unit of the hospital that generally provides acute inpatient care normally payable under the IPPS. The expectation is that a patient located in an acute care unit or ward of the hospital is receiving a level of care that is consistent with what would be payable under the IPPS.[98]

In response to a comment, the Secretary confirmed that the intent of the 2003 revisions to the regulation was to ensure that § 412.106(a)(1)(ii) clearly reflected its longstanding policy because the *Alhambra* Court's interpretation of that regulations was contrary to the underlying 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. . . .

[98] 68 Fed. Reg. at 45417 (emphasis added beyond the 9th Circuit decision name).

> *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 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.[99]

Thus, the above excerpts from the preamble to the 2003 Final Rule make clear that, when applying § 412.106(a)(1)(ii) to determine 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***," without regard to whether or not the Medicare program separately certifies the unit.[100] In this regard, § 412.106(a)(1)(ii) operates as "*a proxy measure* that is based upon the location at which the services were furnished"[101] and, as explained by the Secretary, a day-by-day or patient-by-patient review is unduly burdensome and contrary to the applicable regulation.[102]

B. The Providers have failed to meet their burden of proof to establish that the type of care generally provided in each unit, as a whole, at Spencer and Meadowlake, is care that would be generally payable under IPPS.

The Board is aware of the weighty impact that this dispute has on Baptist and Spencer as illustrated by the fact that, if the Board were to reverse the adjustments at issue Baptist's DSH payment would increase from $4,839,649 to approximately $16,198,552 (a 235 percent increase) and Bass's DSH payment would increase from $2,990,666 to approximately $5,279,906 (a 75 percent increase).[103] However, as set forth below in Sections B as well as C through G, the Board

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[99] *Id.* at 45418.
[100] (Emphasis added.)
[101] 68 Fed. Reg. at 45417 (emphasis added).
[102] *Id.*
[103] Exhibit P-26 (showing for Baptist that FY 2007 NPR allowed an operating and capital DSH payments of $4,555,420 and $284,229 for a total DSH payment of $4,838,649 and that a reversal of the adjustments at issue would increase operating and capital DSH payments by $11,099,791 and $259,112); Exhibit P-29 (showing for Bass that the

finds that Integris has failed to establish that the type of care generally provided in each of the units, as whole, at Spencer and Meadowlake is care that would be generally payable under IPPS.

1. *The opinion of the OHCA CEO upon which the Providers' rely has no foundation and no evidentiary value.*

In support of their contention that the PRTF care furnished in Spencer and Meadowlake would be generally payable under IPPS, the Providers place great weight to the ***post-hoc*** opinion of the OHCA CEO that, ***for purposes of the Medicare DSH calculation***, PRTF care days are "acute care days." Specifically, in a letter dated October 2, 2008, the OHCA CEO stated:

> As the designated Medicaid agency in Oklahoma, [OHCA] *believes* that the days of patients in a hospital-based [PRTF] are ***acute care*** *days that should be included in the hospital's Medicare DSH calculation*.
>
> Federal Medicaid rules permit State Medicaid programs to cover inpatient psychiatric services furnished to persons under the age of 21. *See* 42 C.F.R. §§ 440.160, 441.151. Consistent with these Federal rules, under Oklahoma Code § 317:30-5.94.23, Oklahoma Medicaid covers inpatient psychiatric care for children under the age of 21 furnished in a hospital setting, a hospital-based PRTF, or a freestanding PRTF.
>
> The Medicaid payment methodology for these inpatient psychiatric services differ by setting. Specifically, Oklahoma Medicaid pays a hospital DRG payment with the potential for "outlier" payments. On the other hand, Medicaid makes per diem payments for services furnished in a hospital-based PRTF. *The State considers both DRG* ***and*** *per diem paid services to be* ***acute care*** *services*. *The staffing and care requirements* for the provision of psychiatric care services are the ***same*** for both DRG paid and per diem paid services. *While the per diem paid stays are typically longer than the stays paid under DRGs*, the length of stay does not determine the acuity of care furnished. For these reasons, it is incorrect to distinguish between DRG paid and per diem paid days on the grounds that the DRG paid days are acute care and the per diem paid days are not acute care.[104]

The Board declines to give any evidentiary weight to the OCHA CEO's *post hoc* opinion because it is based on general and conclusory statements that are not supported by either the OCHA-issued regulations governing under-18 PRTF care or the Federal regulations governing PRTFs (upon which the OCHA PRTF regulations are necessarily based). For example, it is unclear how the above

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FY 2007 NPR allowed a total DSH payment of $2,990,666 and that a reversal of the adjustments at issue would increase the total DSH payments by $2,289,240). *See also supra* note 86 and accompanying text (discussing financial planning and reduction in work force).

[104] Exhibit P-1.

opinion can be reconciled with the OHCA/OMP definition of PRTF in effect during the time period at issue which specifies that a PRTF may be "freestanding" or "hospital-based"[105] and defines a PRTF as a "non-hospital"[106] or "facility **other than a hospital**"[107] that provides "***non-acute*** inpatient facility care for recipients who have a behavioral health disorder and need 24-hour supervision and specialized interventions."[108] Further, the Providers did not present the OHCA CEO (or any OHCA employee) as a witness. Absent testimony to allow the Board to understand the foundation for the opinion, and the inconsistencies between the opinion and the OHCA/OMP regulations, the Board must conclude that there is no evidentiary value to the OCHA CEO's *post hoc* opinion.[109]

2. *The record is clear that the units at Spencer and Meadowlake are overwhelmingly providing PRTF care and, thus, they are each, as a whole, providing PRTF care.*

The testimony of Integris' witness at the hearing (as well as the post-hearing affidavit of that witness) was that Spencer and Meadowlake do not differentiate between the degree to which acute care versus PRTF care is provided in each of their units.[110] Indeed, since this appeal is a CIRP group (and the Providers have presented no evidence to the contrary), the Board assumes the facts are *materially* the same[111] across all of the units at Spencer and Meadowlake as supported by the following facts in the record:

- All beds at Spencer and Meadowlake were *dually licensed* as under-18 psychiatric acute care and under-18 residential treatment care.[112]

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[105] Okla. Admin. Code at § 317:30-5-95(c) (defining PRTF and describing PRTFs as both hospital-based and freestanding).
[106] *Id*. at § 317:30-5-95(d).
[107] *Id*. at § 317:30-5-95(b)(4) (emphasis added).
[108] *Id.* at § 317:30-5-95(a) (emphasis added).
[109] Sections B.2 to E of the Discussion, *infra*, include further discussion on how the OCHA CEO's opinion lacks any foundation. Similarly, they demonstrate that the following *post-hoc* Oklahoma State Senate resolution referenced by the Providers in their Post-Hearing Brief is conclusory and does not have any foundation:

> WHEREAS, the federal government provides Medicare [DSH] payments to qualifying hospitals that serve a large number of low-income individuals; and
> *WHEREAS, the DSH calculation is based, in part, on the number of inpatient hospital days for Medicaid-eligible patients*; and
> WHEREAS, federal law permits state Medicaid programs to cover ***inpatient*** psychiatric services to children under the age of twenty-one (21).
> NOW, THEREFORE, BE IT RESOLVED BY THE SENATE . . . :
> THAT consistent with federal Medicaid law, *all Medicaid covered psychiatric services provided to persons under the age of twenty-one (21) who are admitted as inpatients in a hospital in Oklahoma are* ***acute, inpatient hospital services***, regardless of the level of state Medicaid reimbursement provided for such services.

Okla. Sen. Res. 71, 55th Legis. 2R (May 12, 2016) (italics and bold emphasis added) *available at*: https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SR/71.pdf (last visited Feb. 14, 2023).
[110] *See, e.g.*, Tr. at 57-58; 61-62; Exhibit P-45 at ¶ 10. *See also* Providers' Post-Hearing Brief at 20-21.
[111] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(2), (f)(2), (g); Board Rule 13 (July 2015) ("A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members.").
[112] Tr. at 45-47; Provider's Post-Hearing Brief at 20 (with citations to the record).

- A Medicaid patient in any of these units did not have to be moved to another bed (or unit) if OMP switched that patient from being authorized for under-18 acute psychiatric care (which is paid on a DRG basis) to under-18 PRTF care (which is paid on a per diem basis).[113]

- Summary data for FY 2011 discharges from Spencer[114] include break outs across the 5 units at Spencer showing that the 2 adolescent units were 92 percent PRTF care,[115] the 2 child units was 93.8 percent PRTF care,[116] and the STAR unit was 99.4 percent PRTF care.[117]

A review of the record confirms that the type of care furnished in both Spencer and Meadowlake during FY 2007 was *overwhelmingly* residential psychiatric care in the PRTF in that 95 percent or more of the days of care during FY 2007 were for PRTF care:

TABLE 1 – BREAKOUT OF LEVELS OF CARE FOR FY 2007
Based on Exhibits P-8, P-31 and P-32[118]

	Days		
	Acute	PRTF	Total
Baptist	1,587	32,434	34,021
Spencer	5 %	95%	100%
Bass	309	14,518	14,827
Meadowlake	2 %	98%	100%

While the record does not include a breakout of how many FY 2007 discharges at Spencer were for acute care versus PRTF care,[119] it does for Meadowlake at Exhibit P-14 as follows:

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[113] Tr. at 48, 58, 79-80; Providers' Post-Hearing Brief at 21; Exhibit P-36A at 360 (noting that "[t]he RTC and Psychiatric patients [at Spencer] are completely comingled within each pod."); Exhibit P-37A at 388 (stating Meadowlake "does not segregate the patients by Acute versus RTC").

[114] The cover email and narrative suggests that Novitas obtained the FY 2011 discharge data from Bass during its Meadowlake site visit. Exhibit P-36 at 344.

[115] *Id.* (reporting that the adolescent unit had: (1) 405 PRTF discharges totaling 13,755 days with an average length of stay of 34.0 days; and (2) 269 acute care discharges totaling 1,163 days with an average length of stay of 4.3 days).

[116] *Id.* (reporting that the child unit had: (1) 118 PRTF discharges totaling 4,890 days with an average length of stay of 41.44 days; and (2) 112 acute care discharges totaling 323 days with an average length of stay of 2.9 days).

[117] *Id.* (reporting that the STAR unit had: (1) 122 PRTF discharges totaling 15,076 days with an average length of stay of 123.6 days; and 39 acute care discharges totaling 96 days with an average length of stay of 2.5 days).

[118] The Spencer total under-18 psychiatric care days listed in this table (32,434 PRTF days and 1,587 acute care days) are taken from Lines 10.04 and 10.05 from the Worksheet S-3 for FY 2007 at Exhibit P-8, at 28 and are restated in Exhibit P-25 at 276. The audit adjustment report suggests that The Meadowlake total under psychiatric care days listed in this table (14,518 PRTF days and 309 acute care days) are taken from the audited Worksheet S-3 at Exhibit P-32 (since the as-filed Worksheet S-3 at Exhibit P-9 did not break out Meadowlake days separate from days in Adults and Pediatrics and the Medicare Contractor broke out those days as part of its audit).

[119] Unlike the audited FY 2007 Worksheet S-3 for Meadowlake included at Exhibit P-32, the audited Worksheet S-3 for Spencer at Exhibit P-31 does not list *discharges* either for the under-18 PRTF care or acute care at Lines 10.04 and 10.05 respectively. Similarly, Integris does not include that breakout in Exhibit P-38 when calculating the average length of stay for Baptist *as a whole* (*i.e.*, Spencer plus the rest of the hospital). Notwithstanding, the Medicare Contractor's FY 2007 workpaper for Spencer at P-23 states that "the average length of stay for acute care services was only 3 to 4 days[.]"

TABLE 2 – MEADOWLAKE – FY 2007 AVERAGE LENGTH OF STAY
Based on Exhibits P-14 & P-32

	PRTF	Acute Care	Total
Discharges	312	157	469
Discharges as a percentage	66.5%	33.5%	100%
Days	14,518	309	14,827
Average Length of Stay ("ALOS")	46.5 days	2.0 days	31.6 days

Further, when the Medicare Contractor conducted a site visit at Spencer and Meadowlake, it collected discharge and length of stay data for FY 2011 for Spencer and FY 2012 for Meadowlake and the 2011/2012 data is consistent with the FY 2007 (*i.e.*, not materially different) and supports the Board's finding that the units at Spencer and Meadowlake *overwhelmingly* provide PRTF care.[120] In this regard, the Board notes that it has placed greater weight on the "days" data than "discharge" data. Specifically, because it more closely reflects the type of care *generally* provided on a day-to-day basis for FY 2007, the "days" data is more probative of the level of care *generally* provided in each unit *as a whole*. Nonetheless, the Board notes that, for FY 2011 or FY 2012, 60 percent or more of the discharges from Spencer and Meadowlake were for PRTF care. As a result, for FY 2011 or FY 2012, the average length of stay for PRTF care was 52.3 days and 66.0 days for Spencer and Meadowlake while the average length of stay for acute care was 3.8 days and 1.5 days respectively.

TABLE 3 – BREAKOUT OF LEVELS OF CARE FOR FY 2011 OR FY 2012
Based on Exhibits P-36 & P37

	Discharges			Days			ALOS	
	Acute	PRTF	Total	Acute	PRTF	Total	Acute	PRTF
FY 2011 Baptist	420	645	1065	1,582	33,721	35,303	3.8 days	52.3 days
Spencer	39%	61%	100%	4 %	96%	100%		
FY 2012 Bass	138	211	349	211	13,936	14,709	1.5 days	66.0 days
Meadowlake	40%	60%	100%	5 %	95%	100%		

Accordingly, the Board finds that the record is clear that the units at Spencer and Meadowlake are *overwhelmingly* providing PRTF care. Thus, each of their units, *as a whole*, was providing PRTF care for the relevant time period.

3. *The swing bed exception at 42 C.F.R. § 412.106(a)(1)(ii)(B) is not applicable to Spencer or Meadowlake.*

The Board recognizes that 42 C.F.R. § 412.106(a)(1)(ii)(B) specifies that "[b]eds otherwise countable under this section used for . . . skilled nursing swing bed services" are excluded. However, Integris' witness confirmed that neither Spencer nor Meadowlake provide skilled nursing swing bed services.[121] As such, it would appear that the exception at

[120] *See* Exhibits P-36, P-37.
[121] The corrected Transcript at page 47 at Exhibit P-47 reflects a "No" response from Integris' witness in response to whether Spencer and Meadowlake provide skilled nursing swing bed services. Integris submitted the corrected

§ 412.106(a)(1)(ii)(B) is not applicable since the discussion of swing bed services appears to be focused on the context of an acute care bed swinging to furnish skilled nursing services.[122]

Notwithstanding, it appears that both Spencer and Meadowlake made *an operational decision*[123] to organize the department to, in essence, swing their beds between acute care and PRTF care since, as previously noted: (a) each of their beds is dually licensed to provide under-18 psychiatric acute care and under-18 PRTF care;[124] and (b) a patient did not have to be moved to another bed (or unit) if OMP switched that patient from being authorized for under-18 acute psychiatric care to under-18 PRTF care.[125] In reviewing the applicability of the "swinging bed" concept, the Board notes that the Secretary specified in the 2003 Final Rule that "Observation beds and swing-beds are both special, *frequently* ***temporary***, *alternative uses of acute inpatient care beds*."[126] Thus, the alternative use of an acute care bed is expected to be generally temporary and not its dominant use. Consistent with this expectation,[127] it is the Board's reading of § 412.106(a)(1)(ii) (2007) that the exceptions in clauses (A) to (D) are reached only if there is a finding that the unit, *as a whole*, furnishes acute care services generally payable under IPPS:

> (ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under

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Transcript page as part of its post-hearing filing. The original transcript issuance reflects a "Yes" response on page 47. Exhibit P-47.

[122] *See* 68 Fed. Reg. at 45418 (stating that "[a] swing-bed is a bed that is otherwise available for use to provide acute inpatient care and is also occasionally used to provide SNF-level care.").

[123] Providers' Post-Hearing Brief at 51 (stating "[t]he Hospitals have 'self-designated' their beds as available to furnish care reimbursed as both acute and residential by the State[.]"). It is unclear why Integris organized Spencer and Meadowlake with dually-licensed beds as opposed to splitting up the under-18 psychiatric acute care and under-18 PRTF care into separate distinct units similar to what St. Anthony did. *See* PRRB Dec. No. 2022-D29 at 15 (discussing "[t]he relevance of the St. Anthony's OMP participation as a PRTF" and stating: "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."). Similarly, it is unclear whether OHCA treats the beds as swing beds for purposes of the OMP.

[124] *See supra* notes 33, 112.

[125] *See supra* note 113.

[126] 68 Fed. Reg. at 45418-19 (emphasis added).

[127] *See also* 69 Fed. Reg. 48916, 49093 (Aug. 11, 2004) (stating "In the May 19, 2003, FY 2004 IPPS proposed rule (68 FR 27205), we discussed proposed changes to our policies for counting beds and patient days in relation to the IME and DSH adjustments. Specifically, we proposed to amend § 412.105(b) and § 412.106(a)(1)(ii) as they pertain to the counting of beds and patients days for determination of the IME adjustment and DSH payment adjustment. We proposed to amend § 412.105(b) to indicate that the bed days in a unit that is unoccupied by patients receiving a level of care that would be generally payable under the IPPS (IPPS level of care) for the 3 preceding months are to be excluded from the available bed day count for the current month. In addition, we proposed that the beds in a unit that was occupied by a patient(s) receiving an IPPS level of care during the 3 preceding months should be counted unless they could not be made available for patient occupancy within 24 hours, or they are used to provide outpatient observation services or swing-bed skilled nursing care (68 FR 27204). *Regarding* ***nonacute*** *care beds and days*, we proposed to revise § 412.105(b) to clarify that beds in units or wards established or used to provide a level of care that is not consistent with what would be payable under the IPPS cannot be counted. We also proposed to revise the DSH regulations at § 412.106(a)(1)(ii) to clarify that the number of patient days includes only those days attributable to patients that receive care *in units or wards that furnish a level of care that would generally be payable under the IPPS (68 FR 27205)*. . . . In the August 1, 2003 final rule (68 FR 45346), we finalized some of these proposals . . . . The proposals for ***nonacute*** *care beds and days*, observation and swing-bed days, LDP beds and days, and days for 1115 demonstration projects were finalized in the August 1, 2003 final rule." (emphasis added)).

> the prospective payment system ***and*** excludes patient days associated with— (A) …. (B) …. (C) ….(D).[128]

The Board's reading is consistent with the fact that § 412.106(a)(1)(ii) operates as "*a proxy measure* that is based upon the location at which the services were furnished."[129] Accordingly, the Board never reaches the swing-bed exception and its potential application.[130]

Further, the Board finds that, *for FY 2007*, the Medicare Contractor was not consistent in how it applied § 412.106(a)(1)(ii) to Spencer and then to Meadowlake. First, for Baptist, the Medicare Contractor apparently found the units at Spencer, *as a whole*, did not furnish acute care generally payable under IPPS and, as such, excluded all Medicaid eligible days associated with Spencer for FY 2007. In contrast, for Bass, the Medicare Contractor excluded *only* the Meadowlake PRTF care days and allowed the small percentage of Meadowlake acute care days for FY 2007. As explained above, a determination must first be made on the unit, *as a whole*, before applying any exceptions. As set forth below, the Board finds that PRTF care does not qualify as acute care and, as a result, none of the units at Spencer or Meadowlake, as a whole, furnished acute care generally payable under IPPS.

4. The fact that the PRTF patients at Spencer and Meadowlake were "inpatients" pursuant to 42 U.S.C. § 1396d(h)(1) does not, in and of itself, provide any evidentiary value for determining whether the PRTF care furnished at those facilities was "acute care."

Integris emphasizes that the Medicaid program covers "inpatient psychiatric hospital services for individuals under age 21" pursuant to 42 U.S.C. § 1396d(h)(1). Based on this conclusion, Integris then leaps to the conclusions that: (1) all such services, including PRTF care, are "acute

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[128] (Emphasis added.)

[129] 68 Fed. Reg. at 45417 (emphasis added).

[130] In making this finding, the Board notes, if a unit, as a whole, is found to generally provide inpatient acute care normally payable under IPPS then all the days in that unit unless days are excluded under § 412.106(a)(1)(ii)(A)-(D). As a result, there are situations where days in a unit may not fall under these exceptions and yet not be generally payable under IPPS. The preamble to the 2003 Final Rule recognized this by giving the following example:

> The proposed policy is not intended to focus on the level or type of care provided to individual patients in a unit, but rather on the level and type of care provided in the unit as a whole. *For example, the bed days for a patient participating in an experimental procedure that is not covered under the IPPS should be counted* ***as long as the patient is treated in a unit of the hospital that generally provides acute inpatient care normally payable under the IPPS***. The expectation is that a patient located in an acute care unit or ward of the hospital is receiving a level of care that is consistent with what would be payable under the IPPS.

68 Fed. Reg. at 45417 (emphasis added). Similarly, the following discussion in the preamble reinforces this concept:

> 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*.

Id.

care;" and (2) any such "acute care" would be generally payable under IPPS. However, that is not the case. Section 1396d(h)(1)(A) specifies that these "inpatient services" only include services "provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title *or in another inpatient setting that the Secretary has specified in regulations*[.]"[131] Based on the Secretary's implementation of this *Medicaid* benefit at 42 C.F.R. § 440.160 and Part 441, Subpart D, the under-21 inpatient psychiatric benefit may be furnished in the following inpatient settings:

- *An inpatient psychiatric hospital (or inpatient psychiatric hospital distinct part) that meets the requirements for participating in the Medicare program as a psychiatric hospital in § 482.60*.— For purposes of the Medicare programs, these settings are subject to the Medicare inpatient psychiatric prospective payment system which, as explained in the Administrator's decision in *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), are excluded from IPPS per 42 U.S.C. 1395ww(d)(1)(B)[132] and, as such, cannot be used as a point of reference for what the § 412.106(a)(1)(ii) phrase "acute care services generally payable under [IPPS]" means.[133]

- *A psychiatric unit of an acute care hospital*.

- *A PRTF* — As previously noted, a PRTF is defined as a "nonhospital" facility providing "nonacute care."[134]

Similarly, the facts surrounding the inpatient subacute care unit at issue in *Alhambra* and the Secretary's 2003 revisions to § 412.106(a)(1)(ii) (issued in response to the *Alhambra* decision) confirm that simply being a hospital "inpatient" does not mean that the patient is receiving "acute care" services.[135] Accordingly, the fact that PRTF care is "inpatient" care does not mean that the care provided in a PRTF is "acute care," much less "acute care services generally payable under [IPPS]."

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[131] (Emphasis added.)
[132] *See supra* note 66 and accompanying text.
[133] *St. Anthony*, Adm'r Dec. (*vacating & remanding* PRRB Dec. No. 2018-D12) at 16-18. *See also* St. Anthony, PRRB Dec. No. 2022-D29 (Sept. 19, 2022), *on remand from*, Adm'r Dec. (*vacating & remanding* PRRB Dec. No. 2018-D12), *decl. rev.*, Adm'r Dec. (Nov. 17, 2022).
[134] *See* Section B.5 of Discussion, *infra*; 42 C.F.R. § 441.151(b), 483.352; 63 Fed. Reg. 64195 (Nov. 19, 1998); 66 Fed. Reg. 7148 (Jan. 22, 2001); 72 Fed. Reg. 68077, 68081 (Dec. 4, 2007). The concept that a *nonhospital* facility can provide services under inpatient psychiatric hospital services benefit for those under 21 originates from the final rule issued on January 14, 1976. *See* 41 Fed. Reg. 2198, 2198 (Jan. 14, 1976) (acknowledging a comment that "[t]he requirement that psychiatric services to patients under 21 must be provided by an institution which is a psychiatric hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) is too narrow an interpretation of the legislation."; and responding that "[t]hroughout the regulations [governing the under 21 inpatient psychiatric hospital services benefit] the word 'hospital' has been changed to 'facility'" and that "[t]his includes any institution ***other than*** *a hospital* which provides ***inpatient care*** and is accredited as a psychiatric facility by JCAH." (emphasis added)).
[135] *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 § 2202.1 (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.").

5. *OMP certification as a PRTF is not simply a payment mechanism but rather reflects the nature and type of care generally furnished in the PRTF program.*

While acute care provided under the OMP would appear very close to that provided in a short-term acute care hospital, the care provided in a PRTF is very different and is not comparable. First, it important to acknowledge that the Medicare program *neither* recognizes *nor* certifies distinct hospital units (or facilities) as PRTFs. Rather, PRTFs are a Medicaid program creation in general, similar to nursing facilities ("NFs") and intermediate care facilities for the mentally retarded ("ICF/MRs").[136] Both the HHS regulations governing State Medicaid programs and the Medicare Claims Processing Manual recognize that PRTFs, such as Spencer and Meadowlake, 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.[137]

Contrary to the OHCA CEO's characterization in his October 2, 2008 letter, PRTFs are not simply a payment mechanism, but are subject to accreditation and State inspection to confirm that they meet the relevant OMP conditions of participation as a PRTF.[138] Further, it is clear that these PRTF standards and conditions of participation are designed to address both the nature and level 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.[139] To this end, all of the beds in both Spencer and Meadowlake were dually licensed to provide psychiatric acute care as well as psychiatric residential care.

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 2007, the year at issue in this appeal. Under the amended definitions, the OMP defines a PRTF as a "non-hospital"[140] or "facility **other**

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[136] *See* Medicare Benefits Policy Manual, CMS Pub. No. 100-07, § 1000B (as revised May 21, 2004) (stating: "Medicaid is a State program that provides medical services to clients of the State public assistance program and, at the State's option, other needy individuals, as well as augments hospital and nursing facility (NF) services that are mandated under Medicaid. States may decide on the amount, duration, and scope of additional services, except that care in institutions primarily for the care and treatment of mental disease may not be included for persons over age 21 and under age 65. When services are furnished through institutions that must be certified for Medicare, the institutional standards must be met for Medicaid as well. *In 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).").

[137] *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, Ch. 26, § 10.5 (Revised Sept. 1, 2006) (specifying 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.").

[138] *See* Okla. Admin. Code §§ 317:30-5-95(d)-(e), 317:30-5-95.40, 317:30-5-95.42.

[139] *See id*. at § 317:30-5-95.29-.30.

[140] *Id*. at § 317:30-5-95(d).

than a hospital"[141] that provides "***non-acute*** inpatient facility care for recipients who have a behavioral health disorder and need 24-hour supervision and specialized interventions."[142] Moreover, PRTFs are defined to specifically include both freestanding and hospital-based PRTFs.[143]

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."[144] 42 C.F.R § 483.352 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 children and adolescents whose* ***illnesses are less acute*** *but who still require a residential environment*.[145]

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.[146]

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[141] *Id*. at § 317:30-5-95(b)(4) (emphasis added).
[142] *Id.* at § 317:30-5-95(a) (emphasis added).
[143] *Id.* at § 317:30-5-95(c) (defining PRTF and describing PRTFs as both hospital-based and freestanding).
[144] (Emphasis added.)
[145] 66 Fed. Reg. 7148, 7148 (Jan. 22, 2001).
[146] *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, 59627 (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

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 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.

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facility that *provides* ***a less medically intensive program of treatment*** *than a psychiatric hospital or a psychiatric unit of a general hospital*." (emphasis added)).

> 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.[147]

The categorization of every PRTF 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)).[148]

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.***"[149]

Furthermore, based on the Secretary's discussion of its longstanding policy in the preamble to the 2003 Final Rule, for a unit to be included in the calculation of the Medicaid DSH fraction, the care provided must be consistent with the care provided to acute care patients. The classification of a provider unit or program, by its very nature, reflects the type of care generally furnished in that unit or program. In this case, it is clear that each of Spencer and Meadowlake participated in the OMP as a hospital-based PRTF as well as a provider of psychiatric acute care services. Similar to the California Medicaid Program classification of the hospital unit as sub-acute in *Alhambra*, the classification of Spencer and Meadowlake 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 both 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 Spencer and

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[147] 59 Fed. Reg. 59624, 59625-27 (Nov. 17, 1994) (emphasis added).

[148] 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.

[149] *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 hospitals, 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.

Meadowlake's designation and participation in the OMP as PRTFs and how this classification relates to the determination of the level of care generally provided in those units.[150]

Further, the Secretary's PRTF policy and the OMP Regulations lead to the conclusion that PRTF services are *not* of the type that are "generally payable under the prospective payment system" because they are "non-acute."[151] Further, the overwhelming majority of patient days associated with Spencer and Meadowlake (95 percent or more) were PRTF care. After examining the OMP regulations, in conjunction with the *Alhambra* discussion in the 2003 Final Rule preamble, the inevitable conclusion is that every unit, as a whole, within Spencer and Meadowlake was providing nonacute care. Thus, the days associated with these units can not to be included in the calculations at 42 C.F.R. § 412.106(a)(1)(ii).

The relevance of the Spencer and Meadowlake's OMP participation as a PRTF is reinforced by the fact that, during the fiscal year at issue, their patient days were predominantly ***Medicaid paid*** days.[152] As a result, ***each*** such patient underwent a *prior authorization process* to confirm that admission to the PRTF setting was the appropriate level of medical care pursuant to OMP requirements.[153] Before admitting Medicaid patients, PRTFs are required to obtain prior authorization from the OMP to determine "if the recipient meets *the medical necessity criteria*" for PRTF services.[154] There are also requirements for periodic re-authorizations for extension of *continued* medical necessity.[155] 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 the OHCA."[156] The OMP process is designed to determine the appropriate level of medical care both *prior to* admission ***and*** *following* admission through periodic re-authorizations.[157] In other words, the OMP considered both psychiatric acute

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[150] The Board again notes that the type of care furnished in both Spencer and Meadowlake during FY 2007 was overwhelmingly residential psychiatric care in the PRTF in that 95 percent or more of the days of care during FY 2007 were for PRTF care. *See supra* notes 25, 30 and accompanying text.

[151] Integris confirmed that *the Medicare program* has not paid for any services furnished in either Spencer or Meadowlake (whether for acute care or PRTF care). *See* Tr. at 107-108, 131.

[152] *See supra* notes 27, 32 and accompanying text (establishing that, for FY 2007, 97 percent of the PRTF days at Baptist Spencer were Medicaid paid days and, at least, 84 percent of the days at Meadowlake were Medicaid paid days).

[153] *See* Tr. at 60-61 where Integris' witness testified as follows:

> Q. Integris draws a 16 distinction then between acute care for those patients who are dangerous to themselves and/or others, and RTC car [*sic*] who have psychiatric, emotional, and behavioral problems, but aren't necessarily dangerous to themselves and others. Is that correct?
> A. These labels are put there based on the designation by the Medicaid agent. The care is certified as necessary medically, necessary on an inpatient basis for all of these children, and in accordance with the federal Medicaid regulations.

See also Tr. at 148 (stating: "Q. And regarding payment for these days, you testified that all of the days for Medicaid patients are preauthorized. A. Correct. Q. So you wouldn't expect to see many, if any, days that weren't paid by Medicaid for these patients, correct? A. Correct.").

[154] 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).

[155] Okla. Admin. Code § 317:30-5-95.31b).

[156] *Id.* § 317:30-5-95.24(3) (emphasis added). *See also Id.* § 317:30-5-95.31 (a). Note that the OHCA manual referenced in Okla. Admin. Code § 317:30-5-95.24(3) is not part of the record before the Board.

[157] *Id.* § 317:30-5-95.24 ("All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay."); *Id.* § 317:30-5-95.24(3) ("Inpatient psychiatric services in all acute hospitals and

care and PRTF care psychiatric when applying its medical necessity criteria during both prior approval and re-authorization.[158] Following that process, the OMP found the vast majority of patients qualified for authorization of PRTF services (since the vast majority of Medicaid paid days at Spencer and Meadowlake are PRTF care days[159]). Thus, the OMP did review the medical necessity of virtually all of the PRTF days at issue *on a prior authorization basis* and found that PRTF services rather than acute care services was the appropriate level of care.

Similarly, to the extent a child/adolescent receiving Medicaid was transferring from inpatient acute care to PRTF care, the OMP was necessarily finding that one phase of mental health care had ended (*i.e.*, psychiatric acute care services) and a new one was beginning (*i.e.*, PRTF services). Contrary to Integris' allegations, there are material differences between the OMP standards for psychiatric acute 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"[160] while PRTF services are "nonacute care"[161] and "longer-term."[162] 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 seven (7) days while those in a PRTF setting must be reviewed at a *twice as long* interval of every 14 days.[163]

- The criteria for admission differ 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)[164] 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).[165]

- The required staff supervision level is different where 24-hour nursing/medical supervision is required in an acute psychiatric care setting[166] while only 24-hour observation and treatment for PRTF care.[167]

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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." (emphasis added)).

[158] 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 <u>all</u> treatment documentation*** completed by the [Oklahoma Health Care Authority's] designated agent to determine efficacy of treatment." *Id.* § 317:30-5-95.31(b). Indeed, because the STAR Program at Spencer had an average length of stay well above 3 months, it is clear that, as part of the prior authorization process, OMP would have reviewed all treatment documentation for most patients in the Star Program. *See supra* note 196 and accompanying test.

[159] *See supra* notes 25, 26, 30, 31 and accompanying text.

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

[161] *Id.* § 317:30-5-95(a).

[162] *Id.* § 317:30-5-95.22(b)(7).

[163] *Id.* § 317:30-5-95.33(b)(7).

[164] *Id.* § 317:30-5-95.25(5).

[165] *Id.* § 317:30-5-95.29(5).

[166] *Id.* § 317:30-5-95.25(6).

[167] *Id.* § 317:30-5-95.29(6).

- The minimum number of "individual treatments provided by the physician" is different where a minimum three (3) treatments per week is required for acute psychiatric care versus a minimum of one (1) treatment per week is required for PRTF care.[168]

- For psychiatric acute care only, "[a] registered nurse must document patient progress at least weekly. The progress note must contain recommendations for revisions in the individual plan of care, as needed, as well as an assessment of the patient's progress as it relates to the individual plan of care goals and objectives."[169] The Board did not identify any similar requirement for PRTF care.

Accordingly, the Board finds that: (1) Spencer and Meadowlake were enrolled and accredited as PRTFs; (2) while some psychiatric acute care was furnished in Spencer and Meadowlake, the overwhelming majority of services being furnished were for PRTF care; (3) the days of PRTF care at Spencer and Meadowlake were predominantly paid by Medicaid; (4) these Medicaid days were specifically reviewed for medical necessity by the OMP (both prior to admission and then regularly for reauthorization of continued care); and (5) the OMP authorized, *and* paid for, PRTF services based on its own periodic medical necessity reviews. These findings define the nature of the care provided in the units at Spencer and Meadowlake and demonstrate that that the care in each of these units did not, *as a whole*, rise to an acute level of care.[170]

C. A Comparison of the OMP medical necessity criteria and benefit requirements for under-18 psychiatric acute care versus under-18 PRTF care demonstrates material differences between them, confirming that PRTF care is not acute care.

In reviewing the type of care provided to patients at Spencer and Meadowlake, the Board first points to the admission criterion for Spencer.[171] Significantly, the admission criteria mimic the OMP medical necessity criteria for acute care psychiatric admissions[172] and the OMP medical necessity criteria for PRTF admissions for children/adolescents.[173] At Exhibit P-36A, Spencer lists the criteria to be eligible for admission to the acute level of care and criterion 5 for admission as a psychiatric acute care patient states:

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[168] *Id.* § 317:30-5-95.34(c)(1).
[169] *Id.* § 317:30-5-95.38.
[170] There could be other bases for finding that the PRTF care did not rise to an acute level of care had the Board had more information about the units at Spencer and Meadowlake. For example, it is unclear whether these units had wait lists for PRTF admission, transfers from other acute care facilities, and passes to leave the facility similar to St. Anthony as discussed in PRRB Dec. No. 2022-D29.
[171] Exhibit P-36A. At Exhibit P-37A is the documentation related to Meadowlake. However, TrialBlazer apparently did not obtain the admission criterion for the psychiatric acute care and PRTF patients. However, this is a moot point since the admitting criterion for psychiatric acute care and PRTF patient can be found in the Oklahoma Administrative Code ("OAC") (copy at Exhibit P-41) and Integris has admitted that its admission criteria for psychiatric acute care and PRTF care mirror the applicable OAC provisions. Okla. Admin. Code §§ 317:30-5-95.25 (psychiatric acute care), 317:30-5-95-29 (PRTF care)); *see* Tr. at 85-86; Exhibit P-45 at ¶ 12 ("These criteria mirror the State requirements for admission to a facility providing inpatient psychiatric hospital services")..
[172] Okla. Admin. Code § 317:30-5-95.25.
[173] *Id.* § 317:30-5-95-29. *See also* Exhibit P-41 (copy of the Oklahoma Administrative code for Acute and PRTF patients).

> Within the past 48 hours, the adolescent [or child] is exhibiting at least one of the following behaviors that present an **imminent** *life-threatening* **emergency**:
>
> (a) Suicide attempt, suicide intent, or serious threat by the adolescent [or child]
> (b) Pattern of escalating incidents of self-mutilation behaviors
> (c) A significant pattern of unprovoked physical aggression and pattern of escalating physical aggression in intensity and duration
> (d) Incapacitating depression or psychosis that is resulting in inability to function or care for basic needs.[174]

At Exhibit P-36A, Spencer lists the criteria to be eligible for admission to the "residential," *i.e.*, PRTF, level of care and criterion 5 of that policy states:

> The adolescent [or child] is demonstrating an escalating pattern of **self-injurious** or **assaultive behaviors** as evidenced by:
>
> (a) Suicidal ideation and/or threat
> (b) History of or current self-injurious behaviors
> (c) Serious threats or evidence of physical aggression
> (d) Current incapacitating psychosis or depression.[175]

Absent from the admission criterion in residential/PRTF admission criterion are the words "imminent" and "emergency." A patient admitted with acute care status, and paid on a DRG basis, is in an "imminent, life-threatening emergency" situation and must be admitted immediately. These patients *generally* receive an acute level of care for approximately 2 to 6 days[176] and, once stabilized, are either discharged from the hospital or discharged to another care setting (*e.g.*, discharged from acute care followed by admission to PRTF which is paid on a per diem basis[177]). From the above, it is evident that the PRTF patient is not in an emergency or in imminent danger, but is experiencing a pattern of self-injurious or assaultive behaviors and needs additional treatment.

There are material differences between the care provided under psychiatric acute care vs. PRTF care. First, an acute care admission requires that the adolescent or child] "requires **secure** 24-hour

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[174] Exhibit P-36A at 352 (Spencer policy for admission to adolescent programs for "*acute* level of care" (emphasis added)); Exhibit P-36A at 355 (Spencer policy for admission to child programs for "*acute* level of care" (emphasis added)).

[175] Exhibit P-36A at 352-53 (Spencer policy for admission to adolescent programs for "*residential* level of care" (emphasis added)); Exhibit P-36A at 355-56 (Spencer policy for admission to children programs for "*residential* level of care" (emphasis added)).

[176] *See* Tables 2 and 3, *supra*; Exhibit P-36 at 344 (Novitas narratives stating that, for Spencer, "the ALOS for Psych units [*i.e.*, acute care units] range between 2 to slightly under 5 days" and table showing FY 2011 ALOS for Adolescent Psych as 4.32, for Child Psych as 2.88, and Star Psych as 2.46); Exhibit P-37 at 348 (table for Meadowlake showing FY 2011 aggregate Psych ALOS of 5.60 days).

[177] Integris maintained and reported this separate discharge data for the acute care and PRTF care at Spencer and Meadowlake as part of the cost reporting process. *See also, e.g.,* Okla. Admin. Code § 317:30-5-95.29 (setting forth "criteria for admission" to PRTFs).

nursing or medical supervision."[178] In contrast, for PRTF care, the patient "[r]equires 24-hour **observation** and treatment."[179] Similarly, there are material differences between the intensity of care provided between acute care and PRTF care, confirming that they reflect different levels of care. For acute care, the patient must see a physician three (3) times a week, receive individual therapy two (2) hours a week, process-based group therapy three (3) hours a week, and expressive-based group therapy four (4) hours a week. In contrast, a PRTF patient must only see a physician one (1) time a week, receive individual therapy one (1) hour a week, process-based group therapy two (2) hours a week, and expressive-based group therapy three (3) hours a week.[180]

Before admitting an under-18 patient for either psychiatric acute care or PRTF care, a provider must obtain prior authorization from the OMP to determine if the recipient meets the medical necessity criteria for the relevant services as well as periodic re-authorization for extension of continued medical necessity.[181] 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]."[182] The OMP process is designed to determine the appropriate level of medical care both prior to admission, and at certain intervals after admission when re-authorization is required.[183] Further, the days at issue for Spencer and Meadowlake are predominately Medicaid ***paid*** PRTF days and, as such, received prior authorization from OMP as PTRF services and were claimed and paid on a per diem basis *as PRTF* services.[184]

When patients' care needs to be extended, the OMP can extend psychiatric acute care for up to 5 days; *up to 10 days for PRTF* (double the time of acute care), and up to 21 days for specialty programs.[185] In other words, when considering the prior authorizations granted for the PRTF days at issue in this case, the OMP applied its medical necessity criteria for both acute psychiatric care and PRTF services; and following that process, found the patients qualified for authorization of PRTF services at either Spencer or Meadowlake. Thus, the OMP did review the medical necessity of the vast majority of PTRF care days 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. Integris has not presented any medical testimony, or similar evidence, to refute these medical necessity determinations. Thus, contrary to the OHCA CEO's assertion in his October 2, 2008 letter, the staffing and care requirements for the provision of under-18 psychiatric acute care services and under-18 PRTF services are ***not*** the same.

Similarly, the Providers' assertion that staffing levels for the provision of PRTF and acute care are the same during FY 2007 is not confirmed in the staffing-related documents included at Exhibits P-36A and P-37A which appear to have been gathered around the June 2014 site visits

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[178] Okla. Admin. Code § 317:30-5-95.25(6).
[179] *Id.* § 317:30-5-95.29(6).
[180] *See* Exhibit P-36A.
[181] *See supra* notes 153-159 and accompanying text.
[182] Okla. Admin. Code § 317:30-5-95.24(3) (emphasis added). *See also id.* § 317:30-5-95.31.
[183] *See supra* note 157.
[184] *See supra* note 25, 26, 30, 31 and accompanying text.
[185] Exhibit P-36A at 351.

and are either undated or dated after the year at issue.[186] For example, the staffing policies for the adolescent and children's units at Meadowlake are for FY 2013-2014 (well after the year at issue) and provide flexibility based on acuity (*e.g.*, acute care vs. PTRF care):

> **Availability of necessary staff.**
> The [Adolescent or Children's or Dual Diagnosis Adolescent] Unit operates 24 hours per day, seven days a week. Staffing levels are determined using productivity standards for similar type units. The unit participates in Visionware Productivity guidelines to regularly evaluate productivity. This data compares staffing levels and other criteria for determining the best practices for [insert name of unit] units. Staffing levels are adjusted normally based on patient census. *Staffing levels can be adjusted for acuity*; *the Charge Nurse and Program Director can confer with the physician to increase staffing if needed on a particular shift or to address a particular patient care need*. Staff to patient ratio is [1:4 on the Adolescent Unit or 1:3 on the Children's Unit or 1:4 on the Adolescent Dual Diagnosis Unit] The unit maintains a full time roster of R.N.'s, L.P.N.'s, and Mental Health Specialists. A RN is scheduled on the unit 24 hours per day, seven days a week. A Board Certified Psychiatrist is Medical Director for the unit. A full time licensed Case Manager/Therapist provides psychological counseling . . . . Psychological testing is available as ordered by the physician. Patients participate in psycho-educational and psychotherapy groups, as well as recreational and music therapy groups. Family therapy is greatly encouraged, and sessions are held weekly.[187]

The FY 2013-14 Meadowlake staffing policy for the children's units also states that "The very acute suicidal or aggressive child may be placed on a physician ordered 1:1 for safety."[188]

For Spencer, the record does not include similar policies (whether for the year at issue or other years) but rather only an undated "staffing grid" for "24 Hour Children/Adolescent/Star Programs" and, unlike Meadowlake, there is no description of the staffing policies for any of the 5 units at Spencer. The only other evidence of staffing levels was made by Integris' witness. However, the Board gives no weight to her testimony regarding staffing or similar matters as she

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[186] The materials at Exhibits 36, 36A, 37, and 37A (including but not limited to the staffing-related materials) were provided to CMS by the Medicare Contractor by email dated September 8, 2014 as confirmed by: (1) the emails on page 1 of Exhibits P-36 and P-37 and (2) the post-hearing declaration from Integris' witness which states that "[Chair] Nix asked for the additional enclosures referenced in the MAC's emails included as Provider Exhibits 36 and 37" and that "[t]hose additional documents are enclosed as new Provider Exhibits P-36A and P-37A." Exhibit P-45 at ¶ 12. The Board suspects that these documents relate to the site visit that the Medicare Contractor conducted in or about June 2014 (as supported by the fact that some of the materials are dated "FY 2013-14"). Tr. at 82. The materials at Exhibits P-36, P-36A, P-37, and P-37A appear to be a mixture of documents/materials that Integris created and that the Medicare Contractor created.

[187] Exhibit P-37A at 377, 380, 383 (underline and italics emphasis added) (2013-2014 staffing policies for the Base Meadowlake adolescent unit, child unit, and dual diagnosis unit).

[188] *Id.* at 379.

was the Reimbursement Director (who educational background is a Bachelor of Science in Accounting and nonmedical)[189] and, as such, she had no direct involvement in staffing, medical care, or program operations at either Spencer or Meadowlake.

D. While not dispositive, the average lengths of stay at Spencer and Meadowlake support the Board's finding that they do not provide the type of care generally payable under IPPS.

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."[190] In contrast, "Residential treatment services" furnished in PRTFs are defined as "psychiatric 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."[191] Thus, one basic differentiating factor between "residential treatment services" and "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" (*i.e*., PRTF care). Per the 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."[192] 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***"[193] while "residential treatment" services consist of "longer-term" treatment in a highly structured environment. The purpose of stabilization is to remove the imminent threat from the patient, and if additional care is needed, to move the patient to a lower, less costly, level of care. For Spencer and Meadowlake, this type of care situation[194] entailed moving patients from an acute care treatment program (with an average length of stay of no greater than 6 days[195]), to a longer and less intensive PTRF treatment program (with units having an average length of stay ranging from approximately 34 days to 123 days[196]).

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[189] Tr. at 32, 33.
[190] Okla. Admin. Code § 317:30-5-95.22(b)(1) (emphasis added).
[191] *Id.* § 317:30-5-95.22(b)(7) (emphasis added).
[192] *Id.*§§ 317:30-5-95.22(b)(1), (7).
[193] *Id.* § 317.30-5-95-22 (emphasis added.)
[194] It is unclear how many patients during FY 2007 were initially admitted as acute care but then discharged from acute care for admission into the PRTF care. However, it is clear that is did occur given the testimony regarding dually licensed beds and the fact that a patient did not need to be moved when discharged from acute care into PRTF care. *See supra* notes 112-113 and accompanying text. Since Medicaid was the overwhelming primary payor, these types of situations would have gone through the prior authorization process (*i.e.,* medical necessity review of admission to acute care, discharge from acute care, and admission into PRTF care). *See supra* notes 152-59, 181-85 and accompanying text (discussing the OMP prior authorization process).
[195] *See supra* note 176 and accompanying text.
[196] *See* Tables 2 and 3, *supra*; Exhibits P-36 at 344 (table for Spencer showing FY 2011 ALOS for the Adolescent RTC as 33.96 days, the Child RTC as 41.44 days, and the STAR RTC as 123.57 days); P-37 at 348 (table for Meadowlake showing FY 2011 aggregate RTC ALOS of 66.05 days); Exhibit P-36A at 369 (undated STAR Program materials stating "[i]t typically takes a 6 to 8 month period to complete the STAR Program.").

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.* LTCHs, psychiatric hospitals, cancer hospitals and children's hospitals) were excluded from IPPS[197] 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."[198] When CMS (then known as the Health Care Financing Authority ("HCFA")) implemented IPPS in 1983, it recognized that "the standardized amounts [payable under IPPS] are based on expenditures in short-term general hospitals"[199] and that LTCHs, psychiatric, cancer and children's hospitals were excluded because they were "organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities."[200] Even the *Alhambra* court recognized that IPPS is generally "not used to reimburse hospitals for long-term care."[201]

Similarly, in the regulation at 42 C.F.R. § 412.1(a) providing an overview of the IPPS for operating and capital costs, the Secretary describes IPPS as "payment 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."[202] Further, when the Secretary issued regulations to implement IPPS, the Secretary established a policy whereby 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 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

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[197] 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).

[198] 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)) (explaining that the proposed exemptions and exceptions to IPPS: "Psychiatric, Long-Term Care, Rehabilitation and Children's Hospitals. Such hospitals would be specifically 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.").

[199] 48 Fed. Reg. 39772, 39782 (Sept. 1, 1983).

[200] *Id.* at 39760. *See also* 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (restating 1983 discussion); 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.").

[201] 259 F.3d 1071, 1072 (9th Cir. 2001)

[202] 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).

> transferring hospitals (i.e., paid under [IPPS]), and payment to both facilities would be appropriate.[203]

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, the average lengths of stay at Spencer and Meadowlake were driven by the overwhelming "residential" nature of the care furnished in those departments. As a result, during FY 2007, the Spencer/Meadowlake departments had average length of stay well above what would be expected in a short-term acute care hospital; and the Board is not confronted with a small percentage of outlier long-stays in a department, but rather alleged acute care departments operating, in essence, as outliers relative to treatment of similar diagnoses paid under IPPS. For FY 2007, the average length of stay of the units at the Spencer and Meadowlake PRTFs ranged between approximately 34 days to 124 days[204] and the primary discharge diagnoses from the disputed units are the diagnoses associated with DRG 425, 426, 427, 428, 430, and 431.[205] These lengths of stay are much longer than the average IPPS length of stay for IPPS hospitals (5 days)[206] and the minimum average length of stay needed to qualify as a long term care hospital (greater than 25 days).[207] Further, in the context of IPPS, the units at Spencer and Meadowlake, as a whole, would clearly be outliers[208] since their average lengths of stay are much longer than the mean lengths of stay for IPPS hospitals for DRGs 425, 426, 427, 428, 430, and 431[209] as published in FY 2007 IPPS Final Rule *for the year at issue*:

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[203] 48 Fed. Reg. at 39759-60 (emphasis added). *See also* 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (IPPS final rule that finalized the IPPS interim final rules published on Sept. 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)).

[204] *See supra* note 196 and accompanying text.

[205] Exhibit P-21.

[206] *St. Anthony* Adm'r Dec. at 13 n.24 (citing to publicly available information). Baptist and Bass appear to be below this average once Child Behavioral Health days and discharges (including PRTF days/discharges) are removed from consideration from the average lengths of stay ("ALOS") calculated at Exhibits P-38 and P-39. For example, following this removal, Bass would have an ALOS of 4.0 (*i.e.*, 19,867 hospital days less 2,329 nursery days is 17,538 adjusted hospital days which divided by 4,348 hospital discharges (excluding nursery) results in the ALOS.

[207] 42 C.F.R. § 412.23(e).

[208] 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 alleged volume of underlying services. This is reinforced by the fact that, until FY1998, 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 425, 426, 427, 428, 430 and 431 could be no greater than 27.2, 27.7, 27.6, 28.9, 30.5 and 29.5. *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 425,426, 427, 428, 430, and 431 as 3.2, 3.7, 3.6, 4.9, 6.5 and 5.5 respectively).

[209] Exhibit P-21.

TABLE 5 – FY 2007 IPPS LOS[210]

DRG	DRG Title	Geometric Mean LOS	Arithmetic Mean LOS
425	Acute Adjustment Reaction & Psychosocial Dysfunction	2.6	3.5
426	Depressive neuroses	3.1	4.3
427	Neuroses Except Depressive	3.2	4.7
428	Disorders of personality & Impulse control	4.5	7.3
430	Psychoses	5.8	8.0
431	Childhood mental disorders	4.2	6.8

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Indeed, the Board takes similar administrative notice that these long lengths of stay are much longer than even the average lengths of stay for DRGs 425, 426, 427, 428, 430, and 431 under the ***long-term care*** prospective payment system as published in the FY 2007 IPPS Final Rule:

TABLE 5 – FY 2007 LTCH LOS[211]

LTC-DRG	DRG Title	Geometric Average LOS	5/6s of Geometric Average LOS
425	Acute Adjustment Reaction & Psychosocial Dysfunction	17.0	14.2
426	Depressive neuroses	22.5	18.8
427	Neuroses Except Depressive	21.0	17.5
428	Disorder of Personality & Impulse Control	24.5	20.4
430	Psychoses	23.1	19.3
431	Childhood mental disorders	21.0	17.5

Further, as previously discussed, these lengths of stay are consistent with Spencer and Meadowlake being licensed as PRTFs by OMP and fit squarely within the OMP distinction between acute care services (short-term treatment) and *residential* care services (longer-term treatment). Indeed, the Secretary has noted that the 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 [IPPS]. In a report to Congress, "Hospital

[210] 71 Fed. Reg. 47870, 48196 (Aug. 18, 2006) (Table 5 entitled "List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Lengths of Stay (LOS)").
[211] *Id.* at 48328 (Table 11 entitled "FY 2007 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay").

> 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 [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.[212]

While the length of stay is not dispositive, the nature of PRTF care is "residential" and the available guidance on length of stay supports the conclusion that, on the whole, the care provided to the PRTF patients in Spencer and Meadowlake were organized for treatment of conditions "distinctly unlike" treatment encountered in short-term acute care facilities. This distinction is important because IPPS was "not designed to account" for the types of treatment provided in these units such that they would be "systemically underpaid" if all the services in them were paid under IPPS. Accordingly, the Board finds that above discussion on length of stay supports the finding that the services provided for PRTF patients do not resemble the type of care generally payable under IPPS.

E. The fact that the Medicare program has DRGs that use the same diagnoses as that assigned to the PRTF patients at Spencer and Meadowlake has no evidentiary value.

Integris contends that "[e]very patient stay that was disallowed from the DSH calculation by the [Medicare Contractor] would be payable under one of the nine Medicare-allowable DRG codes under IPPS."[213] In support of this argument, Integris includes Exhibits P-21 and P-30:

- Exhibit P-21 – A listing of all the patients and their *admitting* diagnosis and principle diagnosis as well as the DRG that would be assigned to those patients based on those diagnoses had the PRTF stay been a Medicare-covered acute care stay.

- Exhibit P-30—a listing all Medicare patients in FY 2007 that had a DRG that used the same diagnoses as those assigned to the PRTF patients at Spencer and Meadowlake (as listed in P-21). Significantly, ***none*** of these Medicare patients were in Spencer or Meadowlake but rather were in the main medical-surgical portions of Baptist and Bass. Indeed, Integris has confirmed that "[b]ecause Medicare generally does not cover children and adolescents, none of the patient days claimed in the Medicaid fraction for either facility relate to patients who were entitled to benefits under Medicare part A."[214]

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[212] 67 Fed. Reg. at 55957 (emphasis added).
[213] Providers' Post-Hearing Brief at 37.
[214] Providers' Post-Hearing Brief at 27. *See also supra* note 71.

Integris' witness confirmed that the Medicare DRGs listed on the Exhibit P-21 for Spencer and Meadowlake are the same DRG's assigned by the accounting system on Exhibit P-30, for Baptist and Bass.[215] Simply because PRTF patients have a diagnosis that can be used to assign a DRG does not mean that the assignment of a DRG is appropriate. For Medicare program purposes, a DRG is ***only*** assigned when the care being provided is *acute* care. The assignment of a diagnosis does not mean acute care is being provided (*e.g.*, not all pneumonia cases require acute care). Similarly, the fact that a patient's admitting diagnosis to a PRTF is the same diagnosis the patient had while receiving acute psychiatric care, does not mean the patient continues to receive (much less require) acute care services in the PRTF. This fact is highlighted by the Oklahoma Medicaid medical necessity criteria for psychiatric care facilities and PRTFs having the same universe of qualifying diagnoses yet providing treatment at different levels.[216] Accordingly, the Board concludes that the primary diagnosis of the PRTF patients, alone, does not have any evidentiary value in this matter.[217]

F. The Secretary's Treatment of New Born Days Is Not Relevant.

Integris points out that Medicare allows new born days, that are not payable under IPPS, to be counted in the Medicaid DSH fraction. The Provider then argues that it would be arbitrary and capricious to exclude the Spencer and Meadowlake days from being included in the Medicaid DSH fraction when non-IPPS new born days are included.[218] However, Integris has *not* alleged that the new born days are *not* acute care days. Here, the Board has concluded that PRTF care is not acute care (much less psychiatric acute care generally covered under IPPS). On the other hand, the Board must assume that new born days are, in fact, for acute care since the preamble to the 2003 Final Rule specifically states that they are to be included in the numerator of the Medicaid fraction.[219] Moreover, newborn days are not at issue in this case. Accordingly, the arguments about new born days are irrelevant.[220]

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[215] Tr. at 51-53.

[216] Compare Okla. Admin. Code § 317:30-5-95.25(1) (medical necessity criteria for psychiatric acute care) with § 317:30-5- 95.29(1) (medical necessity criteria for PRTF care).

[217] Along a similar line of reasoning, Integris states that "[t]he part A/SSI fraction includes all Medicare patient days in a unit or area of a subsection (d) hospital that is not a distinct-part unit and that provides inpatient hospital services that are payable by Medicare." They go on to state that "[s]ince these days would have been included in the part A/SSI fraction as patient days ***to the extent the patients were eligible for Medicare***, they should also be included as patient days in the Medicaid fraction." In summary they state, if the days would be included in the part A/SSI fraction, then why should they not be included in the Medicaid fraction. Providers' Post-Hearing Brief at 41-42. The Board finds this argument to be a red herring since Integris assumes that the patient is Medicare Part A eligible when they never billed to those services *as IPPS acute care* and similarly were never as such paid by the Medicare program. Also, the Board notes that PRTFs are a creature of the Medicaid program and not the Medicare program. The real question is, does the service provided by a PRTF qualify to be paid under the Medicare program as IPPS acute care. 42 C.F.R § 412.106(a)(1)(ii) (2007). Since the admissions to the PRTFs were not t*o stabilize* a patient in an ***imminent*** life-threatening ***emergency*** and the PRTF patients have an average length of stay much greater than IPPS or LTCH-PPS for patients with similar diagnoses, the Board finds these PRTF days would not be generally payable under IPPS.

[218] Providers' Post-Hearing Brief at 33, 61.

[219] *See* 68 Fed. Reg. at 45417 (discussing the inclusion of healthy newborn nursery days in the Medicaid fraction of the DSH calculation).

[220] Another difference between newborn days and the PRTF days at Spencer and Meadowlake that may factor into the Secretary's then-stated policy of including newborn days in the Medicaid fraction is the unique fact that the baby's Medicaid coverage is *through the mother* since the baby, when delivered, would be generally covered under the mother's Medicaid for 12 months and is tied to coverage of the mother's delivery. *See* 68 Fed. Reg. 45417 (Aug. 1, 2003) (stating "The costs, days, and beds associated with a healthy newborn nursery are excluded from inpatient calculations for Medicare purposes. Meanwhile, for the purpose computing the Medicaid patient share computation of

G. The Board's Treatment of Days Is Not Arbitrary and Capricious

Integris also claims that the Medicare's Contractor's different treatment of these days at Spencer and Meadowlake, as well as at St. Anthony, is arbitrary and capricious. At Spencer, the acute care and PRTF days were excluded while at Meadowlake, only the PRTF days were excluded from the Medicaid DSH fraction.[221] The Board agrees that there should be consistent treatment of the Spencer and Meadowlake days. As previously noted, the Board finds that the unit, *as a whole*, must first be reviewed to see if it furnishes acute care services generally payable under IPPS. Here, it is clear that the care furnished in the units at Spencer and Meadowlake are overwhelmingly PTRF care and, as such, these units are furnishing PTRF care, *as a whole*, not acute care generally payable under IPPS. Accordingly, the Board finds that: (a) for Spencer, the Medicare Contractor properly excluded all of the under-18 psychiatric care days (both acute care and PRTF); (b) for Meadowlake, the Medicare Contractor improperly excluded only the under-18 PTRF days and should have also excluded the under-18 acute care days.[222]

Integris' final argument is that "even if an interpretation of a regulation is reasonable and otherwise permissible, it cannot be applied retroactively to penalize a party that did not have 'fair notice' of the interpretation.'"[223] In support, Integris contends that: (1) for FY 1999, it sought and received approval from the Medicare Contractor to include PTRF care days in its Medicaid eligible day count for the numerator of the DSH Medicaid fraction and total days count for the denominator of the DSH Medicaid fraction; (2) Meadowlake and Spencer reported PRTF days consistent with this approval for FYs 2000 through 2006 and the Medicare Contractor allowed those days; and (3) the original/initial FY 2007 NPR for Baptist and Bass was not issued until May 2015, seven years after their respective FY 2007 cost report had been filed.[224]

The Board finds that its exclusion of all of the days for Spencer and Meadowlake is not arbitrary and capricious because: (1) there was an intervening event with the issuance of the Secretary's clarification on its nonacute days policy in 42 C.F.R. § 412.106(a)(1)(ii) and the Board's actions are consistent with that clarification and the associated revisions to the regulation; (2) there is no written evidence of the Medicare Contractor's approval of Integris' practice of reporting Spencer and Meadowlake days;[225] (3) it is unclear to what extent the Spencer and/or Meadowlake days

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the DSH patient percentages, these days are included both as Medicaid patient days and as total patient days. Newborn nursery costs, days and beds are treated this way because the costs are not directly included in calculating Medicare hospital inpatient care costs because Medicare does not generally cover services for infants. However, Medicaid does offer extensive coverage to infants, and nursery costs would be directly included in calculating Medicaid hospital inpatient care costs. Therefore, these costs, days, and beds are excluded for Medicare purposes, but included for determining the Medicaid DSH percentage."). Moreover, the Board suspects newborns stays are very short in duration. In contrast, the under-18 PRTF patients at Spencer/Meadowlake had to qualify for Medicaid based on their own merits for stays that are very long in duration given the "residential" nature of the care.

[221] Providers' Post Hearing Brief at 54-55.

[222] The Board's decision here is consistent with its recent decision on remand for St. Anthony, PRRB Dec. No. 2022-D29 as well as the Administrator's March 6, 2018 remand in that case that resulted in PRRB Dec. No. 2022-D29. The Board further notes that Integris was aware of this March 6, 2018 remand because, on August 13, 2018, it filed a requested that the Board promptly issue its decision and not further delay the issuance of this decision asserting that the March 6, 2018 remand did not otherwise justify further delay in this case.

[223] Providers' Post-Hearing Brief at 52.

[224] *Id.* at 53-54.

[225] Moreover, the Board declines to give any evidentiary weight to Integris' claim that they received *verbal* approval/guidance from the Medicare Contractor for FY 1999 as explained *supra* note 83.

were scoped for audit during any of the prior years but regardless, there is no evidence of any CMS involvement in the audit for those fiscal years; (4) the record confirms that, for FY 2007, the Medicare Contractor scoped Spencer and Meadowlake days for review and sought guidance from CMS on the inclusion of the days in the Medicaid DSH calculation;[226] (5) the Providers are deemed to be on notice of the 2003 rulemaking; and (6) the Board's decision here is consistent with that 2003 rulemaking.

Decision

After considering Medicare law, regulations and guidance, testimony and arguments presented, and the evidence admitted, the Board makes the following findings regarding the two participants in this CIRP group, Baptist and Bass:

1. During FY 2007, Baptist operated 5 child and adolescent psychiatric units in a hospital department known as Spencer and, similarly, Bass operated 3 child and adolescent psychiatric units in a hospital department known as Meadowlake;

2. For FY 2007, the level of care that Spencer and Meadowlake generally furnished in their respective child/adolescent psychiatric units, *as a whole*, was a PRTF level of care;

3. The furnished PRTF level of care was not equivalent to the psychiatric acute care services provided in a short-term acute care hospital subject to the IPPS and, thus, is not generally payable under the IPPS;

4. The Medicare Contractor *properly* excluded all of the days associated with the units at Spencer (both days for psychiatric acute care and PRTF care) from the Medicaid fraction used in Baptist's DSH calculation for FY 2007; and

5. The Medicare Contractor *improperly* excluded only the PRTF care days associated with the units at Meadowlake from the Medicaid fraction used in Bass's DSH calculation for FY 2007.

Accordingly, the Board remands this case to the Medicare Contractor and instructs it to exclude all days (both psychiatric acute care and PRTF care days) associated with the units at Meadowlake from the numerator and denominator of the Medicaid fraction of Bass's DSH adjustment calculation for FY 2007.

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For the Board:

2/17/2023

X Clayton J. Nix

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

[226] Medicare Contractors' Final Position Paper at 12.