PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D12

PROVIDER –
St. Anthony Hospital

Provider No.: 37-0037

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING –
March 30-31, 2015 and
May 27-28, 2015

Cost Reporting Periods Ended:
December 31, 2006

CASE NO.: 14-2968

INDEX

ISSUE STATEMENT

Whether the Medicaid days attributable to child and adolescent patients who received services in three of the Provider's inpatient behavioral health units (namely the ACCENTS Unit, the Human Restoration Unit, and the Positive Outcomes Unit) can be included in the Medicaid fraction of the formula used to calculate the Provider's Medicare disproportionate share hospital ("DSH") payment.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence presented at the hearing, the Board majority concludes that St Anthony Hospital's ("St. Anthony's" or "Provider's") patient days from the ACCENTS Unit, the Human Restoration Unit, and the Positive Outcomes Unit meet the Medicare requirements for acute level of care such that these days should be included in the Medicaid fraction of the Medicare DSH payment calculation. Accordingly, the Board reverses the Medicare Contractor's adjustment and orders the Medicare Contractor to include these days in the Medicaid fraction for St. Anthony's fiscal year ("FY") 2006.

INTRODUCTION

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

St. Anthony operates six separately identifiable hospital-based units that provide inpatient psychiatric care to children and adolescents under the age of 21, all of which are generally covered and reimbursed under the Oklahoma State Medicaid program (collectively referred to as the "Six Psychiatric Units"). Two of these units are certified as psychiatric acute care units by the Oklahoma Medicaid program and the Medicare Contractor agreed to include the patient days from these two units in the Medicare DSH calculation.[3]

The remaining four units are licensed as residential treatment centers ("RTCs") and participate in the Oklahoma Medicaid Program as hospital-based Psychiatric Residential Treatment Facilities ("PRTFs").[4] The Medicare Contractor determined that the Children's RTC Unit, also licensed as

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

[2] The term "Medicare contractor" refers to fiscal intermediaries and Medicare administrative contractors.

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

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

a residential treatment facility, met the standard for providing acute care, thus the Contractor included inpatient days from this unit in the Medicare DSH calculation. Inpatient days for patients in three remaining PRTF's (ACCENTS Unit, the Human Restoration Unit, and the Positive Outcomes Unit, collectively referred to as the "Three Disputed Units" or "Units") were not included in the Medicare DSH fraction and are at issue in this case.

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

STATEMENT OF FACTS

The Medicare program generally pays hospitals a fixed, predetermined rate for each inpatient discharge based on the patient's diagnosis-related group ("DRG").[5] In addition to the DRG payment, the Centers for Medicare & Medicaid Services' ("CMS") inpatient prospective payment system ("IPPS") adjusts a hospital's payment based on various hospital-specific factors, one of which is the Medicare DSH adjustment[6] at issue in this appeal. The DSH adjustment is a proxy measure representing the number of low-income patients that a hospital serves[7] as measured in "patient days."[8] The DSH adjustment is calculated by adding two fractions, generally referred to as the Medicare fraction and the Medicaid fraction.[9] Specifically, this appeal involves a dispute over the number of patient days that may be included in the numerator of the Medicaid fraction.

Until 2008, another Medicare Contractor had allowed the patient days from the Three Disputed Units to be included in the Medicaid DSH fraction.[10] In a May 2008 desk review of St. Anthony's FY 2006 cost report, the new Medicare Contractor, TrailBlazer, disallowed patient days from the Three Disputed Units on the basis that the care provided in the Units did not meet the criteria for acute care.[11] At the direction of CMS, the Medicare Contractor conducted a medical review of all of the Six Psychiatric Units and prepared a report of its findings (the "TrailBlazer Report").[12]

Based on the detail of the exhibit in the record, the Medicare Contractor sampled a total of thirty patients' records from all of the inpatient adolescent psychiatric units using InterQual Inpatient

[5] 42 U.S.C. § 1395ww(d)(2)-(3). *See also* 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[6] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[7] *Id.*
[8] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] *Id. See* Metropolitan Hosp. v. U.S. Dept. of Health and Human Services, 712 F.3d 248, 251 (6th Cir. 2013).
[10] Provider's Position Paper at 11;Tr. at 95-96 (May 28, 2015).
[11] *See* Medicare Contractor's Exhibit I-19; Medicare Contractor Exhibit I-10 at 3.
[12] Medicare Contractor Exhibit I-10 at 4.

criteria for acute inpatient admission.[13] The Medicare Contractor concluded that two of the acute psychiatric units, the Children's Unit and the Adolescent Unit, met the criteria for acute care. The Children's RTC Unit was later determined to also meet the criteria. Regarding the Three Disputed Units, the Medicare Contractor concluded that less than 50 percent of the patient days sampled met the acute inpatient admission criteria.[14]

The Medicare Contractor issued St. Anthony its FY 2006 Notice of Program Reimbursement ("NPR") on February 13, 2014, and charged St. Anthony with an overpayment of $5,535,004.[15]

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

The Medicare Contractor argues that the care provided in the Three Disputed Units did not meet the standard for "acute care" as defined by the Secretary, i.e., "necessary treatment of a disease or injury for only a short period of time in which a patient is treated for a brief but severe episode of illness."[16] In support of its argument, the Medicare Contractor cites the following facts pertaining to the Units: some patients were placed on a waiting list until a bed was available, some patients had passes to leave the facility, and the patients' recreational and educational activities indicated that the patients did not receive the type of care provided in an acute care setting.[17] Finally, the Medicare Contractor argues that St. Anthony's registration of the Three Disputed Units as RTCs under the Oklahoma State Medicaid Program belies the claim that these units provide acute care.[18] The Medicare Contractor states that St. Anthony "self-designated" its Psychiatric Units as RTCs which, under Oklahoma law, do not provide acute care services.

St Anthony contends that patients in the Three Disputed Units were acutely ill and had diagnoses that squarely fit within the DRGs payable under a prospective payment system.[19] St. Anthony also argues that the Medicare program covers inpatient psychiatric care (regardless of length of stay) and that the intensity of services furnished in the Three Disputed Units (*e.g.*, nature of care, frequency of physician visits and levels of staffing)[20] qualifies as acute inpatient care in the psychiatric community. Finally, while the Oklahoma Medicaid Program designated the Units as PRTFs, St. Anthony's claims that this designation is irrelevant as it is only necessary for the state Medicaid payment purposes.

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[13] *Id.*
[14] *Id.* at 11.
[15] Provider Exhibits P-1, P-2, P-4.
[16] Medicare Contractor's Final Position Paper, at 13-14 (emphasis omitted).
[17] *Id.* at 14-15.
[18] *Id.* at 17.
[19] Provider's Position Paper at 16, 39, and Provider Exhibit P-28.
[20] Provider's Position Paper at 40-42; Provider's Post-Hearing Brief at 24-27.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

A. ARGUMENTS RELATING TO THE ADMISSIBILITY OF DR. BAER'S TESTIMONY

As a preliminary matter, the Board addresses St. Anthony's objection to the hearing testimony of Dr. Richard Baer. Dr. Baer, a former Medicare Part A Medical Director at National Government Services, Inc., appeared as a witness for the Medicare Contractor. St. Anthony objected to his testimony based on its claim that the regulations at 45 C.F.R. Part 2 (the "Touhy Regulations") bar testimony of current and former employees of the Department of Health and Human Services ("DHHS") who fail to obtain prior written authorization from the CMS Administrator as required.[21]

After considering the regulations and pertinent case law, the Board finds that St. Anthony does not have standing to enforce the Touhy Regulations. DHHS promulgated the Touhy Regulations as "housekeeping regulations" for the benefit of DHHS, not for private litigants, and only DHHS can enforce the regulations.[22] In the preamble to the Final Rule, the DHHS, of which CMS is a part, made clear that the purpose of the regulation was to "maintain the [DHHS's] policy of strict impartiality with respect to *private* litigants and to minimize the disruption of *official duties*."[23] The authorizing statute and regulation do not allow a private litigant such as St. Anthony to enforce DHHS's self-described "housekeeping regulation," particularly when Medicare contractors routinely participate as parties to Board hearings as part of their official duties to audit provider cost reports.[24]

The U.S. Court of Appeals for the Seventh Circuit ("Seventh Circuit") supported this conclusion in a decision regarding a similar regulation promulgated by the Department of the Army, reiterating the "policy of strict impartiality in private litigation" as the reason for the regulation, not to protect the defendant's interest based on the agency's impartiality policy.[25]

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[21] Tr. at 440-41 (Mar. 31, 2015).

[22] If CMS had intended to allow a private litigant to invoke the restrictions of 45 C.F.R. Part 2, CMS could have done so and notified the public of that right when it revised the Board's governing regulations in the final rule published on May 23, 2008. *See* Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008). This final rule revised the Board's regulations to clarify when the restrictions in the Touhy Regulations apply. Significantly, in defining when they do apply, CMS did not specify either in the revised regulations or the preamble that private litigants would have standing to enforce the Part 2 restrictions or, at a minimum, notify the public that the Touhy Regulations applied whenever *a Medicare contractor* called a CMS or DHHS employee as a witness. To the contrary, in response to comments on whether Medicare contractors could call CMS employees, CMS recognized in the preamble that Medicare contractors "occasionally ask a CMS employees to testify at an oral hearing[]" and did not specify or even suggest that Touhy Regulations applied in that instance. *Id.* at 30216.

[23] Testimony by Employees and the Production of Documents in Proceedings Where the United States is Not a Party, 52 Fed. Reg. at 37145 (Oct. 5, 1987) (emphasis added), *available at* 1987 WL 139614(F.R.).

[24] *Id*.-; 45 C.F.R. § 2.2 (definition of "employee of the Department").

[25] The Seventh Circuit Court of Appeals upheld the agency policy of "strict impartiality in private litigation" as the basis to uphold the Touhy Regulation in the context of a Department of Army employee who was required to get the Headquarters for the Department of Army's approval to testify as an expert based on information acquired while employed. *United States f/b/o Treat Bros. Co. v. Fidelity and Deposit Co. of Md.*, 986 F.2d 1110, 1118 (7th Cir.

B. **ARGUMENTS RELATING TO THE ACUITY OF CARE FURNISHED IN THE THREE DISPUTED UNITS**

The precise language of the regulation requires the Board to determine whether the degree and intensity of medical services in the Three Disputed Units is comparable to "acute care services generally payable under [IPPS]" as required under 42 C.F.R. § 412.106(a)(1)(ii) (2006). For the purposes of the DSH calculation, § 412.106(a)(1)(ii) limits "patient days" to those:

> [A]ttributable to units or wards 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 . . . .

CMS revised this regulation in a Final Rule published on August 1, 2003 (the "2003 Final Rule"),[26] in response to a Ninth Circuit Court of Appeals decision in *Alhambra Hosp. v. Thompson* ("*Alhambra*").[27] Taking exception to the Ninth Circuit's ruling, CMS clarified that some patient days are to be excluded from the DSH calculation, stating:

> Generally, as discussed previously, *if the nature of the care provided in the unit or ward is consistent with what is typically furnished to acute care patients, and, therefore, would be characteristic of services paid under the IPPS, the patient days, beds, and costs of that unit or ward would be classified as inpatient acute care* (except for observation bed days and swing bed days, as discussed later in this preamble). Conversely, if the intensity and type of care provided in the unit or ward are not typical of a service that would be paid under the IPPS (for example, nonacute care), we proposed that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations of beds and patient days at § 412.105(b) and § 412.106(a)(1)(ii).

1993). *See also United States ex. rel. Liotine v. CDW Gov., Inc.*, No. 05-33-DRH, 2012 WL 2807040, at *1, 5-6 (S.D. Ill. July 10, 2012).

[26] Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year 2004 Rates, 68 Fed. Reg. 45346 (Aug. 1, 2003).

[27] 259 F.3d 1071, 1073 (9th Cir. 2001). Similar to the facts in the current appeal, the *Alhambra* hospitals operated units licensed in California as skilled nursing facility ("SNF") beds but were not certified by Medicare as such. The California Medicaid Program classified the units as "subacute" care units because they provided less intensive care than did acute care units, but more intensive skilled nursing care than is typically provided in a SNF. The Ninth Circuit ruled that days that were in, or adjacent to, an acute care 'area' and that Medicare had not separately certified as nonacute (i.e. beds providing care generally below the level of routine inpatient acute care) should be considered to be in the 'areas of the hospital that are subject to the prospective payment system' and counted in calculating the Medicare DSH patient percentage.

> 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.*[28]

Based on the language of the regulation cited above, the Board majority will focus not on whether the individual patient's *condition* is acute, but on the level and type of care provided in the Three Disputed Units as a whole. The proper question in this case is "whether the Provider has marshalled sufficient evidence to demonstrate whether the type and level of care provided in the Accents, Human Restoration and Positive Outcomes units 'is consistent with what is typically furnished to acute care patients.'"[29] As will be discussed below, the Board majority finds that the care provided in the Three Disputed Units did meet the standard for acute care provided in an inpatient psychiatric treatment facility.

In reaching its decision, the Board majority has examined the Medicare Contractor's methodology in conducting the review of the care provided in the Three Disputed Units. At the behest of CMS, the Medicare Contractor conducted an "audit" of a sample of patients' records. This action seems to contradict CMS' 2003 preamble language which advocated against a patient-by-patient medical record review to establish the level of care.[30] Further, CMS rejected the Medicare Contractor's recommendation to hire an external Child and Adolescent Psychiatrist to perform secondary medical reviews and instead told unspecified Contractor staff to utilize the InterQual Behavioral Health Child and Adolescent Acute Care screening criteria. The hearing record is bereft of information about who actually performed the audit and whether the auditor had appropriate experience or training to actually conduct a medical audit. While the record includes some representations that a "sample" of files was abstracted, the Medicare Contractor provided no evidence about the sampling methodology and whether the chosen sample was statistically valid. The record also indicates that the Medicare Contractor's Medical Director reviewed the patients' medical files to generate a "broad clinical impression of each encounter to discern the need for acute or non-acute services[,]"[31] however, there is no evidence in the record regarding the Medical Director's qualifications to make determinations specifically related to inpatient psychiatric care.[32]

Specifically, the Medicare Contractor used InterQual Behavioral Health Child and Adolescent Acute Care screening criteria and randomly selected 30 patients, reviewing sixty-two "episodes" of care.[33] InterQual guidelines are widely used by the hospital industry to determine whether an

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[28] 68 Fed. Reg 45346, 45417 (emphasis added).
[29] August 11, 2015 Submission of the Updated Post-Hearing Brief at 8.
[30] 68 Fed. Reg. 45417. CMS also stated "Further, we believe that it is administratively inefficient and impracticable to calculate a hospital's inpatient days based on a determination, on a day-by-day basis, of whether a particular patient in a particular inpatient bed is receiving a level of care that would be covered under the IPPS." *Id*. at 45418.
[31] Medicare Contractor's Final Position Paper Exhibit I-10, at 4 (Exhibit I-10 is the TrailBlazer Report; the Medical Director's assessment can be found at Appendix D of the TrailBlazer Report at 23-37).
[32] *See* Provider Exhibit P-53, at 1 (copy of CMS Pub. 100-10 §4620).
[33] Medicare Contractor Exhibit I-10 at 4.

individual patient should be admitted to the hospital and whether the hospital is likely to get paid for the inpatient stay.[34] They are not generally used to determine whether a particular hospital unit or facility provides an acute level of care.[35]

Nevertheless, the Medicare Contractor applied the guidelines and determined that if 50% or more of the patients met the InterQual threshold, the *facility* provided the level and type of care generally determined to be acute care provided in an IPPS facility.[36] If the facility did not meet the 50% threshold, the Contractor rejected 100% of the inpatient days from the Medicaid fraction of the DSH calculation.

In the Board majority's view, the use of the InterQual methodology may be a valid and useful tool to evaluate the status of an individual patient's condition upon admission to a facility, however, the Board majority questions whether it can be properly used to determine the nature of care provided in that facility. For example, while the Medicare Contractor established that 68% of the patients in the Adolescent Unit required an acute level of care, does it necessarily follow that the Adolescent Unit provides more acute care than say, the Human Restorations Unit in which approximately 48% of the patients required an acute level of care?[37] One can only conclude from this study that since some of the patients in each Unit require acute care, the facility, indeed, must be providing some acute care.

The Board majority also questions whether the Medicare Contractor used a statistically valid sample of the inpatient population from each of the Six Psychiatric Units to conduct this study as two of the Units that were deemed to provide acute care had sample sizes of 13 and 17 patients while the three Units that were deemed not to provide acute care had sample sizes of 5-7 patients. As noted by one of St. Anthony's experts, the confidence in the Medicare Contractor's extrapolation of the study results is based on the number of items sampled—i.e., "the more items sampled the greater the precision of the extrapolation."[38]

The Board majority further finds, as will be discussed at length below, the preponderance of the evidence in this case establishes that the Three Disputed Units did provide the level of care that would be provided in an acute care facility. St. Anthony's proffered evidence that the patients' conditions were unstable and required ongoing residential care to provide treatment. Extensive

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[34] *Alexander v. Cochran*, No. CV11-1703, 2017 WL 522944 (D. Conn. 2017) following remand from U.S. Court of Appeals in *Barrows v. Burwell*, 777 F.3d 106 (2d Cir. 2015).

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

[36] Medicare Contractor Exhibit I-10 at 22.

[37] *Id.* at 19- 20.

[38] Declaration of Peter Dressel, Provider Exhibit P-44 at 3. The expert also stated that the Medicare Contractor used a "point estimate" in arriving at its conclusion, rather than the statistical "range of probable results," lowering the confidence level of the extrapolation. The expert also noted that this methodology is inconsistent with the Department of Health and Human Services, Office of Inspector General's own Program Integrity standards. *Id.* at 5-6.

testimony from experts in the field of adolescent psychiatry detailed the nature of the care provided by the Three Disputed Units. The Board majority concludes that the level of care provided by the Three Disputed Units is consistent with the level of care furnished to acute care patients and paid under the IPPS. As the patient days provided in the Three Disputed Units meet the level of care requirement of 42 C.F.R. § 412.106(a)(1)(ii), these days should be included in St. Anthony's DSH calculation.

C. ACUTE CARE MUST BE "SHORT TERM"

The Medicare Contractor argues that acute care must be, by definition, "short term,"[39] citing a 2010 regulation that addressed Medicaid funding for development of medical records technology in "short-term acute-care hospitals," defining an average length of stay of 25 days or less.[40] Dr. Baer opined that "Acute care psychiatric inpatient services are generally characterized as tendered to *short term* acutely ill psychiatric patients who are a danger to themselves or others or who are unable to care for themselves as a result of their acute psychiatric symptoms."[41] He disputed that patients in the Three Disputed Units remained in need of acute care because new medications could control the psychotic episodes in "a week [to] twenty days"[42] and compared these adolescent patients to Medicare patients who received inpatient psychiatric hospitalization for an average of eleven days.[43] Dr. Baer made these general statements without having examined any of the patient records. He did not participate in the preparation of the Trailblazer Report. His testimony was, in part, based on his knowledge as a former medical director for a Medicare Contractor dating back to 1994.[44]

St. Anthony's witnesses disputed the definition of short term in treating acute psychiatric conditions. Dr. Kaminski, a consulting psychiatrist, expressly disputed the notion that acute care was limited to 25 days,[45] asserting that psychiatry was a "different animal" and that "short term" could mean "six months to a year"[46] and that when treating "adolescent psychiatric patients the nature of the conditions, the nature of the treatment and the length of treatment is very different…"[47]

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[39] Medicare Contractor's Final Position Paper at 13-14.
[40] *Id.* at 14; Tr. at 63-64 (Mar. 30, 2015) (citing to the final rule published at 75 Fed. Reg. 44314 (Jul. 28, 2010) (copy included as Medicare Contractor Exhibit I-12)). The Board majority finds this definition inapplicable because CMS promulgated this final regulation well after the time at issue and should be applied only in context of the Medicaid electronic health record incentive program.
[41] Tr. at 387-388 (Mar. 31, 2015) (emphasis added).
[42] *Id.* at 391.
[43] *Id.*
[44] Dr. Baer's Curriculum Vitae, Medicare Contractor Exhibit I-21 at 4-5.
[45] Tr. at 323, 328 (Mar. 31, 2015).
[46] *Id.* at 318.
[47] *Id.* at 314. *See also* Declaration of Joseph J. DiVincenzo, M.D., Provider Exhibit P-46.

The Board majority has not identified any applicable statute, regulation, or program guidance that specifically defines or references the term "acute care"[48] nor, for that matter, what constitutes a "short term" length of stay specifically for inpatient psychiatric care. The Board majority notes that the Medicare program itself places a 190-day lifetime limit on the length of coverage for inpatient psychiatric care in a freestanding psychiatric hospital.[49] Based on the transcript of the hearing, both parties appear to agree that the average length of stay in the Three Disputed Units is 128 to 162 days—well below Medicare's inpatient psychiatric benefit coverage standard.[50] The Board majority finds that the Medicare Contractor's definition that acute care must be "short-term," i.e. 25 days or less, is based on a regulation wholly unrelated to Medicare payment policy and is irrelevant to the determination in this case.

The Board majority also finds that Dr. Baer's generalizations about the patients, without having examined the medical records, contradicts the testimony of the medical professionals who did examine the patients' records. Dr. Holloway disputed Dr. Baer's assertion that the patients' conditions were stable and no longer acute when admitted to the Units. He asserted that the patients had a high likelihood of acute episodes which required ongoing monitoring by staff and daily involvement by physicians.[51] Dr. Holloway testified that many of the patients had multiple psychiatric diagnoses, are in imminent risk of harm to themselves or others and were referred to the Human Restorations Unit or Accents Unit because they failed treatment or treatment was unsuccessful in other acute and non-acute treatment settings.[52] Dr. Holloway testified that the patients generally required higher doses of medications and that the physicians and staff were required to continually deal with emergent issues with a change, or immediate administration, of medications.[53] The Board majority finds that St. Anthony's evidence regarding the patients' conditions is well established in the record and that the patients in the Three Disputed Units required an acute level of care.

D. THE MEDICARE STANDARD FOR INPATIENT PSYCHIATRIC ACUTE CARE

None of the patients in the Three Disputed Units are Medicare-eligible individuals whose care would be covered by Medicare. Nonetheless, the Board majority believes that the most appropriate and applicable method to identify the level of care that would be payable as *acute*

[48] This limit contrasts with 60 lifetime reserve days in addition to a 90-day maximum length of stay for acute inpatient hospital care. In both cases, it should be noted, these maximums relate solely to the number of days Medicare will pay for, or "cover" during a patient's benefit period or lifetime, not to the actual length of hospitalization that a patient's treating physician might regard as medically necessary.

[49] This lifetime maximum of 190 days on inpatient psychiatric care in a freestanding hospital does not apply to a distinct part or excluded unit. *See* 42 C.F.R. § 409.62. St. Anthony's Three Disputed Units are not freestanding hospitals. They are licensed as beds included as part of St. Anthony Hospital and they are not "distinct part" or "excluded" units. Tr. at 38 (Mar. 30, 2015).

[50] Tr. at 323 (Mar. 31, 2015). In any case, it appears that none of the patients within St. Anthony's Three Disputed Units are Medicare beneficiaries. Nevertheless, this lifetime maximum may be indicative of the standard for Medicare's short term, acute inpatient psychiatric care.

[51] *Id.* at 120-121, 125-126, 138.

[52] Tr. at 88, 91, 93-94, 95-96 (Mar. 30, 2015).

[53] *Id.* at 111-112, 115-116.

care under IPPS, as required by 42 C.F.R. § 412.106(a)(1)(ii), is Medicare's standard for payment for inpatient psychiatric care for Medicare-eligible individuals. Thus, in order to establish what Medicare considers *acute inpatient psychiatric* care, the Board majority turns to Medicare law and policy governing Medicare payment of inpatient psychiatric care for Medicare beneficiaries.[54]

Medicare defines an inpatient psychiatric hospital as "an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. . . maintains clinical records . . . necessary to determine the degree and intensity of the treatment provided to [the mentally ill patient]; and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution."[55] To receive Medicare payment, psychiatric hospitals must meet specific conditions of participation, including:

a) Document an admitting diagnosis and reasons for admission for each patient at the time of admission;
b) Perform a psychiatric evaluation within 60 hours of admission;
c) Develop an individual comprehensive treatment plan;
d) Maintain progress notes which must be updated weekly for the first 2 months; then once a month thereafter. These notes must contain revisions in the treatment plan as necessary and precise assessment of the patient's progress.
e) Develop a discharge plan; and
f) Have adequate numbers of professional and supportive staff including a clinical director to provide leadership required for an intensive treatment program; a doctor or medicine or osteopathy to provide normal medical and surgical services; director of psychiatric nursing services, and insure the availability of a registered nurse 24 hours each day; and staff to provide social services as well as a therapeutic activities program.[56]

Based on testimony from St. Anthony's witnesses and the record, the Three Disputed Units meet Medicare requirements for payment as an inpatient psychiatric facility. Each facility had a clinical director: Dr. Brent Bell was the clinical director for the Adolescent Unit (whose patient days did count for the DSH calculation) and the Positive Outcomes Unit,[57] and Dr. Willis Holloway was the clinical director for the Accents and Human Restoration Units.[58] Each testified that the clinical director had one-on-one patient visits on the Units at least once per week, that the nurse practitioner met with patients two times per week, and had team meetings with Unit staff, patients and family members.[59] Dr. Holloway indicated that he, or someone else on the

[54] 42 C.F.R. § 412.1(a)(2) (2006). Medicare pays for inpatient psychiatric care through its inpatient psychiatric facility prospective payment system.
[55] 42 U.S.C. § 1395x(f).
[56] 42 C.F.R. §§ 482.61-482.62.
[57] Tr. at 5 (Mar. 31, 2015).
[58] Tr. at 85(Mar. 31, 2015).
[59] Tr. at 42, 59-60 (Mar. 31, 2015). Medicare policy requires that a physician meet with therapists, review the medical record and conduct regularly scheduled patient interviews, "at least once per week." MBPM at § 30.2.3.

staff, observed or had interaction every 15 minutes for a patient on a precaution. Dr. Bell spends four to five hours at the Positive Outcomes Unit on a daily basis providing treatment for patients and supervising clinical staff.[60] Dr. Kaminiski described the role of a doctor in a psychiatric facility as the "captain of the ship" who must be present to observe patients for therapeutic purposes and available to the nursing staff at all times. He contrasted this role to a surgeon on a medical surgical unit in an acute care hospital who performs surgery and then disappears from the unit.[61]

St. Anthony's proffered evidence that registered nurses and therapists equaled or exceeded staffing that was provided in a medical-surgical unit of a hospital.[62] Dr. Holloway described a "one to three" nursing staff-to-patient ratio, four therapists, a full-time nurse practitioner, and four therapeutic recreational therapists in the Human Restoration and Accents Units.[63] Dr. Kaminski, qualified as an expert in assessing the level of acuity and treatment in adolescent psychiatric patients, noted that the level of staffing was "about the same as or higher," as that in a psychiatric hospital.[64]

Clinical records indicate that each patient was assigned an admitting diagnosis and the reason for admission as well as a patient history.[65] Each patient had a psychological evaluation within 24 hours of admission as well as an individualized plan for treatment and discharge.[66] Medical records indicated that the patients' conditions were unstable and require medication changes which were documented in treatment notes.[67] Dr. Brent Bell, the Medical Director of the Adolescent and Positive Outcomes Units testified that he saw little difference in patients and their treatment between the Positive Outcomes Unit and the Adolescent Unit.[68] Dr. Bell's review of the patient records also indicated that patients were put on a "hold" or were administered "now" medications in emergent situations in which a patient had assaulted another patient, staff member or attempted suicide.[69] Evidence in the record indicates that each patient had an "active treatment plan" for one-on-one counseling, therapy, education, and recreational activities.[70] Dr. Bell testified that while some patients did leave the facility for short visits to family members in the community, these visits were necessarily therapeutic in nature to test the ability of the patient to function outside the facility.[71]

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[60] Tr. at 49-50 (Mar. 31, 2015).
[61] *Id*. at 201-207.
[62] Tr. at 37, 40 (Mar. 31, 2015). Tr. at 216, 227 (May 27, 2015). *See also* Provider Exhibit P-26.
[63] *Id*. at 171-186. *See also* Provider Exhibits P-26A, 26B.
[64] Tr. at 164-169 (Mar. 31, 2015). The Medicare Contractor determined that the Adolescent Unit provided an acute level of care. Dr. Bell also testified that the level of staffing in the Positive Outcomes Unit was the same as that found in the Adolescent Unit. Tr. at 39-40 (Mar. 31, 2015).
[65] *Id*. at 14-15, 87-90 (Mar. 31, 2015). *See also* Provider Exhibit P-11, at 2.
[66] Tr. at 104 (Mar. 30, 2015); Provider Exhibit P-11, at 2; Provider's Updated Exhibits, Exhibit 57-D at 15-19.
[67] Tr. at 112-113, 115 (Mar. 30, 2015); Tr. at 48-50 (Mar. 31, 2015).
[68] *Id.* at 25-26, 112.
[69] *Id*. at 59-60. Dr. Bell additionally noted that patients are not allowed to move about the Unit without being accompanied by a staff member because of the danger to themselves or others. *Id.* at 28-29.
[70] Provider Exhibit P-12 at 4, Exhibit 57-A at 31-44, Provider's Updated Exhibit 57-D at 20-22.
[71] Tr. at 67, 74-75 (Mar. 31, 2015). *See also* Provider's Updated Exhibit P-57-A at 16.

Following review of 15 of the 17 patient records, Dr. Kaminski concluded that the patients in the Three Disputed Units had schedules of activities and treatment similar to those in other acute adolescent facilities.[72] He testified that the levels of medication, medication changes and, in particular, the frequency of the "now" medications for emergent situations was the same as that he would see in an adolescent acute care setting.[73]

This testimony and the documentation in the record convinced the Board majority that the level of care provided by the Three Disputed Units met the Medicare requirements for inpatient psychiatric care under the statute and regulation and that it was the level of care that would typically be provided to a patient in an acute care setting sufficient to satisfy the DSH regulation at 42 C.F.R. § 412.106(a)(1)(ii). Contrary to Dr. Baer's assertion that the patients' conditions were stable and that the patients were no longer receiving active treatment in the Three Disputed Units, the Board majority finds that the evidence is clear that these patients were not stable and received active treatment.

E. Designation of the Three Disputed Units under Oklahoma Law.

The parties dispute whether the designation of the Three Disputed Units as RTCs under Oklahoma Medicaid regulations is significant in the determination of whether the Units provide acute care. The Board majority finds that Oklahoma's criteria for PRTFs is irrelevant for the final determination in this case. The Board majority concludes that federal Medicaid law allowed States to pay for acute inpatient psychiatric services for adolescents/children either in a psychiatric hospital or in a residential treatment facility. A 1973 Medicaid statute authorized payment for inpatient psychiatric services for individuals under 21 years of age for services provided in a psychiatric hospital and gave the Secretary authority to allow Medicaid payment for these services to *"other"* institutions as well.[74] In 2001, the Secretary authorized Medicaid payment to PRTFs to provide inpatient psychiatric hospitalization for individuals under 21 as well.[75] Preamble language indicated that PRTFs would provide "a less restrictive alternative to a hospital for treating children and adolescents whose illnesses are *less acute* but who still require a residential environment."[76] This language implies that, at least with regard to federal Medicaid payment, CMS considers that both psychiatric hospitals and PRTFs are facilities available to provide acute care services for individuals under 21 years of age.[77] The Board majority concludes that the designation of a facility that provides mental health treatment to individuals

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[72] Tr. at 172-174, 180, 181-182 (Mar. 31, 2015).
[73] *Id.*, at 189-191.
[74] 42 U.S.C. § 1396d(h)(1)(A) (emphasis added). *See also Collins v. Hamilton*, 349 F.3d 371, 374–75 (7th Cir. 2003).
[75] 66 Fed. Reg. 7148 (Jan. 22, 2001).
[76] *Id.* (emphasis added).
[77] The Medicare Contractor proffers an Oklahoma Medicaid program regulation which defines a PRTF as providing "non-acute care." The date of the last amendment of the regulation was 6-25-11 so it is unknown whether this definition existed in 2006, the fiscal year at issue in this case. Medicare Contractor's Final Position Paper, Exhibit I-4.

under 21 years of age as an inpatient psychiatric hospital or PRTF is insufficient to conclude that a PRTF does not provide acute care under federal Medicaid law.

The evidence in this case, including statements by Dr. Baer, indicate that the Three Disputed Units provided a comprehensive and intense level of services to the patients.[78] The Board majority finds that because federal Medicaid law allows PRTFs to provide an acute level of inpatient psychiatric care to individuals under 21 years of age, it is irrelevant as to whether a facility is certified as psychiatric hospital or a PRTF—that is, either may provide an acute level of care to meet the needs of under 21 year old patients. The Board majority concludes that the certification of the Three Disputed Units under Oklahoma Medicaid is irrelevant to the nature of the care being provided by these Units and that these services meet the definition of acute care services that would be paid under the hospital prospective payment system.

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence presented at the hearing, the Board majority concludes that the patient days from the ACCENTS Unit, the Human Restoration Unit, and the Positive Outcomes Unit of St. Anthony meet the Medicare requirements for acute level of care to include the Medicaid days in the Medicaid fraction of the Medicare DSH payment calculation. Accordingly, the Board reverses the Medicare Contractor's adjustment and orders the Medicare Contractor to include these days in the Medicaid fraction for St. Anthony's FY 2006 DSH calculation.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Clayton J. Nix, Esq. (concurring in part, dissenting in part)
Gregory Ziegler, CPA, CPC-A

FOR THE BOARD:

/s/
L. Sue Andersen
Chairperson

DATE: December 29, 2017

[78] Tr. at 400, 418 (Mar 31, 2015).

CLAYTON J. NIX, ESQ., *concurring in part and dissenting in part*

I concur with the Board majority that Dr. Baer's testimony should be admitted but respectfully disagree with their conclusion that the Medicaid days at issue should be counted in the disproportionate share hospital ("DSH") adjustment calculation for St. Anthony Hospital ("St. Anthony" or "Provider"). More specifically, as explained more fully below, I could not conclude that the degree and intensity of on-going services in the ACCENTS Unit, the Human Restoration Unit, and the Positive Outcomes Unit (the "Three Disputed Units") rose to a level of care comparable to "acute care services generally payable under [IPPS]" as required under 42 C.F.R. § 412.106(a)(1)(ii) (2006).

A. THE ADMISSIBILITY OF DR. BAER'S TESTIMONY

I agree with the Board majority that, for purposes of the Touhy Regulations, Dr. Baer is an "employee of the Department" and would be providing "testimony" and conclude that St. Anthony does not have standing to object to the admissibility of Dr. Baer's testimony because neither the authorizing statute, the Touhy Regulations, nor the 1987 Final Rule that promulgated those regulations[1] permit a private litigant such as St. Anthony to enforce an agency's self-described "housekeeping regulation."[2]

Further, even if St. Anthony were to have standing, it is clear that the restrictions in the Touhy Regulations would not apply to Dr. Baer's testimony at the Board hearing because the Board's governing regulations at 42 C.F.R. Part 405, Subpart R, as amended in 2008,[3] only provide for application of the Touhy Regulations in certain limited circumstances not applicable to Dr. Baer's testimony. In promulgating these revisions, CMS had the authority to preclude DHHS employees from testifying through the Board's governing regulations if it intended to do so. In two subsections, CMS did invoke the restrictions in the Touhy Regulations to make them applicable in certain limited circumstances. Specifically, 42 C.F.R. § 405.1843(b)(2) states explicitly that the restrictions in the Touhy Regulations apply when "*the Board* . . . call[s] as a witness" a CMS or DHHS employee.[4] Similarly, 42 C.F.R. § 405.1853(e)(2)(iii)(B) states explicitly that the restrictions in 45 C.F.R. Part 2 apply as to whether an employee or officer of CMS or DHHS will appear for a deposition. Because the Board is independent yet still part of DHHS, it is logical for CMS to clarify as a "housekeeping matter" that the Board itself does not have the authority to call a DHHS or CMS employee as a witness or require them to appear for a deposition.[5]

Finally, when CMS promulgated the Board's regulations as amended in 2008, CMS recognized that Medicare contractors advocate on behalf of CMS interests and, in so doing, may call CMS

[1] *See* 52 Fed. Reg. 37145 (Oct. 5, 1987).
[2] *Id.* at 37145.
[3] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[4] (Emphasis added.)
[5] If CMS had intended to allow a private litigant to invoke the restrictions of 45 C.F.R. Part 2, CMS could have done so and notified the public of that right when it made the 2008 revisions. *See* 73 Fed. Reg. 30190 (May 23, 2008).

employees as witnesses[6] and, unlike its treatment of the Board, CMS did not specify or even suggest that the Touhy Regulations restricted the ability of Medicare contractors to call such witnesses. It is logical that CMS would not restrict Medicare contactors from calling such witness because it is clear that, through the definition of the term "employee of the Department" in 45 C.F.R. § 2.2, Medicare contactors are part of "the Department" and their participation as a party to a Board hearing is in furtherance of their program integrity functions relating to cost report audits as an agent of CMS.[7]

B. THE ACUITY OF CARE FURNISHED IN THE THREE DISPUTED UNITS

1. CONTRARY TO ST. ANTHONY'S CONTENTION, THE CLASSIFICATION OF A PROVIDER OR UNIT BY A STATE MEDICAID PROGRAM IS RELEVANT AND CAN BE DEFINITIVE (AS IT IS IN THIS CASE) OF WHETHER THAT PROVIDER/UNIT FURNISHES ACUTE CARE.

This appeal centers around what the term "acute care" means in the following excerpt from 42 C.F.R. § 412.106(a)(1)(ii) (2006): The Medicaid fraction includes "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 – . . . (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 . . . ." No other statute, regulation, or Medicare program guidance in effect during 2006 (the time at issue) has been identified that specifically defines the term "acute care."[8]

Accordingly, it is necessary to review the guidance CMS gave when CMS promulgated § 412.106(a)(1)(ii) in the final rule published on August 1, 2003 (the "2003 Final Rule").[9] In this guidance, CMS confirms that it revised § 412.106(a)(1)(ii), in part, as a result of its disagreement with the decision of the Ninth Circuit Court of Appeals in *Alhambra Hosp. v. Thompson* ("*Alhambra*").[10] *Alhambra* is relevant to this appeal because the facts and circumstances of St. Anthony's appeal are strikingly similar to those in *Alhambra* and, as such, CMS' discussion of *Alhambra* in the 2003 Final Rule is significant.

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[6] *See* 73 Fed. Reg. at 30216 (recognizing that "[c]urrent practice at the Board is that an intermediary will occasionally ask a CMS employees to testify at an oral hearing").

[7] The fact that the Touy Regulations define "employee of the Department" to encompass Medicare contractors further highlights the flaws in St. Anthony's interpretation because its interpretation would effectively preclude a Medicare contractor that is a party to a Board hearing from even calling its own employees as witnesses without written prior authorization from the CMS Administrator. To this end, unlike the Touhy Regulations, the Board regulations define the term "employee or officer of [DHHS] or CMS" so that it does not encompass Medicare contractors. *See* 73 Fed. Reg. at 30215-20216.

[8] The Medicare Contractor has cited to a definition of "acute care" that CMS issued by final rule in 2010. *See* Tr. at 63-64 (Mar. 30, 2015) (citing to the final rule published at 75 Fed. Reg. 44314 (Jul. 28, 2010) (copy included as Medicare Contractor Exhibit I-12)). However, this definition is not applicable to this case because CMS promulgated this definition well after the time at issue in the context of the Medicaid electronic health record incentive program.

[9] 68 Fed. Reg. 45346 (Aug. 1, 2003).

[10] 259 F.3d 1071 (9th Cir. 2001).

In *Alhambra*, the hospitals operated units that were licensed in California as skilled nursing facility ("SNF") beds but were not certified by Medicare as such. Further, the California Medicaid Program classified the units as "subacute" care units that provide less intensive care than do acute care units, but more intensive skilled nursing care than is typically provided in a SNF.[11] The Ninth Circuit "ruled that days attributable to groups of beds that are not separately certified [by the Medicare program] as distinct part beds (that is, nonacute care beds in which care provide 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."[12] In the preamble to the 2003 Final Rule, CMS disagreed with the Ninth Circuit's ruling because it was contrary to its longstanding policy and confirmed that the intent of its revisions to § 412.106(a)(1)(ii) was to ensure that this regulation clearly reflected that longstanding policy:

> *Comment:* Several commenters objected to our proposal and indicated that we were attempting to codify the Secretary's litigation position in *Alhambra* and administratively overrule the Ninth Circuit's decision in that case. . . .
>
> *Response:* We disagree that our proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. . . .
>
> We also do not believe that by placing our longstanding interpretation of our rules in regulations we are unlawfully overruling or nullifying the decision by the Ninth Circuit in *Alhambra Hospital v. Thompson*, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit decision focused on an interpretation of CMS' previous regulation at § 412.106(a)(1)(ii)—not on an interpretation of the statute. . . . Although we respectfully disagree with the Ninth Circuit's 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.[13]

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[11] *Id.* at 1073.
[12] 68 Fed. Reg. at 45417.
[13] 68 Fed. Reg. at 45418.

Further, CMS described its longstanding policy on how to determine which patient days are excluded from the DSH calculation as follows:

> [I]f 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 [by the Medicare program]* 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, [*sic* 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, what 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.[14]

Accordingly, the proper focus for determining whether a unit provides a level of care that would generally payable under IPPS is on the level and type of care provided in unit as a whole rather than a day-by-day or patient-by-patient review without regard to whether the Medicare program separately certifies the unit.[15]

Based on CMS' discussion of its policy in the preamble to the 2003 Final Rule, the classification of a provider unit by a state Medicaid program *is* relevant to determining the level of care provided in that unit because the classification by its very nature reflects the type of care furnished in that unit. In this case, each of the Three Disputed Units participated in the Oklahoma Medicaid program as hospital-based psychiatric residential treatment facilities ("PRTFs"). As explained below, this PRTF classification definitively resolves this appeal. Indeed, that was the whole issue in *Alhambra*. CMS' position was that the California Medicaid Program classification of a hospital unit as sub-acute was relevant notwithstanding the fact that the Medicare program did not specifically certify that unit as a distinct unit excluded from the Medicare program. In the 2003 Final Rule, CMS essentially ratified that position as discussed above. Accordingly, it is necessary to review the Oklahoma Medicaid classification of the Three Disputed Units as PRTFs and how this intersects with the Medicare program.

At the outset, it is important to recognize that the Medicare program neither recognizes nor certifies distinct hospital units (or facilities) as PRTFs. Rather, PRTFs are a creature of the

[14] 68 Fed. Reg. at 45417 (emphasis added).
[15] *Id.*

Medicaid program in general.[16] The parties recognize this.[17] Indeed, the Medicare Claims Processing Manual, CMS Pub. No. 100-04, § 10.5 specifies that the place of service ("POS") codes used on claims for PRTFs is POS code 56 which specifies that a PRTF is either "a facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment." Here, it is clear that the Three Disputed Units are hospital-based PRTFs that are distinct parts of St. Anthony yet not formally excluded by the Medicare program from IPPS pursuant to 42 C.F.R. § 412.25.

Significantly, the Oklahoma Medicaid Program amended the definitions of PRTF, acute care and residential treatment services in its administrative code in June 2006. It is apparent that the amended definitions reflect Oklahoma Medicaid policy over all of 2006 (*i.e.*, the time period at issue) because the *underlying* administrative code laying out the standards for furnishing psychiatric acute care versus residential treatment services did *not* change. For example, as discussed more fully below, the distinctions between the Oklahoma Medicaid administrative code definitions of "acute care" and "residential treatment services" did *not* change when the code was amended in 2006 and these definitions reflect the expected significant distinctions between the medical necessity and active treatment standards for psychiatric acute care versus residential treatment services.[18]

Under the amended definitions, the Oklahoma Medicaid Program defines a PRTF as a "non-hospital"[19] or "facility *other than* a hospital"[20] that "provide[s] *non-acute* inpatient facility care for recipients who have a behavioral health disorder and need 24-hour supervision and specialized interventions."[21] Moreover, PRTFs are defined to specifically include both freestanding PRTFs and hospital-based PRTFs such as the Three Disputed Units.[22] The use of the term "non-hospital" in the PRTF definition appears to mirror the federal Medicaid regulation at 42 C.F.R. § 483.352 (2006) which defines PRTF 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." Further, the use of the term "non-acute" care in this definition is consistent with the choice of "non-hospital." Thus, under the Oklahoma Medicaid

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[16] *See* Medicare Benefits Policy Manual, CMS Pub. No. 100-07 ("MBPM"), § 1000B (as revised May 21, 2004) (stating "[i]n general, the only types of institutions participating solely in Medicaid are NFs, Psychiatric Residential Treatment Facilities (PRTF), and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)"); 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)").

[17] *See, e.g.*, Provider's Post-Hearing Brief at 37-39.

[18] *See* Okla. Reg. Vol. 23, No. 19 (June 15, 2006) (relocating without substantively changing the medical necessity and active treatment standards for both psychiatric acute care and residential treatment services). *See also* Provider Exhibits P-6 (excerpts from administrative code effective prior to June 2006), P-7 (excerpts from the administrative code effective after June 2006).

[19] Okla. Admin. Code § 317:30-5-95(d) (emphasis added) (copy included at Provider Exhibit P-7 at 1).

[20] Okla. Admin. Code § 317:30-5-95(b)(4) (emphasis added).

[21] Okla. Admin. Code § 317:30-5-95(a).

[22] Okla. Admin. Code § 317:30-5-95(d) (defining PRTF and describing PRTFs as both hospital-based and freestanding).

regulations, a psychiatric unit enrolled in the Oklahoma Medicaid Program as a PRTF would generally provide "non-acute inpatient facility care."

Based on the *Alhambra* discussion in the preamble to the 2003 Final Rule, the Board's review could stop here based on the finding that PRTF services are not "generally payable under the prospective payment system" because the PRTFs are a distinct care unit which, although not specifically excluded from IPPS, is both excluded from Medicaid acute care services by being described as "non-hopsital" and "non-acute."[23] Notwithstanding, further review and analysis support the conclusion that the Three Disputed Units do not provide "acute care" pursuant to 42 C.F.R. § 412.106(a)(1)(ii).

2. IPPS IS GENERALLY SHORT-TERM IN CONTRAST WITH "RESIDENTIAL TREATMENT SERVICES" WHICH ARE INHERENTLY LONG-TERM.

How the Oklahoma Medicaid Program defined "acute care" versus "residential treatment services" in the context of psychiatric care is instructive. The amended administrative code defines "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."[24]

In contrast, the amended administrative code defines "residential treatment services" 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."[25] Accordingly, under the Oklahoma Medicaid definitions, one thing that differentiates "residential treatment services" from "acute care" is the fact that "residential treatment services" are "longer-term" treatment while "acute care" is "short-term" treatment.

Similarly guidance from CMS and Congress describes IPPS as being applicable to short term care. "The DRG system was developed for short-term acute care general hospitals and [did] not take into account special circumstances of diagnoses requiring long stays."[26] As a result, when Congress adopted IPPS in 1983, it specifically excluded hospitals that did not provide short-term acute care such as long-term care hospitals ("LTCHs"), psychiatric hospitals, cancer hospitals and children's hospitals from IPPS.[27] In 1983, when CMS (then known as the Health Care Financing Authority ("HCFA")) implemented IPPS, CMS recognized that "the standardized

[23] St. Anthony also confirmed that the Medicare program has not paid for any services furnished in the Three Disputed Units. *See* Tr. at 124-28 (May 28, 2015).
[24] Okla. Admin. Code § 317:30-5-95.22(b)(1) (emphasis added) (copy included at Provider Exhibit P-7 at 24).
[25] Okla. Admin. Code § 317:30-5-95.22(b)(7) (emphasis added) (copy included at Provider Exhibit P-7 at 25).
[26] H.R. Rep. No. 98-25, pt. 1. at 141 (1983) (accompanying H.R. 1900 which became Pub. L. No. 98-21, 97 Stat. 65 (1983)) (excerpt included at Medicare Contractor Exhibit I-14).
[27] *See id.*; 42 U.S.C. § 1395ww(d)(1)(B); 42 C.F.R. §§ 412.20(b), (e), 412.23; 67 Fed. Reg. 55,954, 55,957 (Aug. 30, 2002).

amounts [payable under IPPS] are based on expenditures in short-term general hospitals"[28] and that LTCHs, psychiatric hospitals, cancer hospitals and children's hospitals like were excluded because they were "organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities."[29] To this end, 42 C.F.R. § 412.1(a)(1) states that the hospitals subject to IPPS are "generally, short-term, acute-care hospitals."[30] Indeed, the Ninth Circuit in *Alhambra* recognized that IPPS generally "is not used to reimburse hospitals for long-term care."[31] Similarly, when CMS issued regulations to implement IPPS. CMS stated that "we believe that hospitals and units excluded from the prospective payment system are organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities."[32] While guidance from Congress and CMS describe IPPS as applying to short-term care, that guidance does not definitively limit IPPS to short-term care and, in particular, does not limit the application of IPPS to certain lengths of stay, it is supportive of an finding that the Three Disputed Units do not provide "services generally payable under the prospective payment system," particularly since the Oklahoma Medicaid Program uses length of stay as one means to differentiate residential care services from acute care services (*i.e.,* longer-term treatment versus short-term treatment). Indeed, consistent with the Oklahoma Medicaid characterization of residential treatment services as "longer term," the average length of stay in the Three Disputed Units was *over 4 months*.[33]

3. THE RECORD FAILS TO ESTABLISH THAT EITHER THE OVERALL ACUITY OF THE PATIENTS IN THE THREE DISPUTED UNITS OR THE OVERALL INTENSITY OF CARE FURNISHED IN EACH OF THE THREE DISPUTED UNITS IS CONSISTENT WITH AN ACUTE LEVEL OF CARE.

a. Classification as an "inpatient" does not necessarily reflect the level of care furnished.

A hospital "inpatient" is not synonymous with "acute care" as highlighted by the fact that the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2201.1 defines "inpatient" as a person who has been admitted to a hospital or skilled nursing facility for bed occupancy to receive inpatient hospital or skilled nursing services." A patient who is an

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[28] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[29] *Id*. at 39760. *See also* 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (restating the 1983 discussion) (excerpt included at Medicare Contractor Exhibit I-16); 67 Fed. Reg. 55954, 55957 (Aug. 30, 2002) (explaining that Congress had excluded these hospitals from IPPS because they "typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system").
[30] *See* 48 Fed. Reg. at 39817 (originally located at 42 C.F.R. § 405.470(a)(1)).
[31] 259 F.3d 1071, 1071 (9th Cir. 2001).
[32] 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (IPPS final rule that finalized the IPPS interim final rules published on Sept. 1, 1983). *See also id*. at 237 (stating "[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").
[33] *See* Medicare Contractor Exhibit I-19 (showing that, for FY 2006, the average length of stay was 162 days for the ACCENTS Unit, 128 days for the Human Restoration Unit, and 156 days for the Positive Outcomes Unit).

"inpatient" in a hospital does not necessarily receive "acute care" as the very facts of *Alhambra* itself confirm.

b. The fact that a patient has an "acute diagnosis" does not mean that the patient requires acute care.

Much of the testimony at the hearing focused on the diagnosis of the patient. However, Dr. Baer's testimony[34] as well as testimony from St. Anthony's medical director for the ACCENTS and Human Restorations Units[35] confirms that the diagnosis itself is not dispositive of the level of care furnished. For example, a patient who has pneumonia may be very ill, need an acute level of care and, thus, need to be admitted as a hospital inpatient under the primary diagnosis of pneumonia. However, not all patients who are diagnosed with pneumonia need an acute level of care provided by a hospital. Similarly, a patient may be very ill as reflected by an "acute" diagnosis or episode of illness; however, an "acute" diagnosis or episode of illness is not synonymous with "acute care" as highlighted by the fact that a patient could have an "acute" ingrown toe nail and the care needed would not rise to the level of acute care.

Further, the fact that the diagnosis for a patient being admitted to a PRTF upon transfer from a psychiatric care unit is the same diagnosis that the patient had while he/she was in a psychiatric acute care unit does not mean the patient *continues* to need acute care in the PRFT as highlighted by the fact that the Oklahoma Medicaid medical necessity criteria for psychiatric acute care facilities and PRTFs have the *same* universe of qualifying diagnoses yet provide treatment at different levels, as explained more fully below.[36] Thus, the discharge diagnosis used to assign a DRG for an inpatient acute care stay does not necessarily reflect the level of care that a subsequent facility gives upon transfer of that patient even when the discharge diagnoses at transfer are the same as those for admission to the receiving facility.

c. The evidence in the record does not establish that the intensity of care in the Three Disputed Units rose to an acute care level.

At the outset, it is important to note that much of the evidence on the intensity of care in the Three Disputed Units centers on, is based on, or derived from the 17-patient sample used for the Trailblazer Report at Medicare Contractor Exhibit I-19. However, it is unclear how much weight should be given to this sample because:

1. The record contains no evidence that definitively confirms that the 17-patient sample is a representative sample of the patients for FY 2006 in the Three Disputed Units which represent 90 beds in the aggregate.[37] The sample very well could be a probe

[34] *See* Tr. at 144-147 (May 27, 2015).
[35] *See, e.g.*, Tr. at 312. 413-412 (Mar. 30, 2015).
[36] Compare OAC § 317:30-5-95.25(1) (medical necessity criteria for psychiatric acute care) *with* OAC § 317:30-5-95.29(1) (medical necessity criteria for PRTF care).
[37] *See, e.g.*, Tr. at 487-492.

sample (as opposed to a statistically-valid representative sample) as highlighted by the small size of the sample and the fact that only certain portions of 17 patient records were reviewed.[38] Indeed, St. Anthony itself has questioned the representativeness of the sample because the Medicare Contractor's review did not use the complete medical record for each of the patients included in the sample.[39]

2. In the preamble to the 2003 Final Rule, CMS confirmed that the proper focus for determining whether a unit provides a level of care that would generally payable under IPPS is on the level and type of care provided in unit as a whole rather than a day-by-day or patient-by-patient review.[40]

3. It is unclear the extent to which the Medicare Contractor relied on the Trailblazer Report in making its determination for the Three Disputed Units. In this regard, it should be noted that the Medicare Contractor had already concluded in 2007 prior to the Trailblazer Report that the Three Disputed Units furnished "non-acute care."[41]

Next, in analyzing intensity of services, it is important to first review the Oklahoma Medicaid standards for providing acute psychiatric care versus residential treatment services in a PRTF. Consistent with the definition of "residential treatment services," the Oklahoma Health Care Authority ("OHCA") recognizes that the level of care is *less* in a facility such as a PRTF that is *not* providing acute care to adolescent or child Medicaid patients. The following chart summarizes Oklahoma Medicaid's *minimum* requirements for active treatment in an acute care setting versus a PRTF:[42]

TYPE OF SERVICE PER WEEK	ACUTE CARE	PRTF	DIFFERENCE
Physician Visit	3 times	1 times	2 times
Individual Therapy	2 hours	1 hour	1 hour
Family Therapy	1 hour	1 hour	0 hours
Process Group Therapy	3 hours	2 hours	1 hour
Expressive Group Therapy	4 hours	3 hours	1 hour
Rehabilitative Treatment	2 hours group or 1 hour individual	2 hours group or 1 hour individual	0 hours

With knowledge of the differences in the Oklahoma Medicaid requirements for acute care versus residential treatment in a PRTF, St. Anthony opted to obtain a license for "residential child care"

[38] *See* Medicare Contractor Exhibit I-10. The 17-patient sample consists of 3 patients from the ACCENTS Unit, 7 patients from the Human Restorations Unit, and 5 patients from the Positive Outcomes Unit; however, only portions of the medical record were reviewed for these 17 patients. *See id.*
[39] *See, e.g.*, Tr. at 29-3 (Mar. 30, 2015). Similarly, the Provider's experts reviewed only the sample or a subset of this sample. *See* Provider's Post Hearing Brief at 9 (confirming Dr. Kaminski reviewed the records for all of the 17-patient sample while Dr. DiVincenzo only reviewed 13).
[40] *See* 68 Fed. Reg. at 45417.
[41] *See* Provider Exhibit P-33 at 474.
[42] Okla. Admin Code § 317:30-5-95.34(c).

and to enroll the Three Disputed Units as PRTFs in the Oklahoma Medicaid Program rather than as psychiatric acute care units.[43] Accordingly, the Oklahoma Medicaid Program paid the Three Disputed Units on a *per diem* basis rather than on a prospectively-set lump sum basis. The difference between these payment methodologies is significant because the lump sum payment methodology typically results in payment of a few thousand dollars per patient[44] while the per diem payment methodology may result in payment in the tens of thousands dollars per patient due to the fact that patient stays in the Three Disputed Units can be lengthy (*e.g.*, the average patient stay for FY 2006 was close to $70,000 in Human Restoration Unit and $90,000 in Positive Outcomes Unit average).[45]

Further, St. Anthony's own characterization of the Three Disputed Units as residential treatment facilities under the Oklahoma State Medicaid regulations rather than as acute care units casts doubt on claims that these units generally provide acute care payable under IPPS. Consistent with the PRTF classification, St. Anthony drafted its scopes of care for the Three Disputed Units tracking the Oklahoma regulatory standards governing PRTF admissions and treatment rather than higher regulatory standards governing acute care admissions and treatment.[46] In particular, consistent with these regulatory standards, the Scopes of Care for the ACCENTS and Human Restoration Units do not mention "acute care" other than to explicitly state in the admission criteria that the referral "[d]oes *not* require an acute care setting."[47]

St. Anthony suggests that it made the representation in the Scopes of Care that Three Disputed Units did not provide acute care to the patient population and their parents in order to provide

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[43] *See* Provider Exhibit P-62 (copies of St. Anthony's Oklahoma licensure for "residential child care"); Tr. at 156 (May 28, 2015).

[44] Tr. at 128-129 (May 28, 2015).

[45] *See* Provider Exhibit P-3 at 158; Medicare Contractor Exhibit I-19 at 1.

[46] *Compare* Okla. Admin. Code § 317: 30-5-95.29 (required admission criteria for PRTF which includes that the child "[d]emonstrates escalating pattern of self injurious or assaultive behaviors" and "[r]equires 24-hour observation and treatment") *with* Okla. Admin. Code § 317: 30-5-95.25 (required admissions criteria for acute psychiatric unit which includes that "[w]ithin the past 48 hours, the [child's] behaviors present an imminent life threatening emergency" and the child "requires 24-hour nursing/medical supervision"). *See also* Provider Exhibit P-9 at 3 (consistent with Okla. Admin. Code § 317:30-5-95.28, the admission criteria in the scope of care for the ACCENTS Unit includes that the referral "is at risk of self-injurious/assaultive behaviors" and "[r]equires 24 hour observation and treatment"); Provider Exhibit P-11 at 4 (consistent with Okla. Admin. Code § 317:30-5-95.28, the admission criteria in the scope of care for the Human Restoration Unit includes that the referral "[d]emonstrates escalating pattern of self-injurious or assaultive behaviors" and "[r]equires 24 hour observation and treatment"); Provider Exhibit P-13 (consistent with Okla. Admin. Code § 317:30-5-95.28, the admission criteria in the scope of care for the Positive Outcomes Unit includes that the referral has "[d]ocumented occurrences of inappropriate sexual behavior(s) that are considered illegal and/or dangerous to self or others and presents an imminent danger of physical harm to others and the community" and that "less restrictive alternative levels of care have been ruled out as inappropriate based on the resident's needs for a structured, supervised Inpatient program).

[47] Provider Exhibit P-9 at 3 (emphasis added) (stating in the admissions criteria for the ACCENTS Unit that the referral "[d]oes not require an acute care setting or crisis stabilization, but is not stable enough to be discharged home"); Provider Exhibit P-11 (emphasis added) (stating in the admissions criteria for the Human Restoration Unit that the referral "[d]oes not require an acute care setting, but cannot be maintained in a less restrictive setting for treatment of medical or psychiatric symptoms").

them with information as to how these services would be reimbursed.[48] However, this explanation does not pass the smell test because the scope of care does not provide any actual details on how the services would be reimbursed (much less by whom as there are multiple potential payors) but rather focuses on the circumstances warranting an admission and a description of the care.[49] Accordingly, it makes more sense that the scope of care was intended to describe the level of care being provided because: (1) the scopes of care mirror the Oklahoma Medicaid Program's "medical necessity criteria for admission" to a PRTF;[50] and (2) the Oklahoma Medicaid program requires PRTFs to obtain prior authorization before admitting Medicaid patients in order to determine "if the recipient meets the medical necessity criteria."[51]

Finally, the Oklahoma Medicaid Program subjects PRTFs to "active treatment" requirements that are less intensive than those for psychiatric acute care units. St. Anthony introduced hours of testimony in an effort to establish how severe the conditions of the patients in the Three Disputed Units may be, how heavily staffed the units were, and how thorough the care was.[52] Although the evidence suggests that the Three Disputed Units may at times have provided more therapy at times than the Oklahoma Medicaid regulations required, acute care requires more individual, group and expressive group therapy than residential treatment and there is insufficient evidence to determine the degree and frequency at which St. Anthony provided more therapy care during these lengthy stays than was required under the Oklahoma Medicaid regulations governing PRTFs. For example, while acute care requires three physician visits per week, residential treatment requires just one visit per week. Similarly, acute care requires 24-hour medical/nursing *supervision*, but residential treatment only requires 24-hour *observation*.[53] Even if one were conclude (as St. Anthony has argued) that the Oklahoma Medicaid standard for "acute care" was met at all times during the inpatient stays of the patients that were sampled from the Three Disputed Units, there would be insufficient evidence to make a finding that the care provided in the Three Disputed Units was of a level payable under IPPS because, as previously noted, it is unclear whether the sample was representative of the care furnished in the Three Disputed Units.

Similar to the Oklahoma Medicaid "active treatment" requirements, Medicare guidance confirms that psychiatric acute care is only for those patients whose admission is required for "active treatment" of an intensity that can be provided appropriately *only* in the inpatient hospital setting. "Active treatment" not only includes the physician services but also therapy services, medication, and physician meetings with the treatment team members.[54] There is insufficient evidence presented to conclude that the Three Excluded Units typically provided services of a degree and intensity comparable to acute care level. It is true that the treatment provided in the

[48] *See* Provider's Responsive Brief at 7.
[49] Medicaid is not the only payor and any details on the Medicaid reimbursement methodology when Medicaid is primary likely would not matter to either the parents or the referral sources. *See, e.g.*, Tr. at 106 (Mar. 31, 2015).
[50] Okla. Admin. Code § 317:30-5-95.29.
[51] Okla. Admin. Code § 317:30-5-95.31(a).
[52] *See generally* Tr. at 84-272 (Mar. 30, 2015); Tr. at 4-83 (Mar. 31, 2015).
[53] Tr. 140-142 (Mar. 30, 2015); Provider Exhibits P-26-A, P-26-B, P-26-C.
[54] MBPM, Ch. 2, § 30.2.3.

Three Disputed Units may potentially meet one element of the Medicare requirements for active treatment for acute psychiatric care, namely that the physician have "regularly scheduled patient interview, at least once per week."[55] However, it is not clear that the psychiatric care being provided in the Three Disputed Units was typically of a degree and intensity consistent with psychiatric acute care because physician care is just one component of that care as highlighted by the above chart.[56]

Moreover, Dr. Baer's testimony calls into question the sufficiency of the once-per-week physician visit. Specifically, he opined that the weekly physician visits in the Three Disputed Units allowed for only "minimal" physician interaction with the patients as the weekly physician visit was on average only 10 minutes.[57] Further, consistent with the Oklahoma Medicaid requirements, Dr. Baer presented testimony that the "active treatment" standard used by the Medicare program and other third party payers was at least 3 physician visits per week but as high as 5 physician visits per week and that a visit by a physician extender (*e.g.*, nurse practitioner) does not count as a physician visit.[58] Indeed, consistent with this standard of care and in contrast with the Three Disputed Units, St. Anthony's two psychiatric acute care units do furnish physician visits 5 times per week.[59]

Other indicators that the Three Disputed Units did not typically furnish acute care include:

1. *Transfers from acute psychiatric facilities*.—Each of the Three Disputed Units receive many of its patients for admission directly from psychiatric acute care units (including but not limited to transfers from St. Anthony's two psychiatric acute care units).[60] The Oklahoma Medicaid criteria governing the medical necessity of acute care specify that "*[w]ithin the past 48 hours*, the behaviors of the patient present an imminent life threatening emergency."[61] In contrast, the medical necessity criteria governing the medical necessity of PRTF care specifies that "the patient demonstrates escalating pattern of self injurious or assaultive behaviors."[62] It is unclear based on the Oklahoma Medicaid medical necessity criteria and the conflicting testimony of the parties witnesses presented whether patients being transferred from a psychiatric acute care unit to a PRTF *typically* continue to meet the "within the past 48 hours" criteria for acute care, particularly since

[55] MBPM, Ch. 2, § 30.2.3 (copy included at Medicare Contractor Exhibit I-22).
[56] *See* Tr. at 427 (testimony of Dr. Baer that active treatment is not setting specific because active treatment can be at any level of care including in inpatient, residential treatment, and outpatient settings).
[57] Tr. at 407 (Mar. 31, 2015). *See also id.* at 412 (testifying that "[y]ou can't see somebody once a week if you're going to have that intensive inpatient acute treatment and figure out what's going on with the patient").
[58] *See* Tr. at 414-15; 478-79; 497 (Mar. 31, 2015). Further, Dr. Baer explains that, in order for a physician visit to be counted, it must be documented in the patient record because "[i]t's a communication thing. So if a physician has an interaction with a patient, and it's either therapeutically, psychotherapeutically meaningful or having to do with, you know, medicine or precautions or whatever it might be, you've got to document that so [*sic* as] that's the methodology by why [sic which] he informs the staff." *Id.* at 416-17.
[59] *See* Tr. at 412 (Mar. 31, 2015)
[60] *See* Tr. at 88-89 (Mar. 31, 2015)
[61] Okla. Admin. Code § 317:30-5-95.25(5) (emphasis added).
[62] Okla. Admin. Code § 317:30-5-95.29(5).

each patient *must* receive prior authorization from the Oklahoma Medicaid program regarding the appropriateness of the admission.[63]

2. *Wait Lists*.—St. Anthony's medical director for the Positive Outcomes Unit confirmed that they have waiting periods for admission that was one to two weeks.[64] It is unclear how wait listing a patient is consistent with the need for acute care. St. Anthony argues that wait listed patients are not left untreated as evidenced by the fact that patient may as an interim measure be admitted to and transferred from acute care units.[65] However, the Oklahoma Medicaid criteria governing the medical necessity of acute care specify that "*[w]ithin the past 48 hours*, the behaviors of the patient present an imminent life threatening emergency."[66] As a result, it is unclear at the time of admission to the Positive Outcomes Unit whether patients that had been wait listed for one to two weeks would still be in an emergent situation, particularly if the patient had received treatment from a psychiatric acute care unit during the wait period.

3. *Passes to Leave the Facility*.—As part of the treatment regime, the Three Disputed Units may allow a patient passes and these passes may range from 2 hours to overnight.[67] It is unclear how the issuance of these passes to leave the facility without facility supervision is consistent an acute level of care. The St. Anthony medical director for the ACCENTS and Human Restorations Units explained that the "acute episode" may wax and wane and that such passes would be provided only during waning periods.[68] However, even assuming that testimony is correct, we know that an "acute episode" does not always correlate with a need for an acute level of care. Moreover, it is unclear, however, how the issuance of these passes to leave the facility without facility supervision is consistent an acute level of care. Visits to the community without staff present clearly suggest that no acute care is being provided, or necessary, during this period.

4. *Pre- and re-authorizations from the Oklahoma Medicaid Program for the Medicaid days at issue as residential treatment services*.—Under the Oklahoma Medicaid pre-authorization and extension process, it "will approve lengths of stay using the current . . . medical necessity criteria and following the current inpatient provider manual approved by [Oklahoma Medicaid]."[69] Thus, it is clear that this process is designed to determine the appropriate level of care prior to admission and at certain intervals

[63] *See* Okla. Admin. Code §§ 317:30-5-95.31(a) (stating that "[a] prior authorization will be issued . . . if the recipient meets medical necessity criteria").
[64] Tr. at 87 (Mar. 31, 2015).
[65] *See* Provider's Post-Hearing Brief at 30.
[66] Okla. Admin. Code § 317:30-5-95.25(5) (emphasis added). *See also* Tr. at 451 (Mar. 31, 2015) (testimony from Dr. Baer testifying that wait lists are incongruous with a need for acute care because that patients come into an acute care unit with an emergent crisis).
[67] Tr. at 240-243 (Mar. 30, 2015); Tr. at 67, 74-77 (Mar. 31, 2015).
[68] Tr. at 281-282 (Mar. 30, 2015). Similarly, the medical director for the Positives Outcomes Unit testified that they would not give a pass for a patient if there were a danger to the community. *See* Tr. at 99 (Mar. 31, 2015).
[69] Okla. Admin. Code § 317:30-5-95.24(3). *See also* Okla Amin. Code § 317:30-5-95.31.

following admission when re-authorization is required. During the hearing, St. Anthony confirmed that all of the days at issue received pre-authorization from the Oklahoma Medicaid Program and were claimed, adjudicated and paid on a *per diem* basis as PRTF services.[70] Thus, for each of the patient stays underlying the days at issue, the Oklahoma Medicaid Program necessarily applied its medical necessity criteria for both psychiatric acute care and residential treatment services and determined that the criteria applicable to those stays was that for residential treatment services.

In summary, all of the evidence demonstrates that St. Anthony deliberately set up its psychiatric care units in a way that enabled it to provide short-term acute care to adolescents and children in units that were designated as acute care units. In contrast, St. Anthony set up the Three Disputed Units to provide primarily longer-term less-intensive residential treatment. There is nothing improper about St. Anthony's decision to provide residential treatment services rather than acute care services in the Three Disputed Units. But St. Anthony cannot claim the benefits of a designation as a distinct PRTF unit - less intensive requirements and different payment provisions than those applying to acute psychiatric care facilities - while simultaneously receiving additional Medicare DSH payments that are calculated based on the number of acute care days provided.

/s/
Clayton J. Nix, Esq.
Board Member

Dated: Sept. 25, 2017

[70] *See* Tr. at 164-166 (May 28, 2015). *See also id*. at 155-56.