# CENTERS FOR MEDICARE AND MEDICAID SERVICES

*Order of the Administrator*

**In the case of:**

**St. Anthony Hospital**

**Provider**

**vs.**

**Medicare Administrative Contractor - Novitas Solutions, Inc.**

**Claim for:**
**Cost Reporting Periods Ending**

**December 31, 2006**

**Review of:**
**PRRB Dec. No. 2018-D12**

**Dated: December 29, 2017**

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This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Medicare Administrative Contractors' (MAC) and the CMS' Centers for Medicare (CM) submitted comments, requesting that the Board's majority decision be reversed. The Provider submitted comments, requesting that the Administrator decline review and allow the Board's majority decision to stand. The parties were notified of the Administrator's intention to review the Board's majority decision.[1] Subsequent comments were received from the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

## BACKGROUND

The Provider operates a 685-bed hospital in Oklahoma. Within the hospital, the Provider operates six 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. Two of these units – a children's psychiatric unit and an adolescent acute psychiatric unit are certified as psychiatric acute care units by the Oklahoma Medicaid program and the MAC agreed to include the patient

[1] The Governor of the State of Oklahoma and the United States Congressional delegation for the State of Oklahoma and other members of the community submitted letters in support of the Provider's position.

days from these two units in the Medicare Disproportionate Share Hospital (DSH) payment calculation.

The remaining four units participate in the Oklahoma Medicaid Program as hospital-based Psychiatric Residential Treatment Facilities (PRTFs). The MAC determined that the Children's RTC unit, met the standard for providing acute care, thus, the MAC included inpatient days from this unit in the Medicare DSH calculation. The MAC disallowed patient days in the three remaining Disputed Units, the ACCENT's RTC, the Human Restoration RTC and the Positive Outcomes RTC, based on its determination that the care provided in those Units did not meet the criteria for acute care. The Provider appealed. The Provider has categorized the services provided by the three hospital-based PRTFs, (collectively referred to as the "Three Disputed Units or Units) as "acute care" that should be included in the Medicare disproportionate share (DSH) calculation.

## ISSUE AND BOARD'S DECISION

The issue is 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. The Board majority held that the Provider's patient days from the Three Disputed Units in question met 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. In reaching this determination the Board majority focused on the level and type of care provided in the Three Disputed Units as a whole not on whether the individual patients' condition was acute and concluded that the Provider had marshalled sufficient evidence to demonstrate that the type and level of care provided in the Three Disputed Units was consistent with what is typically furnished to acute care patients. In addition, the Board majority concluded that the designation of the Three Disputed Units as PRTFs under Oklahoma law was irrelevant for a final determination in this case. The Board majority concluded that Federal Medicaid law allows States to pay for acute inpatient psychiatric services for adolescents/children either in a psychiatric hospital or in a residential treatment facility. As such, the Board majority reversed the MAC's adjustment and ordered the MAC to include the days of the Three Disputed Units in the Medicaid fraction for the Provider's fiscal year 2006.[2]

One member of the Board dissented from the Board majority determination. The Dissenter made three major points. Contrary to the Provider'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 the provider furnishes acute care. This dissenter found that the appeal centers around what the term "acute care" means Accordingly, the proper focus for

[2] Medicare DSH payments are based, in part, on the number of Medicaid inpatients treated by the hospital.

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.

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. Among other things, based on CMS' discussion of it policy in the preamble to the 2003 Final Rule, the dissenting Board member concluded that the classification of a provider unit by a state Medicaid program is relevant to determining the level of care furnished in that unit.[3] In this case, each of the Three Disputed Units participated in the Oklahoma Medicaid program as hospital-based PRTFs. The PRTF classification definitively resolves this appeal

The dissenting Board member noted that, each of the Three Disputed Units participated in the Oklahoma Medicaid program as hospital-based PRTFs and that the Oklahoma Medicaid Program defines a PRTF as a "non-hospital"[4] or "facility other than a hospital"[5] that "provides[s] non-acute inpatient facility care for recipients who have a behavioral health disorder and need 24-hour supervision and specialized intervention."[6] In addition, PRTFs are defined to specifically include both freestanding PRTFs and hospital-based PRTFs such as the Three Disputed Units.[7] Finally, 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 PTF as "a facility other than a hospital, that provides psychiatric services, as described in subpar 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 the definition is consistent with the choice of "non-hospital."

Thus, the Dissenter noted that, under the Oklahoma Medicaid 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 dissenting Board member stated that the Board majority's review should have stopped based on the finding that PRTF services are not "generally payable under the IPPS

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[3] For guidance, the dissenting Board member also reviewed the guidance CMS gave when CMS promulgated § 412.106(a)(1)(ii) in the final rule published on August 1, 2003, 68 Fed. Reg. 45346 (Aug. 1, 2003). In this guidance, CMS confirmed 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, 259 F.3d 1071 (9th Cir. 2001).

[4] Okla. Admin. Code § 317:30-5-95(d).

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

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

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

because the PRTFs are a distinct unit which, although not specifically excluded from IPPS, is both excluded from Medicaid acute care services by being described as "non-hospital" and non-acute."

The dissenting Board member also found that IPPS hospitals provide short term and acute care. IPPS is generally short-term in contrast to "residential treatment services" which are inherently long term. The record also failed to establish that the overall acuity of the patients in the three units is consistent with an acute level of care. Classification as an "inpatient" does not necessarily reflect the level of care furnished. The fact that a patient has an "acute diagnosis" does not mean that the patient requires acute care. Finally, the evidence in the record does not establish that the intensity of care in the Three Disputed Units rose to an acute care level and several factors directly mitigate against such a conclusion.

## SUMMARY OF COMMENTS

The CM contended that the MAC properly denied the days associated with the Provider's Three Disputed Units from being included in the Medicaid fraction of the Medicare DSH payment calculation and confirmed, point by point, the correctness of the dissenter's opinion. The Provider did not meet its burden of proof in showing that the degree and intensity of services in the disputed units rose to a level of care comparable to acute services generally payable under the IPPS within the meaning of 42 C.F.R. §412.106(a)(1)(ii). CM recommended that the Board majority's decision be reversed. In sum, CM stated that the patient days for the Three Disputed Units should not be included in the Medicare DSH computation as the Units are not acute care units.

The Provider contended that the Medicare program covers inpatient psychiatric care (regardless of length of stay) and that the intensity of services furnished in these Units squarely fit within the DRGs, payable under IPPS. While Medicare reimbursement rules require these patients to be treated in units that provide acute care services of the type that are reimbursable under the IPPS, Medicare does not require that every patient receive acute care services, only that the unit provide those services generally. Here, each of the Three Units in question was dully licensed, as required by the State of Oklahoma, meaning that all of the beds were licensed as acute care hospital beds and as residential child care facilities, as the Medicaid statue allows. While the State of Oklahoma Medicaid Program designated these Units as hospital-based PRTFs, the Provider claims that this designation is irrelevant as it is only necessary for payment purposes by the State of Oklahoma Medicaid Program. Finally, the Provider noted that the classification hospital-based PRTFs will soon be reclassified to "Acute 2" units by the Oklahoma Medicaid Program.

The MAC also confirmed that the Dissenter made the correct factual and legal conclusions and contended, inter alia, that the care provided in these Units do 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."[8]

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's majority decision. All comments received timely are included in the record and have been considered

a. Payment Under Medicare

Section 1811 provides for an insurance program (Part A) that, inter alia, provides basic protection against the costs of hospital care. Among the benefits provide under section 1812 is inpatient hospital services. Hospitals with a provider agreement under section 1866 of the Act, are a type of provider which is eligible for payment for services furnished to a Medicare beneficiary under section 1814. The Social Security Act at section 1861 defines a hospital as:

> (e) The term "hospital" ... means an institution which—
> (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
> (2) maintains clinical records on all patients;
> (3) has bylaws in effect with respect to its staff of physicians;
> (4) has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;
> (5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
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> 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)).

[8] 75 Fed. Reg. 1843, 1930 (Jan. 13, 201) (Exhibit I-12).

Pursuant to section 1861(b) the term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital:

> (1) bed and board;
> (2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and
> (3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements.[9]

b. Inpatient Prospective System and the Disproportionate Share Hospital Payment

Pursuant to the Social Security Amendments of 1983,[10] Congress established the inpatient prospective payment system (IPPS) for inpatient operating costs (PPS) as reflected in section 1886(d) of the Social Security Act. Section 1886(d)(1)(A) states that a subsection (d) hospital is defined in subparagraph (B):

> As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—
> (i) a psychiatric hospital (as defined in section 1861(f)),
> (ii) a rehabilitation hospital (as defined by the Secretary),
> (iii) a hospital whose inpatients are predominantly individuals under 18 years of age,
> (iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days,
> (v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31,

[9] Further, section 1862(a)(1) of the Social Security Act states that: "No payment maybe made under Part A…for any expenses incurred for items or services—(1)(A) which,… are not reasonable and necessary for the diagnoses or treatment of illness or injury or to improve the functioning of a malformed body member…".Surgical procedures diagnostic tests and other treatments are generally appropriate for inpatient hospital payment under Medicare Part A where the physician determines a stay is required and admits the patient on that basis.

[10] Social Security Amendments of 1983, §601, Pub. L. No. 98-21, 97 Stat. 65, 149-163 (1983).

> 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,
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> (vi) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997;
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> and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

Thus, the type of hospital subject to IPPS, as further confirmed in 42 CFR 412.1, is the generally short-term, acute care hospital. The inpatient hospital data also forms the underlying data for the IPPS prospective and DRG payment methodology. Excluded from IPPS payment and the underlying data used to make payment under IPPS are psychiatric hospitals, long term care hospitals, cancer hospitals and children hospitals and units.

The IPPS contains a number of provisions that adjust payments based on hospital-specific factors. The "disproportionate share hospital" or DSH adjustment requires CMS to provide increased PPS payments to hospitals that serve a "significantly disproportionate number of low-income patients." Section 1886(d)(5)(F)(i) requires:

> The Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—
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> (I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)),

Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends in part, on the hospital's "disproportionate patient percentage (DPP). Two separate fractions are added together to produce the DPP: the Medicare fraction and the Medicaid fraction. The basic unit of measurement in both fractions is a hospital's inpatient days. Relevant to this case is the Medicaid fraction which is defined at §1886(d)(5)(F)(vi)(II) of the Act as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A

> of this title, and the denominator of which is the total number of the hospital's patient days for such period.

In implementing the provision in regulation, the Secretary explained:

> [W]e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of subsection (d) hospital, which is the only type of hospital subject to the prospective payment system. Section 1886(d) (1) (B) of the Act defines a subsection (d) hospital as a "hospital located in one of the fifty States or the District of Columbia *** and does not include a psychiatric or rehabilitation unit of a hospital which is a distinct part of the hospital." In providing for the disproportionate share adjustment, section 1886(d) (5) (F) of the Act specifically refers to a subsection (d) hospital. Thus, section 1886(d) (5) (F) (i) of the Act refers only to "an additional payment amount for each subsection (d) hospital ***." Other references in section 1886(d) (5) (F) of the Act are to "hospital" and "such hospital" However, since 1886(d) (5) (F) of the Act incorporates the definition of "hospital" by reference to "subsection (d)," all further references in that subparagraph, unless stated otherwise, are taken to mean a subsection (d) hospital….
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> Moreover, this reading of section 1886(d) (5) (f) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals, or from hospital units subject to prospective payment system are used in determining both the qualifications for and the amount of additional payment to hospitals that are eligible for a disproportionate share adjustment.[11]

CMS implemented the DSH adjustment statute pursuant to the regulation at 42 C.F.R. §412.106. As a result of litigation, in the 2003 Proposed Rule, which amended 42 C.F.R. §412.106(a)(1)(ii), the Secretary described CMS' longstanding policy on how to determine which patient days are to be included in the DSH calculation. Section 412.106(a)(1)(ii)(2006) of the regulation defines the inpatient days that are to be included in the Medicaid fraction and states[12] that:

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[11] 53 Fed. Reg. 38476, 38480 (Sept. 30, 1988); *see also* 53 Fed. Reg. 9337 (March 22, 1988).

> 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….[13]

The Secretary explained:

> [I]f 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 [acute care PPS], the patient days, beds, and costs of that unit or ward would be classified as inpatient acute care."[14]

The Secretary further stated that:

> 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, non-acute care), we proposed that the bed and patient days attributable to a non-acute 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).[15]

Thus, consistent with longstanding policy, the Secretary revised the DSH regulations at 42 C.F.R. §412.106(a)(1)(ii) "to clarify that the number of patient days includes only those attributable to patients that received care in units or wards that generally furnish a level of care that would generally be payable under the IPPS."[16]

In response to comments received, concerning the clarification and revision to 42 C.F.R. §412.106(a)(1)(ii), the Secretary in the Final Rule, explained that:

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[13] The calculation at 42 CFR §412.106(a)(1)(ii) 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 or skilled nursing swing-bed services;(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); 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."

[14] 68 Fed. Reg. 27154, 27204 (May 19, 2003). *See also,* 68 Fed. Reg. at 45417 (Aug. 1, 2003).

[15] Id at 2705. See also, 68 Fed. Reg. at 45417 (Aug. 1, 2003).

[16] Id.

Response: We disagree that out proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. In addition, we believe that interpreting the statue as we have historically done is reasonable and permissible. Section 1886(d)(5)(F)(vi)(II) of the Act governs the portion of the disproportionate share percentage made up of the percentage of patient days used by patients eligible for medical assistance under title XIX State plan. Specifically, section 1886(d)(5)(F)(vi)(II) of the Act states that the numerator of such fractions equals the "number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title." The statute does not define the term "hospital's patient days." Thus, the statute is ambiguous and the Secretary has the authority to reasonably interpret that term.

We note that although the calculation performed under section 1886(d)(F)(vi)(II) of the Act includes a count of patient days used by Medicaid-eligible individuals, the calculation actually is used to determine how much additional payment the hospital should receive under the Medicare for the higher Medicare costs associated with treating a disproportionate share of low-income individuals. This point is demonstrated in the rationale for establishing the DSH adjustment as described in the Committee Report accompanying Pub. L. 99-272: "Hospitals that serve a disproportionate share of low-income patients have higher Medicare costs per case" (H. Rept. No. 99-242(I), 99$^{th}$ Cong., 2d Sess., (1985), p. 16).

Furthermore, we view section 1886(d)(5)(F)(vi)(II) as purely a Medicare, inpatient hospital provision, given that there already exists a distinct formula for computing DSH payments under title XIX-the Medicaid title. Because the DSH formula in title XVIII of the Act is intended to provide an add-on payment to inpatient hospitals for additional amounts, they incur in treating low-income, Medicare patients, we believe it is reasonable to count only those days spent in wards or units that would generally provide an acute level of care.

We believe it is reasonable to interpret that phrase "hospital's patient days," to mean only the hospital's inpatient days at a level of care that would be covered under the IPPS payment adjustment. 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. Therefore, we proposed to use, as a proxy, the level of care that is generally provided in particular units or wards, and to

> exclude patient days attributable to units or wards in which care delivered is not generally of a type that would be covered under the IPPS.[17]

CMS finalized these revisions in the 2003 Final Rule[18] and stated "a patient-by-patient, day-by-day review of whether the care received would be paid under the [acute care PPS] would be unduly burdensome."[19] Rather, the proper focus was the level and type of care provided in units as a whole.[20] Finally, the Secretary noted that care provided in units that were paid outside the acute care IPPS would be excluded even though some of the care provided might be of a type that would be payable under the acute care PPS if the care was provided in an acute care IPPS unit.[21] In sum, the final rule clarified 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 a 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. That is, the focus is also whether the level of care generally being provided is inpatient subsection (d) (IPPS) acute hospital care.

c. Analysis of Board Majority Decision

In this case, the Provider has categorized the services provided by the Three PRTFs Disputed Units as "acute care" that would be payable under IPPS. In examining this issue, consistent with the language of the regulation cited above, the Board majority determined that it would 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.

There is agreement that the proper focus is to determine whether a unit provides a level of care that would generally payable under IPPS and that the focus should be 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. However, as further discussed below, the Administrator finds that a remand is proper in order for the Board to determine if the units provided the level of care generally payable under IPPS. The Administrator finds that the Board applied the incorrect standard when comparing the generally level of care provided in the units to the level of care provided in non-IPPS hospitals.

1. The Board majority rejected a point made by the Contractor that the average length of stay for the PRTFs was not consistent with "acute care" services provided in an IPPS hospital and that acute care services meant that the acute care must be of short but intense duration. The Board disagreed with that argument and found that:

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[17] 68 Fed. Reg. at 45418, (Aug.1, 2003).
[18] 68 Fed. Reg. at 45417 (Aug. 1, 2003).
[19] *Id.*
[20] *Id.*
[21] *Id.*

> The Medicare Contractor argues that acute care must be, by definition, "short term," 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. The Board majority has not identified any applicable statute, regulation, or program guidance that specifically defines or references the term "acute care" 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. 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. 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.

Notably, the average length of stay of 25 days or less criteria with respect to IPPS services is not a random number as maybe suggested, but is actually tied to the definition of a subsection (d) hospital under section 1886(d) of the Social Security Act. The payment calculation at issue is a payment made to IPPS hospitals based on, in part, the subsection (d) hospital's low income patient percentage. In defining subsection (d)("IPPS") hospitals, the statute provides that: "the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—…. (iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days,"[22] including discrete units. As the dissenter noted:

> In 1983, when CMS (then known as the Health Care Financing [Administration] ("HCFA")) implemented IPPS, CMS recognized that "the standardized amounts [payable under IPPS] are based on expenditures in short-term general hospitals"[] 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."[Citing 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).] 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."[Citing 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,

[22] The Secretary has gone on to specify criteria for long term hospitals.

> on average, longer or more costly than would be predicted by the DRG system").]

Therefore, the Board should determine whether the level of care generally provided in the disputed units is consistent with the level of care generally payable under IPPS as that term is defined within the context of a short term general hospital.

Further, the Board incorrectly relies on the 190 day lifetime limitation for psychiatric care in a psychiatric hospital as a proxy for the average length of stay that may be expected for acute care psychiatric services in a general IPPS hospital in rejecting the short term acute care nature of the IPPS services. Pursuant to section 1886(d), as noted, a psychiatric hospital is not a subsection (d) (IPPS) hospital and, therefore, would not provide the appropriate comparison for IPPS inpatient hospital acute care.[23] Contrary to the Board's assumption, the number of days provided as a benefit for a provider/facility type is not related to the average length of stay for that provider/facility type. For example, nationally, while the average length of stay from publically available data is about 5 days[24] in an acute care IPPS hospital, Medicare covers up to 90 days in a hospital per benefit period and offers an additional 60 days of coverage with a high coinsurance. A benefit period begins when a beneficiary enters a hospital or a skilled nursing facility, and ends when the beneficiary is discharged from the hospital or skilled nursing facility (SNF), or stops receiving Medicare-covered skilled services at the SNF, for at least 60 days in a row. Therefore, for many reasons, the 190 day lifetime limitation for psychiatric care in a psychiatric hospital is not a relevant measure to define an acute care length of stay against which the Provider's units' average length of stay should be compared. Instead, the proper comparison of the units' services is to acute care psychiatric services provided in a section 1886(d) (acute care)

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[23] Inpatient psychiatric services at psychiatric hospitals and psychiatric hospital units, since 2005, have been paid under an inpatient psychiatric facility prospective payment system (IPF PPS) based on a per day (per diem) IPF PPS rate that is, inter alia, adjusted by coded patient level adjustments and by facility level adjustments (e.g., geographic wage index factors). The IPF PPS also recognizes the higher costs of early days in psychiatric stays (and lower costs of later days) and includes outlier and interrupted stay adjustments., *see, e.g.*, "MEDPAC Data Book, June 2016, Section 6, Acute Inpatient Service, Short Term Hospitals-Inpatient Psychiatric Facilities", Chart 6-29, showing Length of Stay (in days) 2004-2014.
http://medpac.gov/docs/default-source/data-book/june-2016-data-book-section-6-acute-inpatient-services.pdf

[24] *See, e.g., id.* at Chart 6-9 showing 2006 Medicare beneficiary and non-Medicare beneficiary length of stays. See also "2015 CMS Statistics" Table IV.1 "Medicare/Short-Stay Hospital Utilization" 1990 -2014 Average length of stay from 1990 through 2014 (All short-stay 1990 - 2014 and showing "Excluded units" 1990 through 2014 and Table IV.3 "Medicare Average Length of Stay/Trends". https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf.

hospital, rather than in an excluded psychiatric (non-subsection (d)) hospital which should be the Board's focus.[25]

The Provider in support of its position that the unit generally provided acute level care, submitted Provider's Exhibit 28, to show the DRGs related to acute care services provide to patients in one unit and the complexity of the derived case mix. At the May 29, 2015 Oral Hearing the Provider witness explained the derivation of the projected case mix that the Provider used to argue that the intensity level of the care for the type of patient at the units was equivalent to an acute level of care provided under IPPS. In doing so, the witness explained that a DRG was assigned to the billings for patients. The witness clarified that the DRG was on the bill, "but [Medicaid] pays per diem", that is, the DRG was not used for payment purposes. (Transcript of Oral Hearing (Tr.) 105.) The witness went on to answer that, regarding the DRGs listed in Exhibit 28: "On more than 200 occasions these DRGs were used to bill the Medicare program", not for these units, but under the acute IPPS for St Anthony's Hospital for Medicare beneficiaries. (Tr. 109-110.) Consequently, the Provider assigned a DRG, used under IPPS, that was not used for payment in the disputed units to argue the comparability of the type of services provided under IPPS. However, when the IPPS DRGs assigned to the patients in the unit are examined within the context of acute care IPPS, where they are actually used for payment, the following is shown nationally in the IPPS 2006 Final Rule: DRG 426 has an arithmetic mean length of stay (LOS) of 4.1368 days, DRG 430 has a LOS of 7.698 days, and DRG 432 has a LOS of 4.2583 days. [26]

The witness later confirmed that the average length of stay for patients in the IPPS hospital for the related DRG was 5 to 6 days. (Tr.128) In contrast, the services associated with the patients "assigned" that DRG (but not paid pursuant to that DRG) in the Provider's disputed units had an average length of stay of 128-162 days. The witness and counsel also offered that the charge for the IPPS inpatient stay for the related DRG (which consisted of the hospital DRG charge only) would be approximately $3000 whereas the "per diem rate" for the unit (which it is not clarified as to what that covers) would be $357 a day cost times the LOS of 152 days for $54,000. Consequently, an evaluation of the relevance of the Provider's "assignment" of IPPS DRGs that were not used for payment (and upon which the Provider based its case mix) of the disputed units should be made in light of the foregoing comparison to the intensity and level of services that would have been provided

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[25] *See e.g.*, the arithmetic mean LOS for DRGs (pre-ICD 10) in the FFY 2006 IPPS, Tables 7A/B,.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS1255496.html
For the recent MEDPAR data collected for the 2016 IPPS rule, for Table 7A, (ICD 10)
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html

[26] *See, e,g,* the arithmetic mean LOS for DRGs (pre-ICD 10) in the FFY 2006 IPPS, Tables 7A/B for DRG 426, DRG 430 and DRG 432 and other DRGS cited in Provider Exhibit 28. https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download- Items/CMS1255496.html

under IPPS acute for those psychiatric services. For example, included in the review should also be whether, *inter alia*, the length of stay of the disputed units when compared to similar diagnoses/DRGs under IPPS indicates the days attributable to the dispute units of the hospital were providing acute care services generally payable under the prospective payment system.

2. Further, in evaluating whether the level of care in the unit was generally inpatient IPPS hospital acute level care, the Board also incorrectly looked to the standards applied to psychiatric hospitals. The Board stated that:

> [I]n 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. The Board specifically looked to the Medicare definition of a 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" and referred to the specific conditions of participation.

Based on testimony from St. Anthony's witnesses and the record, the Board majority found that the Three Disputed Units meet Medicare requirements for payment as an inpatient psychiatric facility, which requires "active treatment." The Board majority found that the 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). The Board majority found that 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 found that the evidence is clear that these patients were not stable and received active treatment."

However, the specific standards applied by the Board are not those for an IPPS acute care hospital. Notably, a Medicare beneficiary may receive psychiatric services in a general acute care IPPS hospital, not just an IPPS excluded psychiatric hospital and it is the former which is the measure of whether the days may be included in the IPPS Hospital DSH calculation. A characteristic of the appropriate measure is that the inpatient stay is for an acute short term duration generally payable under the prospective payment system. Therefore, the Board majority finding that the testimony and the documentation in the record supports a finding 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), needs to be evaluated within the context of IPPS acute care services and not psychiatric hospital services.

3. The Board majority also found that the Federal Medicaid law allows PRTFs to provide an "acute" level of inpatient psychiatric care to individuals under 21 years of age and, therefore, it is irrelevant as to whether a facility is certified as psychiatric hospital or a PRTF—that is, either type of facility may provide an "acute" level of care to meet the needs of under 21 year old patients. However, the Administrator finds that legal conclusion is not supported by the law and, regardless, would not resolve the issue for this provider because a psychiatric hospital is not a section 1886(d) IPPS hospital and is specifically excluded from IPPS.

Relying in part on the history of the "psychiatric_21 benefit" under Medicaid, the Board found that there was no difference between the "psychiatric_21_benefit" provided in a psychiatric hospital (that must meet section 1861(f) of the Social Security Act) and those provided in the PRTF. However, reviewing Title XIX and Title XVII, together, a PRTF is not the equivalent of a hospital by law. Looking first to Title XVIII, section 1861(f) of the Act in defining a hospital states that: "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))." In addition, a section 1861(f) psychiatric hospital by law is not a subsection (d) IPPS hospital.

Looking next to Title XIX, section 1905(a) provides for "medical assistance" for "inpatient hospital services" but specifically provides for "(1) inpatient hospital services (other than services in an institution for mental diseases [IMD])." The Secretary pointed out that: "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 facilities, or other institutions 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." 59 Fed Reg. 59625.[27] Under Title XIX, an exception pursuant to section 1905(a)(16)[28] was created to the IMD prohibition for "Inpatient psychiatric hospital services for individuals under age 21" which is authorized under subsection (h):

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[27] 59 Fed Reg. 59624- 59625 (Nov. 17, 1994).The Secretary set forth a full and detailed discussion of the history of the statutory authority for the "psych 21 benefit" in this rule.

[28] Section 1905(a)(16)(A) provides medical assistance effective January 1, 1973, for "inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h)…."

> (1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—
> (A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) *or in another inpatient setting that the Secretary has specified in regulations…*

This legislation would have been concurrent with the establishment of IPPS, where Congress specifically excluded psychiatric hospitals from IPPS and designated that they were not subsection (d) hospitals, meanwhile, Congress was specifically authorizing the Medicaid payment of the "psych-21-benefit" to section 1861(f) certified [non-IPPS] Medicare psychiatry hospitals or "another inpatient setting that the Secretary has specified in regulation."

Consequently, a review of the statutory history of the provision shows that a psychiatry hospitals is not the same as a PRTF. Further, the numerous definitions and references to the PRTF in the Federal regulations and the Federal preamble are all references to a nonhospital facility. [29] The focus thus is not whether the PRTF is proving care equivalent to a psychiatric hospital but rather is the PRTF (a nonhospital) generally providing the level of care that would typically be provided to a patient in an IPPS (section 1886(d) hospital acute care setting.

An issue is whether the classification of the PRTF by its very nature reflects the type of care furnished in that unit/facility, just as the classification of a facility or provider type across the Medicaid and Medicare programs reflects the type of care provided in that type of facility or provider. While the Medicare program neither recognizes, nor certifies distinct hospital units (or facilities) as PRTFs, CMS specifically permitted States to allow for the placement of a Medicaid certified distinct part PRTF unit in a hospital facility (that is, they were not required to be freestanding) but still distinguished them from a section 1861(f) psychiatric hospital.[30] The placement of the PRTF in the general hospital did not alter the

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[29] *See 4*2 C.F.R. §483.352 regarding the definition of a PRTF: Psychiatric Residential Treatment Facility means 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." 42 CFR §441.151 sets forth the general Federal Medicaid requirements: Inpatient psychiatric services for individuals under age 21 must be: (1) Provided under the direction of a physician; (2) Provided by – A psychiatric hospital *** A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

[30] 59 Fed Reg. 59624- 59625 (Nov. 17, 1994).

definition of a PRTF as a nonhospital facility nor by law can they ever be considered a hospital.[31]

In sum, the Board was incorrect in finding the services provided were the same regardless of whether the benefit was provided in the psychiatric hospital or the PRTF. In addition, in equating the services provided under a PRTF as being the same as those services provided in a (non-IPPS) section 1861(f) hospital, the Board finding does not provide support for inclusion of the days in this case. The focus should be on the level of care generally provided in the PRTF compared to *acute care psychiatric services provided in a general IPPS (short term) hospital.* In addition, not addressed by the parties is the impact if any of the PRTF, as identified as an IMD at 59 Fed Reg. 59624, in light of, *inter alia*, the statutory definition of a hospital under section 1861(e), the definition of an section 1886(d) hospital and the exclusion as of IMD services as inpatient hospital services under section 1905 of the Act. Therefore a remand, for the application of the proper standard as discussed in the foregoing opinion, is proper.

d. Conclusion

Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the case should be remanded for further review and, as the Board finds appropriate, further briefing by the parties consistent with the foregoing discussion to determine whether the services generally provided in the disputed units were services generally payable under IPPS.

> Accordingly, the decision of the Board is vacated and remanded in accordance with the foregoing opinion; and.

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[31] In promulgating regulations, in November 17, 1994, CMS (formerly HCFA) discussed that the PRTF was not a hospital and that the intent was of a level of care below the level of care provided in a general hospital setting and established a definition of the term "psychiatric residential treatment facility" (PRTF) while proposing conditions of participation for this type of facility. 59 Fed Reg. 59624- 59625 (Nov. 17, 1994).CMS explained that: "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. The interim final rule at 66 Fed. Reg. 7148 (Jan. 22, 2001) implemented only one of the conditions of participation (CoPs) set forth in the November 1994 proposed rule and adopted the definition of a psychiatric residential treatment facility "as a facility other than a hospital that provides inpatient psychiatric services." 66 Fed. Reg. 7148 (Jan. 22, 2001) ("Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21" ).

A final decision issued by the PRRB will be subject to 42 CFR 405.1875

Date: 3/6/18 /s/

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