PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2024-D33

PROVIDER-
Oklahoma State University
Medical Center

Provider No.:
37-0078

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc. c/o
GuideWell Source

HEARING DATES –
October 22-23, 2019 &
February 20-21, 2024

Fiscal Year Ending –
11/30/2008

CASE NO. –
16-2092

CONTENTS

ISSUE STATEMENT:

Whether the fiscal year ("FY") 2008 Medicare Disproportionate Share Hospital ("DSH") payment for the Oklahoma State University Medical Center (the "Provider" or "OKSU-MC") was understated because, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi) and other authorities, the payment did not include the inpatient days for which the patients in OKSU-MC's four child, early adolescent, and adolescent behavioral health units (the "Four Units") were "eligible for medical assistance under a state plan approved under Title 19, but who were not entitled to benefits under Medicare Part A" as required by the statute, HCFA Ruling 97-2, Program Memorandum A99-62, CMS Ruling 1498-R1 and other authorities.[1]

DECISION:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds as follows:

1. The Medicare Contractor properly determined that the Four Units at OKSU-MC did not "provid[e] acute care services generally payable under the prospective payment system" in accordance with 42 C.F.R. § 412.106(a)(1)(ii) (as of Dec. 1, 2007); and

2. Accordingly, the Medicare Contractor properly took the following actions:

   a. Excluded 12,006 days associated with the Four Units from the Medicaid Days reported at Worksheet S-3, Part I, Line 1, Column 5, and 13,169 days associated with the Four Units from the Total Patient Days reported at Worksheet S-3, Part I, Line 1, Column 6, moving these days to the same respective columns on Worksheet S-3, Part I, Line 16;

   b. Excluded these days from the relevant aspects of the DSH Medicaid fraction calculated for use in the Allowable DSH percentage reported on Worksheet E, Part A, Line 4.03; and

   c. Changed other calculations which use Total Patient Days or Medicaid Days through these adjustments to days, including, but not limited to, Indirect Medical Education ("IME"), Graduate Medical Education ("GME"), and Capital IPPS DSH.

INTRODUCTION:

OKSU-MC is a licensed 345-bed short-term acute care hospital located in Tulsa, Oklahoma.[2] Until March 1, 2008, the Medicare contractor[3] assigned to OKSU-MC for this appeal was

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[1] Transcript of Proceedings at 6 (Oct. 22, 2019). The initial hearing occurred over two (2) days, namely October 22-23, 2019, and the transcript for these 2-day proceedings will hereinafter be referred to, by day, as "2019-Day-1 Tr." and "2019-Day-2 Tr." The Board reconvened the hearing on February 20-21, 2024, and the transcript for these 2-day proceedings will hereinafter be referred to, by day, as "2024-Day-1 Tr." and "2024-Day-2 Tr."

[2] Exhibit ("Ex.") P-46.

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

Chisolm Administrative Services ("Chisolm"). On March 1, 2008, TrailBlazer Health Enterprises, LLC ("Trailblazer") succeeded Chisolm and then, on October 29, 2012, Novitas Solutions, Inc. c/o GuideWell Source ("Novitas") succeeded Trailblazer.[4] The Board will refer to Chisolm, Trailblazer and Novitas, collectively, as "the Medicare Contractor."

OKSU-MC's FY 2008 is the fiscal year under appeal and covered the period from December 1, 2007 through November 30, 2008. During FY 2008, OKSU-MC was owned by Ardent Health Services ("AHS"),[5] and operated the inpatient child and adolescent psychiatric treatment units known as the "Four Units." On July 1, 2008 (7 months into FY 2008), AHS transferred the Four Units from OKSU-MC to another AHS hospital, Hillcrest Medical Center ("AHS Hillcrest") and then, later in April, 2009 (*i.e.*, after the close of FY 2008), AHS sold the OKSU-MC.[6] The OKSU-MC's appeal concerns the portion of FY 2008 from December 1, 2007 until June 30, 2008 (*i.e.*, until the date when the Four Units were transferred to AHS Hillcrest).[7]

For FY 2008, the Four Units at the OKSU-MC provided psychiatric care to patients under 18 years old and participated in the Oklahoma Medicaid Program ("OMP") as providers of both: (1) psychiatric acute care paid on the basis of a Diagnostic Related Group ("DRG") rate; and (2) psychiatric residential treatment facility ("PRTF") (also referred to as a residential treatment center ("RTC")) care, paid on a per diem rate.[8] The Four Units operated 72 beds in total, all of which were dually licensed as psychiatric acute care beds and PRTF or psychiatric residential beds.[9] The Medicare Contractor excluded 12,006 days associated with the Four Units from the Medicaid Days reported at Worksheet S-3, Part I, Line 1, Column 5, and 13,169 days associated with the Four Units from the Total Patient Days reported at Worksheet S-3, Part I, Line 1, Column 6. As a result of excluding these days, the Medicare Contractor only used 13,182 Medicaid-eligible days in the numerator of the Medicaid Fraction for calculating the FY 2008 DSH payment for the OKSU-MC.[10]

Significantly, the 12,006 days removed from the Medicaid Days statistics were Medicaid eligible days but included the two different types of care furnished in the Four Units, namely acute care

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[4] Oklahoma State University Medical Center's Final Position Paper ("Provider's FPP") at 2 & n.1 (Mar. 20, 2019).
[5] 2019-Day-1 Tr. at 22. *See also* Provider's FPP at 8, which discusses how AHS Tulsa Regional Medical Center LLC owned OKSU-MC; however, this LLC was ultimately owned by AHS as made clear at the hearing through testimony of Mr. Adams, the Ardent Vice President of Reimbursement. 2019-Day-1 Tr. at 56-62.
[6] Provider's FPP at 8.
[7] *Id.*
[8] *See id.* at 8-9 ("The Four Units had a combined total of 72 inpatient beds in FY 2008 . . . . Each of these beds was also licensed by the State Medicaid program as residential treatment beds."); *id.* at 16 ("Four Units (dually licensed as a hospital and ***psychiatric residential treatment facility*** *unit*, and often children or adolescents were 'transferred' *from one* ***program*** *to another* without ever changing rooms/beds)" (emphasis added)); *id.* 39 (stating "One crucial legal issue in this appeal is whether hospital-based RTCs, *which are also licensed under Oklahoma law* ***as psychiatric residential treatment facilities*** *('PRTFs')*, can provide inpatient hospital acute care services that are generally payable under IPPS" (emphasis added)); Oklahoma State University's Post-Hearing Brief at 24-25, n.20 (July 1, 2024) ("Provider's PHB") ("Oklahoma explicitly recognizes 'hospital-based' psychiatric residential treatment facilities ('PRTFs'), ***such as the Four Units***" (emphasis added and citation omitted)). *See also* Provider's FPP at 17 (discussing how OMP pays the Four Units under both the "acute" methodology and the "residential" methodology).
[9] Provider's FPP at 8-9, 16, 55-56 ("the unique structure of the Four Units[,] dually licensed as a hospital and psychiatric residential treatment facility unit"). *See also* 2019-Day-1 Tr. at 67-68.
[10] Ex. C-7 at 4.

(paid by OMP on a DRG basis), and PRTF care (paid by OMP on a per diem basis).[11] The Medicare Contractor removed these days because, pursuant to 42 C.F.R. § 412.106(a)(1)(ii), the level of care on the Four Units did not rise to the same level of care as a patient with a psychiatric diagnosis admitted to a general Inpatient Prospective Payment System ("IPPS") paid short term bed.[12] Further, the Medicare Contractor's process for determining whether any days in the Four Units rose to the level of "acute care" did not include conducting a medical review.[13]

Similarly, the Medicare Contractor removed 13,169 days from the Total Days statistics that are used in the denominator of the Medicaid fraction since: (1) the denominator includes all inpatient days as defined in 42 C.F.R. § 412.106(a)(1); (2) none of the days in the Four Units were eligible to be considered in the DSH adjustment calculation based on the above finding applying § 412.106(a)(1); and (3) the 13,169 day count represents all days from the Four Units during FY 2008 (*i.e.*, all days regardless of whether the patient was Medicaid eligible).[14]

OKSU-MC disputes the revisions to the numerator and denominator of the Medicaid fraction and claims the *net* amount in controversy resulting from this removal is $526,969 once the full impact on the following Medicare payment adjustments for FY 2012 is taken into account:

1. DSH	$2,280,228
2. IME	– $ 811,150
3. GME	– $ 829,864
4. OP Cost	– $ 7
5. Pysch Sub IP Cost	$ 18
6. IP Capital	– $ 112,256
TOTAL	**$ 526,969**[15]

OKSU-MC's original amount in controversy focused on OKSU-MC's FY 2008 DSH payment, and reversal of the adjustments would result in *an additional $2,280,228 for DSH*; however, OKSU-MC later revised the amount in controversy in its FPP to also take into account the *negative* effect that the reversal of the Medicare Contractor's adjustments would have on its FY 2008 capital DSH payment as well as its FY 2008 payments for DGME and IME.[16]

OKSU-MC timely appealed the Medicare Contractor's final determination and has met the jurisdictional requirements for a hearing before the Board. A live hearing was held on October 22 and 23, 2019, which was continued and reconvened on February 20 and 21, 2024.[17] The

[11] Ex. P-4 at 15-18 and 35-36 (Individual Appeal Request, Adjustments 1-7 & Issue Statement); Provider's FPP at 19. *See also* Ex. P-17.
[12] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 4 (Apr. 16, 2019).
[13] *Id.* at 2.
[14] Ex. C-7; 42 C.F.R. § 412.106(a)(1)(ii), (b)(4); PRM 15-1 § 2205.
[15] Ex. P-18. OKSU-MC's appeal request listed the amount in controversy as $2,280,228, but that amount only factored in the operating DSH adjustment and OKSU-MC later revised that amount in its FPP to account for the full impact across areas, including IME, DSH, and GME. Provider's FPP at 19; Ex. P-18.
[16] Provider's FPP at 19; Ex. P-4 at 39-40.
[17] The delay in reconvening the hearing is well documented in the record as set forth in the Board's January 24, 2024 denial of postponement request. Briefly, the initial delay resulted from OKSU-MC requesting to continue the hearing after discovering errors in its experts' reports and summary sheets of Dr. Salve and Ms. Edford that could not be

OKSU-MC was represented by Roberth Roth, Esq. and Arthur Peabody, Esq. of Hooper, Lundy & Bookman, P.C. The Medicare Contractor was represented by Edward Lau, Esq. and Joseph Bauers, Esq. of Federal Specialized Services, LLC.

STATEMENT OF FACTS AND RELEVANT LAW:

A. Background on OKSU-MC and the Four Units at OKSU-MC

As noted above, during FY 2008, OKSU-MC operated four child and adolescent psychiatric units in a hospital department referred to as "the Four Units," which was located on the eighth floor of the main hospital building[18] and each of the units had an age range.[19] While the Four Units were licensed by the State of Oklahoma to operate 96 beds, the units only contained 72 beds[20] and these beds were dually licensed as acute care beds and PRTF (*i.e.*, psychiatric residential) beds.[21] Indeed, as a result of its participation in the OMP as a hospital-based PRTF, the Four Units received a separate participation/billing number for PRTF care services.[22] The 72 beds were broken down across the Four Units as follows:

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corrected at the hearing. OKSU-MC requested a continuance to submit a corrected expert report within one week and the Medicare Contractor did not object to the request. The Board granted this request; however, on January 24, 2020, due to OKSU-MC's failure to promptly file corrected reports, the Board ordered OKSU-MC to file the corrected expert reports no later than January 31, 2020. OKSU-MC complied by filing on January 31, 2020, but the filing was 582 pages long (roughly double the original filing due to Board-required redlines). The Board sought input from the parties to reschedule the case, but before it could do so, the Covid-19 pandemic ensued in March 2020 resulting in CMS announcing maximum telework status for all Agency employees including the Board, as set forth in Board Alert 19 (available at https://www.cms.gov/files/document/prrb-alerts.pdf). Due to the complex nature of the dispute, the number of witnesses (including three expert witnesses), and the sheer volume of the record, the Board determined an in-person hearing was the appropriate forum. Effective December 7, 2022, the Board lifted Alert 19, via Board Alert 23, and resumed normal operations. Shortly after this, the Board sought input from the parties resulting in an in-person hearing being set for September 2023. However, this hearing was further delayed as a witness was unavailable due to an unexpected medical event. As a result, the in-person hearing was reset for the February 21-22, 2024, hearing dates.

[18] Provider's FPP at 8.

[19] 2019-Day-1 Tr. at 173.

[20] *See id.* at 67-68.

[21] Provider's FPP at 17 ("When billing for these services, hospitals in Oklahoma, including [OKSU-MC], are required by the State to use separate Medicaid provider numbers for 'acute' vs. 'residential' payment , even for services provided in the same unit."); *id.* at 9, 16, 55-56; Oklahoma State University Medical Center's Response to Medicare Contractor's Final Position Paper at 20 (May 20, 2019); Provider's PHB at 86; Ex. P-9 at 2 (showing the OKSU-MC FY 2007 workpaper entitled "Analysis of Available Beds" showing 72 "Psych Residential" beds with footer reading "OSUMC MCR avail[able] beds 8.31.07 recon[ciliation] to Ok license"). *See also* Provider's FPP at 17 (acknowledging the Four Units were paid under OMP's "acute" methodology as well as "residential" methodology for under 18 psychiatric care services); Ex. P-31 at 5 (Oklahoma Health Care Authority calculation of Medicaid DSH that includes "***on-site*** Psychiatric Residential Treatment Facility (PRTF) days") (emphasis in original)).

[22] Provider's PHB at 24-25, n.20; Okla. Admin. Code § 317:30-5-95 (defining PRTFs and hospital-based PRTFs and requiring PRTFs to meet certain accreditation requirements). The Four Units had a separate OMP participation agreement and participation number/billing number as a PRTF (2019-Day-1 Tr. at 123-24; 2024-Day-1 Tr. at 252; 2024-Day-2 Tr. at 223-24), similar to the PRTFs in the *St. Anthony* case to which OKSU-MC compares the Four Units. *See infra* n. 79-80 and accompanying text & *infra* n. 150. Indeed, OKSU-MC characterizes itself as OMP-licensed RTCs/PRTFs (*see supra* notes 8 and 9 discussing the fact that the Four Units were licensed by OMP as PRTF units) and did not dispute the Medicare Contractor's characterization of the Four Units as participating in OMP as hospital-based PRTFs. *See, e.g.*, 2024-Day-1 Tr. at 42-43 (in its opening statement, the Medicare Contractor stated: "These units were referred to as the four units. The four units participate in the Oklahoma Medicaid program as

- The Children's Unit 2-11 years old 14 beds[23]
- The Early Adolescent Unit 11-13 years old 28 beds
- The Adolescent Acute Unit 13 to 17 years old 12 beds
- The Adolescent Residential Unit 13 to 17 years old 18 beds[24]

The rooms and associated beds in the Four Units were not set up or equipped like rooms and associated beds in a typical medical surgical unit of a short-term acute care hospital as highlighted by the fact that: (1) the rooms and associated beds available in the Four Units did not have oxygen or gas line hookups;[25] and (2) the Four Units did not have regular hospital beds but rather had behavioral health beds, which had a wood frame with a custom mattress designed for safety in behavioral health units.[26] OKSU-MC's witness recognized that these type of wooden beds could not be raised or lowered like a traditional hospital bed.[27] OKSU-MC's witness further recognized that none of the patients on the Four Units required *regular* IV treatment, like many patients on a Medical Surgical Unit in a hospital.[28]

1. Type of Services Offered in the Four Units

Beds in the Four Units were assigned to patients based on patient's diagnosis/behavior, age, and physical sizing,[29] although patients may be moved to a different unit within the Four Units if they are not integrating with other patients in their current unit, or to boost the morale of a patient who might view a move as making progress.[30] OKSU-MC represents that, generally, a Medicaid patient in any of the Four Units did not have to be moved to another bed (or unit) if OMP switched that patient from being authorized for under-18 acute psychiatric care (which is paid on a DRG basis) to under-18 PRTF care (which is paid on a per diem basis).[31]

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hospital based Psychiatric Residential Treatment Facilities, or the acronym PRTFs. This hearing is a continuation of the original hearing that took place back in October 2019. Since that time, the Board has issued several decisions involving other Oklahoma hospitals who also operated hospital based PRTFs, those Board decisions are St. Anthony and Integris."); Medicare Contractor's FPP at 5 ("The burden is on the Provider to establish that the level of care provided by its PRTFs met the level of care requirement under Medicare for inpatient psychiatric care found in the statute and regulation."); Medicare Contractor's Supplement to its Final Position Paper at 8 (June 2, 2023) (stating: "Although more may come out of the work-up when the hearing resumes, the report does not present the in-depth review sufficient to turn the OSUMC PRTFs into an acute care non psychiatric unit equivalency. The analysis looked at 102 stays over a 35-month period.").

[23] Note on the staffing grid, this unit is identified as "Children Acute 5804." Ex. P-13 at 22.

[24] 2019-Day-1 Tr. at 60, 173-74. *See also* Ex. P-13 at 22 (staffing grid for each of these units but the maximum census listed for each unit is not the same as the testimony except for the Children Unit).

[25] 2019-Day-1 Tr. at 205-206. In identifying available beds in an IPPS hospital, one of the factors considered is whether the rooms include oxygen and gas-line hook ups for routine inpatient acute care. *See, e.g.*, *Northwest Tex. Healthcare Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2015-D24 (Sept. 16, 2015), *decl'd review* CMS Adm'r (Oct. 29, 2015); *Altoona Hosp. v. Thompson*, 131 Fed. Appx. 355, 356 (3rd Cir. 2005).

[26] 2019-Day-1 Tr. at 206-207; 2024-Day-2 Tr. at 236-37.

[27] 2024-Day-2 Tr. at 237.

[28] 2019-Day-1 Tr. at 205; 2024-Day-2 Tr. at 236-37.

[29] Provider's FPP at 9, 17; 2019-Day-1 Tr. at 185.

[30] 2024-Day-2 Tr. at 248 ("If it's better for that patient to move, maybe there's not a good mix. So, sometimes you'll get four or five patients who are picking on a different patient. . . . sometimes we would go ahead and move them, especially to give their mindset that they're improving . . . . that happened occasionally.").

[31] 2019-Day-1 Tr. at 177; 2024-Day-1 Tr. at 280; 2024-Day-2 Tr. at 227.

While no *outside* schoolwork was allowed in the Four Units,[32] it operated two different "schools" for two age groups and those schools were located in the Four Units.[33] Each of the two schools were technically considered a public school,[34] and each was convened in one large room on the Four Units with all participants together.[35]

OKSU-MC's staffing mix policy states that "[t]he mix of nursing staff, including R.N., Psych Tech, and Unit Secretary is determined by the number and acuity of patients on each unit and the requirements of state licensure laws, rules and regulations."[36] This policy specifies that the "[m]inimum staff for each . . . unit each shift is one R.N. for every 15 patients" and "a minimum of one mental health technician or nurse aide per shift, with more added depending on the unit status and patient acuity levels."[37] This policy is reflected in staffing grids for each unit.[38] However, high acuity patients could present scenarios and behaviors, such as the need for seclusion or one-to-one supervision of a patient, which would require OKSU-MC to bring in additional staff to the Four Units.[39] Accordingly, OKSU-MC's staffing policy addressed when staffing needed to be augmented beyond the levels specified in the staffing grid. OKSU-MC's policy states "[t]he ***average*** acuity of behavioral health patients on *each* unit has been taken into consideration when calculating the number of staff to be assigned per shift per unit."[40] To that end, the policy requires that "[e]ach shift, the RN on each unit completes an 'Acuity Alert Form' which documents the acuity of the milieu and the patients on the unit" so that the charge shift RN can use this information to adjust the staff levels based on current patient needs.[41]

As patients progressed toward discharge, they could be given passes to physically leave their unit either to the cafeteria or off hospital grounds.[42] And, while OKSU-MC claims that a patient who is given a pass may still be receiving an "acute" level of care,[43] the OKSU-MC manual describing the "Program Basics" for the Four Units specifically states: "Passes are ***not*** *allowed on* ***acute*** *status* and are approved for residential status only by the doctor and/or therapist depending on your ability to maintain safety."[44] The "Program Basics" manual further describes the number of hours granted for each type of pass: (1) on-grounds passes are for one hour on Tuesdays and Thursdays during visitation times; and (2) off-grounds passes are for six hours on Saturdays, Sundays, and approved holidays where the patient must return no later than 8 pm.[45] OKSU-MC's witness acknowledged that it would not be safe to grant an acute care patient a pass to leave the Four Units.[46] Instead, as patients worked toward discharge, they may be given a

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[32] Ex. P-11 at 3.
[33] 2024-Day-2 Tr. at 53.
[34] *Id.* at 143.
[35] 2024-Day-2 Tr. at 252-253.
[36] Ex. P-13 at 21.
[37] *Id.*
[38] *Id*. at 22.
[39] *See* 2024-Day-2 Tr. at 228-229; 2019-Day-1 Tr. at 180, 216.
[40] Ex. P-13 at 16 (emphasis added).
[41] *Id.* Change factors on the "Acuity Alert Form" include a patient needing 1:1 observation, two or more patients needing line of sights, two or more admissions, and three or more discharges/transfers. *Id*. at 17.
[42] Ex. P-11 at 3; 2019-Day-1 Tr. at 200-201.
[43] *Id.* at 210-212.
[44] Ex. P-11 at 3 (emphasis added).
[45] *Id.*
[46] 2019-Day-1 Tr. at 200-201; 2024-Day-2 Tr. at 233-234.

pass(es) as a trial(s) to see if their behavior or condition regressed while off their unit[47] and to facilitate a safe re-entry to the community.[48]

Underlying all treatment on the Four Units, the ultimate goal after a patient's admission was to manage their condition and help them re-enter the community safely.[49] A patient could not be discharged to the community until they were stable,[50] and, understandably, OKSU-MC has acknowledged that most would progress in their treatment to where they were non-acute and stable enough for discharge prior to actually being released to the community (or lower level of care, as relevant).[51]

2. FY 2008 Statistics for the Four Units

The total days at issue for OKSU-MC are the 12,006 days removed from the numerator of its Medicaid Fraction,[52] but the total number of days of care provided at the Four Units for portion of FY 2008 at issue was 13,169, which were also removed from the denominator of its Medicaid Fraction.[53] Of those total days of care, 2,587 (19.64 percent) were paid by the OMP using a DRG rate for providing acute care, while 10,582 (80.36 percent) were paid by the OMP using a per diem rate for providing PRTF care.[54] Specifically, in its response to the Medicare Contractor's Supplemental Final Position Paper, OKSU-MC agrees that the following chart summarizes the inpatient stay data for the Four Units during FY 2008:[55]

All Days & Discharges

Amounts	**Days**	**Discharges**	**ALOS**
DRG	2,587	499	5.18437
Per Deim	10,582	483	21.9089
Total	13,169	982	13.4104
Percentages	Days	Discharges	
DRG	19.64%	50.81%	
Per Diem	80.36%	49.19%	
Total	100.00%	100.00%	

This chart's characterization of discharges is consistent with testimony from OKSU-MC's witness that, when a Medicaid patient changes status from acute care to PRTF care, there would be a

[47] 2019-Day-1 Tr. at 200-201.
[48] *See* 2024-Day-2 Tr. at 104-105. *See also* Ex. P-11 at 3.
[49] 2019-Day-1 Tr. at 192-196; 2024-Day-2 Tr. at 61.
[50] 2024-Day-2 Tr. at 103.
[51] 2019-Day-1 Tr. at 192-196; 2019-Day-2 Tr. at 38.
[52] Ex. P-4 at 15-18 and 35-36; (Individual Appeal Request, Adjustments 1-7 & Issue Statement); Provider's FPP at 19. *See also* Ex. P-17.
[53] Oklahoma State University Medical Center's Response to the MAC's Supplemental Final Position Paper, 22-23 (July 19, 2023) ("Provider's Response to Medicare Contractor's SFPP").
[54] *Id.*
[55] *Id.* (footnotes omitted). *See also* Ex. P-3 at 5 (FY 2008 audit adjustment report showing the following adjustments on Worksheet S-3 Part I, Line 1.00: (a) 12,006 Medicaid inpatient days removed from Column 5.00; (b) 13,169 days removed from Column 6; (c) 806 discharges removed from Column 14; and (d) 982 discharges removed from Column 15).

discharge from acute care followed by an admission to PRTF care.[56] Significantly, this chart uses the statistics *required* to be on the as-filed cost report to arrive at an average length of stay ("ALOS") of 13.4104 days across the Four Units. When only PRTF care is considered, the ALOS increases to 21.9089 days. As required by Medicare, this ALOS is based on ***discharge*** which the cost reporting instructions in effect for FY 2008 specified to be "[a] patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)"[57]

OKSU-MC muddies the water by presenting other "ALOS" statistics in this supplemental filing and other filings that are ***not*** based on the *discharge* data included in its as-filed cost report for FY 2008. First, OKSU-MC represents that the ALOS *based on an inpatient* "***case***" across the Four Units as a whole for the 7-month portion of FY 2008 under appeal is 24.1633 using only 545 "[inpatient] ***cases***" and 13,169 inpatient days.[58] While OKSU-MC does not explicitly describe or define what "case" meant or means, it seems to suggest that it arrived at the 545 "case" statistic by treating as one "case" an acute care psychiatric stay where, upon discharge, the patient is immediately transferred and admitted for PRTF care and then later discharged from PRTF care. Regardless, 545 "cases" is significantly less (roughly 45 percent less[59]) than the 982 "discharges" OKSU-MC reported on the FY 2008 as-filed cost report for the Four Units.

Second, OKSU-MC touts yet a different "ALOS" calculated by its statistical expert that, similarly, is ***not*** based on the *discharge* statistics reported on the as-filed cost report. In his *first* expert report issued on June 7, 2019, OKSU-MC's statistical expert states he calculated an ALOS but did not specifically state what that ALOS. Rather, he represented this undisclosed ALOS calculation was based upon "545 discrete patient ***stays***" without defining what "patient stay" meant.[60]

However, on January 31, 2020, (7 months later, which was also ***after*** *the sample had been drawn and reviewed* ***and after*** *the first hearing*), the statistical expert issued a "corrected" report.[61] The

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[56] 2019-Day-1 Tr. at 177-78 (stating: "MR. PEABODY: And a question came up this morning, as to whether, if one was transferred from acute status to residential status, a discharge and readmission took place. Could you explain that process to the Board? MR. [*sic* MS.] TALLMAN: In as far as the nursing staff, it would be like a transfer of care, but in – it was a discharge of an acute stay, to an admission of a residential stay, meaning that we stopped this, started a new chart, and started this.").

[57] Specifically, PRM 15-2 § 3605.1 includes instructions for Worksheet S-3, Part I and specifies the following for Columns 12 through 14: "Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)"

[58] Provider's FPP at 10 (emphasis added). OKSU-MC also alleges that, *from "2004 through 2015*, the average length of stay ('ALOS') in the Four Units in the aggregate was 23.19 days and the first part of the inpatient stay was typically paid under the Oklahoma Medicaid 'acute' DRG methodology." *Id.* at 3. Thus, if the same methodology was used for FY 2008 alone, then it would suggest that the 24.1633 ALOS for FY 2008 was calculated treating any acute care stays immediately followed by a PRTF stay as one "[inpatient] ***case***." This tracks with the year-by-year chart of the ALOS in the Four Units which is included at page 10 of the Provider's FPP and shows an ALOS of 24.1633 based on 13,169 inpatient days.

[59] ((982 – 545) / 982) x 100 = 44.50 percent.

[60] Ex. P-41 at ¶¶ 7-8 and 10 (emphasis added). *See also generally* P-41. The closest to a definition of "stay" was the statement that "[t]he purpose of the sample is to determine whether (a) the patients that were admitted to the Four Units required an acute inpatient hospital level of care at the time of admission and throughout their inpatient stays at the Four Units[.]" *Id.* at ¶ 6. This statement suggests that a patient could have more than one "stay" in the Four Units and, as such, the sampling unit of "patient stay" would suggests that a patient could have two "stays" in the FY 2008 population for the Four Units.

[61] Ex P-51.

"***corrected***" expert report contends that: (1) the total "population" of stays across the Four Units for FY 2008 had an "ALOS" of 25.0 days and (2) the ALOS is based on 540 "patient stays" using an *undisclosed* number of total days[62] (NOTE—*while undisclosed, the total days have to be* ***materially higher*** *than the 13,169 total days statistic report reported on the as-filed cost report*[63]). In his "*corrected*" report, the statistical expert again did not define the sampling unit "stay" but then noted that OKSU-MC's representative asked him "to redefine," ***on a post-hoc basis***, the sampling unit, such that it encompassed two additional situations: (1) "the new definition of a patient stay accounts for the fact that a patient could be discharged from the Four Units and then be readmitted on the very next day where the stay should be considered continuous" and (2) "if a patient was discharged in one FY, then was readmitted on the same day and was subsequently discharged during the next FY, that stay was also counted as two separate and distinct stays in the original population" but "[i]n the updated population, these stays are counted as one contiguous stay."[64] However, the *"corrected*" report then proceeds to represent in footnote 1 that the statistical expert accepted OKSU-MC's representative's request that he make an exception to this newly redefined sampling unit and not combine one set of two stays separated by one day *based on the representative's representation* that "these two patient stays should not be combined because the patient was discharged and then admitted the next day for a reason separate from the discharge."[65] Significantly, the "corrected" report itself does not explain why or upon what basis he was asked to make the correction "to redefine," ***on a post-hoc basis***, the sampling unit used in the statistical sampling other than OKSU-MC's representative asking him to do so. Nonetheless, it is clear that the statistical expert was not involved in the decision-making process to make a correction by redefining the sampling unit *on a post-hoc basis*.

On February 20, 2024, at the second hearing, the statistical expert testified that the "patient stay" sampling unit was defined by Mr. Adams, the AHS Vice President of Reimbursement.[66] Mr. Adams testified that the original sampling unit was defined to essentially include all continuous days in the Four Units regardless of whether "the totality of the stay" was divided between a Medicaid acute care stay (having its own unique encounter number with an admission and discharge date) immediately followed by a Medicaid PRTF care stay (similarly having its own unique encounter number with an admission and discharge date).[67] This sampling unit was further modified as described above in the "*corrected*" expert report.

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[62] *Id.* at 6, 8. *See also* 2024-Day-1 Tr. at 92.
[63] 13,169 divided by 540 = 24.3870. If this same formula was used to calculate the 25.0 ALOS statistic, then the total days used would have to be 25.0 x 540 which equals 13,500, an increase of 331 days or 2.5 percent.
[64] Ex. P-51 at ¶ 9.
[65] *Id.* at 4, n.1. *See also* 2024-Day-1 Tr. at 87-88 (testimony on footnote 1 in the "corrected" report).
[66] 2024-Day-1 Tr. at 83-84 (stating: "So, in mid 2019, I received one Excel spreadsheet that was created, I believe, by Mr. Adams, at the client, and it had three tabs, and I looked at the Excel spreadsheet, and -- It had a unique encounter ID associated with each of the rows, where there was information, and those were the predefined stays, as I understand by Mr. Adams, that needed to be sampled. I investigated that each [en]counter ID that showed up within each of those three tabs was, in fact, unique, and that was the information upon which I drew my samples, for each of the years, so that's a static data set.").
[67] *Id.* at 101-03, 114-15.

B. The DSH Adjustment Under the IPPS

The Medicare program generally pays hospitals a fixed, predetermined rate for each inpatient discharge based on the patient's DRG.[68] In addition to the DRG payment, the IPPS adjusts a hospital's payment based on various hospital-specific factors, one of which is the Medicare DSH adjustment[69] at issue in this appeal. The DSH adjustment is a proxy measurement, intended to represent the number of low-income patients that a hospital serves[70] as measured in "patient days."[71] The DSH adjustment is calculated by adding two fractions, generally referred to as the Medicare fraction and the Medicaid fraction.[72]

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

> (ii) For purposes of this section, the number of patient days in a hospital *includes* ***only*** those days attributable to units or wards of the hospital providing acute care services *generally payable under the prospective payment system* ***and excludes*** patient days associated with—
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> (A) Beds in excluded distinct part hospital units;
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> (B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts;
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> (C) Beds in a unit or ward that is ***not*** occupied to provide a *level of care* that would be *payable under the acute care hospital inpatient prospective payment system* at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month); and
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> (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.[73]

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[68] 42 U.S.C. § 1395ww(d)(2)-(3). *See also* 42 C.F.R. Part 412.
[69] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[70] *Id.*
[71] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[72] *Id. See also Metropolitan Hosp. v. U.S. Dept. of Health & Human Servs*., 712 F.3d 248, 251 (6th Cir. 2013).
[73] (Emphasis added.)

The Medicare Contractor found that, consistent with its application of the above regulation, none of the Four Units days were eligible to be counted in either the numerator or denominator of OKSU-MC's DSH Medicaid fraction for FY 2008.[74] OKSU-MC challenges the Medicare Contractor's removal of the Four Units' days from the numerator and denominator of its Medicaid fraction when calculating its FY 2008 DSH adjustment. As addressed in OKSU-MC's revised amount in controversy calculations, the elimination of these days (and their related bed days available) from the Adults & Pediatrics line of the cost report Worksheet S-3 also resulted in payment changes for other issues; and, if the Medicare Contractor's adjustments were reversed, as OKSU-MC requests, then: (1) IME add-on payment would decrease by over $800,000, as would the GME payment; and (2) the Inpatient Capital PPS payment would decrease by over $100,000, also, resulting in over $1,750,000 in decreased payments.[75] OKSU-MC has not argued whether the changes (increases in settlement) for IME/GME/Capital PPS are incorrect as a result of the days adjustments, but did revise its calculation of the amount in controversy for this case to reflect those subsidiary effects on settlement of their requested adjustment reversal.

C. Summary of OKSU-MC's Position

OKSU-MC claims that the days associated with treatment of children and adolescents on its Four Units have been improperly excluded from *both* the numerator and the denominator of its Medicaid fraction.[76] It acknowledges that, pursuant to 42 C.F.R. § 412.106(a)(1)(ii), Medicaid-eligible days can be included in a provider's Medicaid fraction if the days are from a unit not excluded from the IPPS[77] and the unit was "providing acute care services generally payable under the prospective payment schedule."[78]

OKSU-MU explains how, in 2008, CMS notified another Oklahoma hospital, St. Anthony Hospital ("St. Anthony"), that it would be disallowing days related to care in its six (6) child and adolescent behavioral health units.[79] It further asserts that, as a result of efforts by St. Anthony, the Oklahoma Hospital Association, and the Oklahoma Congressional delegation to persuade CMS not to make this disallowance, CMS decided to direct St. Anthony's assigned Medicare contractor, TrailBlazer, to conduct a medical review to determine if the six St. Anthony behavioral health units were providing acute care services generally payable under IPPS.[80]

Following its medical review, TrailBlazer issued a report[81] detailing the examination of patient days for thirty (30) inpatient stay records from the six behavioral health units at issue for St. Anthony.[82] The review only related to certain portions of those patient's inpatient stay and used the InterQual Behavioral Health Child and Adolescent Acute Care screening criteria ("InterQual

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[74] Ex. C-7.
[75] Ex. P-18 at 1.
[76] Ex. P-4 at 35-36 (Individual Appeal Request, Issue Statement); Provider's FPP at 19.
[77] OKSU-MC claims its Four Units was ***not*** a distinct part psychiatric unit which would be excluded from IPPS, and the record does not contain any evidence to the contrary. Provider's FPP at 28-29; 2019-Day 1 Tr. at 80; Provider's Response to Medicare Contractor's SFPP at 10.
[78] 42 C.F.R. § 412.106(a)(1)(ii). *See also,* P-4 at 35-36 (Individual Appeal Request, Issue Statement).
[79] Provider's FPP at 1.
[80] *Id.* at 1-2.
[81] Ex. P-1.
[82] *Id.* at 6.

Criteria") to analyze those portions.[83] For each patient day reviewed, the InterQual Criteria were used to determine:

- Whether the severity of the patient's illness required an acute level of care; and
- Whether the patient received the intensity of services required for an acute level of care.[84]

OKSU-MC describes the application of the Trailblazer methodology to a patient stay as follows:

1. Review the day of admission under the InterQual Criteria and if the day meets this criteria, then the stay is deemed to have met the acute care inpatient criteria for the geometric mean length of stay of the DRG plus five days;
2. Review the next 10 days applying the InterQual continuing care criteria; and
3. If the patient remained admitted on day 61, review an additional 5 days starting there.[85]

Based, in part, on the InterQual Criteria, the Medicare contractor concluded that three of St. Anthony's psychiatric units met the criteria for acute care.[86] The Trailblazer medical review "validated the [Medicare contractor's] audit results for the [t]hree [d]isputed [u]nits concluding that they did not satisfy the acute care requirements for IPPS because less than 50 percent of the patient days sampled met the acute inpatient admission criteria."[87]

OKSU-MC notes that, unlike the St. Anthony review, the Medicare Contractor disallowed all the days from its Four Units without conducting any medical review to determine whether the Four Units were providing an acute level of care during FY 2008.[88] OKSU-MC argues that, without any medical review of the care provided in the Four Units, this disallowance is not supported by substantial evidence in violation of the Administrative Procedure Act.[89]

In addition, OKSU-MC contends that, for the *St. Anthony* case, TrailBlazer's medical review counted all days paid under the "acute" Oklahoma DRG methodology (generally seven days) plus an additional five days for a total of twelve days.[90] OKSU-MC's stresses this contention because, if it is assumed that twelve days were "acute", then the Four Units would be very close to the 50 percent threshold since OKSU-MC's ALOS across 2004 through 2015 was 23.19 days.[91]

In support of its position, OKSU-MC also points to the testimony of the Medicare contractor's expert in the Board hearing for the *St. Anthony* case and characterizes his testimony as stating "the ALOS for acute care hospitals should be approximately 25 days." OKSU-MC states that

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[83] *Id.*
[84] *Id*. at 5.
[85] Provider's PHB at 19 (citing to Ms. Edford's testimony but having a typo as it cited to geographic mean length of stay as opposed to the geometric mean length of stay).
[86] *St. Anthony Hosp. v. Novitas Solutions, Inc.*, PRRB Dec. 2022-D29 at 4-5 (Sept. 19, 2022) (included as Ex. P-59) (stating that the TrailBlazer medical review was conducted to validate the audit results).
[87] *Id.* at 5.
[88] Provider's FPP at 2.
[89] *Id.* at 2-3, 43-45.
[90] *Id.* at 3.
[91] *Id.* at 3-4 (noting the average length of stay for the Four Units between 2004 and 2015 was 23.19 days).

this 25-day ALOS is higher than the overall ALOS for the Four Units across 2004 through 2015 (23.19 days).[92] OKSU-MC takes issue with the fact that all of its patient days from the Four Units were disallowed without any consideration of the ALOS therein and, similarly, claims that the disallowance of *all* days from the Four Units without any medical review is arbitrary and capricious when considering the fact that, in the *St. Anthony* case, CMS allowed *some* days following a medical review.[93] OKSU-MC also claims that the Medicaid days from the Four Units were allowed to be included in OKSU-MC's DSH Medicaid fraction for nearly a decade preceding FY 2008, and that applying a "new" policy without notice-and-comment rulemaking violates the Medicare statute.[94] However, OKSU-MC did not include any documentary evidence to support this contention on historical treatment.

One of the most prominent arguments made by OKSU-MC is that the payment designation from OMP of acute care (with a DRG payment) versus residential or PRTF/RTC care (with *per diem* payment) is not relevant to the actual level of care provided because these are simply payment designations unrelated to the level of care.[95] In support, OKSU-MC cites to a *post-hoc* statement from the Chief Executive Officer ("CEO") of the Oklahoma Health Care Agency ("OHCA") that administers the Oklahoma Medicaid Agency ("OMA") and characterizes that statements as stating that "services in hospital-based units, such as the Four Units, are 'acute care' services."[96] OKSU-MC strongly maintains that the treatment provided was always an inpatient level of care and was never affected by a change in payment designation from acute with a DRG payment to PRTF/RTC care with a *per diem* payment.[97]

To further support its position, OKSU-MC conducted its *own* medical review using what it contends is the *same* methodology as that which TrailBlazer used in the *St. Anthony* case.[98] To perform the medical review, OKSU-MC first engaged with a consulting firm to draw a random sample of claims for FYs[99] 2006, 2007, and 2008.[100] The sampling and extrapolation expert from this firm, Dr. Michael Salve, testified at the hearings as a statical sampling expert and explained that: (1) he stratified the universe by FY; (2) he drew a sample of 34 claims from each stratum (*i.e.*, each FY), totaling 102 total stays for the universe; and (3) these three samples were random and representative with regard to the ALOS of the entire universe of stays across the three stratums, namely FYs 2006, 2007, and 2008.[101]

Once this sample was prepared, OKSU-MC engaged a licensed coding specialist who conducted a medical record review of the 102 patient stays using what it alleges is the same medical review methodology that TrailBlazer performed for the *St. Anthony* case.[102] That is, the coding specialist

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[92] *Id.* at 4.
[93] *Id.* at 4, 58-61.
[94] *Id.* at 5 (citing 42 U.S.C. § 1395hh(a)(2)), 62-64.
[95] *Id.* at 33-34.
[96] *Id.* (citing to Ex. P-28).
[97] Provider's FPP at 10-13, 50-58; 2019-Day-1 Tr. at 182-183, 254-255; 2024-Day-1 Tr. at 232-235; 2024-Day-2 Tr. at 71-72, 229-230, 254).
[98] Ex. P-52 at 3.
[99] As discussed *infra*, there is some question as to whether the sample drawn was based on fiscal year or calendar year.
[100] 2019-Day-1 Tr. at 266. Note that the original report from the statistical expert included a typo where it states that the strata were based on calendar year as opposed to fiscal year. Ex. P-41 at ¶ 6.
[101] *Id.* at 266-270, 288-291, 298. *See also* Ex. P-51 (copy of updated expert report).
[102] 2019-Day-2 Tr. at 44-48; 2024-Day-1 Tr. at 157.

evaluated the medical records to determine if each of the 102 stays qualified as "acute" at the time of admission based on InterQual criteria and ultimately found that all 102 stays did, in fact, qualify as "acute" at the time of admission.[103] The coding specialist then conducted a review on the continued care but only for a subsample of fifteen patient stays, which were selected using RAT-STATS, a statistical program developed by the Office of Inspector General.[104] This fifteen stay subsample included five stays from each stratum (*i.e.*, five from each of the FYs 2006, 2007 and 2008) and involved 330 total days.[105] OKSU-MC asserts that the coding specialist found that 282 of these days met the InterQual criteria for an acute level of continuing care, while forty-eight days did not.[106]

Finally, OKSU-MC engaged Virginia Heller, a psychiatrist who worked on the Four Units from 2014-2015,[107] to conduct a second level of review over the forty-eight days which did not meet the InterQual criteria for an acute level of continuing care. Rather than using the InterQual criteria, Dr. Heller used her professional experience and opinions to determine whether an acute level of continuing care was provided for these 48 days.[108] She found that, for thirty-eight of those days, the patients required an acute inpatient hospital level of care.[109] Significantly, Dr. Heller's review only involved two sampling units from FY 2008 (namely 2008-13 and 2008-19) and reviewed seventeen days from those sampling units but only found seven of those days (or 41 percent) to be acute care.[110] Based on these two levels of review, OKSU-MC maintains that 320 of the 330 days in the fifteen stay subsample it created needed and received an acute inpatient hospital level of care.[111]

OKSU-MC filed the reports containing the findings of Dr. Salve, Ms. Edford, and Dr. Heller with the Board on June 7, 2019 and those reports totaled 263 pages in the aggregate. However, at the initial hearing held on October 22-23, 2019, OKSU-MC requested to continue the hearing after discovering errors in its experts' reports and the related summary sheets of Dr. Salve and Ms. Edford that could not be corrected at the hearing.[112] OKSU-MC requested a continuance to submit a corrected expert report within one week and the Medicare Contractor did not object to the request and, as a result, the Board granted that request.[113] Three months later on January 31, 2020, OKSU-MC filed the promised "corrected" reports.

Finally, the Board recognizes that: (1) OKSU-MC contends that the *redacted*[114] billing records at Exhibit P-12 corroborate its position in this appeal because they document one case where

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[103] 2024-Day-1 Tr. at 172. *See also* Ex. P-52.
[104] 2024-Day-1 Tr. at 177.
[105] *Id.* at 177; Ex. P-52 at 8. (P-52 at 7 indicates the subsample was 360 days, but 330 is then indicated in the final calculations at 8. 330 days was confirmed by the witness in the hearing. *See* 2024-Day-1 Tr. at 183.)
[106] 2024-Day-1 Tr. at 181-183; Ex. P-52 at 8.
[107] 2024-Day-2 Tr. at 47-48.
[108] *Id.* at 44-45.
[109] Ex. P-53 at 2.
[110] Ex. P-53 at 15-17.
[111] *See* Provider's PHB at 21.
[112] Board's Denial of Request for Postponement (Jan. 24, 2024).
[113] *Id.*
[114] OKSU-MC made the redactions to the ***billing*** records at Ex. P-12 pursuant to Board Rule 1.4 (2018) which specifies that: "[b]ecause the record in Board proceedings may be disclosed to the public, the parties must carefully

Medicare paid an IPPS patient/claim for psychiatric care of an adolescent based on an alleged patient stay beginning in August 2010;[115] and (2) these billing records suggest that patient is also a Medicaid beneficiary since the billing history includes submission of bills to OMA.[116] However, Exhibit P-12 provides no evidentiary value in this appeal as highlighted by the following analysis: (1) the 2011 inpatient stay occurred several years after FY 2008 (the fiscal year at issue) and, since OKSU-MC no longer operated the Four Units as of July 2008, it is unclear to what extent the new owner changed the operations of the Four Units; (2) it is not clear from the face of the *redacted* billing records whether the care underlying those records was even provided in the Four Units or in some other part of AHS Hillcrest (in this respect the Board notes, by example, that OKSU-MC had an excluded psychiatric unit in addition to the Four Units)[117]; (3) it is not clear from the *redacted* billing records what the precise dates of admission and discharge are or what the length of stay was, much less whether the patient was treated as part of the PRTF program; and (4) as the patient appears to have had Medicaid, it is possible that this stay could have been prior authorized by OMP for acute care, thereby validating the level of care furnished as acute.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

As set forth in 42 C.F.R. § 412.106(a)(1), "[t]he factors considered in determining whether a hospital qualifies for a [DSH] payment adjustment include the number of beds, the number of patient days, and the hospital's location." This case focus on the "patient days" factor used in the DSH adjustment calculation. The "patient days" factor is governed by 42 C.F.R § 412.106(a)(1)(ii) (as of Dec. 1, 2007):

> (ii) For purposes of this section, the number of patient days in a hospital *includes* ***only*** those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system ***and excludes*** *patient days associated with—*
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> *****

review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (untraceably remove) the names and numbers and replace them with non-identifying sequential numbers." However, this Rule also makes clear that a Party may seek permission from the Board to submit *unredacted* records with protected health information or other personally identifiable information "[i]f the confidential information itself is *necessary* to support your position." (Emphasis added.) OKSU-MC did not request permission from the Board to submit unredacted *billing* record documentation. As such, the Board must look to the evidentiary value of the ***redacted*** *billing* records without consideration of what information has been redacted. In this respect, the following OKSU-MC contention on what Exhibit P-12 establishes is not supportable from the fact of the redacted Exhibit P-12 (indeed, it is not clear that an unredacted exhibit would wholly support the contention since they are *billing* records as opposed to patient medical records): "Exhibit P-12 (redacted) contains documents related to a claim for services provided during a 35-day inpatient stay (from August 18 through September 22, 2010) in the Adolescent Residential Unit to a 17-year old who became eligible for Medicare after a kidney transplant and remained on Medicare during the entire stay." Provider's PHB at 31.

[115] Provider's PHB at 31. *See also* 2019-Day-1 Tr. at 81-83. Note that the alleged admission and discharge dates cannot be verified as they were redacted from the billing records at Ex. P-12. Indeed, the earliest *unredacted* date in Ex. P-12 is May 17, 2011. Ex. P-12 at 1.

[116] Ex. P-12 at 3.

[117] Ex. P-3 at 24 (referencing "update[ing] Subprovider Inpatient Psychiatric Prospective Payments to PSR").

> (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)[.][118]

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

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

Analysis of this appeal must begin with the meaning of the term "acute care" in the applicable regulatory framework. The inquiry starts with the above excerpt from 42 C.F.R. § 412.106. During the time period relevant to this appeal, the Board has identified no other statute, regulation or Medicare program guidance in effect that specifically defined the term "acute care."

As such, the Board turns to the guidance provided by the Secretary when 42 C.F.R. § 412.106 was promulgated through the final rule published on August 1, 2003 (the "2003 Final Rule").[119] In its discussion of the 2003 Final Rule, the Secretary confirmed that it was revising § 412.106(a)(1)(ii), in part, as a result of its disagreement with the decision in *Alhambra*[120] regarding the Ninth Circuit's interpretation of that regulation.[121] In *Alhambra*, the provider operated units that were licensed in California as skilled nursing facility ("SNF") beds but were not similarly certified by Medicare. The California Medicaid Program classified the units as "subacute" care units that provided less intensive care than acute care units, but more intensive skilled nursing care than is typically provided in a SNF.[122] In the following excerpt from the preamble to 2003 Final Rule, the Secretary addressed the *Alhambra* court's ruling and clarified his policy on counting days in § 412.106(a)(1)(ii):

> As noted previously, a recent decision in the Ninth Circuit Court of Appeals (*Alhambra v. Thompson*) ruled that days attributable to groups of beds that are not separately certified as distinct part beds (that is, nonacute care beds in which care provided is generally at a level below the level of routine inpatient acute care), but are adjacent to or in an acute care "area," are included in the "areas of the hospital that are subject to the prospective payment system" and should be counted in calculating the Medicare DSH patient percentage.
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> In light of the Ninth Circuit decision that our rules were not sufficiently clear to permit exclusion of bed days based on the area where the care is provided, in the May 19, 2003 proposed rule, we proposed to revise our regulations to be more specific. Therefore, we proposed to clarify

[118] (Emphasis added.)
[119] 68 Fed. Reg. 45346 (Aug. 1, 2003).
[120] 259 F.3d 1071 (9th Cir. 2001).
[121] 68 Fed. Reg. at 45417.
[122] 259 F.3d at 1073.

> that beds and patient days are excluded from the calculations at § 412.105(b) and § 412.106(a)(1)(ii) ***if the nature of the care provided in the unit*** or ward ***is inconsistent with what is typically furnished to acute care patients***, *regardless of whether these units or wards are separately certified or are located in the same general area of the hospital as a unit or ward used to provide an acute level of care*. Although the intensity of care *may vary* within a particular unit, such that some patients may be acute patients while others are nonacute, [we] believe that a patient-by-patient, day-by-day review of whether the care received would be paid under the IPPS would be unduly burdensome. Therefore, we believe it is more practical to apply this principle (that is, that we should consider only the inpatient days to which the IPPS applies) ***by using a proxy measure*** *that is based upon the location at which the services were furnished*.
>
> In particular, we proposed to revise our regulations to clarify that the beds and *patient days attributable to a* ***nonacute*** *care unit or ward should not be included in the calculations at § 412.105(b) and § 412.106(a)(1)(ii)*, ***even if the unit is not separately certified by Medicare as a distinct-part unit and*** *even if the unit or ward is within the same general location of the hospital as areas that are subject to the IPPS* (that is, a unit that provides an IPPS level of care is on the same floor of the hospital as a subacute care unit that does not provide an IPPS level of care).
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> Exceptions to *this policy to use* ***the level of care generally provided in a unit*** or ward ***as proxy*** *for the level of care provided to a particular patient on a particular day* are outpatient observation bed days and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit.
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> The proposed policy is not intended to focus on the level or type of care provided to individual patients in a unit, *but rather on the level and type of care* ***provided in the unit as a whole***. For example, the bed days for a patient participating in an experimental procedure that is not covered under the IPPS should be counted as long as the patient is treated in a unit of the hospital that generally provides acute inpatient care normally payable under the IPPS. The expectation is that a patient located in an acute care unit or ward of the hospital is receiving a level of care that is consistent with what would be payable under the IPPS.[123]

In response to a comment, the Secretary confirmed that the intent of the 2003 revisions to the regulation was to ensure that § 412.106(a)(1)(ii) clearly reflected its longstanding policy because

[123] 68 Fed. Reg. at 45417 (emphasis added beyond the 9th Circuit decision name).

the *Alhambra* Court's interpretation of that regulation was contrary to the underlying policy:

> *Comment*: Several commenters objected to our proposal and indicated that we were attempting to codify the Secretary's litigation position in *Alhambra* and administratively overrule the Ninth Circuit's decision in that case. . . .
>
> *Response*: We disagree that our proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. . . .
>
> We also do not believe that by placing our longstanding interpretation of our rules in regulations we are unlawfully overruling or nullifying the decision by the Ninth Circuit in *Alhambra Hospital v. Thompson*, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit decision **focused on an interpretation of CMS' previous regulation at § 412.106(a)(1)(ii)—not on an interpretation of the statute**. . . . Although we respectfully disagree with the Ninth Circuits interpretation of the existing regulations, we are nonetheless amending them, through notice and comment rulemaking **to ensure that going forward** the regulations clearly reflect our longstanding position. Therefore, we do not agree with the commenter's assertion that our proposed policy is an illegal attempt to administratively overrule the Ninth Circuit's decision in Alhambra. Therefore, going forward, we plan to apply the clarified regulation to hospitals in all U.S. jurisdictions, including hospitals in the Ninth Circuit.[124]

Thus, the above excerpts from the preamble to the 2003 Final Rule make clear that, when applying § 412.106(a)(1)(ii) to determine whether a hospital unit provides a level of care that would generally be payable under IPPS, the proper focus must be "on the level and type of care *generally provided in the unit*, ***as a whole***," without regard to whether or not the Medicare program separately certifies the unit.[125] In this regard, § 412.106(a)(1)(ii) operates as "*a proxy measure* that is based upon the location at which the services were furnished"[126] and, as explained by the Secretary, a day-by-day or patient-by-patient review is unduly burdensome and contrary to the applicable regulation.[127]

B. OKSU-MC has failed to meet its burden of proof and evidence to establish that the type of care generally provided in the Four Units, as a whole, is care that would be generally payable under IPPS.

42 C.F.R. § 405.1871(a)(3) directs the Board to determine "whether [OKSU-MC] carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue." As set forth below, the

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[124] *Id.* at 45418.
[125] (Emphasis added.)
[126] 68 Fed. Reg. at 45417 (emphasis added).
[127] *Id.*

Board finds that OKSU-MC has not carried its burden of production of evidence and burden of proof and, specifically, that it has failed to establish, by a preponderance of the evidence, that the type of care generally provided in each of the Four Units, as whole, is care that would be generally payable under IPPS.

1. *The opinion of the OHCA CEO upon which OKSU-MC relies has no foundation and no evidentiary value.*

In support of their contention that the PRTF care furnished in the Four Units would be generally payable under IPPS, OKSU-MC points[128] to the ***post-hoc*** opinion of the OHCA CEO that, ***for purposes of the Medicare DSH calculation***, PRTF care days are "acute care days." Specifically, in a letter dated October 2, 2008, the OHCA CEO stated:

> As the designated Medicaid agency in Oklahoma, [OHCA] *believes* that the days of patients in a hospital-based [PRTF] are ***acute care*** *days that should be included in the hospital's Medicare DSH calculation*.
>
> Federal Medicaid rules permit State Medicaid programs to cover inpatient psychiatric services furnished to persons under the age of 21. *See* 42 C.F.R. §§ 440.160, 441.151. Consistent with these Federal rules, under Oklahoma Code § 317:30-5.95.23, Oklahoma Medicaid covers inpatient psychiatric care for children under the age of 21 furnished in a hospital setting, a hospital-based PRTF, or a freestanding PRTF.
>
> The Medicaid payment methodology for these inpatient psychiatric services differ by setting. Specifically, Oklahoma Medicaid pays a hospital DRG payment with the potential for "outlier" payments. On the other hand, Medicaid makes per diem payments for services furnished in a hospital-based PRTF. *The State considers both DRG-paid **and** per diem paid services to be **acute care** services*. *The staffing and care requirements* for the provision of psychiatric care services are the ***same*** for both DRG paid and per diem paid services. *While the per diem paid stays are typically longer than the stays paid under DRGs*, the length of stay does not determine the acuity of care furnished. For these reasons, it is incorrect to distinguish between DRG paid and per diem paid days on the grounds that the DRG paid days are acute care and the per diem paid days are not acute care.[129]

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

[128] Provider's FPP at 33-34, 49-50. *See also* 2019-Day-1 Tr. at 71-72.
[129] Exhibit P-28.

opinion can be reconciled with the OHCA/OMP *regulatory* definition of PRTF in effect during the time period at issue which specifies that a PRTF may be "freestanding" or "hospital-based"[130] and defines a PRTF as a "non-hospital"[131] or "facility **other than a hospital**"[132] that provides "***non-acute*** inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions."[133] Further, OKSU-MC did not present the OHCA CEO (or any OHCA employee) as a witness. Absent testimony to allow the Board to understand the foundation for the opinion, and the inconsistencies between the opinion and the OHCA/OMP *regulations*, the Board must conclude that there is no evidentiary value to the OCHA CEO's *post hoc* opinion.[134]

2. *The record is clear that the Four Units, as a whole, are overwhelmingly providing PRTF care.*

The testimony of OKSU-MC's witnesses at the hearing was that the Four Units do not differentiate between the degree to which acute care versus PRTF care is provided in each of their units.[135] The Board notes, however:

- All beds on the Four Units were *dually licensed* as under-18 psychiatric acute care and under-18 residential treatment care.[136]
- A Medicaid patient in any of the Four Units did not necessarily move to another bed (or unit) if OMP switched that patient from being authorized for under-18 acute psychiatric care (which is paid on a DRG basis) to under-18 PRTF care (which is paid on a per diem basis).[137]

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[130] Okla. Admin. Code at § 317:30-5-95(d) (2008) (defining PRTF and describing PRTFs as both hospital-based and freestanding). All citations to the Oklahoma Administrative Code in this decision are to the 2008 version unless otherwise specified.

[131] *Id*.

[132] *Id*. at § 317:30-5-95(b)(5) (emphasis added).

[133] *Id.* at § 317:30-5-95(a) (emphasis added).

[134] **Subsections B.2 to E** of the Discussion, FINDINGS OF FACT, AND CONCLUSIONS OF LAW include further discussion on how the OCHA CEO's opinion lacks any foundation. Similarly, they demonstrate that the following *post-hoc* Oklahoma State Senate resolution is conclusory and does not have any foundation:

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

Okla. Sen. Res. 71, 55th Legis. 2R (May 17, 2016) (italics and bold emphasis added) *available at*: https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SR/71.pdf (last visited Sept. 26, 2024).

[135] *See, e.g.*, 2019-Day-1 Tr. at 182-83, 254-55; 2024-Day-1 Tr. at 232-35; 2024-Day-2 Tr. at 71-72, 229-30, 254.

[136] *See supra* note 8 and 9 and accompanying text.

[137] 2024-Day-2 Tr. at 227; 2024-Day-1 Tr. at 280.

- It is uncontested that ***80.36 percent*** of inpatient days in the Four Units, as a whole, for the period of FY 2008 at issue in this appeal, were for PRTF care.[138]

A review of the record confirms that the type of care furnished in the Four Units, as a whole during FY 2008, was *overwhelmingly* residential psychiatric care in the PRTF in that 80 percent or more of the days of care during FY 2008 were for PRTF care.[139] In this respect, the Board notes that the room set up with wooden beds lacking gas and air hook-ups (as discussed above in **Subsection A** of the STATEMENT OF FACTS AND RELEVANT LAW) is more indicative of residential/PRTF care, rather than acute care generally payable under IPPS. Thus, the Four Units, *as a whole*, was providing PRTF care for the relevant time period.

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

The Board recognizes that 42 C.F.R. § 412.106(a)(1)(ii)(B) specifies that "[b]eds otherwise countable under this section used for . . . skilled nursing swing-bed services" are excluded. However, OKSU-MC specifically states "it is indisputable that **none** of the services in the Four Units were 'outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services.' *See* 42 C.F.R. §412.106(a)(1)(ii)(B)."[140] As such, it would appear that the exception at § 412.106(a)(1)(ii)(B) is not applicable since the discussion of swing bed services appears to be focused on the context of an acute care bed swinging to furnish skilled nursing services (as opposed to psychiatric residential treatment facility care).[141]

Notwithstanding, it appears that the Four Units made *an operational decision* to organize the department to, in essence, swing their beds between acute care and PRTF care since, as previously noted: (a) each of their beds is dually licensed to provide under-18 psychiatric acute care and under-18 PRTF care;[142] and (b) a patient did not have to be moved to another bed (or unit) *if OMP switched that patient from being authorized for under-18 acute psychiatric care to under-18 PRTF care*.[143] In reviewing the applicability of the "swinging bed" concept, the Board notes that the Secretary specified in the 2003 Final Rule that "Observation beds and swing-beds are both special, *frequently* ***temporary***, *alternative uses of acute inpatient care beds*."[144] Thus, the alternative use of an acute care bed is expected to be generally temporary and not its dominant use. Consistent with this expectation,[145] it is the Board's reading of § 412.106(a)(1)(ii)

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[138] Provider's Response to Medicare Contractor's SFPP at 22-23.
[139] *Id.*
[140] Provider's FPP at 46 (underline and bold emphasis added).
[141] *See* 68 Fed. Reg. at 45418 (stating that "[a] swing-bed is a bed that is otherwise available for use to provide acute inpatient care and is also occasionally used to provide SNF-level care.").
[142] *See supra* notes 8 and 9.
[143] *See supra* note 137.
[144] 68 Fed. Reg. at 45418-19 (emphasis added).
[145] *See also* 69 Fed. Reg. 48916, 49093 (Aug. 11, 2004) (stating "In the May 19, 2003, FY 2004 IPPS proposed rule (68 FR 27205), we discussed proposed changes to our policies for counting beds and patient days in relation to the IME and DSH adjustments. Specifically, we proposed to amend § 412.105(b) and § 412.106(a)(1)(ii) as they pertain to the counting of beds and patients days for determination of the IME adjustment and DSH payment adjustment. We proposed to amend § 412.105(b) to indicate that the bed days in a unit that is unoccupied by patients receiving a level of care that would be generally payable under the IPPS (IPPS level of care) for the 3 preceding months are to be excluded from the available bed day count for the current month. In addition, we proposed that the beds in a unit

(as of Dec. 1, 2007) that the exceptions in clauses (A) to (D) are reached only if there is a finding that the unit, *as a whole*, furnishes acute care services generally payable under IPPS:

> (ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system ***and*** excludes patient days associated with— (A) …. (B) …. (C) ….(D).[146]

The Board's reading is consistent with the fact that § 412.106(a)(1)(ii) operates as "*a proxy measure* that is based upon the location at which the services were furnished."[147] Accordingly, the Board never reaches the swing-bed exception and its potential application.[148]

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that was occupied by a patient(s) receiving an IPPS level of care during the 3 preceding months should be counted unless they could not be made available for patient occupancy within 24 hours, or they are used to provide outpatient observation services or swing-bed skilled nursing care (68 FR 27204). *Regarding* ***nonacute*** *care beds and days*, we proposed to revise § 412.105(b) to clarify that beds in units or wards established or used to provide a level of care that is not consistent with what would be payable under the IPPS cannot be counted. We also proposed to revise the DSH regulations at § 412.106(a)(1)(ii) to clarify that the number of patient days includes only those days attributable to patients that receive care *in units or wards that furnish a level of care that would generally be payable under the IPPS (68 FR 27205)*. . . . In the August 1, 2003 final rule (68 FR 45346), we finalized some of these proposals . . . . The proposals for ***nonacute*** *care beds and days*, observation and swing-bed days, LDP beds and days, and days for 1115 demonstration projects were finalized in the August 1, 2003 final rule." (emphasis added)).

[146] (Emphasis added.)

[147] 68 Fed. Reg. at 45417 (emphasis added).

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

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

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

> Therefore, we proposed to clarify that beds and patient days are excluded from the calculations at § 412.105(b) and § 412.106(a)(1)(ii) if the nature of the care provided in the unit or ward is inconsistent with what is typically furnished to acute care patients, *regardless of whether these units or wards are separately certified* or are located in the same general area of the hospital as a unit or ward used to provide an acute level of care. *Although the intensity of care may vary within a particular unit, such that some patients may be acute patients* ***while others are nonacute***, *[we] believe that a patient-by-patient, day-by-day review of whether the care received would be paid under the IPPS would be unduly burdensome*. Therefore, we believe it is more practical to apply this principle (that is, that we should consider only the inpatient days to which the IPPS applies) ***by using a proxy measure*** *that is based upon the location at which the services were furnished*.

Id.

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

OKSU-MC notes that the Medicaid program covers "inpatient psychiatric hospital services for individuals under age 21" pursuant to 42 U.S.C. § 1396d(h)(1).[149] Based on this conclusion, OKSU-MC then leaps to the conclusions that: (1) all such services from the Four Units, including PRTF care, are "acute care"; and (2) any such "acute care" would be generally payable under IPPS. However, that is not the case. Section 1396d(h)(1)(A) specifies that these "inpatient services" only include services "provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title *or in another inpatient setting that the Secretary has specified in regulations*[.]"[150] Based on the Secretary's implementation of this *Medicaid* benefit at 42 C.F.R. §§ 440.160 and 441.151, and Part 441, Subpart D generally, the under-21 inpatient psychiatric benefit may be furnished in the following inpatient settings:

- *An inpatient psychiatric hospital (or inpatient psychiatric hospital distinct part) that meets the requirements for participating in the Medicare program as a psychiatric hospital in § 482.60*.— For purposes of the Medicare programs, these settings are subject to the Medicare inpatient psychiatric prospective payment system which, as explained in the Administrator's decision in *St. Anthony Hosp. v. Novitas Solutions, Inc.,* Adm'r Dec. at 6-7 (Mar. 6, 2018), *vacating and remanding* PRRB Dec. No. 2018-D12 (Dec. 29, 2017), are excluded from IPPS per 42 U.S.C. 1395ww(d)(1)(B) and, as such, cannot be used as a point of reference for what the § 412.106(a)(1)(ii) phrase "acute care services generally payable under [IPPS]" means.[151]

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

- *A PRTF* — As previously noted, a PRTF is defined as a "nonhospital" facility providing "nonacute care."[152]

Similarly, the facts surrounding the inpatient subacute care unit at issue in *Alhambra* and the Secretary's 2003 revisions to § 412.106(a)(1)(ii) (issued in response to the *Alhambra* decision) confirm that simply being a hospital "inpatient" does not mean that the patient is receiving

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[149] Provider's FPP at 49-50.

[150] (Emphasis added.)

[151] *St. Anthony*, Adm'r Dec. (*vacating & remanding* PRRB Dec. No. 2018-D12) at 16-18. *See also St. Anthony*, PRRB Dec. No. 2022-D29 (Sept. 19, 2022), *on remand from*, Adm'r Dec. (*vacating & remanding* PRRB Dec. No. 2018-D12), *decl. rev.*, Adm'r Dec. (Nov. 17, 2022).

[152] *See* Subsection B(5) of the DISCUSSION, STATEMENT OF FACTS, AND CONCLUSIONS OF LAW; 42 C.F.R. §§ 441.151(b), 483.352; 63 Fed. Reg. 64195 (Nov. 19, 1998); 66 Fed. Reg. 7148 (Jan. 22, 2001); 72 Fed. Reg. 68077, 68081 (Dec. 4, 2007). The concept that a *nonhospital* facility can provide services under inpatient psychiatric hospital services benefit for those under 21 originates from the final rule issued on January 14, 1976. *See* 41 Fed. Reg. 2198, 2198 (Jan. 14, 1976) (acknowledging a comment that "[t]he requirement that psychiatric services to patients under 21 must be provided by an institution which is a psychiatric hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) is too narrow an interpretation of the legislation."; and responding that "[t]hroughout the regulations [governing the under 21 inpatient psychiatric hospital services benefit] the word 'hospital' has been changed to 'facility'" and that "[t]his includes any institution ***other than*** *a hospital* which provides ***inpatient care*** and is accredited as a psychiatric facility by JCAH." (emphasis added)).

"acute care" services.[153] Accordingly, the fact that PRTF care is "inpatient" care does not mean that the care provided in a PRTF is "acute care," much less "acute care services generally payable under [IPPS]."

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

While acute care provided under the OMP would appear very close to that provided in a short-term acute care hospital, the care provided in a PRTF is very different and is not comparable. First, it is important to acknowledge that the Medicare program *neither* recognizes *nor* certifies distinct hospital units (or facilities) as PRTFs. Rather, PRTFs are a Medicaid program creation, in general, similar to nursing facilities ("NFs") and intermediate care facilities for the mentally retarded ("ICF/MRs").[154] Both the HHS regulations governing State Medicaid programs and the Medicare Claims Processing Manual recognize that PRTFs, such as the Four Units, may be located in a hospital but are not recognized (nor formally excluded) by the Medicare program from IPPS pursuant to 42 C.F.R. § 412.25.[155]

Contrary to the OHCA CEO's characterization in his October 2, 2008 letter, PRTFs are not simply a payment mechanism, but are subject to accreditation and State inspection to confirm that they meet the relevant OMP conditions of participation as a PRTF.[156] Further, it is clear that these PRTF standards and conditions of participation are designed to address both the nature and level of the care furnished in the PRTF as illustrated by the medical necessity criteria for admission to a PRTF *as well as* for ***continued*** stay in a PRTF.[157] To this end, all of the beds in the Four Units were dually licensed to provide psychiatric acute care as well as psychiatric residential care.[158]

The OMP amended the definitions of PRTF, acute care, and residential treatment services in its administrative code in June 2006. Notably, the underlying Oklahoma Administrative Code

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[153] *Alhambra* addressed the inclusion of patient days from "subacute" care units in the DSH calculation. 259 F.3d at 1073. *See also* PRM 15-1 § 2202.1 (an "inpatient" is a "person who has been admitted to a hospital or skilled nursing facility for bed occupancy to receive inpatient hospital or skilled nursing services.").

[154] *See* Medicare Benefit Policy Manual, CMS Pub. No. 100-07, § 1000B (as revised May 21, 2004) (stating: "Medicaid is a State program that provides medical services to clients of the State public assistance program and, at the State's option, other needy individuals, as well as augments hospital and nursing facility (NF) services that are mandated under Medicaid. States may decide on the amount, duration, and scope of additional services, except that care in institutions primarily for the care and treatment of mental disease may not be included for persons over age 21 and under age 65. When services are furnished through institutions that must be certified for Medicare, the institutional standards must be met for Medicaid as well. *In general, the only types of institutions participating* ***solely*** *in Medicaid are* NFs, ***Psychiatric Residential Treatment Facilities (PRTF)***, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR)." (emphasis added)); One-time Notification, CMS Pub. No. 100-20, Transmittal No. 80 (May 7, 2004) (stating that manual revisions had been made "to assign . . . provider numbers for a new Medicaid provider, Psychiatric Residential Treatment Facilities (PRTF).").

[155] *See* 42 C.F.R § 483.352 (defining "Psychiatric Residential Treatment Facility" as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting."). *See also* Medicare Claims Processing Manual, CMS Pub. No. 100-04, Ch. 26, § 10.5 (Revised Sept. 1, 2006) (specifying that the place of service ("POS") codes used on claims for PRTFs is POS code 56 which specifies that a PRTF is either "a facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.").

[156] *See* Okla. Admin. Code §§ 317:30-5-95(d)-(e), 317:30-5-95.40, 317:30-5-95.42 (2008).

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

[158] *See supra* notes 8 and 9 and accompanying text.

setting the standards for furnishing psychiatric acute care versus residential treatment services did not change and the amended definitions are clearly applicable to all of the 7 months at issue in FY 2008. Under the amended definitions, the OMP defines a PRTF as a "non-hospital"[159] or "facility ***other than*** *a hospital*"[160] that provides "***non-acute*** inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions."[161] Moreover, PRTFs are defined to specifically include both freestanding *and* hospital-based PRTFs.[162]

The use of the term "non-hospital" in the OMP PRTF definition mirrors the Secretary's regulation at 42 C.F.R § 483.352 defining "Psychiatric Residential Treatment Facility" as "a facility ***other than a hospital*****,** that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, *in an* ***inpatient*** *setting*."[163] 42 C.F.R § 483.352 was promulgated as part of the interim final rule published on January 22, 2001 and the preamble confirms that PRTFs are not hospitals (*i.e*., do not provide an acute level of care):

> This interim final rule with comment period establishes a definition of a "psychiatric residential treatment facility" *that is* ***not*** ***a hospital*** ***and*** *that may furnish covered Medicaid* ***inpatient*** *psychiatric services for individuals under age 21*. This rule also sets forth a Condition of Participation (CoP) that psychiatric residential treatment facilities *that are* ***not*** *hospitals* must meet to provide, or to continue to provide, the Medicaid inpatient psychiatric services benefit to individuals under age 21.
>
> ****
>
> The Medicaid program makes Federal funding available for State expenditures under an approved State Medicaid plan for inpatient psychiatric services for eligible individuals under 21 years of age in hospital and nonhospital settings. ***Nonhospital settings***, *which we are defining as* ***psychiatric residential treatment facilities*** *(facilities)*, are rapidly replacing hospitals in treating children and adolescents with psychiatric disorders. *These facilities are generally* ***a less restrictive alternative*** *to a hospital for treating children and adolescents whose* ***illnesses are less acute*** *but who still require a residential environment*.[164]

As referenced in the preamble to the 2001 interim final rule, the Secretary first proposed regulations defining PRTFs as "nonhospitals" in 1994 but never finalized those regulations.[165]

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[159] Okla. Admin. Code at § 317:30-5-95(d).
[160] *Id*. at § 317:30-5-95(b)(5) (emphasis added).
[161] *Id.* at § 317:30-5-95(a) (emphasis added).
[162] *Id.* at § 317:30-5-95(d) (defining PRTF and describing PRTFs as both hospital-based and freestanding).
[163] (Emphasis added.)
[164] 66 Fed. Reg. 7148, 7148 (Jan. 22, 2001).
[165] *See id.* at 7148 (stating: "On November 17, 1994, we published in the Federal Register (56 [*sic* 59] FR 59624) proposed regulations to establish standards for ***nonhospital*** psychiatric residential treatment facilities, to be contained in a new subpart F of 42 CFR part 483." (emphasis added)). *See also* 59 Fed. Reg. 59624, 59627 (Nov. 17, 1994)

The following excerpt from the 1994 proposed rule sheds additional light on how Medicaid coverage of PRTF services for those under 21 years of age is excepted from the Medicaid "IMD" exclusion and how PRTFs provide a level of care less than an inpatient hospital setting:

> Under section 1905(a) of the Act, Medicaid payment is generally not available for any services provided to individuals under age 65 who are patients in "institutions for mental diseases" (IMDs). This statutory preclusion of Medicaid payment is commonly known as the "IMD exclusion." The term "IMD" as defined in section 1905(i) of the Act, includes hospitals, *nursing facilitie*s, *or other institution*s of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.
>
> The psychiatric 21 benefit, at section 1905(a)(16) of the Act, is the *only statutory exception to the IMD exclusion*. The psychiatric 2l benefit is optional, and it is currently covered under 41 State plans.
>
> * * * *
>
> We propose to revise existing regulations to establish a definition of the term "psychiatric residential treatment facility" (PRTF) and conditions of participation for this type of facility. A PRTF is a community-based facility that *provides **a less medically intensive program of treatment** than a psychiatric hospital or a psychiatric unit of a general hospital*.
>
> * * * *
>
> *PRTFs would provide a type of care that is **distinctly different** from the care provided by **acute** care facilities* and therefore a PRTF that is affiliated with a participating psychiatric hospital or general hospital would need to obtain ***separate PRTF certification*** in addition to its hospital certification. The setting(s) that a State chooses to use for the psychiatric 2l benefit would be indicated in its State plan.
>
> * * * *
>
> Currently operating residential treatment facilities include a wide range of providers, from facilities that provide care similar to that provided in psychiatric hospitals to facilities that are more similar to group homes. In addition, many residential treatment facilities are part of multi-service mental health organizations which also provide a range of outpatient services. A number of States have developed or are in the process of developing licensure requirements for these facilities. Treatment in residential treatment facilities generally costs less per

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(stating: "We propose to revise existing regulations to establish a definition of the term "psychiatric residential treatment facility" (PRTF) and conditions of participation for this type of facility. A PRTF is a community-based facility that *provides **a less medically intensive program of treatment** than a psychiatric hospital or a psychiatric unit of a general hospital*." (emphasis added)).

> day than treatment in a psychiatric hospital, but because *the length of stay in residential facilities is generally longer*, treatment in a residential facility is not always less expensive for the total inpatient stay. Rates for residential treatment facility services now range from approximately $140 to $420 per day including professional fees.[166]

The categorization of every PRTF as a "nonhospital" would also suggest that, per the following excerpt from the definition of hospital at 42 U.S.C. § 1395x(e)(9), a PRTF would *not* qualify as a hospital:

> Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)).[167]

Thus, the Board concludes, based on the Secretary's PRTF policy published in the Federal Register *and* the OMP regulations, that a psychiatric unit enrolled as a "PRTF" generally provides "***non-acute inpatient facility care.***"[168]

Furthermore, based on the Secretary's discussion of its longstanding policy in the preamble to the 2003 Final Rule, for a unit to be included in the calculation of the Medicaid DSH fraction, the care provided must be consistent with the care provided to acute care patients. The classification of a provider unit or program, by its very nature, reflects the type of care generally furnished in that unit or program. In this case, it is clear that Four Units participated in the OMP as a hospital-based PRTF as well as a provider of psychiatric acute care services.[169] Similar to the California Medicaid Program classification of the hospital unit as sub-acute in *Alhambra*, the classification of the Four Units as a PRTF is relevant, notwithstanding the fact that the Medicare program did not specifically certify either the sub-acute units in *Alhambra* or the PRTFs in this case. Based on both the Secretary's position in *Alhambra* and the Secretary's affirmation of its longstanding policy in the preamble to the 2003 Final Rule, it is clear that the Medicaid classification of a unit has relevance when determining the level of care generally provided in that unit. As such, it is necessary to examine the Four Unit's designation and participation in the OMP as a PRTF and how this classification relates to the determination of the level of care generally provided in those units.[170]

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[166] 59 Fed. Reg. at 59625-27 (emphasis added).

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

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

[169] *See supra* notes 8 and 9 and accompanying text.

[170] The Board again notes that the type of care furnished the Four Units during FY 2008 was overwhelmingly residential psychiatric care in the PRTF in that 80 percent or more of the days of care during FY 2008 were for PRTF (paid on a per diem rate) care. Provider's Response to Medicare Contractor's SFPP at 22-23. *See also supra* notes 8, 21, 22 and accompanying text discussing PRTF licensure/certification for the Fourt Units.

Further, the Secretary's PRTF policy and the OMP Regulations lead to the conclusion that PRTF services are *not* of the type that are "generally payable under the prospective payment system" because they are "non-acute."[171] Further, the overwhelming majority of patient days associated with the Four Units (80 percent or more) were PRTF care, and paid on a per diem rate.[172] After examining the OMP regulations, in conjunction with the *Alhambra* discussion in the 2003 Final Rule preamble, the inevitable conclusion is that every unit, as a whole, within the Four Units was providing nonacute care. Thus, the days associated with these units cannot be included in the calculations at 42 C.F.R. § 412.106(a)(1)(ii).

The relevance of the Four Units' OMP participation as a PRTF is reinforced by the fact that, during the fiscal year at issue, its patient days were predominantly *Medicaid* ***paid*** days where prior authorization is a prerequisite.[173] As a result, ***each*** such patient necessarily underwent a *prior authorization process* to confirm that admission to the PRTF setting was the appropriate level of medical care pursuant to OMP requirements and medical necessity criteria.[174] Before admitting Medicaid patients, PRTFs are required to obtain prior authorization from the OMP to determine "if the member meets *medical necessity criteria*" for PRTF services.[175] There are also requirements for periodic re-authorizations for extension of *continued* medical necessity.[176] Indeed, this is a condition of the OMA participation agreement:

> **Children**
>
> ***All*** inpatient behavioral health services for patients under 21 years of age ***must be prior authorized*** by an agent designated by the Oklahoma Health Care Authority. *All* inpatient acute and ***residential psychiatric services*** *will be prior authorized* for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.[177]

By definition, the OMP pre-authorization and extension process "will [only] approve lengths of stay using the current . . . ***medical necessity*** *criteria* and following the current inpatient provider manual approved by the OHCA."[178] The OMP process is designed to determine the appropriate level of

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[171] *Supra* note 113 and accompanying text includes discussion of one Medicare IPPS claim paid in connection with an alleged kidney-transplant patient, but this claim occurred during late 2010 well after the year in question. Further, it is not clear whether the billed service was furnished in the Four Units. Regardless, the Board is not saying that the Four Units do not provide acute care (indeed, the Medicaid prior-authorized acute care services confirm that) but rather that the overwhelming majority of the care was non-acute PRTF care.

[172] Provider's Response to Medicare Contractor's SFPP at 22-23.

[173] *See* Provider's Response to Medicare Contractor's SFPP at 22-24 (of the total 13,169 total days for FY 2008, 12,006 (91.17 percent) were Medicaid paid days). *See also* 2019-Day-1 Tr. at 70-71 (OKSU-MC's witness noting that "the majority of the patients admitted to the [F]our [U]nits were Medicaid eligible patients."); *id.* at 73 (OKSU-MC's witness stating that they were paid on a per diem for RTC care and that these payments required prior authorization).

[174] *See* 2019-Day-1 at 73-76, 133-134, 178-79, 236.

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

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

[177] Ex. P-32 at 10 (emphasis added) (copy of the "Standard Oklahoma Medicaid Provider Agreement with Oklahoma Medicaid website extract").

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

medical care both *prior to* admission ***and*** *following* admission through periodic re-authorizations.[179] In other words, the OMP considered both psychiatric acute care and PRTF psychiatric care when applying its medical necessity criteria during both prior approval and re-authorization.[180] Following that process, the OMP found the vast majority of patients in the Four Units during FY 2008 qualified for prior authorization of PRTF services (since the vast majority of the days in the Four Units are PTRF days and the vast majority of the Medicaid *paid* days at the Four Units are PRTF care days, paid at a per diem rate[181]). Thus, the OMP did review the medical necessity of virtually all of the PRTF days at issue *on a prior authorization basis* and found that PRTF services rather than acute care services was the appropriate level of care.

Similarly, to the extent a child/adolescent receiving Medicaid was transferring from inpatient acute care to PRTF care, the OMP was necessarily finding that one phase of mental health care had ended (*i.e.*, psychiatric acute care services) and a new one was beginning (*i.e.*, PRTF services) based on the different medical necessity criteria applicable for each type of care. Contrary to OKSU-MC's allegations,[182] there are *material* differences between the OMP standards for psychiatric acute care and PRTF care such as:

- Psychiatric acute care is for "*short-term* intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders"[183] while PRTF services are "non-acute inpatient facility care"[184] and "longer-term."[185]

- The admission criteria differ where the acute psychiatric care standards focuses on whether the behaviors of the patient "present an imminent life threatening emergency" ***within the last 48 hours*** (*e.g.*, specifically described suicide attempts or suicide intent within the past 48 hours)[186] while the PRTF standard focuses on whether the "[p]atient demonstrates escalating pattern of self injurious or assaultive behaviors" (*e.g.*, suicidal ideation or threat).[187]

- The required staff supervision level is different where 24-hour nursing/medical supervision is required in an acute psychiatric care setting[188] while only 24-hour observation and treatment for PRTF care.[189]

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

[180] The Board notes that "[r]equests for the continued stay of a child who has been . . . in a [PRTF] for 3 months ***will require a review of <u>all</u> treatment documentation*** completed by the [Oklahoma Health Care Authority's] designated agent to determine the efficiency of treatment." *Id.* § 317:30-5-95.31(b).

[181] *See* Provider's Response to Medicare Contractor's SFPP at 22-25.

[182] *E.g.*, Provider's PHB at 61 (alleging that "these slight differences in treatment requirements are not significant"); Provider's FPP at 13 ("there is virtually no difference in the acuity of the 'acute' and 'residential' patient populations"); Provider's PHB at 33 ("the difference in the acuity of the 'acute' and 'residential' patient populations is immaterial.").

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

[184] *Id.* § 317:30-5-95(a).

[185] *Id.* § 317:30-5-95.22(b)(8).

[186] *Id.* § 317:30-5-95.25(5).

[187] *Id.* § 317:30-5-95.29(5).

[188] *Id.* § 317:30-5-95.25(6).

[189] *Id.* § 317:30-5-95.29(6).

- The minimum number of "individual treatments provided by the physician" is different where a minimum three (3) treatments per week is required for acute psychiatric care versus a minimum of one (1) treatment per week is required for PRTF care.[190]

- For psychiatric acute care only, "[a] registered nurse must document patient progress at least weekly. The progress note must contain recommendations for revisions in the individual plan of care, as needed, as well as an assessment of the patient's progress as it relates to the individual plan of care goals and objectives."[191] The Board did not identify any similar requirement for PRTF care.

Accordingly, the Board finds that: (1) the Four Units was enrolled or licensed and accredited by OMP as a PRTF;[192] (2) while some psychiatric acute care was furnished in the Four Units, the overwhelming majority of services being furnished were for PRTF care (approximately 80 percent); (3) the days of PRTF care at the Four Units were predominantly (if not exclusively) paid by Medicaid; (4) these Medicaid days were specifically reviewed for medical necessity by the OMP (both prior to admission and then regularly for reauthorization of continued care); and (5) the OMP authorized, *and* paid for, PRTF services based on its own periodic medical necessity reviews applying the medical necessity criteria for acute care versus PRTF care specified in the Oklahoma Administrative Code. These findings define the nature of the care provided in the units at the Four Units and demonstrate that that the care in each of these units did not, *as a whole*, rise to an acute level of care.[193]

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

There are material differences between the care provided under psychiatric acute care versus PRTF care. First, an acute care admission requires that the adolescent or child] "requires **secure** 24-hour nursing/ medical supervision."[194] In contrast, for PRTF care, the patient "[r]equires 24-hour **observation** and treatment."[195] Similarly, there are material differences between the intensity of care provided between acute care and PRTF care, confirming that they reflect different levels of care. For acute care, the patient must see a physician three (3) times a week, receive individual therapy two (2) hours a week, process-based group therapy three (3) hours a week, and expressive-based group therapy four (4) hours a week. In contrast, a PRTF patient must only see a physician one (1) time a week, receive individual therapy one (1) hour a week, process-based group therapy two (2) hours a week, and expressive-based group therapy three (3) hours a week.[196]

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[190] *Id.* § 317:30-5-95.34(c)(1).
[191] *Id.* § 317:30-5-95.38.
[192] *See supra* notes 8 and 21 and accompanying text.
[193] There could be other bases for finding that the PRTF care did not rise to an acute level of care had the Board had more information about the units included in the Four Units. For example, it is unclear whether these units had wait lists for PRTF admission or transfers from other acute care facilities, similar to the *St. Anthony* case as discussed in PRRB Dec. No. 2022-D29. *See, e.g.*, 2019-Day-1 Tr. at 197-98, 213-14.
[194] Okla. Admin. Code § 317:30-5-95.25(6).
[195] *Id.* § 317:30-5-95.29(6).
[196] *See id.* § 317:30-5-95.34(c).

Before admitting an under-18 patient for either psychiatric acute care or PRTF care, a provider must obtain prior authorization from the OMP to determine if the recipient meets the medical necessity criteria for the relevant services as well as periodic re-authorization for extension of continued medical necessity.[197] By definition, the OMP pre-authorization and extension process "will [only] approve lengths of stay using the current . . . medical necessity criteria and following the current inpatient provider manual approved by [OMP]."[198] The OMP process is designed to determine the appropriate level of medical care both prior to admission, and at certain intervals after admission when re-authorization is required.[199] Further, the days at issue for the Four Units are predominately Medicaid ***paid*** PRTF days and, as such, received prior authorization from OMP as PRTF services and were claimed and paid on a per diem basis *as PRTF* services.[200]

When patients' care needs to be extended, the OMP can extend psychiatric acute care beyond the initial five days. In cases of acute care admission, an extension of acute care, and PRTF admission, all require preauthorization from OMP.[201] In other words, when considering the prior authorizations granted for the PRTF days at issue in this case, the OMP applied its medical necessity criteria for both acute psychiatric care and PRTF services; and following that process, found the patients qualified for authorization of PRTF services at the Four Units. Thus, the OMP did review the medical necessity of the vast majority of PTRF care days on a prior authorization basis (both prior to admission and following admission to periodically extend authorization) and found that PRTF services rather than acute care services was the appropriate level of care. OKSU-MC has not presented any medical testimony, or similar evidence, to refute these medical necessity determinations. Thus, contrary to the OHCA CEO's assertion in his October 2, 2008 letter, the staffing and care requirements for the provision of under-18 psychiatric acute care services and under-18 PRTF services are ***not*** the same.

Similarly, OKSU-MC's assertion that staffing levels for the provision of PRTF and acute care to patients are the same during FY 2008[202] is not confirmed in the record and, in particular, does not address how that staffing relates to individual Medicaid patients receiving acute care versus PRTF care. As discussed above in **Subsection A(1)** of the STATEMENT OF FACTS AND RELEVANT LAW, the Hospital would staff the Four Units with at least the minimum staffing required by regulation (and/or its own policies), but high acuity patients could present scenarios and behaviors, such as the need for seclusion or one-to-one supervision of a patient. As a result, at the end of each staffing shift, OKSU-MC would assess its staffing needs for the next shift based on the Acuity Alert Forms completed at the end of the current shift in order to adjust, as appropriate, its staffing for next shift such as bringing in an additional nurse or nurse aide(s).[203]

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[197] *See supra* notes 176-178 and accompanying text.
[198] Okla. Admin. Code § 317:30-5-95.24(f) (emphasis added). *See also id.* § 317:30-5-95.31(a).
[199] *See supra* notes 176-178.
[200] *See supra* note 175 and accompanying text.
[201] *See* 2019-Day-1 Tr. at 73-76; 178-179.
[202] *See, e.g.*, Provider's FPP at 55-56.
[203] *See also, e.g.,* Ex. P-13 at 18 ("The average acuity of behavioral health patients on each unit has been taken into consideration when calculating the number of staff to be assigned per shift per unit. Each shift, the RN on each unit completes an 'Acuity Alert Form' which documents the acuity of the milieu and the patients on the unit. Any 'extra' staff must be approved by the Clinical Resource Manager. The charge shift RN then uses this information to . . . . increase or decrease the number of scheduled staff."); 2019-Day-1 Tr. at 180.

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

The OMP defined "acute care" as "care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and ***short-term*** intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders."[204] In contrast, "Residential treatment services" furnished in PRTFs are defined as "psychiatric services that are designed to serve children who need ***longer term***, more intensive treatment, and a more highly structured environment than they can receive in family and other community based alternatives to hospitalization."[205] Thus, one basic differentiating factor between "residential treatment services" and "acute care" is the fact that "residential treatment services" are "longer-term" treatment while "acute care" is "short-term" treatment. These definitions also make other clear distinctions between the OMP definitions of "acute care" and "residential treatment" (*i.e.*, PRTF care). Per the OMP definitions, the location of "acute care" services provided must be in a "psychiatric unit" or "psychiatric hospital" versus "residential treatment services" which must be not "family and other community based."[206] Acute care services must include "medical management and monitoring" while residential treatment services require "psychiatric services" with little or no medical involvement.[207]

However, the most telling distinction under these OMP definitions is that "acute care" services are limited to "***short-term*** intensive treatment and ***stabilization***"[208] while "residential treatment" services consist of "longer term" treatment in a "highly structured environment."[209] The purpose of stabilization is to remove the imminent threat from the patient, and if additional care is needed, to move the patient to a lower, less costly, level of care. In addition, the OMP definition of "acute care" parallels the guidance provided by CMS and Congress when describing the type of services generally payable under IPPS. When Congress adopted IPPS in 1983, healthcare facilities that did not provide short-term acute care services (*e.g*. LTCHs, psychiatric hospitals, cancer hospitals and children's hospitals) were excluded from IPPS[210] because, as noted in the legislative history, "[t]he DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays."[211] When CMS (then known as the Health Care Financing Authority ("HCFA")) implemented IPPS in 1983, it recognized that "the standardized amounts [payable under IPPS] are based on expenditures in short-term general hospitals"[212] and that LTCHs, psychiatric, cancer and children's hospitals were excluded because they were "organized for treatment of conditions

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[204] Okla. Admin. Code § 317:30-5-95.22(b)(1) (emphasis added).
[205] *Id.* § 317:30-5-95.22(b)(8) (emphasis added).
[206] *Id.*§§ 317:30-5-95.22(b)(1), (8).
[207] *Id.*
[208] *Id.* § 317.30-5-95-22(b)(1) (emphasis added).
[209] *Id.* § 317.30-5-95-22(b)(8).
[210]42 U.S.C. § 1395ww(d)(1)(B); 42 C.F.R. §§ 412.20(b), 412.20(e), 412.23; 67 Fed. Reg. 55954, 55956-55957 (Aug. 30, 2002).
[211] H.R. Rep. No. 98-25, p. 1 at 141 (1983) (accompanying H.R. 1900 which became Pub. L. No 98-21, 97 Stat. 65 (1983)) (explaining that the proposed exemptions and exceptions to IPPS: "Psychiatric, Long-Term Care, Rehabilitation and Children's Hospitals. Such hospitals would be specifically exempted from your Committee's prospective payment bill. The DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays.").
[212] 48 Fed. Reg. 39772, 39782 (Sept. 1, 1983).

distinctly unlike treatment encountered in short-term acute care facilities."[213] Even the *Alhambra* court recognized that IPPS is generally "not used to reimburse hospitals for long-term care."[214]

Similarly, in the regulation at 42 C.F.R. § 412.1(a) providing an overview of the IPPS for operating and capital costs, the Secretary describes IPPS as "payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (*generally, short-term, acute-care hospitals*) is made on the basis of prospectively determined rates and applied on a per discharge basis."[215] Further, when the Secretary issued regulations to implement IPPS, the Secretary established a policy whereby certain transfers to another hospital would not be considered a discharge and, as a result, potentially would not receive full payment under IPPS. In setting this policy, the Secretary exempted transfers from an IPPS hospital to hospitals excluded from IPPS because the care being received at the excluded hospital is "distinctly" different:

> When patients are transferred to hospitals or units ***excluded*** from [IPPS] (e.g., psychiatric, rehabilitation, children's hospitals), the transfers will be considered discharges and the full prospective payment [under IPPS] will be made to the transferring hospital. Hospitals and units excluded from [IPPS] are *organized for treatment of conditions* ***distinctly unlike*** *treatment encountered in short-term acute care facilities*. Therefore, the services obtained in excluded facilities would not be the same services obtained in transferring hospitals (i.e., paid under [IPPS]), and payment to both facilities would be appropriate.[216]

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

As discussed above in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW, OKSU-MC has put forward multiple different calculations of ALOS. For purposes of the Medicare program, only the ALOS based on "discharge" data (as included by OKSU-MC on its as-filed FY 2008 cost report) is relevant as reflected in OKSU-MC's chart that was reproduced

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

[214] 259 F.3d 1071, 1072 (9th Cir. 2001)

[215] 42 C.F.R. § 412.1(a)(1) (as of Dec. 1, 2007) (originally located at 42 C.F.R. § 405.470(a)(1) as adopted in 1983 at 48 Fed. Reg. at 39817) (emphasis added).

[216] 48 Fed. Reg. at 39759-60 (emphasis added). *See also* 49 Fed. Reg. 234, 244 (Jan. 3, 1984) (IPPS final rule that finalized the IPPS interim final rules published on Sept. 1, 1983) (stating that the reason for treating transfers from IPPS hospital to excluded hospitals differently from transfers between IPPS hospitals "is due to the ***difference*** *in the types of treatment* furnished in the two classes of facilities. As we stated in the interim final rule, we believe that hospitals and units excluded from [IPPS] are organized for treatment of conditions ***distinctly*** *unlike* treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities *would* ***not*** *be the same* services obtained in transferring hospitals (that is, paid under [IPPS]), and payment to both facilities would be appropriate, with the transferring hospital paid at the full DRG prospective payment rate." (emphasis added)). S*ee also Id.* at 237 ("[t]he criteria that define psychiatric units that are excluded from prospective payment were established to identify existing units that provide care that is so similar to the care provided in psychiatric hospitals, and is ***so unlike*** the acute care provided elsewhere in the hospital, as to warrant exclusion." (emphasis added)).

in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW. Using the "discharge" data from that chart, the ALOS in the Four Units breaks out as follows across the acute care and PRTF care programs in the Four Units:

	Total Days	Percentage of Days	ALOS
Acute Care (DRG)	2,587	19.64 %	5.18
PRTF Care (per diem)	10,582	80.36 %	21.91
Four Units as a whole	13,169	100.00 %	13.41

This table highlights how the ALOS at the Four Units for FY 2008 was driven by the overwhelming "residential" nature of the care furnished in those departments (over 80 percent).

The Board also reviewed how the ALOS for the PRTF care compared to the GMLOS for the DRGs associated with the primary diagnoses underlying the PRTF care furnished in the Four Units. In this respect, the Board notes that, according to OKSU-MC, IPPS only has the following twelve (12) DRG codes for psychiatric care where the primary discharge diagnoses is psychiatric in nature: 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897.[217] However, the primary discharge diagnoses in the 2008 34-claim sample that OKSU-MC drew from the Four Units are those associated with DRG 885 (over 61 percent of the sample) as well as DRG 882, 883, 884, and 886.[218] The Board further reconciled the coding expert's (Ms. Edford) *Corrected* Report on Review, Findings and Summary Conclusions (Exhibit P-52) with the original report of Ms. Edford (Exhibit P-42). It was noted that the DRGs for the encounters had changed between the reports for 4 of the cases, including a change from a non-psychiatric DRG (781 – Other antepartum diagnoses w medical complications) to a psychiatric DRG (885 – Psychoses).[219] When questioned about this change at the hearing, Ms. Edford testified that "certainly, in our antepartum diagnosis with medical complications would not be appropriate. And so, I believe that we probably recoded it to the proper, or what we would say would be the correct diagnosis, DRG."[220] As MS DRGs are used for Medicare billing only, the Board notes that these DRGs are not being used for billing purposes in these cases (as the patients are predominantly Medicaid, which uses its own DRG system) and therefore, cannot be verified as the final DRGs actually billed or coded on the claims.[221] Further, it is clear, per the changes in the expert report, that OKSU-MC and its expert have assigned or re-assigned these DRGs, based upon their analysis. The Board does not have in the record any of the data, such as actual medical records, used to develop these assignments, and thus, cannot verify the accuracy of these DRGs.

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[217] Provider's FPP at 30-31. *See also* Ex. P-26 (copy of 72 Fed. Reg. 47130, 47556 (Aug. 22, 2007) which is an excerpt from Table 5 entitled "List of Medicare Severity-Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Lengths of Stay" for the FY 2008 IPPS rate year).

[218] These DRGs are accumulated from Ex. P-52 (Ms. Edford's "Corrected Report on Review, Findings and Summary Conclusions). See Appendix C for a schedule of full comparison.

[219] Ex. P-42 at 166-67 (Case Review Summary for Encounter #26911675 showing a LOS of 16 and DRG 781); Ex. P-52 at 352-53 (Case Review Summary for Encounters #26911675 & 26920961 showing a total LOS of 16 and DRG 885).

[220] 2024-Day-1 at Tr. 282-283.

[221] Indeed, as discussed below in **Subsection E**, the assignment of a DRG based on a diagnosis *alone* is not an indication of the level of care furnished.

The Board's analysis, included as APPENDIX C, also calls into question the combination of "discharges" into "combined stays" for the sample. The Board notes that quite often, in the sample, the portion of the stay identified as acute care in the sample summary is very comparable to the GMLOS for the MS DRGs, within +/- 3 days in almost all cases.[222] As such, this substantiates the OMP handling of paying a portion of the stay as "acute," using a DRG and a portion as "PRTF/residential," using a per diem.

As noted above, the ALOS for the acute care in the Four Units was 5.18 days which is on par with the average IPPS LOS for IPPS hospitals (five days).[223] In contrast, the ALOS for the PRTF care in the Four Units is 21.91 days which is roughly four times higher than that five-day ALOS for IPPS hospitals. More specifically, the ALOS for PRTF care in the Four Units are much longer than the GMLOS for DRGs 882 to 886 for IPPS hospitals as published in the FY 2008 IPPS Final Rule *for the year at issue* and would clearly be outliers[224]:

FY 2008 IPPS DRG LOS STATISTICS[225]

DRG	DRG Title	Geometric Mean LOS	Arithmetic Mean LOS
882	Neuroses Except Depressive	3.1	4.4
883	Disorders of Personality & Impulse Control	4.6	7.4
884	Organic Disturbances & Mental Retardation	4.0	5.4
885	Psychoses	5.5	7.6
886	Behavioral & Developmental Disorders	4.0	5.9

Indeed, the Board takes administrative notice that these long lengths of stay for PRTF care are on par with the GMLOS for DRGs under the ***long-term care*** prospective payment system ("LTC-PPS") for payment of long-term care hospitals ("LTCHs") as published in the FY 2008 IPPS Final Rule:

FY 2008 LTC-PPS DRG LOS STATISTICS[226]

DRG	DRG Title	Geometric Mean LOS	Short Stay Outlier Threshold	IPPS Comparable Threshold
882	Neuroses Except Depressive	20.3	16.9	6.9
883	Disorders of Personality & Impulse Control	20.3	16.9	11.8
884	Organic Disturbances & Mental Retardation	23.3	19.4	8.3
885	Psychoses	23.8	19.8	12.3
886	Behavioral & Developmental Disorders	20.3	16.9	9.4

[222] APPENDIX C.
[223] *See St. Anthony*, Adm'r Dec. at 13 n. 24 (citing to publicly available information).
[224] If these PRTF care stays were covered and payable under IPPS, they would very likely exceed the threshold for cost outliers under 42 C.F.R. § 412.84 given the extraordinary length of the stays and the alleged volume of underlying services.
[225] Ex. P-26 (copy of 72 Fed. Reg. 47130, 47556 (Aug. 22, 2007) which is an excerpt from Table 5 entitled "List of Medicare Severity-Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Lengths of Stay" for the FY 2008 IPPS rate year).
[226] 72 Fed. Reg. at 48155-56 (Table 11 entitled "FY 2008 MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, Short-Stay Outlier Threshold, and IPPS Comparable Threshold").

The ALOS needed to qualify as a long term care hospital under the Medicare program must be greater than 25 days[227] and the Board notes that the PRTF ALOS is lower than the minimum average LOS needed to qualify. However, the above GMLOS statistics for LTCHs demonstrate that LTCH care of patients with the diagnoses underlying DRGs 882 through 886 are typically shorter than the average LTCH greater-than-25-day LOS, but nonetheless are considered *long-term care*. Indeed, the ALOS for PRTF care in the Four Units is well above the short-stay outlier threshold for LTCHs for these LTC-PPS DRGs and this is consistent with the Four Units being approved/licensed by OMP as PRTFs and fits squarely within the OMP distinction between acute care services (short-term treatment) and *residential* care services (longer-term treatment). Indeed, the Secretary has noted that the DRG payments under IPPS are not designed to account for the types of care in LTCHs, psychiatric hospitals, or other excluded hospitals/units:

> The acute care hospital inpatient prospective payment system [IPPS] is a system of average-based payments that assumes that some patient stays will consume more resources than the typical stay, while others will demand fewer resources. Therefore, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the acute care hospital [IPPS]. In a report to Congress, "Hospital Prospective Payment for Medicare (1982)," the Department of Health and Human Services stated that the "467 DRGs were *not **designed** to account for these types of treatment*" found in the four classes of excluded hospitals, and noted that "including these hospitals will result in criticism and their application to these hospitals would be inaccurate and unfair."
>
> The Congress excluded these hospitals from the acute care hospital [IPPS] because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. . . . Therefore, these hospitals could be ***systemically** underpaid* if the same DRG system were applied to them.[228]

While the length of stay is not dispositive, the nature of PRTF care is "residential" and the available guidance on length of stay supports the conclusion that, on the whole, the care provided to the PRTF patients in the Four Units were organized for treatment of conditions "distinctly unlike" treatment encountered in short-term acute care facilities. This distinction is important because IPPS was "not designed to account" for the types of treatment provided in these units such that they would be "systemically underpaid" if all the services in them were paid under IPPS. Again, the Board notes that the room set up with wooden beds lacking gas and air hook-ups (as discussed above in **Subsection A** of the STATEMENT OF FACTS AND RELEVANT LAW) is more indicative of residential/PRTF care (*i.e.*, longer term care), rather than acute care generally payable under IPPS. Accordingly, the Board finds that above discussion on length of stay supports the finding that the services provided for PRTF patients do not resemble the type of care generally payable under IPPS.

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[227] 42 C.F.R. § 412.23(e)(2)(i).
[228] 67 Fed. Reg. at 55957 (emphasis added).

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

OKSU contends that the conclusion that "the Four Units provided inpatient acute care hospital services payable under IPPS also is clear from the fact that each of the patients in the Four Units had a diagnosis that would have qualified them for Medicare payment under one of the Medicare-allowable DRG codes under IPPS, if they had been Medicare beneficiaries."[229]

Simply because PRTF patients have a diagnosis that can be used to assign a DRG does not mean that the assignment of a DRG is either appropriate or relevant. For Medicare program purposes, a DRG is ***only*** assigned when the care being provided is *acute* care. The assignment of a diagnosis does not mean acute care is being provided (*e.g.*, not all pneumonia cases require acute care, not all bipolar patients need acute psychiatric care). Similarly, the fact that a patient's admitting diagnosis to a PRTF is the same diagnosis the patient had while receiving acute psychiatric care, does not mean the patient continues to receive (much less require) acute care services in the PRTF program. This fact is highlighted by the Oklahoma Medicaid medical necessity criteria for psychiatric care facilities and PRTFs having the same universe of qualifying diagnoses yet providing treatment at different levels of care.[230] The Board also notes that, as discussed in **Subsection D** above, it is clear that the same DRG number and description is used in both IPPS and LTCH PPS, yet the GMLOS is completely different, as would the payment on the DRG. Indeed, OKSU-MC's most commonly identified MS-DRG in 2008 was 885 (Psychoses), as explained above. However, this DRG has a GMLOS of 5.5 in IPPS versus a GMLOS of 23.8 in LTCH PPS. Payment would not be the same in such cases, nor can one presume it would be paid similarly in IPF (Inpatient Psychiatric Facility) PPS, were the provider an excluded unit for Medicare. Accordingly, the Board concludes that the primary diagnosis of the PRTF patients, alone, does not have any evidentiary value in this matter.

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

OKSU-MC points out that Medicare allows newborn days, which are not payable under IPPS, to be counted in the Medicaid DSH fraction.[231] OKSU-MC then argues that it would be arbitrary and capricious to exclude the Four Units' days from being included in the Medicaid DSH fraction when non-IPPS newborn days are included.[232] While OKSU-MC has *not* alleged that the newborn days are *not* acute care days (*e.g.*, has not alleged that newborn days are subacute care days).[233] Here, the Board has concluded that PRTF care is not acute care (much less psychiatric acute care generally covered under IPPS). On the other hand, the Board must assume that newborn days are,

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[229] Provider's FPP at 11.

[230] Compare Okla. Admin. Code § 317:30-5-95.25(1) (medical necessity criteria for acute psychiatric admissions for children) with § 317:30-5- 95.29(1) (medical necessity criteria for admission psychiatric residential treatment [PRTF] for children).

[231] Provider's FPP at 28.

[232] *Id.* at 60.

[233] OKSU-MC has made the allegation that "the healthy newborn nursery . . . by definition does not provide inpatient services." Provider's PHB at 90. OKSU-MC does not provide any further explanation or cite to any support for this conclusory statement notwithstanding the fact that the discussion in the preamble to the 2003 Final Rule makes clear the Secretary's position that the newborn nursery days are inpatient and acute care services, consistent with how the Medicaid program treats them. 68 Fed. Reg. at 45417. Here, in this case, the Board is similarly treating PRTF days consistent with how the Oklahoma State Medicaid program characterizes these patients, namely inpatients receiving nonacute care services.

in fact, for acute care since the preamble to the 2003 Final Rule specifically states that they are to be included in the numerator of the Medicaid fraction.[234] Regardless, newborn days are not at issue in this case. Accordingly, the arguments about newborn days are irrelevant.[235]

G. The Board declines to give any weight to the medical review that OKSU-MC performed for the Four Units as it is fatally flawed and cannot be verified based on the record of this case.

As previously noted, to demonstrate that the Four Units were providing an inpatient, acute level of care, OKSU-MC conducted, *on its own initiative*, a medical review using what it alleges is the same methodology that TrailBlazer used in the *St. Anthony* case.[236] At the outset, the Board notes that it has previously questioned the validity and evidentiary value of the TrailBlazer report, as outlined in the Board's 2022 decision in *St. Anthony*:

> Finally, the numerous questions surrounding validity of the Trailblazer Report (including the underlying sample and methodology used to review that sample) call into question its evidentiary value. Some of the unanswered questions surrounding the Trailblazer Report are:
>
> - Was the sample patient size a statistically valid representative sample?
> - Whether review of partial medical records was representative of the care provided to the sample patients?
> - Whether the medical review inappropriately focused on individual patient care versus unit wide care level?
> - Was the Trailblazer Report the basis of the MAC's determination or confirmation of the MAC's audit determinations?
>
> Similarly, the Board continues to question the value of the InterQual criteria used by the Medicare Contractor to review the sample.

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

[235] Another difference between newborn days and the PRTF days at the Four Units that may factor into the Secretary's then-stated policy of including newborn days in the Medicaid fraction is the unique fact that the baby's Medicaid coverage is *through the mother* since the baby, when delivered, would be generally covered under the mother's Medicaid for 12 months and is tied to coverage of the mother's delivery. *See* 68 Fed. Reg. at 45417 (stating "The costs, days, and beds associated with a healthy newborn nursery are excluded from inpatient calculations for Medicare purposes. Meanwhile, for the purpose of computing the Medicaid patient share computation of the DSH patient percentages, these days are included both as Medicaid patient days and as total patient days. Newborn nursery costs, days, and beds are treated this way because the costs are not directly included in calculating Medicare hospital inpatient care costs because Medicare does not generally cover services for infants. However, Medicaid does offer extensive coverage to infants, and nursery costs would be directly included in calculating Medicaid hospital inpatient care costs. Therefore, these costs, days, and beds are excluded for Medicare purposes, but included for determining the Medicaid DSH percentage."). Moreover, the Board suspects newborn stays are very short in duration. In contrast, the under-18 PRTF patients at the Four Units had to qualify for Medicaid based on their own merits for stays that are much longer in duration given the "residential" nature of the care.

[236] Ex. P-52 at 3.

> InterQual guidelines are widely used by the hospital industry to determine whether an *individual patient should be admitted* to the hospital and whether the hospital is likely to get paid for the inpatient stay. However, they are not generally used to determine whether a particular hospital unit or facility ***provides*** an acute level of care. These same concerns necessarily persist with the opinions of St. Anthony's medical experts because they based their opinion, in large part, on a patient-by-patient review of the sample which, in turn, provided context for their review of any other documents and testimony.[237]

Indeed, OKSU-MC's own coding expert acknowledged that, in her expert opinion, the TrailBlazer methodology is not one that she would use in her normal course of medical review.[238] Similarly, the Board notes that the TrailBlazer Report, itself, explicitly states that "the purpose of the medical review was ***not*** to determine *whether the 'unit' is providing an acute level of care*, but rather, whether the patient met the InterQual criteria of acute care for each day reviewed."[239]

In addition to these issues with the TrailBlazer methodology, which was used for OKSU-MC's medical review of the Four Units, the Board has identified a number of issues with the sample that was actually reviewed which demonstrate that OKSU-MC's medical review is *fatally flawed*. First, the sample design itself was fatally flawed as highlighted by the following non-exhaustive examples:

1. Notwithstanding the fact that the criteria in 42 C.F.R. § 412.106(a)(1)(ii) is to be applied on a unit-by-unit basis, the sample design was ***not*** stratified for each of the Four Units.[240]—Section 412.106(a)(1)(ii) specifies that "patient days associated with . . . [b]eds in ***a unit*** . . . that is not occupied to provide a level of care that would be payable under the acute care hospital [IPPS]" are excluded. OKSU-MC suggests that there were no differences between the Four Units;[241] however, the names of each of the Four Units suggests that may not be true and that two of these Units may be more "acute" focused: the Children's (Acute?[242]) Unit with 14 beds; the Early Adolescent Unit with 28 beds; the Adolescent Acute Unit with 12 beds; and the Adolescent Residential Unit with 18 beds.[243] Indeed, one of OKSU-MC's witnesses stated that he thought "these names were based on the state's payment methodology for the ***majority*** of the patients in those units."[244] Further, two of the Four Units would appear to be focused on younger children which may have materially different care and delivery of care needs from those of the other two Units that appeared to be oriented towards older children. Regardless, how the

[237] PRRB Dec. 2022-D29, *St. Anthony Hospital v. Novitas Solutions, Inc.*, at 23 (Sept. 19, 2022) (citations omitted).
[238] 2019-Day-2 Tr. at 115-116.
[239] Ex. P-1 at 8.
[240] *See* 2019-Day-1 Tr. at 310 (Dr. Salve testifying that "I stratified only by years and not by units.").
[241] *Id.* at 184 (When asked by Mr. Peabody, "I want to direct your attention to the adolescent acute unit and the adolescent residential unit. What [were] the differences there?" Ms. Tallman replied, "Not – programming, nothing at all.") *See also id.* at 185 (Mr. Peabody: "Okay, and, in terms of the care provided, on the two units, the adolescent acute unit and the adolescent residential unit, it was the same?" Ms. Tallman: "Yes, the care was the same.")
[242] Note on OKSU-MC's staffing grid, this unit is identified as "Children Acute 5804." Ex. P-13 at 22.
[243] *See supra* note 24 and accompanying text.
[244] 2019-Day-1 Tr. at 64 (emphasis added).

total 72 beds breaks out across the Four Units demonstrates that the capacity of each unit relative to the others was different since the bed size of each unit was different

Unit	Number of Beds in the Unit	Bed Percentage in the Four Units
Children's Unit	14	19
Early Adolescent Unit	28	39
Adolescent Acute Unit	12	17
Adolescent Residential Unit	18	25
TOTAL	72	100 percent

To highlight this concern, the Board notes that none of the "patient summaries" for the sample drawn from the FY 2008 stratum indicate which of the Four Units the patient was treated in and there are no census counts in the record broken out by unit but rather only as a whole as discussed in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW. As a result, it is unclear whether some units were over-represented and others were under-represented since the Units did not have the same bed counts and also may have differed in their overall census.[245] While OKSU-MC makes assertions that the care across the Four Units did not vary, the sample structure was *not* designed to validate that assertion. In this respect, the sample may be overly representative of one or more of the Four Units, since the sample was drawn by year, and did not consider which unit(s) the sample included[246] and, as described below, the review only looked at the first day of admission. Not breaking out the sampling by each of the Four Units is a ***fatal*** flaw since each unit must provide an acute level of care generally payable under IPPS and there could be material differences in the care generally furnished between the Four Units, as also discussed below.

2. *The stated "unit" being sampled is **not** based on the inpatient "stay" as that term is used in 42 C.F.R. § 412.4 based on discharge and as reported by OKSU-MC on its as-filed cost report for FY 2008*. As discussed above in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW, a patient stay is determined by discharge and, per the FY 2008 cost report data, OKSU-MC had 982 patient stays based on the 982 discharges for FY 2008. Notwithstanding, the OKSU-MC statistical expert *in his initial report* identifies the sampling unit as a "stay" and specifies that he defined the population being sampled for FY 2008 as being comprised of 545 "stays" (*i.e.*, 545 sampling units). As a result, it is

[245] For example, the Children's Unit was a smaller unit which only had 14 beds; as such, it only had half the number of beds as the largest unit, the Early Adolescent Unit with 28 beds. The Children's Unit could have had a low average census count and, as such, could have been over-represented in the sample. In this respect, the Board notes that, per the patient summaries at Exhibit P-52, the *post-hoc*, redefined patient sample of 36 patients includes 13 patients whose ages ranged from 6 to 11 years of age. Each of those patients could have been treated in the Children's Unit since, per the testimony of OKSU-MC's witness, Ms. Tallman, it generally treated patients up to age 11. 2019-Day-1 Tr. at 173. If that were true, it would represent 36 percent of the sample (*i.e.*, (13 patients / 36 patients) x 100 = 36.1 percent), even though this Unit only had 19 percent of the overall beds in the Four Units. Similarly, the Early Adolescent Unit had 28 beds representing 39 percent of the overall beds in the Four Units but only 10 patients fit Ms. Tallman's definition of early adolescent (*i.e.*, ages from 11 to 13) which is only 28 percent of the sample (*i.e.*, (10 patients / 36 patients) x 100 = 27.8 percent). 2019-Day-1 Tr. at 173.

[246] 2024-Day-1 Tr. at 74-77. *See also id.* at 228-29 (as discussed *infra*, the subsample drawn by the coding expert to evaluate the level of continuing care provided did not consider in which of the Four Units any particular stay occurred).

clear that patient "stay" as that term is being used by the statistical expert differs from that being reported in OKSU-MC's as-filed cost report. However, neither his initial report nor his "corrected" report actually defines what a "stay" is within the four corners of those documents.[247] As a result of the *post-hoc* redefining of the sampling unit, the population of the FY 2008 stratum of "stays" being sampled decreased from 545 to 540 "stays." Indeed, this change also ***increased*** the number of days included in the population of the FY 2008 stratum from 13,169 total days to what appears to be 13,500 total days.[248] As discussed below, defining the unit in this manner is contrary to the TrailBlazer Report and introduces material biases and errors into the results since both the sampling unit and the population of the FY 2008 stratum were revised ***on a post-hoc basis***.

3. *The post-hoc modifications to the statistical sampling unit and the FY 2008 stratum are a fatal flaw*. There were ***multiple*** *post-hoc* modifications that, at a minimum in totality, create fatal flaws in the statistical sampling. First, the medical records associated with 9 of the initial units in the 34 unit sample were "unavailable" but no one with first-hand knowledge was able to explain why those records were "unavailable."[249] Also troubling is the fact that there was another sampling unit under 2008-24 (by far the largest sampling unit listed as 165 days) that was ***not*** listed as unavailable for the FY 2008 stratum notwithstanding the fact that there was no patient summary for 2008-24 in the original report from Ms. Edford at Exhibit P-42. As explained in APPENDIX B, the Board is treating this as an unavailable record. While 9 of these unavailable records were replaced[250] and another record was relocated and then later, on a *post-hoc* basis, combined with a 2007 unit (*see* APPENDIX B), these unavailable records represented a significant portion of the original 34 sampled, roughly 30 percent of the sample[251] and 36 percent of days in the sample.[252] As such, it is not credible that these 10 unavailable records had no effect on the statistical validity of the sample, particularly when the sample was not stratified by unit and

[247] The Board recognizes that the "corrected" report discusses the redefinition of "stay" and how it was expanded to include certain additional "stays"; however, it does not define what a "stay" is as that term is for purpose of the sampling unit. Rather, it only documents expansion of the original and still undefined term. In this respect, the "corrected" report states that "the new definition of a patient stay accounts for [*i.e.*, includes] the fact that a patient could be discharged from the Four Units and then be readmitted on the very next day where the stay should be considered continuous." Ex. P-51 at 3, ¶ 9. The report does not document upon what basis is the judgment "should be considered continuous" is being made other than saying that OKSU-MC's representative asked him to make that change in defining the sampling unit but again without actually providing an overall definition of what the "stay" sampling unit actually is. Complicating this issue is the fact that the record does not contain the actual sampling frame (*i.e.*, the universe) that the statistical expert used originally when he drew the sample or the modified sampling frame he used as a result of the *post-hoc* redefining of the sampling frame.

[248] *See supra* note 63 and accompanying text.

[249] OKSU-MC's witness, the AHS VP of Reimbursement, was located in Nashville and indicated that "some of the records" were moved off-site due "some flooding issues" at the Hillcrest Medical Center (implying the records were stored there); however, he was not directly involved in pulling the medical records from storage and did not describe the process or who was charged with pulling those medical records. *See* 2019-Day-1 Tr. at 144-45.

[250] Dr. Salve instructed OKSU-MC to proceed to the next sampling unit on the list if records were unavailable for a sampling unit. Ex. P-41 at 4, ¶ 10.

[251] (10 / 33) x 100 = 30.30 percent.

[252] The original sample had 690 days based on 2008-1 through 2008-4, 2008-6 through 2008-16, 2008-18 through 2008-21, 2008-23, 2008-26 through 2008-31, 2008-36 through 2008-39, and 2008-41 through 2008-43. *See* P-54 at 4 (the total LOS for these sampling units taken from this table total 690 days). The total days for these 9 unavailable patient stays total 246 days based on the LOS data in Ex. P-58 using the Encounter IDS for these units as listed in the table at Ex. P-41 at 14. The percentage of days was calculated as follows: (246 days / 690 days) x 100 = 35.65 percent.

changes in the sample can impact the representation of each unit in the sample (creating under- and over-representation issues as discussed above).[253] Second, as discussed above in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW, Dr. Salve's "*corrected*" report modified the universe of units being sampled by redefining the sampling unit and the redefinition was done on a *post-hoc* basis at the direction of OKSU-MC's representative "to redefine the sampling units." Moreover, the statistical expert was not involved in the decision to exclude a potential sampling unit from the *post-hoc*, redefined sampling unit which appears to have been made by OKSU-MC's representative:

> [OKSU-MC's representative] asked that I make an exception to this new definition for the stays associated with EncounterIDs "[A]" and "[B]." Even though there is a one day gap, [OKSU-MC's representative]stated that these two patient stays should not be combined because the patient was discharged and then admitted the next day for a reason separate from the discharge.[254]

Indeed, in the context of discussing how the *post-hoc*, redefined sampling unit caused five different Encounter IDs to be combined, Dr. Salve could not address how any of these *post-hoc* changes to the sample and universe might affect the representativeness of the sample beyond length of the sampling unit:

> [DR.] SALVE: . . . . That the knowledge needed to combine stays falls for outside my purview as a statistician, when it comes to determining what needs to be reviewed for a stay, to determine acuity or whatever is being done in this matter.
>
> [BOARD CHAIR]: But those determinations could affect, I guess the, the sample itself as to, whether or not it's representative, meaning the. You only looked at one variable for determining representativeness, which is the length of stay, there could be other variables, that could affect the representativeness of the sample. Is that –
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> [DR.] SALVE: It's true that, I looked at only length of stay, because that's the only variable I had to test for representativeness. There could be, other relevant variables that I did not have access to, that I could have used to test, but again, I didn't perform any of those analyses.[255]

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[253] To illustrate this concern, the Board notes that, when the Medicare Program uses statistical sampling to determine an overpayment and a provider fails to produce records for a sampling, the Medicare Contractor does not expand the sample until the Provider can find the records on a sampling unit. Rather, the Medicare Contractor treats the unit as an overpayment. *See* Medicare Program Integrity Manual, CMS Pub. 100-08 ("MPIM"), Ch. 8, § 8.3.1.4.

[254] Ex. P-51 at 4, n.1

[255] 2024-Day-1 Tr. at 87-88.

Another example of a *post-hoc* modification to the sample whose impact could not be addressed outside of the representativeness of the length of the sampling unit is increasing the original stratified 34-unit sample for FY 2008 to a sample of 36 units by virtue of the *post-hoc* redefining of the sampling unit which resulted in three sampling units being moved from the FY 2007 stratum to the FY 2008 stratum of which one was combined with the newly-found 2008-24 (*see* APPENDIX B).[256] Indeed, it is unclear what data Dr. Salve worked with to create the strata for FYs 2006, 2007 and 2008, or what his reordered universe was to create the strata, because neither document was included in the record. The only record that comes close is the Excel spreadsheet at Exhibit P-58; however, Dr. Salve testified that he had never seen that document.[257] In this respect, being able to recreate the universe is a basic tenet of documenting a statistical sample, but that was not done in the present case.[258] Finally, while Dr. Salve testified that the sampling units remained both random and representative following the changes made to the definition of the sampling unit and resulting restructure of the sample and strata,[259] this does ***not*** *match up* with his written opinion. As shown in the redline comparing his initial report to his "corrected" report, *he changed his written opinion* ***from*** "the patient stays used in the review . . . were in my opinion, both random and representative" ***to*** "the updated sample of patient stays used in the review . . . were, in my opinion, representative."[260] While the Board recognizes that the decisions on how to define a "patient stay" fall beyond Dr. Salve's purview as a statistician, the numerous errors and inconsistencies in the underlying data provided to him and the fact he had no opportunity to assess any potential variables outside of length of the sampling unit cause the Board to give no evidentiary value to his findings and thus, the Board finds that the record before it is *insufficient* to establish that the sampling was random and representative.

In the actual execution of the medical review conducted by Ms. Edford, there are also multiple discrepancies and errors and, as a result, the Board declines to give much weight, if any, to her work (particularly given the fact that the randomness and representativeness of the sample has not been established as discussed above). Indeed, the initial hearing had to be postponed because there were discrepancies between her work and the work of Dr. Salve and, notwithstanding her corrected report, additional discrepancies were discovered at the second hearing revolving around the

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[256] These three are 2007-11, 2007-20, and 2007-15 where 2007-15 was combined with 2008-24.

[257] 2024-Day-1 at 81 (in response a request to describe the document and what it reflects, Dr. Salve responded, "P-58, this is the first time that I have seen this document" and further confirmed that "it's not something that [he] worked on, or touched upon").

[258] The Board notes that MPIM, Chapter 8 as of 2018 (last prior revision was in 2011), which precedes the date of the sampling report, is titled, "Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation." While MPIM, Ch. 8, is not directly applicable to cost report audits, it does state some general principles for statistical sampling. One of those is at § 8.4.4.4.1 stating that "[a]n explicit statement of how the universe is defined and elements included shall be made and maintained in writing. Further, the form of the frame and specific details as to the period covered, *definition of the sampling unit(s)*, identifiers for the sampling units (e.g., claim numbers, carrier control numbers), and dates of service and source shall be specified and recorded in your record of how the sampling was done. Sufficient documentation shall be kept so that the sampling frame can be re-created should the methodology be challenged." (Emphasis added.) Here, the sampling unit was not explicitly defined in any written document as discussed in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW. Similarly, the precise universe from which Dr. Salve reordered and developed his stratified sampling is not part of the record, even after corrected expert reports were submitted.

[259] 2024-Day-1 Tr. at 66-67.

[260] Ex. P-51 at 17, ¶ 13. In his "corrected" report, Dr. Salve appears to have deleted ***all*** references to the resulting updated or revised sample being random as shown in the redline at P-51 at 14-15.

sampling unit 2008-24 as discussed in APPENDIX B.[261] Moreover, notwithstanding its burden of proof, OKSU-MC did not include ***any*** of the medical records (redacted or unredacted) that Ms. Edford reviewed[262] to permit the Board to assess and verify her characterization and summary of the medical record, particularly as it relates to her characterization of how acute care stays and PRTF care stays were documented in the OKSU-MC medical records.[263] This is a separate and independent basis upon which the Board bases its declination to give her testimony any weight or value.

Indeed, upon review of Ms. Edford's findings, the Board notes that she mischaracterizes the TrailBlazer methodology as discussed in APPENDIX A by treating consecutive stays where the first stay is a Medicaid acute care stay and the second stay is a Medicaid PRTF care stay, as one stay even though this is not what the TrailBlazer methodology did. Indeed, for the 36-unit sample (as redefined) for the FY 2008 stratum, she only reviewed one day, the day of admission, for 32 of those sampling units which had a total of 810 days. It is not surprising that Ms. Edford found *the first day* to be acute care since each of these 32 sampling units appear to be acute care stays for which OMP gave prior authorization. However, in most of those cases, the acute care stays were followed by PRTF care, and ***none*** *of the that PRTF care* was reviewed by Ms. Edford as exemplified by the following chart that the Board created, based on its review of Exhibits P-52, P-54 at 4 and P-58[264] in conjunction with testimony on these exhibits[265]:

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[261] *See* 2019-Day-2 Tr. at 166-79. *See also* Board's January 24, 2020 letter to OKSU-MC's representative (stating: "As the Provider's representative, you indicated at the hearing that the Provider should be able to submit corrected expert report (with redline) to the Board and the MAC *within a week* of the original hearing date. Notwithstanding, as of the date of this letter, it has been ***three (3) months*** since the initial hearing date and the Board still has not yet received the corrected report. . . . The Board is very concerned about the significant amount of additional time that the Provider's representative has taken to make corrections to what originally had been filed as the final expert report and the initial expectation that the corrected report (with redline) would be submitted posthaste.").

[262] Board Rule 1.4 (2018) makes clear that (1) "[i]f the parties need to include materials with patient names, numbers, or other identifying information, they must redact (untraceably remove) the names and numbers and replace them with non-identifying sequential numbers"; (2) "[i]f the confidential information itself is necessary to support your position, do not file into OH CDMS. Separately submit a sealed envelope containing the confidential information with a cross reference to the non-identifying sequential numbers." Here, OKSU-MC did not indicate that any confidential information was necessary to support its position, nor did it file any under separate cover.

[263] 2024-Day-1 Tr. at 310-311 (Ms. Edford testifying that, based on her review of the medical record *of the patients sampled*, the patients who received PRTF care following acute care had the same plan and treatment). Without the medical record or even sample patient records, the Board and the opposing party were not able to meaningfully examine the witness regarding this characterization of the medical records.

[264] The breakout between the acute care LOS and PRTF care LOS is taken from the patient summaries at Ex. P-52. However, the Board notes that, when compared to the EncourterID information at Ex. P-58 for each of these sampling units, there are at least three (3) potential errors that have not been reconciled: (1) for 2008-16, the breakout of acute care days to PRTF care days in the patient summary in P-52 at 376 appears wrong and should be changed from 6 and 6 to 3 and 9; (2) for 2008-20, the breakout of acute care days to PRTF care days in the patient summary in P-52 at 382 appears wrong and should be changed from 5 and 37 to 4 and 38; and (3) for 2008-43, the breakout of acute care days to PRTF care days in the patient summary in P-52 at 413 appears wrong and should be changed from 6 and 1 to 5 and 2. Ms. Edford's testimony suggests she determined the breakout of days based on her review of the medical record but she did not reconcile her findings with the breakout of days by EncounterID in Ex. P-58. 2024-Day-1 Tr. at 287-291.

[265] In particular, testimony from both Mr. Adams and Ms. Edford on Day 1 of the February 2024 reconvened hearing assisted in the Board's understanding of Ex. P-52. *See, e.g.,* 2024-Day-1 Tr. at 131-140, 256-58, 287-90.

Sample ID	Acute LOS	PRTF LOS	TOTAL LOS	Days Reviewed	Days Not Reviewed
2007-11	5	55	60	1st day only	59
2007-15/ 2008-24*	10	154	164	1st day only	163
2007-20	5	27	32	1st day only	31
2008-1	5	24	29	1st day only	28
2008-2	7	-	7	1st day only	6
2008-3	13	19	32	1st day only	31
2008-4	5	11	16	1st day only	15
2008-6	5	2	7	1st day only	6
2008-7	5	20	25	1st day only	24
2008-8	5	55	60	1st day only	59
2008-9	5	-	5	1st day only	4
2008-10	5	8	13	1st day only	12
2008-11	6	24	30	1st day only	29
2008-14	5	34	39	1st day only	38
2008-15	5	25	30	1st day only	29
2008-16	6	6	12	1st day only	11
2008-18	8	-	8	1st day only	7
2008-20	5	37	42	1st day only	41
2008-21	3	-	3	1st day only	2
2008-23	5	10	15	1st day only	14
2008-26	1	5	6	1st day only	5
2008-27	5	12	17	1st day only	16
2008-28	8	8	16	1st day only	15
2008-29	2	-	2	1st day only	1
2008-31	8	-	8	1st day only	7
2008-36	7	9	16	1st day only	15
2008-37	5	10	15	1st day only	14
2008-38	3	-	3	1st day only	2
2008-39	5	26	31	1st day only	30
2008-41	4	26	30	1st day only	29
2008-42	5	25	30	1st day only	29
2008-43	6	1	7	1st day only	6
Total	177	633	810		778

* *See* APPENDIX B.

The Board notes that, as presented by OKSU-MC, these 32 sampling units represent 86 percent of the days from the sample,[266] but Ms. Edford only reviewed the ***first*** day of these sampling units, notwithstanding the fact that, of these 810 days, 78 percent of these days were for PRTF

[266] *I.e.*, (810 days / 946 days) x 100 = 85.62 percent.

care (paid on a per diem).[267] Indeed, the Board is not surprised by the results given the fact that the initial day of each of the above 32 sampling units likely had prior authorization by the OMP as an acute care stay. However, the Board finds it irregular and unacceptable that the level of care for sampling units can be determined by ***only*** reviewing the first day of admission, when most of these stays had a prior authorization by OMP for a consecutive stay at a lower level of care (PRTF care) than that furnished at admission (acute care) and the review is inconsistent with the TrailBlazer methodology, as discussed at APPENDIX A. As such, it is clear that the medical review methodology was not designed to validate OKSU-MC's overall assertion that the level of care did not change between acute care and PRTF care.

This is further highlighted in Ms. Edford's review of the remaining four sampling units for the FY 2008 stratum. For these, Ms. Edford reviewed the first day of admission and found that it was an acute care stay (again, not surprising since each of these stays appears to have had a Medicaid acute care stay immediately followed by a Medicaid PRTF care stay). However, these four sampling units were selected randomly for additional "continuing care" review for 10 days, following the GMLOS of the DRG associated with the primary diagnosis plus five days. Ms. Edford testified that the continuing care criteria only considered the intensity of services and did not review the severity of illness.[268] The following chart summarizes Ms. Edford's review and demonstrates that there were multiple days that were not reviewed by her:

Sample ID	Acute LOS	PRTF LOS	TOTAL LOS	Days Reviewed[269]	Days Met Based on 1st Day (GMLOS + 5 days)	CCR Add'l Days Met	CCR Days Not Met	Days not Reviewed
2008-12	5	40	45	1st day + 10-19 days	9	10	0	26
2008-13	5	40	45	1st day + 10-19 days	9	3	7	26
2008-19	5	24	29	1st day + 12-21 days	11	0	10	8
2008-30	6	11	17	1st day + 10-17 days	9	8	0	0
Total	21	115	136		38	21	17	60

Based on Ms. Edford's review of these four sampling units, 38 days were approved, based on review of the first day and the DRG GMLOS plus five days. Thirty-eight additional days were reviewed as part of the continuing care review, which found 21 additional days meeting the intensity of service criteria, and 17 of those days (almost 45 percent)[270] did not meet the criteria. The remaining roughly 44 percent of the days[271] were not reviewed by Ms. Edford, and similarly not reviewed by Dr. Heller. Further, the Board questions the value of the continuing care review

[267] *I.e.*, (633 days / 810 days) x 100 = 78.15 percent.
[268] 2019-Day-2 Tr. at 162.
[269] For example, on Sample ID, day 1, and days 10 through 19 were reviewed, out of a total 45 days.
[270] *I.e.,* (17 days / 38 days) x 100 = 44.73 percent.
[271] *I.e.,* (60 days / 136 days) x 100 = 44.12 percent.

since it did not review the severity of illness, notwithstanding the fact that there appears to have been an intervening change in the level of care from Medicaid acute care to Medicaid PRTF care.

Finally, the Board finds that Dr. Heller's review is limited (she only reviewed seven patient records from across three years) and does not support OKSU-MC's position *relative to the period at issue, FY 2008*. For purposes of this hearing, only the FY 2008 stratum is at issue. However, Dr. Heller only reviewed a portion of the days associated with two sampling units associated with the FY 2008 stratum (the remaining five were from the other strata for FYs 2006 and 2007). Specifically, she reviewed 17 days (seven days from sampling unit 2008-13 and ten days from sampling unit 2008-19, respectively), however, her review found that most of those 17 days were ***not*** acute, specifically ten days or 58.8 percent.[272] Thus, the majority of the days reviewed by Dr. Heller for the FY 2008 stratum were found ***not*** *to be acute care*. The Board recognizes that Dr. Heller's corrected report at Exhibit P-43 also includes her opinion on the type of care furnished in each of the Four Units based on her time as Director of Behavioral Medicine at the Four Units from March 2014 until its closure in 2015; however, the Board declines to give any weight or value to that description because her experience occurred more than five years after the time at issue and that experience was under a different owner since ownership of the Four Units changed in July 2008.[273] Regardless, the Board has concerns that the continuing care review was limited to 4 of the 36 sampling units (11 percent) and, as such, the findings from the continuing care review cannot be extrapolated to the FY 2008 stratum.

While OKSU-MC has vehemently argued that a discharge from acute care to PRTF care was merely a billing designation and that the two designations did not affect the level of care being provided,[274] the testimony provided at the hearing contradicts that claim. Patients on an acute admission status were not permitted to leave the Four Units with a pass, while patients on a PRTF admission (residential status) were allowed to do so.[275] Dr. Heller also acknowledged that the treatment for children on the Four Units was very different than an adult would receive in an acute, inpatient general hospital setting.[276] OKSU-MC's witness, Ms. Edford, acknowledged that, at "some point" before discharge, patients potentially become non acute[277] (*i.e.*, they would not be discharged if they were still suffering from an acute behavioral health condition), but OKSU-MC also claims that over 99 percent of all patient stays on the Four Units qualify as acute.[278] Indeed, some patients would be deemed not acute and ready for discharge, but could remain on the Four Units while awaiting placement in a group home,[279] or their parents would not come to pick the

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[272] *I.e.*, (10 days / 17 days) x 100 = 58.82 percent.
[273] *See supra* notes 5-7 and accompanying text. Similarly, the Board declines to give any weight or value to the 8-sentence-long discussion in her written report at Exhibit P-43 that is entitled "Oklahoma Medicaid under the 'Acute' versus 'Residential' Payment Methodology" as she provides no basis for her conclusory statement that "[t]here is no meaningful clinical distinction between the care given to patients whose stays were being paid by Oklahoma Medicaid under the 'Acute' vs. 'Residential' payment methodology." In particular, she fails to acknowledge or discuss the fact that there are different medical necessity criteria for acute care and PRTF care and OMP conducts a prior authorization review of all acute care and PRTF care applying that medical necessity criteria pursuant to Okla. Admin. Code §§ 317:30-5-95.24, 317:30-5-95.25 – 317:30-5-95.26, and 317:30-5-95.29 – 317:30-5-95.30, and 317:30-5-95.31.
[274] *See supra* note 97 and accompanying text.
[275] Ex. P-11 at 3.
[276] 2024-Day-2 Tr. at 117.
[277] 2019-Day-2 Tr. at 38.
[278] 2024-Day-2 Tr. at 246.
[279] *See* 2024-Day-1 Tr. at 270-271.

child up on their discharge date resulting in an extended stay.[280] There was testimony that the nurses on the Four Units had a strong preference to keep a patient in acute status until they are "absolutely safe and ready to move and . . . [are] able to progress right on out of the hospital to home."[281] The desire to keep them in an acute status suggests some difference in the care being provided to the patients. These differences in care are ultimately validated by the fact that OMP required all Medicare under-18 psychiatric services to go through a prior authorization process wherein OMP determined whether an acute care stay versus PRTF care was more appropriate, based on the medical necessity criteria for each type of care. Once approved, OMP periodically reviewed whether continued care at the same level of care was supported or whether a change in the level of care had occurred.

By focusing on only the first day of admission, the medical review conducted by OKSU-MC was not designed to assess whether the acute care level is materially different from the PRTF care a patient later received in a separate stay (as reported to the Medicare program on the FY 2008 as-filed cost report) and, thereby, is fatally flawed. Further, the extent and nature of the change made to "correct" the expert reports (*e.g.*, redefining the sampling unit, expanding the FY 2008 stratum, and including a completely new patient summary (*see* APPENDIX B)) were above the spirit and intent of the Board's reconvening the hearing. Indeed, the accumulation of the flaws noted above combined with the nature and extent of the changes made in the "corrected" reports that were supposed to be submitted within one week of the initial hearing but were not submitted until more than four months later,[282] the Board has no confidence in the statistical sampling and associated medical review of the sampling and, as such, declines to consider or give any weight to them.

Accordingly, based on its findings in **Subsections A to G** above, the Board must conclude that the type of care provided in the acute care situation (prior approved by OMP and paid using a DRG) was different from the type of care provided in the PRTF situation (also prior approved by OMP for the PRTF level of care and paid using a per diem rate). Further, OKSU-MC has admitted that the overwhelming majority of the days in the Four Units (80 percent or more) were at the PRTF level of care, and approved and paid as such by OMP.[283] Thus, the Board finds that the general level of care furnished in the Four Units was at the PRTF level of care and that OKSU-MC has not met its burden under 42 C.F.R. § 405.1971(a)(3) and has failed to establish that the general level of care in the Four Units would be "generally payable under IPPS."

DECISION:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds as follows:

1. The Medicare Contractor properly determined that the Four Units at OKSU-MC did not "provid[e] acute care services generally payable under the prospective payment system" in accordance with 42 C.F.R. § 412.106(a)(1)(ii) (as of Dec. 1, 2007); and

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[280] *See* 2024-Day-2 Tr. at 137.
[281] *Id.* at 239-240.
[282] *See supra* notes 17, 263.
[283] Provider's Response to Medicare Contractor's SFPP at 22-25.

2. Accordingly, the Medicare Contractor properly took the following actions:

   a. Excluded 12,006 days associated with the Four Units from the Medicaid Days reported at Worksheet S-3, Part I, Line 1, Column 5, and 13,169 days associated with the Four Units from the Total Patient Days reported at Worksheet S-3, Part I, Line 1, Column 6, moving these days to the same respective columns on Worksheet S-3, Part I, Line 16;

   b. Excluded these days from the relevant aspects of the DSH Medicaid fraction calculated for use in the Allowable DSH percentage reported on Worksheet E, Part A, Line 4.03; and

   c. Changed other calculations which use Total Patient Days or Medicaid Days through these adjustments to days, including, but not limited to, IME, GME, and Capital IPPS DSH.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

9/30/2024

X Clayton J. Nix

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

APPENDIX A
Analysis of Trailblazer Methodology

OKSU-MC has claimed that it used the same methodology as Trailblazer.[284] The Board disagrees. According to the OKSU-MC, if the day of admission meets the InterQual Criteria, then the stay is deemed to have met the acute care inpatient criteria for the geometric mean length of stay of the DRG plus five days, as highlighted in the following testimony from OKSU-MC's medical billing and coding expert, Ms. Edford:

> MR. ROTH: So under the Trailblazer methodology, by virtue of having met the first day, the admission date, is it correct to say that, the stay was found under the Trailblazer methodology to have been met for the geometric length of stay of the DRG plus five days?
>
> MS. EDFORD: Correct. [285]
>
> *****
>
> MR. ROTH: And so when you did your continuing care – continuing care review we talked about that ***starting after*** *the geometric length of stay plus five days*, then you would review a 10-day period. And then there was a third part of the methodology, of day 61 for five days. Is that correct?
>
> MS. EDFORD: Correct.[286]
>
> ****
>
> MR. ROTH: Oh, so there were some claims of the 15 that the entire length of stay was less than the geometric length of stay plus five days?
>
> MS.EDFORD: Correct.
>
> MR. ROTH: So those never even got to the second [review tier]?
>
> MS. EDFORD: Correct.[287]

Further, it is OKSU-MC's position that the Trailblazer methodology should be applied in a manner where consecutive stays in the same unit (regardless if one was acute care and the other PRTF care) were, in essence, deemed or treated as one consecutive stay.[288] However, when asked directly about it, Ms. Edford said she was unaware of whether Trailblazer encountered consecutive stays:

> [Board Member]: . . . Was there anything in Exhibit P-1, the Trailblazer report that indicated whether they ran

[284] P-52 at 3, 6.
[285] 2024-Day-1 Tr. at 172.
[286] *Id.* at 179 (emphasis added).
[287] *Id.* at 180.
[288] *See id.* at 232-36.

> into a similar situation of contiguous stays versus separate individual encounters?
>
> MS. EDFORD: Not that I recall reading. They didn't talk about it, but I don't think they called in, and they wanted to call in a secondary reviewer, and one of them, somebody, was opposed to it.[289]

Indeed, Ms. Edford testified that she had no understanding of the basis for TrailBlazer's use of the GMLOS of the relevant DRG plus five days:

> [Board Member]: So this geometric mean length of stay plus five, thing, obviously, it came from the Trailblazer report. [W]hat basis did they give for that?
>
> MS. EDFORD: I have no idea where they came up with that or how they came up with it.[290]

However, upon review of the TrailBlazer Report at Exhibit P-1, the Board did identify situations where there were consecutive stays in the same St. Anthony Unit and the TrailBlazer methodology did not treat those consecutive stays as one stay for purposes of the review (*i.e.*, it did not apply the GMLOS plus five days across some or all of the consecutive stay when the initial stay was found to be acute). Rather, in each of the below examples, the same patient had two consecutive stays in the ***same*** St. Anthony Unit, but only the first stay was found to be acute and the second stay was not. Each stay was clearly treated as unique because, had the OKSU-MC interpretation of TrailBlazer methodology been accurate, some or all of the second encounter would have been deemed acute. Specifically, given that the lowest GMLOS for DRGs 880 to 887 is 2.1, then at least the first seven days of the combined consecutive stays would have been deemed acute, but they were not.

1. Per the Secondary Medical Review, Patient Encounter Nos. 4 and 5 involved the same patient and were both to Unit 1926.[291] The admitting diagnosis was described as "unspecified disturbance of conduct with secondary diagnoses of oppositional defiant disorder, attention deficit disorder, pyromania, and impulse control disorder" and the lowest GMLOS for DRGs 880 to 887 is 2.1. As a result under OKSU-MC's interpretation, there should have been at least seven days (2.1 + 5); however, the following chart confirms only the four days associated with the first stay were found to be acute and all of the days in the second encounter were found to be non-acute or not met.[292]

[289] *Id.* at 243-244.
[290] *Id.* at 244.
[291] Ex. P-1 at 29.
[292] *Id.* at 9, 21, 29.

Unit	Encounter No.	LOS	Admit Date	Discharge Date	InterQual Review	Med. Director Findings	Specific Findings By the Medicare Contractor's Medical Director
1926	4	6 days	11/15/06	11/21/06	6 days met criteria	All Acute Inpt.	"According to discharge summary, he was admitted to acute adolescent unit on 11/15/2006 and 'downgraded' to the residential treatment unit on 11/20/2006."
1926	5	16 days	11/21/06	12/07/06	0 days met criteria	All Non-acute Inpt.	"The acuity of care does not reflect acute inpatient level of care, especially after 11/20/2006, as evidenced by the frequency and intensity of the physician visits and the InterQual criteria."

2. Per the Secondary Medical Review, Patient Encounter Nos. 24 and 25 involved the same patient and both were in Unit 1260.[293] The admitting diagnosis was described as "include[ing] pervasive developmental disorder, attention deficit disorder, and cerebral degeneration in childhood."[294] As a result under OKSU-MC's interpretation, there should have been at least seven days (2.1 + 5); however, the following chart confirms only the four days associated with the first stay were found to be acute and all of the days in the second encounter were found to be non-acute or not met.[295]

Unit	Encounter No.	LOS	Admit Date	Discharge Date	InterQual Review	Med. Director Findings	Specific Findings By the Medicare Contractor's Medical Director
1260	24	4 days	1/25/06	1/29/06	4 days met criteria	All Acute Inpt.	"It appears that there was an acute inpatient admission for the period 01/25/2006 and then a transfer to residential care on about 01/29/2006.."
1260	25	180 days	1/29/06	7/28/06	0 days met criteria	All Non-acute Inpt.	"throughout the duration of stay, the review of the InterQual criteria indicates some days that met the intensity of an acute inpatient level of care, but judging from the frequency of the physician visits, the physician orders, and the weekly treatment plan, it appears that the overall stay from 01/29/2006 through 07/28/2006 was not an acute inpatient level of care."

[293] *Id.* at 26-27.
[294] *Id.*
[295] *Id.* at 20, 27. *See also id.* at 7, 9-10 (confirming care documented in Unit 1260).

The Board's finding that the TrailBlazer methodology did not treat consecutive stays in the same unit as one stay is further supported by the fact that in Attachment D to that report, the medical director for St. Anthony's assigned Medicare contractor stated the following:

> For many of these, *there was a clear demarcation in the record when the attending physician ordered a different level of care*, usually as evidenced by a physician order for residential care. *About the time of this demarcation, the patient's acute condition seems to have stabilized*, the frequency of physician visits seems to have declined, and *there was a cascade of events signifying a change in the level of care* including new orders, nursing transfer notes, changes on the treatment plan and a new admission. In some cases this demarcation occurred before the time period of review, but was documented in the records available. It was clear to the Medical Director, that the attending physician was moving the patient to a lower level of care.[296]

It does not appear that Ms. Edford considered Attachment D of the Trailblazer Report. Accordingly, the Board finds OKSU-MC's practice of deeming consecutive stays in the same unit (regardless of whether one was acute care and the other PRTF care) as one stay for the purpose of the medical review is inconsistent with the Trailblazer methodology.

[296] *Id.* at 25 (emphasis added.)

APPENDIX B

Rejection of Belated Summary of Sampling Unit 2008-24

The delay in reconvening the hearing is well documented in the record as set forth in the Board's January 24, 2024 denial of postponement request. Briefly, the initial delay resulted from OKSU-MC requesting to continue the hearing after discovering errors in its experts' reports and related summary sheets of Dr. Salve and Ms. Edford that could not be corrected at the hearing. OKSU-MC requested a continuance to submit a corrected expert report within one week and the Medicare Contractor did not object to the request. The Board granted this request. However, on January 24, 2020, due to OKSU-MC's failure to file corrected reports, the Board ordered OKSU-MC to file the corrected expert reports no later than January 31, 2020, noting the Board's concern at not having received the promised corrected report:

> As the Provider's representative, you indicated at the hearing that the Provider should be able to submit corrected expert report (***with redline***) to the Board and the MAC *within a week of the original hearing date*. Notwithstanding, as of the date of this letter, it has been three (3) months since the initial hearing date and the Board still has not yet received the corrected report. . . . The Board is very concerned about the significant amount of additional time that the Provider's representative has taken to make corrections to what originally had been filed as the final expert report and *the initial expectation that the corrected report (with redline)* ***would be submitted posthaste***.[297]

OKSU-MC complied by filing on January 31, 2020, but the filing was 582 pages long (more than double the original filing due to Board-required redlines).

As discussed in **Subsection A(2)** of the STATEMENT OF FACTS AND RELEVANT LAW, the "corrected" reports included a *post-hoc* redefinition of the sampling unit. As a result of the *post-hoc* redefined sampling unit, the sampling unit under 2007-15 from the FY 2007 stratum was combined with the 2008-24 sampling unit. The "corrected" report for Ms. Edford at Exhibit P-52 included a patient summary for the combined sampling unit under 2007-15/2008-24 that is 2 pages long. As it is a "corrected" report, the Board required a redline to show any changes being made to what had previously been filed at Exhibit P-42. The redline for the new combined 2007-15/2008-24 does not indicate that it is a completely new patient summary not previously filed with the Board; but rather, the redline of this patient summary listed only listed minor changes in the header summary. The fact that there was not previously a patient summary is significant because this sampling unit has a listed LOS of 164 days and is by far the longest LOS not just for the FY 2008 stratum but also for all three stratums covering FYs 2006, 2007, and 2008.

This concern about a patient summary for 2008-24 *belatedly* appearing without explanation is further heighted by the fact that the sampling unit with which it was combined (2007-15) was

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[297] Board's letter (Jan. 24, 2020) (emphasis added).

listed on the original report from the statistical expert as "unavailable" which had led to another sampling unit being added to the FY 2007 stratum.

In considering what action to take regarding the fact that a combined patient summary was *belatedly* filed without explanation, the Board further reviewed Exhibits P-41 and P-42. For the FY 2008 stratum, the statistical expert's report listed the medical records for nine sampling units as "unavailable."[298] The sampling unit under 2008-24 was not listed as one of the 9 "unavailable" sampling units and had a total LOS of 165 days.[299] Notwithstanding the fact that 2008-24 had the longest LOS and it being listed as available, Ms. Edford's original patient summaries at P-42 did not include a patient summary for 2008-24. This report is ***paginated*** with the last page being marked "Page 242 of 242" and, based on the fact that the patient summaries are in order of the sample unit number, the patient summary for 2008-24 should have appeared at "Page 202 of 242" of Exhibit P-42 but instead the next available sampling unit, 2008-26, appears at that page. Neither OKSU-MC or Ms. Edford alerted the Board to this missing record at the original hearing held on October 22-23, 2019. As the examination of Ms. Edford was not completed as described above (the first Board member had not completed his examination before initial errors were discovered[300]), this missing record was not raised at that original hearing held on October 22-23, 2019.

The fact that there was a 10th unit 2008-24 (having 165 day) that was not listed as unavailable for the FY 2008 stratum but was not included in the original report from Ms. Edford at Exhibit P-42 is troubling to the Board. This concern is heightened by the fact that this missing stay was *later* combined with another unavailable sampling unit, 2007-15.[301] It appears as if three (3) months after the initial October 22-23, 2019 hearing, the records for the unavailable 2007-15 sampling unit and 2008-24 were located. However, none of the filings of the "corrected" reports on January 31, 2020 identified this issue. Further, at the reconvened hearing, no one could provide any details on when or how the previously unavailable records for 2007-15 (and then apparently 2008-24) were later found.[302] Similarly, Ms. Edford could not explain why there was no patient summary for 2008-24 in Exhibit P-42, notwithstanding the fact that she was asked at

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[298] Ex. P-41 at 13.
[299] *Id.* at 14.
[300] *See* 2019-Day-2 Tr. at 166-69.
[301] Ex. P-41 at 13-14 (showing 2007-15 as unavailable and 2008-24 as available); Ex. P-42 (Ms. Edford's report which did not include any report for 2008-24 which should have been at page 202 of Ex. P-42).
[302] Testimony at on the first day of the February 2024 hearing:

> [BOARD CHAIR]: Okay Would you have been involved with [the medical records for 2008-24] being found or have knowledge? Would it be expected that, you would have knowledge?
> MR. ADAMS: I'm sure medical records folks continued to dig, and why they were able to find that when they did, I don't know.
> [BOARD CHAIR]: And you don't know if it was found before, or after the October 22, 2019 hearing?
> MR. ADAMS: I don't recall, I'm sorry.
> [BOARD CHAIR]: Were you involved with, after the October 22nd hearing, were you involved with medical records, in specifically identifying any additional medical records?
> MR. ADAMS: From a standpoint of an updated sample list, and providing that, I don't, I'm sorry, it's been a long time. I haven't really looked at this in quite a while.

2024-Day-1 Tr. at 129-30.

the end of the first day of the reconvened hearing and allowed to respond the next morning.[303] It is particularly troubling that no explanation was provided about the missing 2007-15 and unavailable 2008-24 given the issues with the initial report and the amount of time the Board afforded the witness to correct and explain her report.

Accordingly, based on the above findings, the Board concludes that: (1) it cannot give any consideration to the combined patient summary for 2007-15/2008-24 in Exhibit P-52; and (2) it must treat 2008-24 as an "unavailable" sampling unit for purposes of Ms. Edford's initial report at P-42. As a result, the Board finds that there were 10 "unavailable" sampling units associated with Ms. Edford's initial report at P-42 (2008-24 plus the 9 listed as "unavailable" in the chart on page 14 of Exhibit P-41).

[303] When asked on the first day of the reconvened hearing, Ms. Edford could not explain why the original ***paginated*** report at Ex. P-42 (showing at the bottom of each page as "Page X of 232") did not include 2008-24. 2024-Day-1 Tr. at 299-301. The following day, Ms. Edford could only say it was not included in P-42:

> MR. ROTH: . . . . So, because ultimately, the question is whether this claim [2008-24], this patient stay, was included in P-42.
>
> MS. EDFORD: No.

2024-Day-2 Tr. at 9-10. Indeed, Ms. Edford's discussion of the complexity of the patient stay and length (2024-Day-2 Tr. at 7-9) does not explain why there is no accounting of the medical records for 2007-15 and 2008-24 (*see supra* note 303) and why neither 2007-15 nor 2008-24 were included in her original paginated report at P-42. Indeed, based on her description of the medical records, the fact that there are multiple discharges and admits with gaps between stays suggests it should not be treated as one mega sampling unit, particularly since there appears to be an intervening 5-day Med-Surg stay in ICU (2024-Day-2 Tr. at 7-27) and would not appear to meet the new *post-hoc* definition of sampling unit in the statistical expert's report at Exhibit P-52. Again, the Board has no confidence in the review of this patient since Ms. Edford's findings on this patient as set forth in Exhibit P-52 at 342 are based solely on the very first day of admission (apparently August 7, 2007) notwithstanding what appears to be a complex and ever-changing changing medical case given the number of admissions, discharges, and gaps in care (both for ICU and then another one day gap, *id*. at 19-20).

APPENDIX C

Comparison between Ex. P-42 (original expert report) and Ex. P-52 (corrected expert report) with GMLOS and AMLOS per 2008 IPPS Final Rule Table 5.

P-42 Pg. #	P-42 MS DRG	P-52 Sample #	P-52 # of enc	P-52 MS DRG	P-52 Acute LOS	P-52 RTC LOS	P-52 Total LOS	Final Rule GMLOS	Final Rule AMLOS
94	885	2007-11	2	885	5	55	60	5.5	7.6
Not	N.F.	2007-15/							
Found	N.F.	2008-24	4	886	10	154	164	4	5.9
123	885	2007-20	2	885	5	27	32	5.5	7.6
160	885	2008-1	2	885	5	24	29	5.5	7.6
162	885	2008-2	1	885	7	0	7	5.5	7.6
164	884	2008-3	2	884	13	19	32	4	5.4
166	781	2008-4	2	885	5	11	16	5.5	7.6
168	885	2008-6	2	885	5	2	7	5.5	7.6
170	885	2008-7	2	885	5	20	25	5.5	7.6
172	885	2008-8	2	885	5	55	60	5.5	7.6
174	885	2008-9	1	885	5	0	5	5.5	7.6
176	885	2008-10	2	885	5	8	13	5.5	7.6
178	883	2008-11	2	883	6	24	30	4.6	7.4
180	886	2008-12	2	886	5	40	45	4	5.9
183	886	2008-13	2	886	5	40	45	4	5.9
185	882	2008-14	2	885	5	34	39	5.5	7.6
187	882	2008-15	2	882	5	25	30	3.1	4.4
189	885	2008-16	2	885	6	6	12	5.5	7.6
192	885	2008-18	1	885	8	0	8	5.5	7.6
194	885	2008-19	2	885	5	24	29	5.5	7.6
196	883	2008-20	2	883	5	37	42	4.6	7.4
198	885	2008-21	1	885	3	0	3	5.5	7.6
200	882	2008-23	2	882	5	10	15	3.1	4.4
202	886	2008-26	2	886	1	5	6	4	5.9
204	886	2008-27	2	886	5	12	17	4	5.9
206	885	2008-28	2	885	8	8	16	5.5	7.6
208	883	2008-29	1	883	2	0	2	4.6	7.4
210	886	2008-30	3	886	6	11	17	4	5.9
213	881	2008-31	1	885	8	0	8	5.5	7.6
215	885	2008-36	2	885	7	9	16	5.5	7.6
217	885	2008-37	2	885	5	10	15	5.5	7.6
219	885	2008-38	1	885	3	0	3	5.5	7.6
221	882	2008-39	2	885	5	26	31	5.5	7.6
223	886	2008-41	2	886	4	26	30	4	5.9
225	886	2008-42	2	886	5	25	30	4	5.9
227	885	2008-43	2	885	6	1	7	5.5	7.6
				36	198	748	946		

			Prov. ALOS =	26.27778
882	2	5.56%	Avg. GMLOS =	4.916667
883	3	8.33%	Avg. AMLOS =	6.966667
884	1	2.78%		
885	22	61.11%		
886	8	22.22%		
	36	100.00%		