

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

In the Matter of the Hospital Surcharge
Appeal of Olmsted Medical Center

**RECOMMENDATION GRANTING THE
DEPARTMENT OF HUMAN SERVICES
SUMMARY DISPOSITION**

The above-entitled matter came on for hearing before Administrative Law Judge Manuel J. Cervantes (“ALJ”) on July 13, 2010, on the parties’ cross-motions for summary disposition. Barry R. Greller, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (“DHS”). Samuel D. Orbovich, Esq., and Katherine A. Burkhart, Esq., appeared on behalf of Olmsted Medical Center (“OMC”). The record closed on August 16, 2010, upon the timely receipt of the parties’ proposed orders.

STATEMENT OF ISSUE

Did DHS correctly determine that OMC’s main clinic and its ten community branch clinics were licensed under OMC’s hospital license and constitute outpatient departments of the hospital, the non-professional services revenue of which is “net patient revenue,” subject to the hospital surcharge imposed by Minn. Stat. § 256.9657, subd. 2?

Based upon all of the files, records, and proceedings herein, and for the reasons specified in the Memorandum below,

IT IS RESPECTFULLY RECOMMENDED:

1. That the motion of DHS for summary disposition be GRANTED;
2. That the motion of OMC for summary disposition be DENIED; and

3. That the Commissioner of Human Services AFFIRM the order of DHS assessing the hospital surcharge on the ten community branch clinics that were formerly operated as independent physician clinics, now licensed as a part of the hospital.

Dated: September 10, 2010

s/Manuel J. Cervantes

MANUEL J. CERVANTES
Administrative Law Judge

Reported: Digitally Recorded

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record and may adopt, reject or modify these Conclusions and Recommendation. Under Minn. Stat. § 14.61, the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Cal Ludeman, Commissioner of Human Services, Box 64998, St. Paul MN 55155, (651) 431-2907 to learn the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Pursuant to Minn. Stat. § 14.62, subd. 1, the Commissioner is required to serve its final decision upon each party and the Administrative Law Judge by first class mail.

MEMORANDUM

I. Jurisdiction

The Administrative Law Judge and the Commissioner of Human Services have jurisdiction pursuant to Minn. Stat. §§ 14.57 and 256.9657, subd. 6, and Minn. R. 9510.2000 to 9510.2050. OMC was given notice of the hearing in this matter and the DHS has complied with all relevant procedural requirements. The ALJ and the

Commissioner have authority to consider the issues set out in the Notice and Order for Prehearing Conference.¹

II. Regulatory Background

Minnesota imposes a medical care surcharge on various Minnesota health care providers and organizations under Minn. Stat. § 256.9657 (surcharge statute). Subdivision 2 of that statute provides the following surcharge on Minnesota hospitals, such as OMC, to be paid into the Medical Assistance account:

(a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

The current surcharge on Minnesota hospitals under the statute is 1.56 percent of “net patient revenues.”

Minn. R. 9510.2000 to 9510.2050² (surcharge rules) govern administration of the medical care surcharge under the surcharge statute,³ including the hospital surcharge. While the term “hospital” is not defined in the surcharge statute, the following rules and statutes are instructive in ascertaining whether particular components of a hospital are included within the definition of “hospital” for purposes of the imposition of the surcharge:

- a. Minn. R. 9510.2010, subp. 8, states: “‘Hospital’ has the meaning given in part 9505.0175, subpart 16, but does not include federal Indian Health Service facilities and regional treatment centers.”

¹ Statutes are cited to the 2008 Edition. OMC has requested the ALJ to consider the status of three specialty clinics located on OMC’s campus in its appeal. These clinics were not considered by DHS in denying OMC’s request for relief from the surcharge statute and were not referenced in OMC’s appeal; therefore, the ALJ declines to address their status in this contested case. See Exhibits A and B, attached to DHS’ Notice and Order for Prehearing Conference (Notice). Independent of this matter, the parties are free to address the status of any revenues from these clinics that may be subject to the surcharge.

² Rules are cited to the 2009 Edition.

³ Minn. Stat. § 256.9657.

- b. Minn. R. 9505.0175, subp. 16 defines “hospital” as “an acute care institution defined in Minnesota Statutes, section 144.696, subdivision 3, licensed under Minnesota Statutes, sections 144.50 to 144.58, and maintained primarily to treat and care for persons with disorders other than tuberculosis or mental diseases.”
- c. Minn. Stat. § 144.696, subd. 3, refers to hospital licensing statutes for the definition of hospital: “

‘Hospital’ means any acute care institution licensed pursuant to sections 144.50 to 144.58, but does not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

”
- d. Minn. Stat. § 144.50, subd. 2 states:

Hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which any accommodation is maintained, furnished, or offered for five or more persons for: the hospitalization of the sick or injured; the provision of care in a swing bed authorized under section 144.562; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings. Nothing in sections 144.50 to 144.56 shall apply to a clinic, a physician's office or to hotels or other similar places that furnish only board and room, or either, to their guests.
- e. Minn. R. 9505.0175, subp. 4 defines “Clinic” as “an entity enrolled in the medical assistance program to provide rural health clinic services, public health clinic services, community health clinic services, or the health services of two or more physicians or dentists.”
- f. Minn. R. 9505.0250, subp. 1 states "Clinic service" means a preventive, diagnostic, therapeutic, rehabilitative, or palliative service provided by a facility that is not part of a hospital but provides medical or dental care to outpatients.

- g. "Physician's office" is not defined in the surcharge rules but the hospital licensing statute makes clear that physician offices need not be licensed.⁴
- h. Minn. R. 9505.0330, subp. 1 states "Outpatient hospital service" means a health service that is medically necessary and is provided to a recipient by or under the supervision of a physician, dentist, or other provider having medical staff privileges in an outpatient hospital facility licensed under Minn. Stat. § 144.50.

Under the foregoing statutes and rules, if a hospital facility is licensed as a hospital under the provisions of Minn. Stat. §§ 144.50 to 144.58, as administered by the Commissioner of Health, the facility's net patient revenues are subject to the hospital surcharge. Stated alternatively, if a hospital's outpatient department is integrated into hospital operations sufficiently to qualify the facility for coverage under the hospital's license, its net patient revenues are subject to the hospital surcharge.

III. Procedural Posture and Contention of the Parties

OMC appealed a final decision of DHS denying its monthly administrative appeals of an increase in its hospital surcharge issued by Larry Woods, DHS Director of Health Care Operations.⁵ On June 19, 2009, OMC timely requested a contested case hearing with respect to DHS' final decision.⁶

DHS stated its position as follows:

OMC includes a Level IV trauma hospital, two FastCare retail clinics, and 10 community branch clinics.⁷ OMC has obtained Medicare provider based status for its [ten community branch] clinics. In order to obtain provider-based status, a clinic must meet, at a minimum, the five requirements laid out at 42 CFR §413.65. These include, common licensure with the hospital, integrated clinical services, integrated financial operations, public awareness, and that the clinic must fulfill the obligations of an outpatient hospital department as laid out at 42 CFR § 413.65 (d).

In obtaining provider-based status for its clinics, Olmsted Medical Center made the clinics outpatient departments of the hospital for the purposes of Minnesota licensure.

Because the clinics are licensed under the hospital's license and are defined as outpatient departments of the hospital, the non-professional services delivered by the clinics are hospital services and the revenue

⁴ Minn. Stat. § 144.50, subd. 2.

⁵ Notice, Ex. A.

⁶ Notice, Ex. B.

⁷ <http://www.olmmed.org/about/index.html>

received for the provision of those services is hospital revenue subject to the hospital surcharge.

Minnesota statutes require that all hospital revenue, except for Medicare revenue, be subject to the surcharge.⁸ The rates of payment and the characterization of the payment by the payee is (sic) irrelevant. Therefore, Olmsted Medical Center's surcharge for October 2008 through September 2009 is \$918,852.⁹

OMC's position is as follows: OMC acknowledges that in order to obtain provider-based status for Medicare purposes it must meet, at a minimum, the five requirements codified in federal regulations¹⁰ and as enumerated above by DHS, but "[t]he Medicare regulations are clear that provider-based status is used only 'for payment purposes.' This federal regulatory characterization does not change the fundamental nature of these entities. They [OMC's community branch clinics] are physician clinics, not hospitals."¹¹ OMC further contends: 1) the surcharge statute's definition of "hospital" does not apply to its clinics and therefore, the surcharge does not extend to its physician clinics; 2) the "community branch clinics are not 'licensed under the hospital's licensure'"; 3) there is no direct connection between the federal regulations governing provider-based status and the state surcharge statute. "

No section of the Minnesota Statutes or Rules relating to the provider surcharge specifically mentions or references the federal provider-based regulations. The regulations govern Medicare reimbursement alone; they do not affect, nor were they intended to affect, hospital licensure by the states or the definition of what constitutes a "hospital" under state law."¹² and

4) by applying the surcharge statute to OMC's community branch clinics, it has applied an unpromulgated rule.¹³

IV. Undisputed or Uncontroverted Facts

The following findings of fact are based on undisputed facts established by the affidavits and stipulation submitted by the parties:

OMC's facilities in issue in this matter consist of a Level IV trauma hospital, a main clinic, and ten community branch clinics.¹⁴ OMC also operates two FastCare

⁸ Minn. Stat. § 256.9657, subd.2.

⁹ Notice, Ex. A at 1-2.

¹⁰ 42 C.F.R. § 413.65 (d).

¹¹ Notice, Ex. B at 2-3.

¹² *Id.*, at 4.

¹³ *Id.*, at 5-7.

¹⁴ Stipulation of Facts (Stip.), ¶¶ 1, 2, and 5.

walk-in clinics in retail locations.¹⁵ The parties have stipulated that the revenues of the two FastCare clinics have not been reported to DHS, have not been subject to the hospital surcharge, and are not in issue.¹⁶

At all times relevant to this appeal, OMC applied for and obtained provider-based status under Medicare for its main clinic and ten community branch clinics, pursuant to 42 C.F.R. § 413.65.¹⁷ Provider-based status is financially advantageous to a hospital with a significant population of Medicare clients, as it allows the hospital to charge Medicare a “facility charge” and certain other costs that would otherwise not be billable.¹⁸

The parties agree that under the federal regulation, to qualify for provider based status, a remote location of a hospital provider must meet at least the following five requirements:

1. Be operated under the same license as the hospital, except in states where separate licenses are required or where “[s]tate law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license” 42 C.F.R. § 413.65(d)(1);
2. Have clinical services that are integrated with the main hospital provider, as evidenced by six separate factors, including:
 - (i) Professional staff of the facility or organization have clinical privileges at the main provider.
 - (ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.
 - (iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

¹⁵ *Id.*, ¶¶ 3-4.

¹⁶ *Id.*, ¶¶ 10-11.

¹⁷ *Id.*, ¶ 6.

¹⁸ See OMC Mem. In Support, at 4, 5, and 7 (“reimbursement as an outpatient department can be financially advantageous”).

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

42 C.F.R. § 413.65(d)(2);

3. Have financial operations that are fully integrated within the financial system of the main hospital provider, as evidenced by shared income and expenses between the main provider and the facility. 42 C.F.R. § 413.65(d)(3);

4. Be held out to the public and other payers as part of the main hospital provider, such that when patients enter the provider-based facility or organization, they are aware that they are entering the main provider and will be billed accordingly. 42 C.F.R. § 413.65(d)(4); and

5. In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of 42 C.F.R. § 413.65, including treating all Medicare patients, for billing purposes, as hospital outpatients. 42 C.F.R. § 413.65(d)(5)

In order for a physician clinic to qualify as provider-based under the foregoing regulations, it must make significant structural changes in its organization and operations to realize the payment benefits available to provider-based facilities. To attain Medicare provider-based status for its main clinic and ten community branch clinics, OMC established the clinics as outpatient departments of its hospital for purposes of its Minnesota hospital licensure. Correspondence between OMC and the Minnesota Department of Health (“MDH”) shows that OMC sought to achieve recognition of its main and ten branch clinics under its Minnesota hospital license.¹⁹ An OMC representative contacted MDH and stated, “I am writing to request that you *verify*

¹⁹ Stip., ¶ 7 & Ex. B, Higgins to Hirschfield letter.

that our provider-based clinics are listed as part of our licensure.”²⁰ (Emphasis added). MDH’s representative responded, “regarding [the] eleven provider-based clinics that operate as outpatient departments of Olmsted Medical Center....” the clinics “are considered part of Olmsted Medical Center’s hospital license.”²¹ In addition, OMC’s ten community based clinics are listed by OMC at the bottom of its hospital letterhead.²²

The letters noted above were exchanged in 2006. There are no records of MDH indicating that OMC has ever requested that MDH remove OMC’s provider-based clinics from its hospital license,²³ nor does OMC claim that it ever made such a request. Indeed, DHS, MDH, Centers for Medicare and Medicaid Services (CMS, the Federal Medicare regulatory agency), and OMC itself believe the provider-based clinics operate under OMC’s hospital license.

Although MDH does not separately license physician clinics as hospitals, because they do not meet hospital certification standards, MDH does license clinics under a hospital’s license.²⁴ OMC’s 2010 hospital license application includes a list of its clinics, including the main and ten community branch clinics at issue in this matter.²⁵ DHS determined that OMC’s main clinic and its ten community branch clinics constitute outpatient departments of the hospital under the surcharge statute based on the following facts which are either undisputed in the record or are uncontroverted by OMC:

1. The clinics operate under the same Minnesota license as the hospital provider, OMC;
2. The clinical services of the clinics are integrated with the hospital provider;
3. The clinics have financial operations that are fully integrated within the financial system of the hospital provider;
4. The clinics are held out to the public and other payers as part of the hospital provider, such that when patients enter the clinics, they are aware that they are entering the main provider and will be billed accordingly;²⁶

²⁰ *Id.*, Ex. B.

²¹ *Id.*, ¶ 8 & Ex. C, Hirschfield to Higgins letter. The reference to the eleventh clinic relates to OMC’s main clinic in Rochester.

²² *Id.*, Ex. B.

²³ Henderson Aff., ¶ 6.

²⁴ *Id.*, ¶ 3.

²⁵ *Id.*, ¶ 6 & Ex. A.

²⁶ OMC has clearly represented to the public that its clinics are outpatient departments of OMC, as is evidenced on its webpage. See http://www.olmmed.org/patients/provider_based_billing.html, last visited September 1, 2010 (The webpage states, in relevant part, “The Centers for Medicare and Medicaid Services have designated Olmsted Medical Center (OMC) healthcare providers as ‘Provider-based.’ Olmsted Medical Center clinics will be considered outpatient hospital departments.”)

5. As hospital outpatient departments, the clinics must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of 42 C.F.R. § 413.65, including treating all Medicare patients, for billing purposes, as hospital outpatients.

V. Analysis

In 2006, OMC established its main clinic and ten community branch clinics as outpatient departments of the hospital for purposes of benefiting from a Medicare provider-based status, consistent with federal regulations 42 C.F.R. 413.65. In order to be compliant with federal regulations, OMC clinics required Minnesota hospital licensure with MDH. OMC integrated the main clinic and ten community branch clinics with its hospital operations, and OMC holds the clinics out to the public as outpatient departments of the hospital, all pursuant to the requirements of 42 C.F.R. § 413.65. OMC does not dispute that it is in full compliance with the requirements of 42 C.F.R. § 413.65.

OMC contends that 42 C.F.R. § 413.65 regulations are “for payment purposes.” The ALJ’s reading of the regulations does not lead him to that conclusion. In order to obtain the status of “provider-based,” OMC was required to restructure its clinics and integrate them into hospital operations to meet the minimum requirements of the federal regulations. Specifically, OMC was required to operate the clinics under common licensure with the hospital; integrate clinical services and financial operations, including billing; fulfill the obligations of an outpatient hospital department; and make the public aware that the clinic was an extension of the hospital and if additional care or treatment was necessary, the patient would be referred to their hospital for care. It is only after these requirements are met, that OMC is eligible for Medicare payment.

Next, OMC contends its community branch clinics are physician clinics, not hospitals. While “Physician Clinic” is not defined in the rules, “Clinic” is defined as an entity providing health services by two or more physicians.²⁷ “Clinic service” means a preventive, diagnostic, therapeutic, rehabilitative, or palliative service provided by a facility that is *not part of a hospital* but provides medical or dental care to outpatients.²⁸ (Emphasis added.) “Outpatient hospital service” means a health service that is medically necessary and is provided to a recipient by or under the supervision of a physician, dentist, or other provider having medical staff privileges *in an outpatient hospital facility licensed under Minnesota Statutes, section 144.50.*²⁹

Pursuant to Minnesota Statutes section 144.55, subdivision 3, MDH uses Medicare hospital certification regulations, as promulgated pursuant to Title XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq., as minimum standards for the licensure of Minnesota

²⁷ Minn. R. 9505.0175, subp. 4.

²⁸ Minn. R. 9505.0250, subp. 1.

²⁹ Minn. R. 9505.0330, subp. 1

hospitals. MDH does not separately license freestanding physician's offices or clinics as hospitals, because they would be required to meet all of the hospital conditions of participation to satisfy the standards for hospital licensure and certification. The hospital license issued by MDH allows a hospital to operate a department of the hospital, a remote location of the hospital, or a satellite facility, including physician's offices or clinics, as part of the licensed hospital, if the hospital includes those off-site locations on the license application and attests that these locations are being operated under the hospital's license and that the hospital will bill for services provided at the clinic locations using the hospital provider number.³⁰

The statement of Mary Henderson³¹ and the above-referenced rules make clear the transformation of OMC's clinics from physician offices, independent of the hospital, to outpatient hospital facilities integrated into hospital operations. The health services provided by the OMC clinics are an extension of the hospital's services which are permitted by qualifying for the requisite state hospital license. The clinics' state licensure also qualifies them for provider-based status. While OMC is technically correct that the surcharge statute does not specifically reference the federal Medicare regulation, each is constructed to work hand-in-hand with the other.

VI. Summary

OMC, in licensing its clinics under its hospital license and in structurally changing clinic operations to comply with the requirements of 42 C.F.R. § 413.65, has rendered the nonprofessional services revenue of its community branch clinics hospital revenue. This revenue is subject to the hospital surcharge on net patient revenues under Minn. Stat. § 256.9657.

In making the foregoing determination concerning the OMC clinics, DHS relied on the plain language of the surcharge statute and surcharge rules. DHS has not issued a new "interpretation" of the surcharge statute, based on federal regulations, nor has it adopted or applied an unpromulgated interpretative rule.

M. J. C.

³⁰ Henderson Aff., ¶ 3.

³¹ Supervisor- Health Facility Evaluator, Compliance Monitoring Division, MDH