

8-1800-7656-2

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

In the Matter of the Contested Case  
of Fairview Riverside, Fairview  
Southdale, and Fairview Milaca  
Hospitals v. Minnesota Department of  
Human Services

RECOMMENDED ORDER ON CROSS  
MOTIONS FOR SUMMARY DISPOSITION

On August 10, 1993, Fairview Riverside, Fairview Southdale, Fairview Milaca Hospitals (Hospitals or Petitioners) filed a Motion requesting, in essence, summary disposition in this case. On August 11, 1993, the Department filed a similar Motion. Reply Memoranda were filed by the parties on September 7 and September 8, 1993 and oral arguments on the Motions were heard on September 28, 1993. Paul M. Landskroener, Assistant Attorney General, Suite 200, 520 Lafayette Road, St. Paul, Minnesota 55155-4199, appeared on behalf of the Minnesota Department of Human Services (Department). Donald S. Franke, Dorsey & Whitney, Attorneys at Law, 220 South Sixth Street, Minneapolis, Minnesota 55402-1498, appeared on behalf of the Petitioners.

Based upon all the files, records and proceedings herein, and for the reasons set for in the appended Memorandum,

IT IS HEREBY RECOMMENDED:

1. That the Commissioner GRANT the Department's Motion for Summary Judgment and DENY the Hospital's Cross-motion.
2. That the Commissioner hold that the utilization method of settling pass-through costs apply to all hospital admissions prior to March 24, 1987.

IT IS HEREBY ORDERED: That this recommended Order be certified to the Commissioner of Human Services pursuant to Minn. Rules 1400.7600 B. and D. (1991).

Dated this 29th day of October, 1992.

/s/\_Jon\_L.\_Lunde\_\_\_\_\_

JON L. LUNDE  
Administrative Law Judge

MEMORANDUM

I. BACKGROUND

In 1965 Congress enacted Title XIX of the Social Security Act which established the Medicaid program. Prior to 1980, federal law required that states pay for inpatient hospital services under the Medical Assistance (MA) program on a reasonable, cost-related basis. Generally speaking, the costs reimbursed included all direct and indirect costs deemed necessary and proper for the delivery of inpatient hospital services. In 1980 and 1981 significant amendments relating to the payment for MA inpatient hospital services were adopted. In the so-called Boren Amendment, the reasonable cost requirement was eliminated and criteria were adopted requiring that reimbursement rates be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals. Omnibus Reconciliation Act of 1980, P 962; and Omnibus Budget Reconciliation Act of 1981, P 2173.

In 1983, the Department was required to adopt rules implementing new state legislation requiring the establishment of a prospective payment system for inpatient hospital services provided to recipients of Medical Assistance and General Assistance Medical Care (GAMC). Minn. Laws 1983 c. 312, art. 5 PP 9 and 39 (1983 Act). Section 39 stated:

The prospective payment system for inpatient hospital service shall be applied, beginning July 1, 1983, to hospitals with a fiscal year beginning on that date. Each remaining hospital shall continue to be paid on a cost per case basis, limited to a maximum increase of five percent per state fiscal year, until the first date of its first full fiscal year that begins after July 1, 1983; on and after that date it shall be paid through the prospective payment system.

Following enactment of the 1983 Act, the Department promulgated temporary rules establish

In 1984, State laws were amended to require that payment for inpatient hospital services be based upon diagnostic classifications so that a hospital's mix of inpatient hospital services would be reflected in its rates. See, Minn. Laws 1984, c. 534, P 20 (1984 Act). The 1984 Act amended Minn. Stat. P 256.969, subd. 2 to read as follows:

Rates paid to inpatient hospitals shall be based on a rate per admission until the commissioner can begin to reimburse hospitals for services under the medical

assistance and general assistance medical care programs based on a diagnostic classification system appropriate to the service populations. On July 1, 1984, the

commissioner shall begin to utilize to the extent possible existing classification systems, including medicare. The commissioner shall incorporate the grouping of hospitals with similar characteristics for uniform rates upon the development and implementation of the diagnostic classification system. Prior to implementation of the diagnostic classification system, the commissioner shall report the proposed grouping of hospitals to the senate health and human services committee and the house health and welfare committee. Medical assistance and general assistance medical care reimbursement for treatment of mental illness shall be reimbursed based upon diagnosis classifications.

The Department implemented the 1984 Act by establishing a payment system based on diagnostic related groups (DRGs). See Minn. Rules, pts. 9500.1090 to 9500.1155, which became effective August 1, 1985. Under the rules, inpatient hospital services are divided into diagnostic categories representing broad clinical patient groups based on the body system and disease involved. Patients are assigned to a particular diagnostic category based on their principal diagnosis, secondary diagnosis, the presence or absence of operating room procedures, age, sex, and discharge status. Under the rules, hospital payments are related to the treatment provided to each patient.

The rates paid to hospitals under the rules promulgated in 1985 are hospital-specific. Under the rules, hospitals are paid a lump-sum amount for each admission. The lump-sum payment varies with the patient's diagnostic category. Under the rules, the statewide average cost per admission is computed by dividing total reimbursable inpatient hospital costs for all admissions by the total number of admissions. Also, an average cost per admission statewide for each diagnostic category is computed by dividing the total reimbursable inpatient hospital costs in each diagnostic category by the total number of admissions in each category. When those two figures are computed, a relative value is computed for each diagnostic category by dividing the average cost per admission for each diagnostic category by the average cost per admission for all admissions. Thus, if the average cost per admission for all admissions is \$1,000 and the average cost per admission for a particular diagnostic category is \$2,000, the relative value of that diagnostic category would be 2. In other words, a hospital would be paid twice the average cost of all admissions for those admissions in the diagnostic category having an average cost of \$2,000. See, Minn. Rules, pt. 9500.1110 (1986 Supp.).1

Under the rules adopted in 1985, special provisions were made for

pass-through costs, which are reimbursed separately. Pass-through (i.e. fixed) costs include depreciation, rents and leases, property taxes, property insurance, interest, and malpractice insurance. Minn. Rules, pt. 9500.1125, subp. 1 (1985 Supp.). The rule defines pass-through costs as "reimbursable inpatient hospital costs not subjec

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1. The average costs during the base year are increased by a hospital cost index to reflect current conditions. See Minn. Rules, pts. 9500.1115 and 1120.

For a hospital's rate year (budget year) the hospital is required to submit a pass-through cost report which includes actual data for the prior year and budgeted data for the current and budget (rate) years. The budget year pass-through cost per admission are included in the payment a hospital receives for each admission: the "categorical rate per admission."2 The categorical rate per admission consists of the adjusted base year cost per admission multiplied by the Health Care Index. The product is then multiplied by the relative value of the appropriate diagnostic category. The budget year pass-through cost per admission is added to that product. Minn. Rules, pt. 9500.1125, subp. 3. After the end of the hospital's budget year, its estimated pass-through costs per admission for the budget year are compared to its actual pass-through costs per admission and an annual settle-up occurs. The process followed, commonly referred to as the "utilization methodology", is set forth in Part 9500.1125, subp. 4 which states:

Pass-through cost per admission adjustment. After the end of each budget year, the commissioner shall redetermine the categorical rate per admission. The commissioner shall substitute actual pass-through costs as determined by medicare for the budgeted pass-through costs in subpart 2, item B for that year. If the adjustment indicates an overpayment to a hospital, that hospital shall pay to the commissioner the overpayment within 60 days of the written notification from the commissioner. If the adjustment indicates an underpayment to a hospital, the commissioner shall pay that hospital the underpayment within 60 days of written notification from the commissioner.

Not all pass-through costs are necessarily recognized in determining pass-through costs per admission. The pass-through cost per admission is calculated by multiplying the ratio of reimbursable inpatient hospital costs to total reimbursable costs by pass-through costs divided by base year admissions.

Minn. Rules, pt. 9500.1125, subp. 2. Hence, pass-through costs per admission

are:

	Reimbursable Inpatient Hospital Costs	
	<hr/>	x Pass-through
costs	Total Reimbursable Center Costs	
<hr/>		
	Base year Admissions	

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2. The categorical rate per admission consists of a hospital's operating costs and its pass-through costs. The operating cost component constitutes approximately 90% of the total payment rate.

In 1987 part 9500.1125, subp. 4 was amended to change the manner in which actual settle-up, pass-through costs are calculated. The 1987 amendment to the rule was adopted on March 24, 1987. Under the amended rule, a "cost-center" methodology for determining actual pass-through costs was promulgated. Under this methodology, the proportion of total pass-through costs attributable to each hospital service actually provided to MA patients during the rate year is multiplied by the proportion that a hospital's total capital-related pass-through costs bear to that service for all patients. In the Department's brief, the process is described as follows:

To illustrate, suppose that ten percent of a hospital's total capital-related pass-through costs were attributable to the obstetrics department. Further suppose that MA patients were responsible for 25 percent of the obstetrics department's costs. At the end of the year, MA would determi

The issue in this case is whether the method used by the Department to determine actual, settle-up pass-through costs for the hospitals in this proceeding for the calendar years (and fiscal years) 1985 through 1987 is appropriate. The Department applied the provisions of Minn. Rules, pt. 9500.-1125, subp. 4, adopted on July 29, 1985, using the so-called "utilization methodology" to calculate the settle-up figures. The Hospitals argue that the 1987 amendments relating to pass-through cost adjustments should have been applied to them for the three years in question.

## II. Discussion

The Hospital's first argument is that the plain language of Rule 54 requires use of the cost center methodology throughout the three years in question<sup>3</sup> because no settle-up of their pass-through costs had been made when the 1987 amendments became effective on March 24, 1987. In the Hospital's view, use of the cost center methodology is required under Part 9500.1125, subp. 6 (1985). The rule states:

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3. The rate years involved in this case are 1985 and 1986, and for Fairview  
Riverside Hospital, 1987 also.

Effective Date. The categorical rate per admission shall be effective for all admissions that occur on or after the effective date of Parts 9500.1090 to 9500.1155.

The effective date of the parts referred to in the cited rule was June 29, 1985. Hence, the methodology contained in part 9500.1125, subp. 4 applies to admissions on or after July 29, 1985.

When the cost center methodology was adopted on March 16, 1987, the Hospitals argue that the Department did not make any modifications to the effective date applicable to the admissions qualifying for application of the cost center methodology. Instead, the Hospitals argue that the effective date was kept intact under part 9500.1125, subp. 6 (1987), which was amended to read as follows:

The categorical rate for admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 - 9500.1155.

The Hospitals argue that the amendment to subpart 6, which did not change the effective date, evinces an intention by the Commissioner that all admissions on and after July 29, 1985 should qualify for the cost center methodology. In the Hospital's view, retention of the same effective date cannot be characterized as an oversight. If the Commissioner intended that the 1987 amendments were to become effective on some other date, the Hospitals argue that the Commissioner should have said so when the 1987 amendment were promulgated. Because she didn't, the Hospitals argue that Department should have applied the cost center

methodology in calculating the Hospital's pass-through settlements for all admissions occurring on or after July 29, 1985.

The Hospital's position is, in essence, that changes in the methodology for computing the pass-through cost adjustment enacted in 1987 should apply to admissions occurring before the effective date of the amendment. The argument is not persuasive. The rules enacted in 1985 say, in essence, that the Department would pay the pass-through costs incurred with respect to any admission on an estimated basis and would thereafter recompute the pass-through costs to arrive at the actual costs incurred and make an adjustment. The rules state the Department's intention for computing actual pass-through costs using a specified methodology. When patients were admitted while the 1985 rules were in effect, the rules state how the pass-through costs attributable to those admissions will be paid. Those rules are effective for any admission occurring while they are in effect. Although the settle-up may occur after the amendments were made, applying the new rule to prior admissions changes the basic understanding or "bargain" between the parties as to the manner in which pass-through costs would be reimbursed for prior admissions. The manner in which pass-through costs ultimately are reimbursed for an admission is governed by the rules in effect when the admission occurs. The manner in which pass-through costs were estimated and the manner in which settle-ups would be computed become fixed at that time.

In the absence of specific language in the 1987 amendments, they cannot be construed to be retroactive unless clearly and manifestly so intended by the Department. See Minn. Stat. §§ 645.21 and 645.001 (1992). The 1987 amendments do not state that the settle-up provisions should be applied retroactively and there is no clear and manifest language expressing such an intention by the Department. Consequently, the new pass-through methodology enacted in 1987 cannot apply to the admissions occurring prior to the time the 1987 amendments were enacted. Hence, the Hospital's appeal should be denied.

The Hospitals argued that use of the cost center methodology would have no retroactive affect on the Hospitals' costs or conduct; rather, it would only affect the prospective determination of the amount that the Department would recognize and pay for MA and GAMC purposes. Petitioner's Memorandum at 4. That argument is not persuasive because it focuses on the wrong factors. Retroactivity is not based on the affect a newly promulgated rule will have on costs already incurred or conduct already taken. Instead, the focus is on the manner in which vested rights are diminished. In this case, application of the 1987 amendments to prior admissions changes the manner in which the Petitioners' entitlement to reimbursement for certain costs pertaining to admissions already occurring will be computed. Applying the 1987 amendments to

prior admissions is clearly retroactive and unauthorized.

In the Petitioner's view, the 1987 amendment applies to any prior periods for which a settle-up has not been made. Under such a construction, two hospitals having the same fiscal year could be reimbursed differently for pass-through costs depending on the timing of Medicare audits and the pass-through settle-ups. Such a construction makes no sense. The rules applicable to the calculation of a hospital's reimbursement should be uniform for admissions occurring during the same time periods. They should not vary with those who are fortunate or unfortunate enough to have a later settle-up date. Although the Hospitals in this case may benefit from application of the cost centered methodology, other providers might not.

The Minnesota Supreme Court has indicated, citing *Summit\_Nursing\_Home, Inc.\_v.\_United\_States*, 572 F.2d 737 (Ct. Cl. 1978), that rules may be made retroactive if it is reasonable to do so. *Mason\_v.\_Farmers\_Ins.\_Companies*, 281 N.W.2d 344, 348 (Minn. 1979). In that case, it noted, however, that laws are presumed to have no retroactive effect unless clearly and manifestly intended by the legislature and that no lesser standards should be applied to rules promulgated under statutory authority. *Id.* Apparently, the Supreme Court has not decided whether an agency may give retroactive effect to its rules in the absence of a specific grant of authority. The United States Supreme Court, however, has held that agencies do not have authority to promulgate rules having a retroactive effect in the absence of a specific delegation of authority to do so. *Bowen\_v.\_Georgetown\_University\_Hospital*, 488 U.S. 204, 109 S.Ct. 468, 472, 102 L.Ed.2d 493 (1988). No statutory language was cited indicating that the Department is authorized to retroactively apply rules relating to inpatient hospital services for MA and GAMC patients. Furthermore, there is no clear and manifest indication that the Department intends

In *Bowen\_v.\_Georgetown\_University\_Hospital*, 488 U.S. 204, 109 S.Ct. 468, 102 L.Ed.2d 493 (1988), the United States Supreme Court addressed an issue similar to that involved in this case. In the *Bowen* case, the Secretary of Health and Human Services adopted a rule changing the method for calculating a "wage index." The wage index was a factor used to reflect the salary levels for hospital employees in different parts of the country and would affect the reimbursement received by Medicare providers. The Court found that the rule had a retroactive effect and exceeded the Secretary's delegated authority. Applying the cost center methodology to the rate years involved in this proceeding would also have a similar retroactive effect because application of that methodology to prior admissions and rate years changes the manner in which a hospital's reimbursement is calculated. The timing of that calculation is not material in determining the retroactive nature of the rule.

In *Cooper\_v.\_Watson*, 187 N.W.2d 689, 693 (Minn. 1971) the Minnesota Supreme Court cited with approval the definition of a retrospective law contained in 50 AM.JUR, ¶ 476 which reads:

A retrospective law, in the legal sense, is one which takes away or impairs vested rights acquired under existing laws, or creates a new obligation and imposes a new duty, or attaches a new disability, in respect of transactions or considerations already past. It may also be defined as one which changes or injuriously affects a present right by going behind it and giving efficacy to anterior circumstances to defeat it, which they had not when the right accrued, or which relates back to and gives to a previous transaction some different legal effect from that which it had under the law when it occurred. Another definition of a retrospective law is one intended to affect transactions which occurred, or rights which accrued, before it became operative, and which ascribes to them effects not inherent in their nature, in view of the law enforced at the time of their occurrence.

Applying the cost center methodology to prior admissions changes the law in force at the time those admissions occurred and alters the manner in which pass-through costs are determined for those prior admissions. This is clearly a prohibited retroactive or retrospective effect.

The Commissioner has twice held that when a nursing home's cost reports are audited, the rules in effect when cost reports are filed and interim rates established are the rules that must be applied when the cost reports are audited, even though those rules had been repealed before the audit took place.

In the Matter of the Contested Case of Chappel View, Inc. v. Minnesota Department of Human Services, OAH Docket No. HS-88-015-JL, 8-1800-1796-2, Commissioner Order dated June 30, 1988;  
In the Matter of the Contested Case of Greenbrier Homes, Inc. v. Minnesota Department of Human Services, OAH Docket No. HS-88-058-MS, 50-1800-77-2 Commissioner Order dated September 17, 1987. Applying the utilization method in determining the settle-up of pass-through costs is consistent with the Commissioner's holding that the rules in effect when services are provided to nursing home recipients are the rules that must be applied when cost reports for those years are audited, even though the rules have been amended or repealed.

JLL