COURT OF APPEALS
DECISION
DATED AND FILED

December 4, 1997

Marilyn L. Graves
Clerk, Court of Appeals
of Wisconsin

NOTICE

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. ***See*** **§ 808.10 and RULE 809.62, STATS.**

No. 97-0958

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT IV

SAINT JOSEPH'S HOSPITAL OF MARSHFIELD, INC.,

PLAINTIFF-APPELLANT,

V.

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES,

DEFENDANT-RESPONDENT.

APPEAL from an order of the circuit court for Dane County: RICHARD J. CALLAWAY, Judge. *Affirmed.*

Before Dykman, P.J., Vergeront and Deininger, JJ.

DYKMAN, P.J. St. Joseph's Hospital of Marshfield appeals from an order granting summary judgment to the Department of Health and Social Services (DHSS). St. Joseph's Hospital argues that DHSS exceeded its authority by adopting criteria that denied it supplemental funding as a rural hospital under

§ 49.45(5m), STATS. We conclude that DHSS's interpretation of "rural hospital" is entitled to due weight deference and that DHSS's interpretation is at least as reasonable as any interpretation proposed by St. Joseph's. St. Joseph's also argues that the criteria adopted by DHSS violate its constitutional right to equal protection. We conclude that St. Joseph's has not met its burden to prove beyond a reasonable doubt that DHSS's criteria violate its constitutional rights. Accordingly, we affirm.

BACKGROUND

The legislature enacted § 49.45(5m), STATS., in 1991.[1] This statute directs DHSS "to provide supplemental funds to rural hospitals that, as determined by the department, have high utilization of inpatient services by patients whose care is provided from governmental sources."[2]

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[1] *See* 1991 Wis. Act 22, § 2. Section 49.45(5m), STATS., was originally numbered § 49.45(5), but was amended and renumbered by 1993 Wis. Act 16, § 3883.

[2] Section 49.45(5m), STATS., provides in full:

> SUPPLEMENTAL FUNDING FOR RURAL HOSPITALS. (a) Notwithstanding sub. (3)(e), from the appropriations under s. 20.435(1)(b) and (o) the department shall distribute not more than $2,256,000 in each fiscal year, to provide supplemental funds to rural hospitals that, as determined by the department, have high utilization of inpatient services by patients whose care is provided from governmental sources, except that the department may not distribute funds to a rural hospital to the extent that the distribution would exceed any limitation under 42 USC 1396b(i)(3).
>
> (b) The supplemental funding under par. (a) shall be based on the utilization, by recipients of medical assistance, of the total inpatient days of a rural hospital in relation to that utilization in other rural hospitals.

DHSS established guidelines to establish which hospitals qualified for supplemental funding under this section. DHSS's amended Inpatient Hospital State Plan, effective July 1, 1994, provided the following criteria:

> **Qualifying Criteria.** A hospital may qualify for a rural hospital adjustment if it meets the following conditions.
>
> 1. The hospital is located in Wisconsin, is not located in a [Health Care Financing Administration] defined metropolitan statistical area (MSA), and has the [Wisconsin Medical Assistance Program's] Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate.
> 2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
> 3. The hospital is not classified as a Rural Referral Center by Medicare.
> 4. The combined Medicare and Medicaid utilization rate of the hospital has been equal to or greater than 55.0%.

Prior to October 1, 1994, St. Joseph's did not qualify for the rural hospital adjustment because it was classified as a rural referral center by Medicare, and therefore did not meet the third requirement. Effective October 1, 1994, however, St. Joseph's voluntarily canceled its status as a rural referral center. St. Joseph's received the rural hospital adjustment between October 1, 1994, and December 31, 1994.

On May 30, 1995, DHSS informed St. Joseph's that, effective January 1, 1995, St. Joseph's was no longer eligible for the rural hospital adjustment. Effective January 1, 1995, DHSS amended the qualifying criteria for the rural hospital adjustment. DHSS renumbered the previous fourth requirement as requirement number five and added the following requirement for a hospital to qualify for the adjustment:

> 4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics …:
>
> (a) Total discharges excluding newborns,
>
> (b) The Medicare case-mix index,
>
> (c) The Wisconsin Medicaid case-mix index.

In its brief, St. Joseph's defines "case-mix" as "the diagnostic-specific makeup of a health program's workload." In an affidavit, St. Joseph's vice president and chief financial officer explained:

> The Medicare and Medicaid case-mix indices included within the fourth criterion measure the diagnostic make-up of a hospital's workload for recipients of Medicare and Medicaid. Generally, the higher the index is indicates that a hospital is experiencing longer average lengths of stay, greater severity of illness or injury which required hospital treatment, a greater scope of services provides, and higher cost of services provided.

St. Joseph's did not qualify for the rural hospital adjustment after January 1, 1995, because its operating statistics exceeded the median amount for Wisconsin urban hospitals in each of the three statistical categories.

St. Joseph's brought suit against DHSS. St. Joseph's requested the circuit court to declare that the 1995 amendment to the Inpatient Hospital State Plan is invalid because it is inconsistent with § 49.45(5m), STATS., and violates St. Joseph's constitutional right to equal protection. St. Joseph's also requested the circuit court to declare it eligible to receive the rural hospital adjustment and direct DHSS to pay the hospital an amount sufficient to compensate it for the loss sustained by virtue of DHSS's promulgation of the invalid criteria. Both St. Joseph's and DHSS moved for summary judgment. The circuit court denied St. Joseph's motion and granted DHSS's motion. St. Joseph's appeals.

DISCUSSION

We review summary judgments *de novo*, using the same methodology as the trial court. *See* ***Green Spring Farms v. Kersten***, 136 Wis.2d 304, 315-16, 401 N.W.2d 816, 820-21 (1987). Generally, summary judgment is proper where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. ***Id.*** at 315, 401 N.W.2d at 820. When "both parties file countermotions for summary judgment, and neither argues that factual disputes bar the other's motion, the facts are deemed stipulated" and summary judgment is appropriate. ***Hussey v. Outagamie County***, 201 Wis.2d 14, 18, 548 N.W.2d 848, 850 (Ct. App. 1996). Here, neither party argues that the material facts are in dispute or that summary judgment is inappropriate. This case presents only an issue of law: whether DHSS exceeded its authority or violated St. Joseph's equal protection rights when it amended the rural hospital adjustment eligibility requirements in 1995. Because this case presents only an issue of law, the circuit court appropriately decided the issue on summary judgment.

The interpretation of a statute is ordinarily a question of law that we review *de novo*. *See* ***Tannler v. DHSS***, 211 Wis.2d 179, 183, 564 N.W.2d 735, 738 (1997). In certain instances, however, we defer to agency's conclusions of law. ***Id.*** We apply one of three distinct levels of deference to an agency's interpretation of a statute: great weight deference, due weight deference, or *de novo* review. ***UFE Inc. v. LIRC***, 201 Wis.2d 274, 284, 548 N.W.2d 57, 61 (1996). DHSS contends that we should give due weight to its interpretation of

§ 49.45(5m), STATS., while St. Joseph's argues that we should review DHSS's interpretation *de novo*.[3]

St. Joseph's argues that DHSS's interpretation should be reviewed *de novo* because the issue before the agency was clearly one of first impression. *See* ***Coutts v. Wisconsin Retirement Bd.***, 209 Wis.2d 655, 664, 562 N.W.2d 917, 921 (1997). St. Joseph's argues:

> [T]his case does not involve a situation where the administrative agency involved has at least *some* experience in administering and implementing the statute at issue. The Rural Hospital Adjustment authorized by § 49.45(5m), STATS., did not even exist before 1991, and the new criteria adopted by DHSS that excludes Saint Joseph's was implemented for the first time on January 1, 1995. In addition, this is the first time that the DHSS's interpretation has been challenged.

We disagree with St. Joseph's argument. First, the fact that § 49.45(5m), STATS., did not exist before 1991 does not establish that the issue before DHSS is clearly one of first impression. To the contrary, the fact that DHSS has been interpreting this statute since 1991 establishes that the issue is not one of first impression because DHSS has had the opportunity to analyze the issue and formulate an opinion. And although DHSS amended the rural hospital adjustment criteria in 1995, all an agency needs is one opportunity to analyze an issue and formulate a position in order for the agency's interpretation to be given due weight deference. ***UFE***, 201 Wis.2d at 286-87, 548 N.W.2d at 62.

[3] Neither party argues that we should give great weight to DHSS's interpretation. Therefore, we will not address whether DHSS's interpretation is entitled to great weight deference. *See* ***Waushara County v. Graf***, 166 Wis.2d 442, 451, 480 N.W.2d 16, 19 (1992) (we generally do not address issues not raised on appeal).

Furthermore, the fact that this is the first time DHSS's interpretation has been challenged does not mean that we should not give deference to the agency's interpretation. In ***Tannler v. DHSS***, 211 Wis.2d 179, 184-85, 564 N.W.2d 735, 738-39 (1997), the supreme court gave due weight deference to DHSS's interpretation of § 49.453, STATS., because DHSS's Medical Assistance Handbook established that the agency had specialized knowledge on the issue, even though there was a "lack of agency precedent." And in ***Hacker v. DHSS***, 197 Wis.2d 441, 461, 541 N.W.2d 766, 773 (1995), the supreme court gave great weight deference to DHSS's statutory interpretation because the agency had interpreted the statute since the statute's creation, even though "DHSS [did] not cite any cases in which it has demonstrated experience in interpreting the statute." It is apparent from these cases that of importance is not whether the agency's interpretation has been challenged and upheld by a court or regulatory body, but whether the agency has previously interpreted the statute. Because DHSS has interpreted § 49.45(5m), STATS., since 1991, its interpretation is not subject to *de novo* review.

DHSS argues that its interpretation is entitled to due weight deference. We should give an agency's interpretation due weight deference:

> when the agency has some experience in an area, but has not developed the expertise which necessarily places it in a better position to make judgments regarding the interpretation of the statute than a court. The deference allowed an administrative agency under due weight is not so much based upon its knowledge or skill as it is on the fact that the legislature has charged the agency with the enforcement of the statute in question. Since in such situations the agency has had at least one opportunity to analyze the issue and formulate a position, a court will not overturn a reasonable agency decision that comports with

> the purpose of the statute unless the court determines that there is a more reasonable interpretation available.

UFE, 201 Wis.2d at 286-87, 548 N.W.2d at 62.

Here, DHSS has been interpreting and applying § 49.45(5m), STATS., since 1991, and therefore the agency has experience in determining which hospitals are eligible for the rural hospital adjustment. In addition, the legislature has delegated to DHSS the responsibility to provide rural hospitals with supplemental funds under § 49.45(5m). Because DHSS has had at least one opportunity to analyze § 49.45(5m) and interpret the phrase "rural hospital" as it is used in that section, we will give due weight deference to DHSS's interpretation. Under this standard, we will not overturn a reasonable agency decision that comports with the purpose of the statute unless we determine that a more reasonable interpretation is available. ***UFE***, 201 Wis.2d at 286-87, 548 N.W.2d at 62.

St. Joseph's argues that DHSS's interpretation of "rural hospital" contravenes the plain language of the statute. We will not uphold an agency's interpretation of a statute if the interpretation directly contravenes the clear meaning of the statute. ***Id.*** at 282 n.2, 548 N.W.2d at 60-61. St. Joseph's contends that the statute is unambiguous and that there is nothing in the language of § 49.45(5m), STATS., to suggest that the term "rural hospital" should mean anything other than a hospital located in a rural area. St. Joseph's argues that DHSS's fourth eligibility requirement has no bearing on whether a hospital is located in a rural area.

In ***UFE***, 201 Wis.2d 274, 281-82, 548 N.W.2d 57, 60 (1996), the court explained the process of statutory interpretation:

> The ultimate goal of statutory interpretation is to ascertain the intent of the legislature. The first step of this process is to look at the language of the statute. If the plain meaning of the statute is clear, a court need not look to rules of statutory construction or other extrinsic aids. Instead, a court should simply apply the clear meaning of the statute to the facts before it. If, however, the statute is ambiguous, this court must look beyond the statute's language and examine the scope, history, context, subject matter and purpose of the statute. Furthermore, if an administrative agency has been charged with the statute's enforcement, a court may also look to the agency's interpretation.

Accordingly, we must first determine whether the term "rural hospital" is ambiguous. Statutory language is ambiguous if reasonable minds could differ as to its meaning. ***Id.*** at 283, 548 N.W.2d at 61.

In arguing that the language is unambiguous, St. Joseph's turns to WEBSTER'S THIRD INTERNATIONAL DICTIONARY 1990 (1993), which defines "rural" as "living in country areas." But it appears that this definition is intended to be used when "rural" is used as an adjective to describe people, as opposed to places or things. It defines "rural" as "*living* in country areas." (Emphasis added.) People can *live* in country areas; hospitals do not.

The examples of usage for this definition contained in the dictionary support our conclusion that the definition "living in country areas" applies only when "rural" is used to describe people. The examples are "a rural people" and "elected by constituencies which are basically rural." In each instance, "rural" describes where people live, not the location of a place or thing.

Even if we were to conclude that St. Joseph's proposed definition could apply to hospitals, we still believe that the term "rural hospital" is ambiguous. In addition to St. Joseph's proposed definition, WEBSTER'S DICTIONARY also defines "rural" as "characterized by simplicity : lacking

sophistication : UNCOMPLICATED," and "of, relating to, associated with, or typical of the country." ***Id.*** Although these three definitions of "rural" have some similarities, they are ultimately incongruent. Because reasonable minds could differ as to the meaning of "rural," we conclude that the term "rural hospital" as used in § 49.45(5m), STATS., is ambiguous.

Because the statute is ambiguous, we may look to DHSS's interpretation because the agency has been charged with the statute's enforcement. DHSS's interpretation of the statute is provided in the eligibility requirements it set forth for a hospital to receive supplemental funds under § 49.45(5m), STATS. We have already concluded that DHSS's interpretation is entitled to due weight deference. Therefore, we will uphold DHSS's interpretation if it is reasonable and a more reasonable interpretation is not available.

Harvey Aures, an employee of DHSS and a hospital rate analyst for the Wisconsin Medicaid program, explained DHSS's interpretation:

> Ever since [§ 49.45(5m), STATS.] was first enacted by the legislature via 1991 Wis. Act 22, the Department has consistently interpreted that statute as reflecting a legislative intent to give the rural hospital adjustment only to those hospitals that primarily provide basic hospital services to the local rural community.

And regarding DHSS's newly-enacted eligibility requirement, Aures stated:

> The criterion number 4 is designed to include within the class of hospitals qualifying for the rural hospital adjustment only those hospitals that exclusively provide those services that are typically provided by rural hospitals, and to exclude from this class hospitals that provide services of a complexity and intensity characteristic of urban hospitals.

It is apparent from Aures's explanation that DHSS interpreted "rural hospital" consistently with at least one dictionary definition of "rural." By

interpreting § 49.45(5m), STATS., in such a manner as to give the rural hospital adjustment "only to those hospitals that primarily provide basic hospital services to the local rural community," DHSS confined the supplemental payment to those hospitals whose services are "characterized by simplicity" or "uncomplicated." And by limiting the rural hospital adjustment to "only those hospitals that exclusively provide those services that are typically provided by rural hospitals," DHSS also limited the adjustment to those hospitals that are "typical of the country." Because DHSS's interpretation of "rural hospital" is consistent with some dictionary definitions of "rural," we conclude that DHSS's interpretation is reasonable.

St. Joseph's argues that DHSS should have interpreted "rural hospital" consistently with the definition of rural hospital contained in other Wisconsin statutes. For example, § 146.62(1)(b), STATS., defines "rural" as "outside a metropolitan statistical area, as specified under 42 CFR 412.62(ii)(A)" for purposes of the rural hospital loan program, and § 231.35(1)(d), STATS., defines "rural" as "outside a metropolitan statistical area specified under 42 CFR 412.62(ii)(A) or in a city, village or town with a population of not more than 14,000" for purposes of rural hospital loan guarantees under that statute. In support of its argument that we should look to these alternative statutory definitions, St. Joseph's cites ***Sullivan Bros., Inc. v. State Bank***, 107 Wis.2d 641, 648, 321 N.W.2d 545, 548-49 (Ct. App. 1982), which used a definition in the administrative code to provide guidance in defining a similar term contained in the statutes.

We agree that definitions of similar terms contained elsewhere in the statutes may provide guidance in interpreting a particular statute. But DHSS was not confined to looking to other statutory definitions when interpreting "rural

hospital" as that term is used in § 49.45(5m), STATS. In interpreting the term "rural hospital," DHSS was obliged to examine the scope, history, context, subject matter and purpose of the statute. *See* ***UFE***, 201 Wis.2d at 282, 548 N.W.2d at 60. St. Joseph's does not offer any evidence to establish that the purpose of the rural hospital adjustment provided for by § 49.45(5m) is similar to the purpose of the rural hospital loan programs contained in §§ 146.62 and 231.35, STATS. If the legislature had intended "rural hospital" in § 49.45(5m) to have the same definition that "rural hospital" has in §§ 146.62 and 231.35, it could have so provided. It has not done so.

St. Joseph's argues that DHSS's interpretation creates an anomaly between its Inpatient Hospital State Plan and Outpatient Hospital State Plan. DHSS added the new requirement number four to its inpatient state plan, but did not add a similar requirement to its outpatient state plan. Therefore, according to St. Joseph's, it qualifies for the rural hospital adjustment for the outpatient services that it provides to Medicare and Medicaid participants, but does not receive the adjustment for inpatient services.

We recognize that DHSS has set forth different rural hospital adjustment requirements for inpatient and outpatient services, but we do not see how this anomaly makes DHSS's interpretation unreasonable. DHSS added requirement number four to its inpatient state plan to exclude from the rural hospital adjustment "hospitals that provide services of a complexity and intensity characteristic of urban hospitals." Inpatient services are generally more complex than outpatient services. Therefore, it appears to be more practical for DHSS to exclude a hospital's inpatient services from the rural hospital adjustment based on the complexity of those services than it would be for DHSS to exclude a hospital's outpatient services from the adjustment based on the complexity of those services.

Because DHSS reasonably distinguished outpatient services from inpatient services, we conclude that DHSS's interpretation of "rural hospital" is still reasonable.

St. Joseph's argues that DHSS's interpretation of "rural hospital" is arbitrary and capricious. St. Joseph's argues that if DHSS categorizes hospitals as rural based on the lack of complexity in the services provided, as opposed to their location, then urban hospitals that also provide less complex services should be classified as rural hospitals under DHSS's interpretation. St. Joseph's contends that such an interpretation cannot be sustained.

But DHSS does not classify hospitals as "rural hospitals" based solely on the level of complexity in the services they provide. DHSS's first two qualifying criteria for the rural hospital adjustment focus strictly on a hospital's location, not on the complexity of its services. Accordingly, we conclude that St. Joseph's argument that an urban hospital could be classified as a rural hospital under DHSS's interpretation is without merit.

Finally, St. Joseph's argues that DHSS violated its constitutional right to equal protection when it amended the rural hospital adjustment eligibility requirements in 1995. A classification created by an administrative agency is subject to attack on equal protection grounds. ***Wisconsin Hosp. Ass'n v. Natural Resources Bd.***, 156 Wis.2d 688, 718, 457 N.W.2d 879, 891 (Ct. App. 1990). The question of whether a statute or rule is unconstitutional is a question of law that we decide independently of the administrative agency or trial court. ***Phillips v. Wisconsin Personnel Comm'n***, 167 Wis.2d 205, 224, 482 N.W.2d 121, 128 (Ct. App. 1992). Administrative rules, like statutes, are presumed to be constitutional,

and the challenger must prove that the rule is unconstitutional beyond a reasonable doubt. ***Id.***

Because St. Joseph's does not claim that DHSS's eligibility requirements affect a fundamental right, we apply a rational basis test to determine whether St. Joseph's equal protection rights were violated. Under this test, "[e]qual protection of the law is denied only where the legislature has made [an] irrational or arbitrary classification.... The basic test is not whether some inequality results from the classification, but whether there exists any reasonable basis to justify the classification." ***Omernik v. State***, 64 Wis.2d 6, 18-19, 218 N.W.2d 734, 742 (1974) (footnotes omitted).

DHSS amended its rural hospital adjustment eligibility requirements in 1995 so that the adjustment applied only to those hospitals that exclusively provide services that are typically provided by rural hospitals. DHSS has consistently interpreted § 49.45(5m), STATS., as reflecting a legislative intent to give the rural hospital adjustment only to those hospitals that primarily provide basic hospital services to the local rural community. We have already concluded that this interpretation is reasonable. And we do not believe that St. Joseph's has met its burden to prove beyond a reasonable doubt that DHSS irrationally or arbitrarily distinguished rural hospitals from urban hospitals based on the complexity of services provided by the hospital, as well as based on the hospital's location.

St. Joseph's argues that the 1995 amendment to the rural hospital adjustment eligibility requirements excluded only it, and no other hospital, from receiving the adjustment. But the Equal Protection Clause does not deny a state the power to treat persons within its jurisdiction differently so long as the

classifications have a reasonable basis. ***State v. McManus***, 152 Wis.2d 113, 131, 447 N.W.2d 654, 660 (1989).

Although the 1995 amendment added only St. Joseph's to the list of hospitals ineligible to receive the rural hospital adjustment, the added eligibility requirement does not specifically apply only to St. Joseph's. The newly-created fourth requirement is based solely on objective criteria. Additional hospitals could become ineligible for the rural hospital adjustment based on this requirement; St. Joseph's could become eligible for the adjustment if its statistics fell below the mentioned thresholds. The added eligibility requirement was not applied arbitrarily to St. Joseph's only, but applies to all members of the class equally. Because DHSS's rural hospital adjustment eligibility requirements are not irrational or arbitrary, we conclude that St. Joseph's was not denied its right to equal protection.

By the Court.—Order affirmed.

Not recommended for publication in the official reports.