

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

500 Dept of Health

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 1-17-79 Temporary Rule [redacted]

Resubmitted and Received _____

DUE DATE 2-6-79

a. Returned to Agency w/o filing w/Secy of State 2/7
b. Approved 2/8 Date Sent Back to Agency 2/8

- -

1. Rules as Adopted ✓
2. Rules as Proposed ✓
3. Certificate of Board's Authorizing Resolution, where applicable N/A → Referred to in HE report but not in my materials
4. Order for Hearing ✓
5. Notice of Hearing ✓
   (i) Sufficiency ✓
6. Secretary of State's List ✓
7. Certificate of Acquisition of Secretary of State's List ✓
8. Affidavit of Mailing ✓
   (i) At least 30 days prior to hearing ✓
9. Statement of Need and Evidence ✓
10. Hearing Examiner's Report ✓
11. Agency's Findings of Fact ✓
12. Certificate of Board's Resolution Adopting Rules, where applicable N/A
13. Order Adopting ✓
14. Report of Chief Hearing Examiner ✓
    (i) Finding of No Substantial Change ✓
    (ii) Permission to Incorporate by Reference, where applicable _____
15. Certificate of Compliance with Rulemaking Procedures ✓
16. Copy of Notice of Intent to Solicit Outside Opinion, where applicable ✓ a copy was not in the materials submitted but it was referred to in the HE report
17. Petition by Public, where applicable N/A.

Attorney General

Jack Breviu
Special Assistant
Attorney General

February 7, 1979

Joanne E. Hinderaker
Special Assistant
Attorney General

296-4692

In the Matter of Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System

As I discussed with you in our telephone conversation of 1-5-79, the above-captioned rule amendments are approved by this office, subject to the correction by the Health Department of the following typographical errors and ommissions in the text of the adopted rules:

1. Page 6 of the rules, § 1.475 B.2.e, from the Hearing Examiner's Report at Finding #22 and the Department's Post-Hearing Comments at p. 16 it appears that this rule should read: "e. the number of outpatient and emergency visits for the hospital". The existent adopted text deletes "and emergency".

2. Page 7 of the rules, § 1.475 B.3.e, from the Department's Findings at #23 and the Department's Post-Hearing Comments at p. 16 it appears that this rule should read: "e. A statement of the accounts receivable in total and of gross revenue by type of payer."

3. Page 8 of the rules, § 1.475 E, change "Aspectes of the Experiment" to "Aspects of the Experiment".

4. Page 12 of the rules, § 1.487 A.1.b, in the second sentence of this rule the word "hospial" should read "hospital".

5. Page 13 of the rules, § 1.487 A.1.b, the statutory citation in this rule Minn. Stat. §§ 145.71-145.84 should read §§ 145.71-145.831

6. Page 15 of the rules, § 1.487.A.2.b, in the last sentence of this rule the word "interestes" should read "interests".

7. Page 21 of the rules, § 1.487 C.2.b.(2)(e), the word "correspondes" should read "corresponds".

8. Page 22 of the rules, § 1.504 F., the text of the rules contains no underlinings or strikeouts to designate the amendments. Any changes in the rule should be so marked.

After these changes have been made in the text of the adopted rules, please submit at least three copies of the corrected text to this office and I will then file such with the Secretary of State's Office.

If you have any questions in this regard, or on any other matter feel free to contact me.

As I also indicated in our telephone conversation, I will sever the Rule Amendment relating to the Charges for Examination Fees of Health Maintenance Organizations (7 MCAR § 1.372) and will file that rule with the Secretary of State's Office.

JEH:mb

FOX RIVER
Onion Skin
25% COTTON

Adopted

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
DEPARTMENT OF HEALTH

In the Matter of ..., : Rules
Relating to the Minnesota
Hospital Rate Review System

Chapter Twenty-Eight: 7 MCAR § 1.471 - 1.511

§ 1.472 Definitions.

B. "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care, exclusive of newborn admissions.

G. "Charges" means the regular amounts charged less expected and debts, contracted allowances and discounts to patients and/or insurers, prepayment plans and self-insured groups on the patient's behalf, ~~irrespective of any discounts, deductions, or other reductions to those charges which, by contract or other agreement, may be applicable.~~ The terms "charges" and "rates" are synonymous for the purposes of these rules. "Gross charges" means "charges" irrespective of any discounts, deductions, or other reductions which by contract or other agreement, may be applicable. The terms "gross charges" and "gross rates" are synonymous for the purpose of these rules.

R. "Outpatient visit" means an acceptance of a patient by a hospital for the purpose of providing outpatient services. ~~in a distinct outpatient service center.~~

Not proposed

U. "Rate" means "gross charges" as defined in 7MCAR § 1.472G. "Aggregate rate" means the average gross revenue per adjusted admission for a full accounting period determined by dividing total gross revenue by the number of adjusted admissions:

Total Gross Revenue.
Number of Adjusted Inpatient Admissions

Adjusted admissions are determined by:

Number of Outpatient & Emergency Visits X Total Outpatient & Emergency Gross Revenue / Number of Outpatient & Emergency Visits

X 1 / Inpatient Gross Revenue Per Admission PLUS The Number of Inpatient Admissions

The aggregate rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report.

V. "Restricted funds" mean funds donated to the hospital which are restricted for a specific purpose by the donor.

W. "Revenue(s)" or "income(s)" means the value ~~at the~~ of a hospital's ~~full~~ established charges ~~of~~ for all hospital services rendered to patients, ~~regardless of the amounts actually paid to the hospital by or on behalf of patients.~~ less expected and/or incurred bad debts, contracted allowances and discounts granted to patients and/or insurers, prepayment plans and self insured groups. "Gross revenue(s)" or "gross income(s)" means "revenue(s)" or "income(s)" regardless of the amounts actually paid to or received by the hospital.

X. "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

2. Other nursing services (~~special~~ ancillary services),

g. Other ~~special~~ ancillary services.

Adopted

§ 1.474 Report requirements.

A. Annual financial information report. Each hospital shall submit an annual financial information report to the system. This report shall include:

2. a. A detailed statement of income and expenses, including:

(5) Direct gross revenue and gross expense received or incurred from non-hospital operations; and

3. An unaudited copy of the hospital's cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act stated in 20 CFR 405.406(b), and the uniform cost report required under Public Law 95-142, Section 19. ~~This~~ These cost reports shall correspond to the same accounting period as that used in the compilation of data for other requirements for the report of annual financial information.

6. A statement of changes in financial position showing the source and application of all funds.

7. A statement(s) of all fund balance(s).

8. All notes and footnotes to the balance sheet, statement of income and expense, statement of changes in financial position, and statement(s) of fund balance(s).

B. Rate revenue and expense report.

2. Statistical information for the rate revenue and expense report shall include:

a. The number of inpatient days excluding nursery days for the hospital, and each appropriate service center.

d. The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and each appropriate service center, excluding nursery bassinets.

3. Financial information for the rate revenue and expense report shall include:

~~f. A statement of changes in financial position showing the source and application of all funds for each period.~~

g. f. A statement of the capital budget of the hospital.

4. The report of rate revenue and expense shall also contain the following information:

a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution. This will be supplemented by a statement of budgeted increases in charges, revenue and aggregate rates for the budget year including these items:

(1) Date(s) on which gross charges, and gross revenue, ~~and aggregate rates~~ will be adjusted.

(3) For each such date, the resulting aggregate dollar and weight average percent of increase in budget year total hospital gross revenues.

5. If a hospital maintains its accounts in a way which necessarily results in detailed statements of income, expense and statistics differing in form and content from those recommended by this rule and 7 MCAR § 1.481 A. 1., the hospital may substitute the information it has available. However, in all such cases the hospital shall submit a detailed reconciliation of the differences between the two sets of information and presentations in conjunction with the rate revenue and expense report.

C. Interim increase reports.

4. Statistical information for each period established by 7 MCAR §§ 1.474 C. 3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to 7 MCAR §§ 1.474 B.2., and 5., which shall be recorded for each period stated by 7 MCAR § 1.474 C. 3., above. This information

shall indicate any change in the budget year from the projected information then on file with the system.

5. Financial information for each period established by 7 MCAR § 1.474 C. 3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to 7 MCAR § 1.474 B. 3. and 5., which shall be recorded for each period stated by 7 MCAR § 1.474 C. 3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

§ 1.475 Experimental Alternative Reporting Requirements. Each hospital meeting the criteria specified in paragraph A of this section may file annual Rate Revenue and Expense Reports and interim increase reports according to paragraph B of this section, in lieu of information required under §§ 1.474 B. 2. and 1.474 B. 3.

A. Selection Criteria. Non-state non-federal acute care hospitals licensed in the State of Minnesota are eligible if tney belong to the set of hospitals comprising 15% of the total gross acute (inpatient plus outpatient) charges for all non-state non-federal acute care hospitals in the State. Determination of the hospitals to be included in the set of hospitals comprising 15% of total state gross acute charges shall be made as follows:

1. The total gross acute charges used shall be for the hospital's 1977 fiscal year, pursuant to 7 MCAR § 1.474 B. 1. a.

2. The hospital with the lowest total gross acute charges shall be selected first. The hospital with the second lowest total gross acute charges shall be selected second and its gross acute charges shall be added to the first selected hospital's. The hospital with the third lowest gross acute charges shall be

selected third and its total gross acute charges shall be added to the sum of the gross acute charges of the hospitals selected first and second. The procedure shall continue in direct ascending order so as to maximize the number of hospitals included, but the sum of gross patient charges included shall not exceed 15% of the total gross acute charges for all non-state and non-federal acute care hospitals.

B. Rate Revenue and Expense Report.

1. Each hospital shall submit a report of rate, revenue and expense pursuant to 7 MCAR § 1.481 C. This report shall include statistical and financial information for:

a. The prior year as provided by 7 MCAR § 1.474 B. 1. a.

b. The current year as provided by 7 MCAR § 1.474 B. 1. b.

c. The budget year as provided by 7 MCAR § 1.474 B. 1. c.

2. Statistical information submitted in the rate revenue and expense report shall include:

a. The number of inpatient days for the hospital.

b. The number of admissions for the hospital.

c. The average number of full-time-equivalent employees during each accounting period for the hospital and each service center. An employee or any combination of employees which is reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employee.

d. The number of beds licensed, the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital.

e. The number of outpatient and emergency visits for the hospital.

3. Financial information submitted in the rate revenue and expense report shall include: 2. An interim financial statement as provided by § 1.474 B. 3. a.

b. A statement of expenses for the hospital according to natural classifications of expenses as provided by 7 MCAR § 1.474 A. 2. a. (6).

c. A statement indicating the accounting method used to allocate expenses from among the "non-revenue producing centers" to "revenue producing centers" as provided by 7 MCAR § 1.474 B. 3. c.

d. A statement of total "direct" and "indirect" costs and revenues where applicable for the hospital and for each of the following, both or before and after allocation of indirect expenses:

(1) Daily services

(2) Ancillary services (enumerating inpatient, outpatient and emergency)

(3) Non-revenue producing services

e. A statement of the accounts receivable in total and of gross revenue by type of payer of service. Self

f. A statement of the capital budget of the hospital.

g. All information as provided by 7 MCAR § 1.474 B. 4. & 5.

C. Interim Increase Reports.

1. Interim increase reports shall be filed as required under 7 MCAR § 1.474 C. 1. and 2.

2. Statistical and financial information shall be filed as required under 7 MCAR §§ 1.474 C. 3., 4., 5., and 6., except when in conflict with information required in the rate revenue and expense report as provided by 7 MCAR § 1.475 B. In such circumstances, the information required by 7 MCAR § 1.475 B. shall be the required information.

D. Review and Comment. The review and comment upon all experimental reports reviewed pursuant to 7 MCAR § 1.475 B. and C. shall be conducted and made as stated in 7 MCAR § 1.487 C. 2., with the exceptions of 7 MCAR §§ 1.487 C. 2. b. (1) (c) and 1.487 C. 2. b. (2) (b). The following shall substitute for 7 MCAR §§ 1.487 C. 2. b. (1) (c) and 1.487 C. 2. b. (2) (b):

1. Aggregate rates and costs and components of aggregate rates and costs have been demonstrated by the hospital to be consistent or inconsistent with the reasonable operating expenses found in 7 MCAR § 1.487 [A.1.a.(1),(2), (3), (4), (5), (6); B.(1), (a), (2), (3), (4), (5), (6), (7); A.2.; A.3; A.4.]. In addition, a maximum of 5% of 7 MCAR § 1.487 [A.1.a.(1),(2), (3), (4); b. (1)(a)] shall serve in lieu of 7 MCAR § 1.487 A.1. [b.(1), (b), (2), (3), (4); and C.].

2. Sixty-six percent of the 5% plus factor provided in 7 MCAR § 1.475 D. 1. shall be placed in an identifiable depreciation fund and may be used in the manner prescribed in 7 MCAR § 1.487 A. 1. b. and A. 1. b. (i).

E. Aspects of the Experiment.

1. The alternative experimental reporting requirements shall remain in force for a period of four years (four complete reporting cycles) commencing with the effective date of these rules.

2. At the close of third year of the experiment an evaluation of the alternative reporting requirements shall be made by the Department of Health in conjunction with all approved voluntary, non-profit rate review organizations. The evaluation shall address the following, at a minimum:

a. The adequacy of the data,

b. Impact of the reduced data set on the quality of rate reviews,

c. The appropriateness of the set of hospitals chosen to participate in the experiment, and

d. The appropriateness of adopting the requirements permanently.

§ 1.487 Investigations, Analysis and Review Standards.

A. Bases for judging the reasonable use of finances in a hospital. In all investigations, analyses, and reviews conducted pursuant to Minn. Stat. §§ 144.695-144.703, and these rules, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of these rules, hospitals shall address the contents of their reports to and indicated their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses and reviews following these established bases.

1. Financial Requirements of Hospitals. The gross rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories:

a. Current operating needs related to patient care. In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

(5) Bad debt, charity allowances, and contractual allowances.

(a) Gross Rrates should provide finances necessary to recover losses in gross revenue due to bad debts, charity allowances, and governmental contractual allowances.

(iii) ~~"Contractual~~ Governmental contractual allowances~~,~~" ~~"cost-justified-discounts"-and-"non-cost-justified discounts,"~~ are those discounts from the established gross charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by Title V, Title XVIII and Title XIX of the United States Social Security Act.

~~(aa)--"Governmental-contract-adjustments"-are these-discounts-from-the-established-charges-required-due-to-governmental-reimbursement-practices-established-pursuant-to-regulations authorized-by-such-governmental-programs-as-those-created-by-Title V,-Title-XVIII-and-Title-XIX-of-the-United-States-Social-Security-Act.~~

~~(bb) "Cost-justified-discounts"-or-"differentials" means-those-cash,-trade,-or-quantity-discounts-or-differentials-from the-established-charges.--In-order-to-include-the-amount-of-these discounts-or-differentials-in-rates,-hospitals-shall-demonstrate-that the-value,-as-measured-in-money,-of-services-or-other-benefits-for an-accounting-period-provided-by-certain-patients,-groups-of-patients, or-third-party-payers-to-the-hospital-is-equal-to-or-greater-than-the aggregated-amount,-as-measured-in-money,-of-the-differential-or-discount-granted-to-certain-patients,-groups-of-patients-or-third-party-payers-for-that-same-accounting-period.~~

~~(cc)--Discounts-or-differentials-which-are-not cost-justified-in-a-manner-consistent-with-7-MCAR-§-1.487-A.-1.-a.-(5)(a)(iii)(bb),-above,-shall-not-be-included-in-rates-but-shall-be treated-as-reductions-in-revenue-and-recorded-by-the-hospital-as-such.~~

(b) The losses in revenues due to bad debts, charity allowances, and governmental contractual allowances should be offset by available and applicable income from sources other than patients, as identified by 7 MCAR § 1.487 A. 2., before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs.

(6) "Discounts" and/or "price differentials" are those discounts and/or prices granted and/or charged to certain payors (patients, groups of patients, or third party payors), which result in receipts by a hospital of something less than the average expected dollar amount received for services rendered of comparable type, kind, and quality in the absence of such discounts and/or prices. These discounts and/or price differentials shall be classified as either cost justified or non-cost justified.

(a) "Cost justified discounts" and/or "cost justified price differentials" are discounts and/or price differentials, as measured in dollars, for the services and/or other benefits given to a hospital by a payer during an accounting period. Cost reducing benefits and services that shall be considered in a determination of whether a discount is cost justified include:

(i) Hospital administration;

(aa) Payer admitting requirements,

(bb) Payer accounting and audit requirements,

(cc) Payer billing costs,

(ii) Hospital working capital requirements;

(aa) Cash and prepayment,

(bb) The length of time taken to pay bills; and

(iii) Other cost reducing activities undertaken by specific payers that do not simply and inequitably shift costs from one payer to another.

(b) "Non-cost justified discounts" and/or "non-cost justified price differentials" are all other discounts and/or price differentials that are not cost justified in a manner consistent with 7 MCAR § 1.487 A. 1. a. 6. (a).

(c) "Cost justified discounts" and/or "price differentials" shall be granted to payers for hospital services and shall be included in a hospital's financial requirements if:

(i) The amount of the discounts or price differentials as measured in dollars is equal to or less than the value of services or other benefits given to a hospital by a payer during an accounting period; and

(ii) The dollar value, per adjusted admission, of the services or other benefits offered to a hospital by a payer is first segregated from the average cost (which includes the cost saving associated with the service or of benefit given) per adjusted admission for all patients.

(d) "Non-cost justified discounts" and/or "non-cost justified price differentials" shall not be included in a hospital's financial requirements.

b. Plant capital needs. Rates should provide the finances necessary for various plant capital needs. In order to include plant capital needs in rates, the hospital must fund the plant

capital needs in rates, the hospital must fund the plant capital requirement and be in receipt of a certificate of need as required by Minn. Stat. §§ 145.71-145.831. Funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

(1) Finances which relate to land, land improvement, building and building equipment and movable equipment shall be placed in an identifiable fund. The use of the fund shall be restricted to debt principle retirement, new plant and equipment (with certificate of need approval if necessary), major repairs (that are capitalized), replacement of capital equipment (with certificate of need approval if necessary), Hill-Burton free-care expenses in excess of those accounted for by 7 MCAR § 1.487 A. 1. a. (5)(a)(iii) and all other free-care (not to exceed 3% of operating expenses net of Medicare and Medicaid expenses). The annual increment to this fund should be:

(b) Plus ~~inflation factors~~, an amount annually determined (for each hospital) ~~and~~ to be consistent with the established useful lives of land improvements, buildings, building equipment, and movable equipment. ~~These inflation factors~~ This amount shall be determined ~~by the system on the basis of a price level adjustment~~ as follows: ~~index recognized by independent public appraisers as expressing the annual price level adjustment from historical cost of hospital land improvements, buildings, hospital building equipment and movable equipment. The system shall derive these factors from any of the most current indices then available to the system which give specific recognition to the following factors:~~

(i) An index or cumulative index determined by the system and recognized by independent public appraisers as expressing the annual effects of inflation upon historical cost from the year of purchase of hospital land improvements, buildings, hospital building equipment and movable equipment and shall be multiplied by an asset(s) annual depreciation expense.

(ii) The index for the budget year's expected annual depreciation expense shall not exceed 1.04.

(c) The system shall derive these indices from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing land improvements, buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, land improvements, building equipment, and movable equipment.

2. ~~Income~~ Restricted and unrestricted funds from sources other than patients. In all investigations, analyses, and reviews conducted pursuant to these rules, the system shall recognize that hospitals have sources of ~~income~~ funds other than patients which are intended to be or may be used for the reduction of rates. In meeting the reporting requirements of these rules, hospitals shall disclose the extent of which ~~this income is~~ these funds are used to offset costs and to provide service in such a manner as to reduce gross rates charged patients. This income includes:

a. Restricted endowment funds, specific purpose funds, tax funds (tax receipts or appropriations received) and gifts.

(1) ~~Income~~ Monies from endowment funds, ~~or~~ and/or gifts, restricted by donors or monies generated by taxes ~~restricted by donors~~ to provide for services for designated patients should be used to reduce the payment for those services.

(2) ~~Income~~ Monies from endowment funds, ~~or~~ and/or gifts restricted by donors or monies generated by taxes to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, (this may include debt principle retirement) as appropriate.

(6) Monies from endowment funds, and/or gifts restricted by donors or monies generated by taxes to provide for operating expenses should be used to reduce payments for operating expenses.

b. Unrestricted funds from non-patient sources. Unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital. Exceptions to this rule may be granted if the hospital can show that alternative uses of these funds are to the economic benefit of current patients and/or are in the best interests of the community served.

~~3. Variations from budgeted volumes of activity and service. Changes in the aggregate rate may be necessary due to variations from budgeted volumes of activity and service. The financial requirements of a hospital for a budget year should reflect adjustments in volumes of activity and service realized during the prior and current years.~~

a. If a hospital over-projects its volume in a service center, in the next year its financial requirements should be increased by an amount equal to the ratio of fixed to total costs for that service center multiplied by the income loss due to unrealized activity.

b. If a hospital under-projects its volume in a service center, in the next year its financial requirements should be reduced by the ratio of fixed to total costs of that service center multiplied by the income loss due to unrealized activity.

c. The system proposes three alternative procedures for identifying the costs related to increased volume or reduction in expenses anticipated resulting from decreases in volume as compared to original budget forecast.

(1) Alternative 1. The system will establish different fixed to variable expense ratios for different peer groups of hospitals. The ratios will vary from 80%/40% and shall be applied to hospitals in a manner consistent with the hospital's size and complexity of services. The fixed to variable expense ratio will be applied to total patient admissions adjusted for outpatient activity, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.

(2) Alternative 2. In the event that an individual hospital identifies that its fixed to variable expense ratio differs significantly in aggregate total from that established by the system, that hospital may submit supporting data to the system requesting a fixed to variable ratio different than that adopted for its peer group. In such cases, the system may approve a fixed to

~~variable-expense-ratio-other-than-that-established-under-7-MCAR § 1.487-A.-3.-c.-(1).--Under-this-alternative,-the-fixed-to-variable ratio-would-be-applied-to-adjusted-patient-admissions,-with-the-adjustment-based-on-the-ratio-of-outpatient-revenues-to-inpatient-revenues. Revenue-and-rate-adjustment-based-on-volume-variance-within-the provisions-of-Alternative-1-and-2-can-be-made-on-aggregate-average annual-rates-per-adjusted-patient-admissions.--These-rates,-based on-total-approved-budget,-are-identified-at-the-time-of-the-budget review.~~

~~(3)-Alternative-3.--In-the-event-that-a-hospital-has identified-that-its-operating-expenses-by-service-center-depart drastically-from-the-fixed-to-variable-expense-ratio-at-the-aggregate-level,-such-a-hospital-may-submit-supporting-data-to-the-system establishing-a-different-fixed-to-variable-expense-ratio-for-each service-center.--In-such-instances,-the-volume-variances-would be-measured-according-to-the-unit-of-service-established-for-each service-center,-and-the-expense-adjustment-allowance-would-be-based on-the-ratio-of-fixed-to-variable-expenses-for-each-service-center, rather-than-on-the-aggregate-overall-average-expenses-and-per adjusted-admission.~~

3. Variations from budgeted revenue and expense. Changes in aggregate rates may be necessary due to variations from budgeted volume and mix of services, and assumptions about future input prices. The financial requirements of a hospital for a budget year should reflect variations from budgeted revenue and expense as depicted by actual experience in the current and prior years.

a. If actual reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b., as reconciled to an audit, are in excess of actual reasonable revenues, as reconciled to an audit, pursuant to 7 MCAR § 1.487 C. 2. b., by a greater margin than was previously budgeted in the year in question, then the excess may be included in the forthcoming budget year's reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b.

b. If actual reasonable revenues pursuant to 7 MCAR § 1.487 C. 2. b., as reconciled to an audit, are in excess of actual reasonable financial requirements, as reconciled to an audit, pursuant to 7 MCAR § 1.487 C. 2. b., for the year in question, then the excess may be used to offset the forthcoming budget year's reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b.

c. When adjusting the forthcoming year's budgeted reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b. for the conditions described in 7 MCAR §§ 1.487 3. a. and 1.487 3. b.:

(1) Hospitals should not benefit from unanticipated gains resulting from under estimates of projected reasonable revenues, and/or volume, and/or over estimates of the costs of services delivered pursuant to 7 MCAR § 1.487 C. 2. b., however, hospitals should benefit from productivity increases that reduce the reasonable cost of delivered and/or offered services pursuant to 7 MCAR § 1.487 C. 2. b.

(2) Hospitals should not be penalized for incurring unanticipated losses resulting from over estimates of reasonable volume, and/or revenue, and/or under estimates of the reasonable costs of services delivered (when compared to the allowable increase limit

adjusted for actual inflation for the relevant period), however, hospitals should not carry forward losses that result from conditions that should have been averted and/or decreases in productivity.

(3) If current year estimates of unanticipated losses exceed .005 times the hospital's operating budget, then that amount in excess of the loss estimated in the budget year may be carried forward to the forthcoming budget year. The estimated loss carried forward from the budget year must be reconciled to an audit in a subsequent filing (when the budget year becomes the prior year).

C. Review of reports.

2. Review of rate revenue and expense reports and interim increase reports.

b. Comment. The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public prior to the implementation of proposed budgets aggregate rates. The comment shall state that a hospital's existing and proposed aggregate rates are reasonable or are in question.

(1) Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(a) Aggregate Rrates and components of aggregate rates are similar to the average of the aggregate rates and components of aggregate rates in effect in the prior year for other hospitals in a peer group;

(b) Prospective aggregate rates and components of prospective aggregate rates represent a minimal increase which is consistent with ~~the principles of the bases for judging~~ the allowable increase limit established by 7 MCAR § ~~1.487-A.~~ 1.504;

(c) Aggregate rates and components of aggregate rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by 7 MCAR § 1.487 A.

(d) Aggregate costs and components of aggregate costs are similar to the average of the aggregate costs and components of aggregate costs incurred by other hospitals in a peer group during the prior year;

(e) Prospective aggregate costs and components of prospective aggregate costs represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504 and components of the allowable increase limit that corresponds to natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6).

(f) Aggregate costs and components of aggregate costs have been demonstrated by the hospital to be necessary and consistent with the priniciples for judging established by 7 MCAR § 1.487 A.;

(g) Total prior and current year's actual aggregate rates and costs are similar to prior and current year's budgeted aggregate rates and costs;

(h) Actual and budgeted costs and revenues for each service center are similar.

(2) Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(a) Aggregate Rrates and components of aggregate rates deviate from the average of the aggregate rates and components of aggregate rates then in effect in the prior year for other hospitals in a peer group;

(b) ~~Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by 7 MCAR § 1.487 A.~~ Prospective aggregate rates and components of prospective aggregate rates do not represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504;

(c) Rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles of the bases for judging established by 7 MCAR § 1.487 A.;

(d) Aggregate costs and components of aggregate costs are not similar to the average of the aggregate costs incurred for other hospitals in a peer group during the prior year;

(e) Prospective aggregate costs and components of prospective aggregate costs do not represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504 and components of the allowable increase limit that corresponds to natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6).;

(f) Aggregate costs and components of aggregate costs have not been demonstrated by the hospital to be necessary and consistent with the principles for judging established by 7 MCAR § 1.487 A.;

(g) Total prior and current year's actual aggregate rates and costs are not similar to prior and current year's budget aggregate rates and costs;

(h) Actual and budgeted costs and revenues for each service center are not similar.

§ 1.504 Commissioner of Health determination of allowable increase limit.

E. Form. The quarterly allowable increase limit is a single percentage figure which is applicable to the average ~~charges per inpatient admission~~ aggregate rate and average aggregate cost for the hospital.

F. Basis. This single percentage figure is based upon ~~the~~ averaged ~~monthly~~ quarterly consumer and/or wholesale price indexes and/or relevant components of the consumer, wholesale price or other appropriate economic indexes as published by the Division of Labor Statistics, U.S. Department of Commerce. The single percentage figure shall be so constructed so that it will contain the proportionate contribution of each of the natural expense categories presented in 7 MCAR § 1.474A.2.a.(6).

G. Compensation. Should quarterly allowable increase limits prospectively established by the Commissioner according to these rules allow increases in aggregate rates in excess or less than any actual increases in the Consumer and/or Wholesale Price ~~Index~~ Incices, or relevant components of these indices the Commissioner may compensate for this excess by:

2. Adding or reducing by a reasonable proportion of that difference the next set of quarterly allowable increase limits to be established by the Commissioner.

1.509 Fees.

A. Rate revenue and expense report fee. On each occasion which a hospital submits a rate revenue and expense report to the Commissioner of Health as distinct from a voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

If the Number of Licensed Acute Care Beds of the Hospital Is:	Then the Filing Fee Is:
6 to 24	$ 385.00
25 to 49	$ 495.00
50 to 99	$ 710.00
100 to 149	$ 930.00
150 to 199	$1,150.00
200 to 249	$1,370.00
250 to 299	$1,590.00
300 to 349	$1,810.00
350 to 399	$2,025.00
400 to 449	$2,250.00
450 to 499	$2,470.00
500 or over	$2,685.00

Hospital Gross Revenue	Filing Fee Is:
Under $2,500,000	.0005 Times Gross Revenue or $200 (which ever is less) to a Maximum of $800
$2,500,000 - $19,999,999	.0004 Times Gross Revenue to a Maximum of $5,500
$20,000,000 +	.0003 Times Gross Revenue to a Maximum of $7,500

APPROVED AS TO FORM AND LEGALITY

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WARREN SPANNAUS, ATTORNEY GENERAL

BY Joanne Hinderaker

SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
FEB - 8 1979
Joan Anderson Growe
Secretary of State

1:30 PM

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

In the Matter of Proposed Rule
Relating to Charges for
Examination Fees of Health
Maintenance Organizations

7 MCAR § 1.372 Other provisions.

G. Fees. Every filing submitted to the Commissioner by a health maintenance organization subject to Minn. Stat. §§ 62D.01 to 62D.29 (the Health Maintenance Act of 1973) shall be accompanied by the following fees:

4. For ~~all other filings, $25.00~~ each examination, $125.00 per eight hour day.

5. For all other filings, $25.00.

STATE OF MINNESOTA
DEPARTMENT OF STATE
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FEB - 7 1979
Joan Anderson Growe
Secretary of State
3:40 PM

APPROVED AS TO FORM AND LEGALITY
FEB 07 1979
19
WARREN SPANNAUS, ATTORNEY GENERAL
BY Joanne Hilderbee
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Proposed Rule Relating to Charges for Examination Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing before Harry Seymour Crump, Hearing Examiner from the State Office of Hearing Examiners, on September 25, 1978, at 9:00 a.m. in the Minnesota Department of Health Building, Minneapolis, Minnesota.

This Report is part of a rules proceeding hearing pursuant to Minn. Stat. Sec. 15.041 to Sec. 15.0417 and Sec. 15.052, to determine whether the proposed rules should be adopted and given the force of law. Copies of this Report are available for review from the Department of Health and from the Office of Hearing Examiners.

The following members of the Department of Health (Department) panel appeared at the hearing: Frederic L. Sattler, Director, Hospital Rate Review, Department; Diane Harder, Analyst, Department; Kent Peterson, Chief, Planning and Resources Control Section, Department; John Breviu, Special Assistant Attorney General, representing the Department of Health.

Thirty-five persons attending the hearing signed the Register. Ten public witnesses appeared and spoke at the hearing. Two prehearing written comments and five post-hearing written comments were received prior to the date of closing of the record herein. Two public comments were received after the close of the record. Eleven written comments were received from the public subsequent to the publishing of the notice of intent to solicit outside opinions on February 27, 1978. At the hearing, four written public exhibits were received by the Hearing Examiner.

Based upon all the testimony, exhibits and written comments, the Hearing Examiner makes the following:

FINDINGS OF FACT

1. On August 24, 1978, the Department filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules.
(b) The Order for Hearing proposed to be issued.
(c) The Notice of Hearing proposed to be issued.

2. On August 21, 1978, a Notice of Hearing and a copy of the proposed rules were published at 3 State Register 244.

3. On August 22, 1978, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. On August 31, 1978, the Department filed the following documents:

(a) The Order for Hearing and authorizing resolution.
(b) The Notice of Hearing as mailed.
(c) The Affidavit of Receipt of the Secretary of State's list.
(d) The Affidavit of Mailing the Notice to all persons on the Secretary of State's Certificate and list.
(e) The Secretary of State's list.
(f) The Statement of Need and Reasonableness.
(g) All materials received following a Notice of Intent to Solicit Opinion published at 2 State Register 1598.
(h) The names of Department personnel who will represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(i) All materials received following a notice made pursuant to Minn. Stat. Sec. 15.0412, Subd. 6 (Supp. 1977) in the State Register at 2 State Register 1598.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

5. The record remained open through October 16, 1978, for the receipt of written comments and statements, the period having been extended by order of the Hearing Examiner to 20 calendar days following the hearing. The Agency granted the Hearing Examiner an extension of five working days for the issuance of the Report.

STATUTORY AUTHORITY

6. The statutory authority for adopting 7 MCAR Sec. 1.372 relative to health maintenance organizations is provided by Minn. Stat. Sec. 62D.20 (1976), which provides as follows: Regulations. The board may pursuant to chapter 15, promulgate such reasonable rules and regulations as are necessary or proper to carry out the provisions of section 62D.01 to 62D.29. . . .

Minn. Stat. Sec. 62D.14, subd. 6 (1976) reads as follows: Reasonable expenses for examinations under this section shall be assessed by the board against organizations being examined, and shall be remitted to the board for deposit in the general fund of the State Treasurer.

7. The statutory authority for adopting 7 MCAR Sec. 1.471-1.511 relative to hospital rate review is provided by Minn. Stat. Sec. 144.695-144.703 (1976). Minn. Stat. Sec. 144.703 reads as follows: Additional Powers. Subdivision 1. In addition to other powers granted to the board and the commissioner by law, the board and the commissioner may each: (a) adopt, amend, and repeal rules in accordance with chapter 15; . . .

7 MCAR Sec. 1.372. Other Provisions.

8. G. Fees. This rule provides for charges for examination fees and all other filings. The rule drew no comment and is reasonable and needed. See Statement of Need and Reasonableness.

7 MCAR Sec. 1.472 - Proposed Amendments to Rate Review System.

Section 1.472. Definitions. This rule amended the definition of five terms and phrases to reflect past standard accounting practices utilized within the hospital industry. The provisions amended by this rule were items B., C., R., W., and X. These amendments to the rule are needed and reasonable. A public witness suggested amendments to items D. and N. of the existing rule. The Examiner concludes rules not proposed for amendment are

not properly the subject of consideration by the agency or the Examiner as part of the proceedings for promulgation of the rules proposed herein.

9. At the hearing, the Department proposed the following amendment to Sec. 1.472 U: (Rates) means "gross charges" as defined in 7 MCAR Sec. 1.472 G. "Aggregate rates" means the average revenue per adjusted admission for a full accounting period determined by dividing total gross revenue by the number of admissions. This amendment is consistent with the proposed amendments to Sec. 1.472 G. and 1.472 W. Item G. provides for the meaning of charges and Item W. provides for the meaning of revenue. The proposed addition drew no specific comments. The proposed amended rule does not affect a class of persons not represented at the hearing or go to a new subject matter of significant substantive effect, or make a major substantive change that was not raised by the original notice of hearing in such a way as to invite reaction at the hearing or result in a rule fundamentally different from that contained in the notice of hearing. Thus, the amendment does not constitute a substantial change and is needed and reasonable.

7 MCAR Sec. 1.474 - Report Requirements.

10. Sec. 1.474 A.5.inserted the word "gross" to distinguish between revenues and expenses pre and post deductions for allowances and uncollectibles. The amendment simplifies the appropriate calculation and is both needed and reasonable.

12. Sec. 1.474 A.3. provides for the report filed pursuant to the United States Social Security Act to be filed with the Department. The Department considers this report to be an integral part of the hospital's medicare cost report. This rule is needed and reasonable.

12. Sec. 1.474 A.6. requires a statement of changes in financial position showing the source and application of all funds. This reporting requirement was deleted from Sec. 1.474 B.3.f. and included here as a normal part of the hospital's annual financial statement. The rule is reasonable and needed.

13. Sec. 1.474 A.7.and 8. deal with the reporting requirements of specific items relative to the balance sheet. These provisions were added to bring the rules into conformity with standard accounting practice. This information is normally part of the hospital's annual financial statement. These rules are needed and reasonable.

14. Sec. 1.474 B.2.a. provides for the excluding of nursery days from the number of inpatient days contained in the statistical information for the rate revenue and expense report. This amendment is consistent with the change made in Sec. 1.472 B. The rule is needed and reasonable.

15. Sec. 1.474 B.2.d. provides for the exlusion of nursery bassinets for the same reason as stated in Finding No. 14. It is reasonable and needed.

16. Sec. 1.474 B.3.f. was deleted and added in a previous section as found in Finding No. 12. The last provision under this section was renumbered accordingly from g. to f.

17. Sec. 1.474 B.4.a.(1) and (3) received no comment and are both needed and reasonable. The Statement of Need and Reasonableness relative to this rule is adopted by the Hearing Examiner.

18. Sec. 1.474 B.5. provides for hospitals to substitute available detailed statements of income, expenses and statistics differing in form and content from those recommended by this rule and 7 MCAR Sec. 1.481 A.1. However, in such an event the hospital must submit a detailed reconciliation of the differences between the two sets of information. The reconciliation is necessary to facilitate administration of this provision in order that hospitals are protected from unfair comparisons and to prevent the system from making facility assessments. At the hearing, the Minnesota Hospital Association (MHA) suggested that the term "detailed" be deleted in the second sentence of this provision. The Department, however, opposed such suggestion as detailed information is required to be useful. MHA was also concerned that the detailed reconciliation amounted or imposed a cost burden on the hospital staff to administer it and in effect would be mandating uniform reporting and accounting procedures. The Department stated that it is without authority to require a uniform accounting system. The Examiner concludes that this requirement does not amount to a uniform reporting system, but is needed and reasonable as useful statistics to facilitate the administration of the system.

MHA

19. Sec. 1.474 C.4 and 5. deal with statistical and financial information required in the interim increase reports. This rule was amended by inserting the requirement that these reports shall include information in accordance with also Sec. 1.474 B.5. This rule drew no comments and is reasonable and needed. See Finding No. 18.

7 MCAR 1.475 - Experimental Alternative Reporting Requirements.

20. This rule provides for small hospitals to use an alternative method of meeting the reporting requirements of rate revenue and expense and interim increase reports. Sec. 1.475 A. sets forth the criteria to determine which hospitals will be eligible for the experiment. This rule allows small hospitals to do a scaled down procedure to ease the burden of reporting. At the hearing, MHA suggested the following amendment to Sec. 1.475 A.: Once hospitals are identified under the 15% criteria in the experiment, they should have the option to continue to file under Section 1.475 for the duration of the experimental program.

MHA amendment

21. MHA also suggested under Section 1.475 A.1. the following change: The total gross acute charges used shall be for the prior year, pursuant to 7 MCAR Sec. 1.474 B.1.a.; and deleting: shall be adjusted to represent a December 31 fiscal year end. The MHA believes that this is an unneeded calculation since 81% of the reporting hospitals operates on a fiscal year ending between September and December. An adjustment for this period of time to reflect the December 31 fiscal year end would not yield any greater accuracy. The Department was amenable to the above amendments. The Hearing Examiner concludes that the Sec. 1.475 and A(1) and (2) are reasonable and needed. The Examiner, however, urges the Department to consider adopting the above two amendments which will not constitute a substantial change.

MHA

22. Sec. 1.475 B. and subparts (1), (2) and (3) deal with rate revenue and expense report requirements. Under these proposed provisions, the reporting requirements are the same as presently existing rules, but restricting

some of the reporting activities which will prove to be more costly to both the hospital and the reviewing agency. At the hearing, the Department proposed the following amendment to Sec. 1.475 B.2.c.: The average number of full-time equivalent employees during each accounting period for the hospital and each service center. An employee or any combination of employees which is reimbursed by the hospital for 2,080 hours of employment per year is a full-time equivalent employee. It also proposed the following insertion in addition to the proposed amendment under Sec. 1.475 B.2.e.: The number of outpatients and emergency visits for the hospital; and Sec. 1.475 B.3.d.(2): Ancillary services (enumerating in-patient, out-patient and emergency). These proposed rules, as modified, provide necessary data elements and are reasonable and will not constitute a substantial change. Outpatient and emergency also are included normally in ancillary services and are necessary to facilitate calculating adjusted admission.

23. Sec. 1.475 B.3.e. reads: A statement of the accounts receivable by type of purchaser or services. At the hearing, MHA recommended amending this provision to read as follows: A statement of accounts receivable by type of purchaser of service. MHA suggests that it would be reasonable to base the program review on the day's charges in accounts receivable on total hospital receivables for the hospitals under the experimental reporting requirement since small hospitals do not generally have the capability to accurately determine accounts receivable by type of payer with the manual patient accounting system they use. The Department proposed to amend this rule as follows: A statement of the accounts payable and of gross revenue by the type of payer. The Department stated that this insert to the proposed rule is information currently being collected on the "long form" rate revenue and expense report. The rule, as modified, is reasonable and needed and will not constitute a substantial change.

24. Sec. 1.475 C. requires the interim increase reports to be filed as required under other provisions of the rule except where in conflict with information required in the rate revenue and expense report.

25. Sec. 1.475 D. requires all review and comments to be made on the basis of previously adopted rules and/or additions to previously adopted rules as found in Sec. 1.487 C.2. relative to review of rate revenue and expense reports and interim increase reports for review standards. This rule sets forth certain exceptions upon which all experimental reports are reviewed. Sec. 1.475 D.1. provides the basis for the demonstration of normal operating costs. This provision provides for a profitability of 105% of cost to small hospitals under the experimental reporting requirements. At the hearing, MHA stated that the 5% plus factor is based on a study of the relationship of operating expenses to price level depreciation and working capital for small hospitals. MHA cautioned the reader not to interpret the 5% plus factor as an absolute price level adjustment in working capital requirement for all hospitals. In reference to Sec. 1.475 D.1., MHA suggested deleting the reference therein to allowance of "governmental contractual allowances" in the financial requirement by eliminating Sec. 1.487 A.5.(a)

(i)(ii). It is MHA's contention that the inclusion of this reference would dissuade small hospitals from filing under the experimental reporting requirement. The Department, in opposing the above referenced deletion, stated that empirical data suggested that 1.5% of cost was more than adequate to cover the governmental allowances. It is concluded that this rule and its subparts, as proposed, are reasonable and needed.

26. Sec. 1.475 D.2. requires 66% of the 5% plus factor to be placed in an identifiable depreciation fund and to be used in accordance with other provisions of the rules herein. This rule was amended to reflect the grammatical error in a reference to Sec. 1.487 A.1.b.(1). It is concluded that the rule is reasonable and needed.

27. Sec. 1.475 E.(1)(2) deal with the aspects of the experiment. The rule provides for a four year time period to allow the system and hospital to accumulate enough experience to evaluate the reporting requirements and still maintain some continuity in reporting from year to year for small hospitals. The rule drew no comments and is reasonable and needed.

Sec. 1.487 - Investigations, Analysis and Review Standards.

28. Sec. 1.478 A.1. was amended by inserting the term "gross" rates within this provision as a definitional change to conform with Sec. 1.474 A.2.a.(5). Sec. 1.487 A.1.(5) was amended by inserting "gross" revenue and rates to revenue and rates and inserting "governmental" to contractual allowances in order to clarify the application of these provisions. These rules drew no specific comment during the course of the hearing proceedings, and are reasonable and needed as proposed. The Statement of Need and Reasonableness relative to these rules is adopted as a Finding by the Hearing Examiner.

29. Sec. 1.487 A.1.a.(5)(iii) defines governmental contractual allowances. Three subparagraphs, under (aa), (bb), and (cc), have been deleted due to a general reorganization of Sec. 1.487 A.1.a.(5)(a). The rule is the same as a previously adopted rule, and is redefined in subsequent provisions of the rule. The amendments and deletions are reasonable and needed.

30. Sec. 1.487 A.1.a.(5)(b) amended this previously adopted provision by inserting the word "governmental" before contractual allowances to clarify this rule.

31. Sec. 1.487 A.1.a.(6) defines "discounts" and/or "price differentials" and distinguishes them from bad debts, governmental contractual allowances and charity care. In its post-hearing statement, the Department indicated that this provision is one of the most difficult areas with which the rate review program had to deal over the past 12 to 18 months. The amendment is intended to ease the administrative difficulty that the prior adopted rule caused, by adding sufficent specificity so that hospitals, payers, and the rate review agency will have a clearer understanding of the "ground rules" governing discounts. It is the Department's position that the proposed amendments to Sec. 1.487 A.1.a.(6) are not perfect, but they are workable.

32. Sec. 1.487 A.1.a.(6)(a) defines "cost justified discounts" and/or "cost justified price differentials" and distinguishes it from "non-cost justified discount" and/or "differentials". See existing rule Sec. 1.487

A.1.a.(5). Sec. 1.487 A.1.a.(6)(a), subsections (i)-(iii), indicate a partial listing of factors to be considered in determining whether or not a discount of price differential is cost justified.

33. Sec. 1.487 A.1.(a)(6)(b) defines non-cost justified discounts.

34. Sec. 1.487 A.1.(a)(6)(c) provides for both hospitals and payers to benefit from cost savings. It is the Department's position that it creates an incentive for payers to undertake cost saving activities.

Subsection (i) of Sec. 1.487 A.1.(a)(6)(c) limits the discount to the value of service rendered to the hospital by the payer. This provision is to maintain equity among payers as specified by the statute. Subsection (ii) of this rule sets forth the conditions under which the discount may be included in financial requirements. See the Statement of Need and Reasonableness for cases exemplifying the application of this rule which is adopted as a Finding by the Hearing Examiner.

35. Sec. 1.487 A.1.(a)(6)(d) limits non-cost justified discounts and/or non-cost justified price differentials inclusion in hospitals' financial requirements.

36. Sec. 1.487 A.1.(a)(6) and its subparts drew similar criticism from the following representatives of different interest groups: Donald Mill, Minnesota Hospital Association; Dean Lund, Assistant to General Manager of Group Health; E. Lamson, Director of Providers Reimbursement Department, Blue Cross/Blue Shield; David Jones, Fairview Hospital; Terry Klas, Director, North American Life and Casualty Company; and Jean McPherson, Senior Vice President, St. Mary's Hospital, Minneapolis. The representatives urged that the rule regarding cost justified discounts be deleted and that a study be conducted to determine what items and how the calculations should be made. They contended that the subject rule was very difficult to interpret and analyze, and served to produce confusion and frustration among the providers, payers and others charged with regulating the system. It was commented that this proposed rule lacked specificity and was ambiguous and vague.

37. In regard to Sec. 1.487 A.1.(a)(6) and its subparts: "cost justified discounts", and/or "cost justified price differentials", the Hearing Examiner concludes from comparing the proposed rule(s) to that existing rule which was deleted, that the modified language offers sufficient specificity and is a substantial improvement over the previously adopted rule. The proposed rules provide for factors to be considered in determining cost justified discounts. It was brought out at the hearing that the Department had received input of what items qualified for "cost justified discounts" from those interested parties. This rule also complies with the intent of the statute. The Examiner suggests that the Department change the word "may" in Sec. 1.487 A.1.(a)(6)(c) to indicate that discounts "shall" be included provided that the enumerated conditions are present. This removes the possibility of any vagueness within this provision. It is concluded that this rule, with its subparts, are not unreasonable and are needed. The Department's post-hearing comment relative to the rule is adopted as a Finding by the Hearing Examiner.

38. Sec. 1.487 A.1.(b)(1) deals with plant capital needs. One portion of this rule was amended by inserting after major repairs the language that

are capitalized for the purpose of clarity only. The final portion of this rule was amended by adding language relating to the Hill-Burton free care expenses to rectify a problem with the existing rule to establish a source of funds for the hospital to meet a portion of the (remaining) Hill-Burton obligation. This rule establishes the plant capital fund as the source of funds. It complies with the intent of the original rule which provided that up to 50% of the Hill-Burton requirements may be explicitly included in rates. This rule also provides for hospitals to allocate up to 3% of their non-medicare and non-medicaid expenses to free care. This 3% allocation is consistent with Federal Hill-Burton guidelines. In a post-hearing comment, the Department stated the proposed amendment is intended to allow the hospitals the flexibility of meeting part of its Hill-Burton obligation which initially arose from a governmental capital grant, loan or loan guarantee, from the plant capital fund. The dollar amount taken from the depreciation fund to meet the free-care obligation would only minimally deplete the depreciation fund. Five public witnesses speaking in opposition to this rule suggested that this provision be deleted because it would result in the depletion of the hospital's net worth. The Department's data shows that MHA"s concerns are unwarranted. See the Department's Post-Hearing comments. It is concluded that this rule, as proposed, is both reasonable and needed.

39. Sec. 1.487 A.1(b)(1)(b) and (i) and (ii) deal with budget year price level depreciation adjustment. The proposed changes were organizational, grammatical or additional language necessary for the consistent determination of plant capital portion of the financial requirements. Subparagraph (ii) limits the budget year's expected annual depreciation expense to 1.04. Justification for this index factor used by the system is set forth in the Department's Statement of Need and Reasonableness, which is adopted herein by the Hearing Examiner. This factor is a conservative estimate of inflation. Any differences between the index factor used and the actual inflation may be carried forward to the next budget year by the hospitals. This rule drew several comments in opposition to its adoption. MHA objected to the limitation of the inflation index in the budget year to 4%, which is approximately one-half of the actual inflationary rate over the past seven years. MHA argues that the inflation factor for the budget year should be allowed in the same manner as other financial requirements in the budget year which have no arbitrary limits placed upon them. MHA suggested the following deletion and amendment to this rule: The index for the budget year's expected annual depreciation expense ~~shall not exceed 1.4%~~ shall be based on a five year moving average of the cumulative index factors. In a post-hearing comment, Mr. Klas, North American Life and Casualty, argued that the depreciation factor should be changed to 1.00. He argued that since the proposed depreciation fund is to enable hospitals to repurchase facilities presently enjoyed and since there is a great surplus of such facilities within the state and within most hospitals, he does not agree that such facilities will ever be replaced. Thus, to permit hospitals to charge not only a factor within their rates for their future replacement, but also to increase the amount based on

current inflation is counterproductive towards bringing hospitals costs under control. In the Department's post-hearing comment, it stated that the proposed rule is to alleviate an administrative problem thereby it specified a factor in the rule. It did so with some degree of trepidation recognizing that this could expand financial requirements, which the Department pointed out previously is not warranted because the vast majority of hospitals do not ask for full requirements in their pricing for plant capital when the state is faced with substantial excess hospital capacity. It is concluded that the rule is not unreasonable and is needed.

40. Sec. 1.487 A.1.b.(1)(c) drew no comments and is needed and reasonable.

41. Sec. 1.487 A.2. was amended by deleting the word "income" and replacing it with "restricted and unrestricted funds" in order to clarify the meaning of income. It was intended that income would be interpreted in its broadest sense. "Restricted and unrestricted funds" denote types of money received from nonpatient sources. This rule recognizes that hospitals may use this source of income for the reduction of its rates. MHA and Abbott Hospital raised the question of the constitutionality of the proposed rule. Mr. Sprenger, Abbott North Western Hospital, Inc., pointed out this rule was not proper because of possible trust violations. The Department pointed out that it had no intentions of violating the "trust income", but it would look to the language of a trust agreement to determine whether the funds would be applied to reduced rates. The Department in its post-hearing comments stated in a case example that a donor gives a cash gift to the hospital to purchase an x-ray machine. The cash provided by the donor can be used directly to purchase a machine, or alternatively, the cash can be invested and an x-ray machine purchased through (1) borrowing money (which clearly entails an interest charge), or (2) raising rates sufficient to cover the cost of the machine. By borrowing money, an extra charge is imposed upon the patient because interest is an allowable financial requirement. The Department believes that patients should not incur additional costs, e.g., interest, if cash is given to the hospital to meet a specific need. Raising rates to cover the cost of an item, when cash is donated for that item, is clearly inappropriate. This would not occur if the donated cash was offset to financial requirements. The Hearing Examiner concludes that the proposed rule is needed and reasonable. Issues regarding the constitutionality of the rule should be raised through other forums.

42. Sec. 1.487 A.2.(a) deals with restricted funds as an offset to rates. This rule was amended by inserting: tax funds (tax receipts or appropriations received) . . . . Subparagraph (1) under this provision was amended to substitute "monies" for "income". It was also amended to include monies generated by taxes. A similar amendment applies to subparagraph (2). MHA argued in opposition to these proposed rules because the effect of the rules by requiring tax levies to offset financial requirements could reduce the level of medicare and medicaid participation in a health program. MHA requested that the rule be amended to allow hospitals the flexibility of utilizing tax levies in a manner appropriate with their intent. The Department agreed that tax "monies" as an offset has been a general practice by the

rate review system. The Hearing Examiner hereby adopts the Department's post-hearing comments regarding these provisions. Also, see Finding No. 41. The rule, as proposed, is both needed and reasonable.

43. Sec. 1.487 A.2(a)(6) requires funds from gifts restricted by donors or endowment funds or monies generated by taxes to be used to reduce the payments for operating expenses. The Department intended that funds restricted for a specific purpose should be used for that purpose and the cost of such activities should not be included in rates. It is reasonable and needed.

44. Section 1.487 A.3.(a), and (b), and (c) deal with variations from budgeted revenue and revenues and expenses. The existing rules were deleted. These sections were totally rewritten to accommodate concerns expressed by hospitals and the approved alternative rate review organization with regard to the administrative and feasibility of rules as it was originally adopted. At the hearing, MHA generally concurred with the proposed rule changes since this methodology has been utilized by the rate review program since 1975. The Hearing Examiner hereby adopts the Statement and Need and Reasonableness in regard to these rules. It is concluded the modification is needed and reasonable.

45. Section 1.487 A.3.(a)(b) deal with the procedure for reporting variations from budgeted and revenue and expenses in the financial requirements. The agency's rationale for the adoption of these rules were set forth in the Statement of Need and Reasonableness and are part of the evidence presented for Finding No. 48. These rules drew no comments and are needed and reasonable.

46. Section 1.487 A.3.(c)(1) and (2) set forth the treatment of adjustments to the financial requirements, as reconcilled to an audit, in consideration of productivity increases and unanticipated losses. The purpose of these rules was to establish a financial incentive for hospitals to reduce costs and/or increase productivity. MHA concurred with the general premise, however, recommended that the framework to evaluate productivity increases be flexible and recognize the following: (1) productivity costs savings may occur over a number of years; (2) fluctuation and projected versus actual productivity savings may occur; (3) there appears to be no generally accepted means of measurement of productivity. In regard to unanticipated losses, MHA proposed deleting the provision within Sec. 1.487 A.3.(c)(2) containing the language "allowable increase limit" and inserting in lieu of "reasonable inflation factors". The agency opposed any change. The Hearing Examiner concludes that it is a policy decision of the agency to prefer its language over the suggestions and it is reasonable and needed.

47. Section 1.487 A.3.(c)(3) allows excessive unanticipated losses as estimated in the budget year to be carried forward to the forthcoming budget year. The rule provides for cash flow difficulties for hospitals where estimated information may be used to establish the amount of loss until audit information is available. The Department's rationale for requiring the use of audit (actual) figures rather than estimates is that it would eliminate the necessity for a dual adjustment in the estimated figures once the audited figures were available. MHA recommended the deletion of this entire rule

because of its belief that a logical inconsistency existed because of the differences in treatment of gains to losses. In finding MHA's argument without merit, the Hearing Examiner concludes that the rule is reasonable as proposed. It is suggested that the agency consider proposing at another hearing rules relating to gains under this provision.

48. Section 1.487 C.2.(b) was amended by inserting the word "aggregate" before the words "rates" wherever used in the rule. This rule deals with the system which is based upon the review of aggregate rates. Comments on the system should be based upon aggregate rates rather than the individual rates for each service or good offered by the hospital. This rule drew no comments and is reasonable and needed.

49. Section 1.487 C.2.b.(1)(c) and (d) set forth the bases which may be used to comment upon the reasonableness of the hospital's rates. These rules provide for increases consistent with allowable increased limits. Minimum increase should be linked to increases in inflation. It is necessary to specify the nature of the minimum increase in terms of a measure of economic inflation so that the rate increase reflects increases in the price of goods and services purchased by the hospital rather than some other measure that is not germane. These provisions drew comments from representatives of the MHA and St. John's Hospital. They recommended the deletion of all references to the "allowable increase limit" in each of the sections and the inserting of "reasonable inflation guidelines". MHA argues that costs should not be used as a basis for comment in Section 1.487 C.2.b.(1)(e) since the intent of the allowable increase limits is to measure "increases in charges" not costs. MHA also argues that the allowable increase limit should not be based on quarterly consumers price index (CPI) and/or wholesale price index (WPI) and/or components thereof since, historically, the Medicare service components of the CPI including the Minnesota hospital expenditures have exceeded the CPI and WPI by a significant margin. Accordingly, MHA contends that this rule is an unreasonable extension of the Minnesota rate review authority. The Department contends that compliance under these rules for rate setting must require some constraint by the hospital. The Hearing Examiner concludes that the rules appear to comply with the intent of statute. Section 1.487 C.2.b.(b) and (e) are needed and are not unreasonable.

50. Section 1.487 C.2.b.(1)(a), and (c), and (d), and (f), and (g), and (h); Section 1.487 C.2.b.(1)(a), (c), (d), (f), and (h) drew no comments. The Department's Statement of Need and Reasonableness relative to these provisions is hereby adopted as justification for these rules and they are reasonable and needed.

7 MCAR Sec. 1.504 - Commissioner of Health Determination of Allowable Increase Limit

51. Section 1.504 E. is entitled "Form". This rule was amended by deleting "charges per inpatient admissions" and inserting in lieu of "aggregate rates and average aggregate cost" since the terms are synonymous. This rule drew two comments. MHA recommended deletion of the reference to average aggregate cost in the rule. As MHA argued in Finding No. 49, MHA contends Section 1.504 E. cannot be applied as basis for the evaluation of "average

aggregate cost in the rule. As MHA argued in Finding No. 49, MHA contends Section 1.504 E. cannot be applied as basis for the evaluation of "average aggregate costs". It is concluded that this rule is reasonable and needed. See Finding No. 49.

52. Section 1.504 F. deals with the basis for the determination of the allowable increase limit. The "WPI" and "other ~~industries~~ indices" were added to increase the range of alternatives available to the Commissioner of Health in constructing the allowable increase limit. The blending of the ~~industries~~ indices is necessary for a more appropriate and equitable basis because many of the products bought by hospitals are at a wholesale level and are not an explicit component of CPI or WPI. The allowable increase limit will be a single number composed of appropriate components of CPI and WPI. This rule drew two similar comments. MHA suggested deletion of "all reference to the quarterly consumers (CPI) and/or wholesale price indexes (WPI) and all relevant components" and inserting in lieu of "reasonable inflation factors updated quarterly". The rationale for this deletion is the same as its comments under previous Section 1.487 C.2.b. See Finding No. 49. MHA suggests that reasonable inflation factors be defined to mean the most accurate projection of overall hospital expenditure inflation, which considers price, mix, intensity, and volume changes as they affect hospital costs. In its post-hearing comment, the Department stated that it did consider the impact of changing patient mix and treatment intensity on increased costs. When the program assesses hospital performance against the allowable increase limit, in accordance with Section 1.487 C.2.b.(1)(b) and (e), it is adjusted to reflect actual experience in relevant health care components of CPI, WPI and other recognized governmentally sponsored indexes. The Department states that "tying hospital revenue increases to components of CPI and WPI is critical to reasonableness criterion". By post-hearing comment, the Department suggested amending Section 1.504 F. to read as follows: This single percentage figure is based upon average quarterly consumer and/or wholesaler price indexes and/or relevant components of the consumer, wholesale price or other appropriate economic indexes as published by the Division of Labor Statistics, U.S. Department of Commerce. The single percentage figure shall be so constructed so that it will contain the proportionate contribution of each of the natural expense categories presented in 7 MCAR Sec. 1.474 a.2.(6)." This proposed rule, as amended, is needed and reasonable and will not constitute a substantial change.

53. Section 1.504 G. drew no comments and is reasonable and needed. The Statement of Need and Reasonableness relative to this rule is adopted by the Hearing Examiner.

7 MCAR Sec. 1.509 - Fees.

54. Section 1.509 A. sets forth a fee schedule for the review of rate revenue and expense reports under the rule. The fee structure has a built-in inflation adjustment. The fee schedule is tied to revenue which should reflect inflation. It shifts the burden to larger hospitals to finance the program. This rule drew no specific comments and is reasonable and needed.

Based upon the foregoing Findings of Fact, the Hearing Examiner makes the following:

CONCLUSIONS

1. Due, timely and adequate notice of hearing was properly served and published by the Department and Commissioner. All other substantive and procedural requirements have been fulfilled.

2. The Department and Commissioner have demonstrated their statutory authority to adopt the proposed amendments and rules.

3. The Department and Commissioner have demonstrated the need for and reasonableness of the proposed amendments and rules by an affirmative presentation of facts.

4. The modifications of the proposed rules made by the Department at the hearing and in its post-hearing comments do not constitute substantial changes.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATIONS

It is recommended that the proposed rules, as amended, by adopted by the Department of Health.

Dated: November 27, 1978.

Harry Seymour Crump

HARRY SEYMOUR CRUMP
Hearing Examiner

N O T I C E

Pursuant to Minn. Stat. Sec. 15.0412, subd. 4, this Report shall be available for review to all affected individuals upon request for at least five days.

The Department and Commissioner shall, if they propose to adopt the rules as originally proposed or amended, submit the complete hearing record, including its Findings and Order, to the Chief Hearing Examiner no earlier than five days subsequent to the receipt of this Report. This submission shall clearly indicate any changes made to the rules as originally proposed, preferably in the format that will be submitted to the State Register for publication. The Chief Hearing Examiner shall complete his review and submit his report to the Department and Commissioner on the issues of substantial changes in the rule and compliance with Minn. Stat. Sec. 15.0412 within ten calendar days. Thereafter, the Department and Commissioner shall be responsible for filing the rules with the Attorney General and for notifying persons who have indicated that they wish to be notified of such filing.

2. Adding or reducing by a reasonable proportion of that difference the next set of quarterly allowable increase limits to be established by the Commissioner.

§ 1.509 Fees.

A. Rate revenue and expense report fee. On each occasion which a hospital submits a rate revenue and expense report to the Commissioner of Health as distinct from a voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

If the Number of Licensed Acute Care Beds of the Hospital Is:	Then the Filing Fee Is:
6 to 24	$ 385.00
25 to 49	$ 495.00
50 to 99	$ 710.00
100 to 149	$ 930.00
150 to 199	$1,150.00
200 to 249	$1,370.00
250 to 299	$1,590.00
300 to 349	$1,810.00
350 to 399	$2,025.00
400 to 449	$2,250.00
450 to 499	$2,470.00
500 or over	$2,685.00

Hospital Gross Revenue	Filing Fee Is:
Under $2,500,000	.0005 Times Gross Revenue or $200 (which ever is less) to a Maximum of $800
$2,500,000 - $19,999,999	.0004 Times Gross Revenue to a Maximum of $5,500
$20,000,000 +	.0003 Times Gross Revenue to a Maximum of $7,500

(2) Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(a) Aggregate Rrates and components of aggregate rates deviate from the average of the aggregate rates and components of aggregate rates ~~then~~ in effect in the prior year for other hospitals in a peer group;

(b) ~~Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by 7 MCAR § 1.487 A.~~ Prospective aggregate rates and components of prospective aggregate rates do not represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504;

(c) Rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles of the bases for judging established by 7 MCAR § 1.487 A.;

(d) Aggregate costs and components of aggregate costs are not similar to the average of the aggregate costs incurred for other hospitals in a peer group during the prior year;

(e) Prospective aggregate costs and components of prospective aggregate costs do not represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504 and components of the allowable increase limit that corresponds to natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6).;

(f) Aggregate costs and components of aggregate costs have not been demonstrated by the hospital to be necessary and consistent with the principles for judging established by 7 MCAR § 1.487 A.;

(g) Total prior and current year's actual aggregate rates and costs are not similar to prior and current year's budget aggregate rates and costs;

(h) Actual and budgeted costs and revenues for each service center are not similar.

§ 1.504 Commissioner of Health determination of allowable increase limit.

E. Form. The quarterly allowable increase limit is a single percentage figure which is applicable to the average ~~charges per inpatient admission~~ aggregate rate and average aggregate cost for the hospital.

F. Basis. This single percentage figure is based upon the averaged ~~monthly~~ quarterly Consumer and/or Wholesale Price ~~Index~~ Indices, and/or relevant components of the Consumer, Wholesale Price or other appropriate economic indices representing natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6), as published by the Division of Labor Statistics, U.S. Department of Commerce, stated as percent changes, for relevant previous quarters preceding the establishment of a quarterly allowable increase limit.

G. Compensation. Should quarterly allowable increase limits prospectively established by the Commissioner according to these rules allow increases in aggregate rates in excess or less than any actual increases in the Consumer and/or Wholesale Price ~~Index~~ Indices, or relevant components of these indices the Commissioner may compensate for this excess by:

adjusted for actual inflation for the relevant period), however, hospitals should not carry forward losses that result from conditions that should have been averted and/or decreases in productivity.

(3) If current year estimates of unanticipated losses exceed .005 times the hospital's operating budget, then that amount in excess of the loss estimated in the budget year may be carried forward to the forthcoming budget year. The estimated loss carried forward from the budget year must be reconciled to an audit in a subsequent filing (when the budget year becomes the prior year).

C. Review of reports.

2. Review of rate revenue and expense reports and interim increase reports.

b. Comment. The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public prior to the implementation of proposed budgets or aggregate rates. The comment shall state that a hospital's existing and proposed aggregate rates are reasonable or are in question.

(1) Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(a) Aggregate Rrates and components of aggregate rates are similar to the average of the aggregate rates and components of aggregate rates in effect in the prior year for other hospitals in a peer group;

(b) Prospective aggregate rates and components of prospective aggregate rates represent a minimal increase which is consistent with ~~the principles of the bases for judging~~ the allowable increase limit established by 7 MCAR § ~~1.487 A.~~ 1.504;

(c) Aggregate rates and components of aggregate rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by 7 MCAR § 1.487 A.

(d) Aggregate costs and components of aggregate costs are similar to the average of the aggregate costs and components of aggregate costs incurred by other hospitals in a peer group during the prior year;

(e) Prospective aggregate costs and components of prospective aggregate costs represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504 and components of the allowable increase limit that corresponds to natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6).

(f) Aggregate costs and components of aggregate costs have been demonstrated by the hospital to be necessary and consistent with the priniciples for judging established by 7 MCAR § 1.487 A.;

(g) Total prior and current year's actual aggregate rates and costs are similar to prior and current year's budgeted aggregate rates and costs;

(h) Actual and budgeted costs and revenues for each service center are similar.

~~variable-expense-ratio-other-than-that-established-under-7-MCAR § 1.487-A.3.c.(1). Under this alternative, the fixed-to-variable ratio would be applied to adjusted patient admissions, with the adjustment based on the ratio of outpatient revenues to inpatient revenues. Revenue and rate adjustment based on volume variance within the provisions of Alternative 1 and 2 can be made on aggregate average annual rates per adjusted patient admissions. These rates, based on total approved budget, are identified at the time of the budget review.~~

~~(3) Alternative 3. In the event that a hospital has identified that its operating expenses by service center depart drastically from the fixed-to-variable expense ratio at the aggregate level, such a hospital may submit supporting data to the system establishing a different fixed-to-variable expense ratio for each service center. In such instances, the volume variances would be measured according to the unit of service established for each service center, and the expense adjustment allowance would be based on the ratio of fixed-to-variable expenses for each service center, rather than on the aggregate overall average expenses and per adjusted admission.~~

3. Variations from budgeted revenue and expense. Changes in aggregate rates may be necessary due to variations from budgeted volume and mix of services, and assumptions about future input prices. The financial requirements of a hospital for a budget year should reflect variations from budgeted revenue and expense as depicted by actual experience in the current and prior years.

a. If actual reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b., as reconciled to an audit, are in excess of actual reasonable revenues, as reconciled to an audit, pursuant to 7 MCAR § 1.487 C. 2. b., by a greater margin than was previously budgeted in the year in question, then the excess may be included in the forthcoming budget year's reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b.

b. If actual reasonable revenues pursuant to 7 MCAR § 1.487 C. 2. b., as reconciled to an audit, are in excess of actual reasonable financial requirements, as reconciled to an audit, pursuant to 7 MCAR § 1.487 C. 2. b., for the year in question, then the excess may be used to offset the forthcoming budget year's reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b.

c. When adjusting the forthcoming year's budgeted reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b. for the conditions described in 7 MCAR §§ 1.487 3. a. and 1.487 3. b.:

(1) Hospitals should not benefit from unanticipated gains resulting from under estimates of projected reasonable revenues, and/or volume, and/or over estimates of the costs of services delivered pursuant to 7 MCAR § 1.487 C. 2. b., however, hospitals should benefit from productivity increases that reduce the reasonable cost of delivered and/or offered services pursuant to 7 MCAR § 1.487 C. 2. b.

(2) Hospitals should not be penalized for incurring unanticipated losses resulting from over estimates of reasonable volume, and/or revenue, and/or under estimates of the reasonable costs of services delivered (when compared to the allowable increase limit

extent of which ~~this income is~~ these funds are used to offset costs and to provide service in such a manner as to reduce gross rates charged patients. This income includes:

a. Restricted endowment funds, specific purpose funds, tax funds (tax receipts or appropriations received) and gifts.

(1) ~~Income~~ Monies from endowment funds, ~~or~~ and/or gifts, restricted by donors or monies generated by taxes ~~restricted by donors~~ to provide for services for designated patients should be used to reduce the payment for those services.

(2) ~~Income~~ Monies from endowment funds, ~~or~~ and/or gifts restricted by donors or monies generated by taxes to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, (this may include debt principal retirement) as appropriate.

(6) Monies from endowment funds, and/or gifts restricted by donors or monies generated by taxes to provide for operating expenses should be used to reduce payments for operating expenses.

b. Unrestricted funds from non-patient sources. Unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital. Exceptions to this rule may be granted if the hospital can show that alternative uses of these funds are to the economic benefit of current patients and/or are in the best interests of the community served.

~~3. Variations from budgeted volumes of activity and service. Changes in the aggregate rate may be necessary due to variations from budgeted volumes of activity and service. The financial requirements of a hospital for a budget year should reflect adjustments in volumes of activity and service realized during the prior and current years.~~

~~a. If a hospital over projects its volume in a service center, in the next year its financial requirements should be increased by an amount equal to the ratio of fixed to total costs for that service center multiplied by the income loss due to unrealized activity.~~

~~b. If a hospital under projects its volume in a service center, in the next year its financial requirements should be reduced by the ratio of fixed to total costs of that service center multiplied by the income loss due to unrealized activity.~~

~~c. The system proposes three alternative procedures for identifying the costs related to increased volume or reduction in expenses anticipated resulting from decreases in volume as compared to original budget forecast.~~

~~(1) Alternative 1. The system will establish different fixed to variable expense ratios for different peer groups of hospitals. The ratios will vary from 80%/40% and shall be applied to hospitals in a manner consistent with the hospital's size and complexity of services. The fixed to variable expense ratio will be applied to total patient admissions adjusted for outpatient activity, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.~~

~~(2) Alternative 2. In the event that an individual hospital identifies that its fixed to variable expense ratio differs significantly in aggregate total from that established by the system, that hospital may submit supporting data to the system requesting a fixed to variable ratio different than that adopted for its peer group. In such cases, the system may approve a fixed to~~

(d) "Non-cost justified discounts" and/or "non-cost justified price differentials" shall not be included in a hospital's financial requirements.

b. Plant capital needs. Rates should provide the finances necessary for various plant capital needs. In order to include plant capital needs in rates, the hospital must fund the plant capital requirement and be in receipt of a certificate of need as required by Minn. Stat. §§ 145.71-145.84. Funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

(1) Finances which relate to land, land improvement, building and building equipment and movable equipment shall be placed in an identifiable fund. The use of the fund shall be restricted to debt principal retirement, new plant and equipment (with certificate of need approval if necessary), major repairs (that are capitalized), replacement of capital equipment (with certificate of need approval if necessary), Hill-Burton free-care expenses in excess of those accounted for by 7 MCAR § 1.487 A. 1. a. (5)(a)(iii) and all other free-care (not to exceed 3% of operating expenses net of medicare and medicaid expenses). The annual increment to this fund should be:

(b) Plus ~~inflation-factors~~, an amount annually determined (for each hospital) ~~and~~ to be consistent with the established useful lives of land improvements, buildings, building equipment, and movable equipment. ~~These-inflation-factors~~ This amount shall be determined ~~by-the-system-on-the-basis-of-a-price-level-adjustment~~ as follows: ~~index-recognized-by-independent-public-appraisers-as-expressing-the-annual-price-level-adjustment-from-historical-cost-of~~

~~hospital-land-improvements,-buildings,-hospital-building-equipment and-movable-equipment.--The-system-shall-derive-these-factors-from any-of-the-most-current-indices-then-available-to-the-system-which give-specific-recognition-to-the-following-factors:~~

(i) An index or cumulative index determined by the system and recognized by independent public appraisers as expressing the annual effects of inflation upon historical cost from the year of purchase of hospital land improvements, buildings, hospital building equipment and movable equipment and shall be multiplied by an asset(s) annual depreciation expense.

(ii) The index for the budget year's expected annual depreciation expense shall not exceed 1.04.

(c) The system shall derive these indices from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing land improvements, buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, land improvements, building equipment, and movable equipment.

2. ~~Income~~ Restricted and unrestricted funds from sources other than patients. In all investigations, analyses, and reviews conduc pursuant to these rules, the system shall recognize that hospitals have sources of ~~income~~ funds other than patients which are intended to be or may be used for the reduction of its rates. In meeting the reporting requirements of these rules, hospitals shall disclose the

(b) The losses in revenues due to bad debts, charity allowances, and governmental contractual allowances should be offset by available and applicable income from sources other than patients, as identified by 7 MCAR § 1.487 A. 2., before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs.

(6) "Discounts" and/or "price differentials" are those discounts and/or prices granted and/or charged to certain payors (patients, groups of patients, or third party payors), which result in receipts by a hospital of something less than the average expected dollar amount received for services rendered of comparable type, kind, and quality in the absence of such discounts and/or prices. These discounts and/or price differentials shall be classified as either cost justified or non-cost justified.

(a) "Cost justified discounts" and/or "cost justified price differentials" are discounts and/or price differentials, as measured in dollars, for the services and/or other benefits given to a hospital by a payer during an accounting period. Cost reducing benefits and services that shall be considered in a determination of whether a discount is cost justified include:

(i) Hospital administration;

(aa) Payer admitting requirements,

(bb) Payer accounting and audit requirements,

(cc) Payer billing costs,

(ii) Hospital working capital requirements;

(aa) Cash and prepayment,

(bb) The length of time taken to pay bills; and

(iii) Other cost reducing activities undertaken by specific payers that do not simply and inequitably shift costs from one payer to another (primary consideration should be given to activities that serve the long-range interests of a system-wide reduction of hospital costs).

(b) "Non-cost justified discounts" and/or "non-cost justified price differentials" are all other discounts and/or price differentials that are not cost justified in a manner consistent with 7 MCAR § 1.487 A. 1. a. 6. (a).

(c) "Cost justified discounts" and/or "price differentials" shall be granted to payers for hospital services and may be included in a hospital's financial requirements if:

(i) The amount of the discounts or price differentials as measured in dollars is equal to or less than the value of services or other benefits given to a hospital by a payer during accounting period; and

(ii) The dollar value, per adjusted admission, of the services or other benefits offered to a hospital by a payer is first subtracted from the average cost (which includes the cost saving associated with the service or of benefit given) per adjusted admission for all patients.

§ 1.487 Investigations, Analysis and Review Standards.

A. Bases for judging the reasonable use of finances in a hospital. In all investigations, analyses, and reviews conducted pursuant to Minn. Stat. §§ 144.695-144.703, and these rules, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of these rules, hospitals shall address the contents of their reports to and indicate their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses and reviews following these established bases.

1. Financial Requirements of Hospitals. The gross rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories:

a. Current operating needs related to patient care. In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

(5) Bad debt, charity allowances, and contractual allowances.

(a) Gross Rrates should provide finances necessary to recover losses in gross revenue due to bad debts, charity allowances, and governmental contractual allowances.

(iii) "Contractual Governmental contractual allowances," "cost-justified-discounts"-and-"non-cost-justified discounts," are those discounts from the established gross charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by Title V, Title XVIII and Title XIX of the United States Social Security Act.

~~(aa)-"Governmental-contract-adjustments" are-those-discounts-from-the-established-charges-required-due-to governmental-reimbursement-practices-established-pursuant-to-regulations-authorized-by-such-governmental-programs-as-those-created by-Title-V,-Title-XVIII-and-Title-XIX-of-the-United-States-Social Security-Act;~~

~~(bb)-"Cost-justified-discounts"-or "differentials"-means-those-cash,-trade,-or-quantity-discounts-or differentials-from-the-established-charges.--In-order-to-include the-amount-of-these-discounts-or-differentials-in-rates,-hospitals shall-demonstrate-that-the-value,-as-measured-in-money,-of-services or-other-benefits-for-an-accounting-period-provided-by-certain patients,-groups-of-patients,-or-third-party-payors-to-the-hospital is-equal-to-or-greater-than-the-aggregated-amount,-as-measured-in money,-of-the-differential-or-discount-granted-to-certain-patients, groups-of-patients-or-third-party-payors-for-that-same-accounting period.~~

~~(cc)-Discounts-or-differentials-which are-not-cost-justified-in-a-manner-consistent-with-7-MCAR-§-1.487 A.-1.-a.-(5)(a)(iii)(bb),-above,-shall-not-be-included-in-rates-but shall-be-treated-as-reductions-in-revenue-and-recorded-by-the-hospital-as-such.~~

d. A statement of total "direct" and "indirect" costs and revenues where applicable for the hospital and for each of the following, both before and after allocation of indirect expenses:

(1) Daily services

(2) Ancillary services

(3) Non-revenue producing services

e. A statement of the accounts receivable by type of purchaser of services.

f. A statement of the capital budget of the hospital.

g. All information as provided by 7 MCAR § 1.474 B. 4. & 5.

C. Interim Increase Reports.

1. Interim increase reports shall be filed as required under 7 MCAR § 1.474 C.1. and 2.

2. Statistical and financial information shall be filed as required under 7 MCAR §§ 1.474 C. 3., 4., 5., and 6., except when in conflict with information required in the rate revenue and expense report as provided by 7 MCAR § 1.475 B. In such circumstances, the information required by 7 MCAR § 1.475 B. shall be the required information.

D. Review and Comment. The review and comment upon all experimental reports reviewed pursuant to 7 MCAR § 1.475 B. and C. shall be conducted and made as stated in 7 MCAR § 1.487 C. 2., with the exceptions of 7 MCAR §§ 1.487 C. 2. b. (1) (c) and 1.487 C. 2. b. (2) (b). The following shall substitute for 7 MCAR §§ 1.487 C. 2. b. (1) (c) and 1.487 C. 2. b. (2) (b):

1. Aggregate rate and costs and components of aggregate rates and costs have been demonstrated by the hospital to be consistant or inconsistant with the operating expenses found in 7 MCAR § 1.487 A. [1. a. (1), (2), (3), (4), (5)(a)(i)(ii); b. (1)(a)(5), (6), (7); 3., 4.] plus a maximum of 5% of reasonable operating expenses in lieu of 7 MCAR § 1.487 A. 1. [b. (1)(b), (2), (3), (4) and c.].

2. Sixty-six percent of the 5% plus factor provided in 7 MCAR § 1.475 D.1. shall be placed in an identifiable depreciation fund and may be used in the manner prescribed in 7 MCAR § 1.487 A. 1. b. and A. 1. b. (i).

E. Aspects of the Experiment.

1. The alternative experimental reporting requirements shall remain in force for a period of four years (four complete reporting cycles) commencing with the effective date of these rules.

2. At the close of the third year of the experiment an evaluation of the alternative reporting requirements shall be made by the Department of Health in conjunction with all approved voluntary, non-profit rate review organizations. The evaluation shall address the following, at a minimum:

a. The adequacy of the data,

b. Impact of the reduced data set on the quality of rate reviews,

c. The appropriateness of the set of hospitals chosen to participate in the experiment; and

d. The appropriateness of adopting the requirements permanently.

tion may file annual Rate Revenue and Expense Reports and interim increase reports according to paragraph B of this section, in lieu of information required under §§ 1.474 B. 2. and 1.474 B. 3.

A. Selection Criteria. Non-state non-federal acute care hospitals licensed in the State of Minnesota are eligible if they belong to the set of hospitals comprising 15% of the total gross acute (inpatient plus outpatient) charges for all non-state non-federal acute care hospitals in the State. Determination of the hospitals to be included in the set of hospitals comprising 15% of total state gross acute charges shall be made as follows:

1. The total gross acute charges used shall be for the prior year, pursuant to 7 MCAR § 1.474 B. 1. a., and shall be changed adjusted to represent a December 31 fiscal year end.

2. The hospital with the lowest total gross acute charges shall be selected first. The hospital with the second lowest total gross acute charges shall be selected second and its gross acute charges shall be added to the first selected hospital's. The hospital with the third lowest gross acute charges shall be selected third and its total gross acute charges shall be added to the sum of the gross acute charges of the hospitals selected first and second. The procedure shall continue in direct ascending order so as to maximize the number of hospitals included, but the sum of gross patient charges included shall not exceed 15% of the total gross acute charges for all non-state and non-federal acute care hospitals.

B. Rate Revenue and Expense Report.

1. Each hospital shall submit a report of rate, revenue and expense pursuant to 7 MCAR § 1.481 C. This report shall include statistical and financial information for:

a. The prior year as provided by 7 MCAR § 1.474 B. 1. a.

b. The current year as provided by 7 MCAR § 1.474 B. 1. b.

c. The budget year as provided by 7 MCAR § 1.474 B. 1. c.

2. Statistical information submitted in the rate revenue and expense report shall include:

a. The number of inpatient days for the hospital.

b. The number of admissions for the hospital.

c. The average number of full-time-equivalent employees during each accounting period for the hospital. An employee or any combination of employees which is reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employ

d. The number of beds licensed, the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital.

e. The number of outpatient visits for the hospital.

3. Financial information submitted in the rate revenue and expense report shall include:

a. An interim financial statement as provided by § 1.474 B. 3. a.

b. A statement of expenses for the hospital according to natural classifications of expenses as provided by 7 MCAR § 1.474 A. 2. a. (6).

c. A statement indicating the accounting method used to allocate expenses from among the "non-revenue producing centers" to "revenue producing centers" as provided by 7 MCAR § 1.474 B. 3. c.

6. A statement of changes in financial position showing the source and application of all funds.

7. A statement(s) of all fund balance(s).

8. All notes and footnotes to the balance sheet, statement of income and expense, statement of changes in financial position, and statement(s) of fund balance(s).

B. Rate revenue and expense report.

2. Statistical information for the rate revenue and expense report shall include:

a. The number of inpatient days excluding nursery days for the hospital, and each appropriate service center.

d. The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and each appropriate service center, excluding nursery bassinets.

3. Financial information for the rate revenue and expense report shall include:

~~f. A statement of changes in financial position showing the source and application of all funds for each period.~~

g. f. A statement of the capital budget of the hospital.

4. The report of rate revenue and expense shall also contain the following information:

a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution. This will be supplemented by a statement of budgeted increases in charges, revenue and aggregate rates for the budget year including these items:

(1) Date(s) on which gross charges, and gross revenue, ~~and aggregate rates~~ will be adjusted.

(3) For each such date, the resulting aggregate dollar and weight average percent of increase in budget year total hospital gross revenues.

5. If a hospital maintains its accounts in a way which necessarily results in detailed statements of income, expense and statistics differing in form and content from those recommended by this rule and 7 MCAR § 1.481 A. 1., the hospital may substitute the information it has available. However, in all such cases the hospital shall submit a detailed reconciliation of the differences between the two sets of information and presentations in conjunction with the rate revenue and expense report.

C. Interim increase reports.

4. Statistical information for each period established by 7 MCAR § 1.474 C. 3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to 7 MCAR § 1.474 B.2., and 5., which shall be recorded for each period stated by 7 MCAR § 1.474 C. 3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

5. Financial information for each period established by 7 MCAR § 1.474 C. 3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to 7 MCAR § 1.474 B. 3. and 5., which shall be recorded for each period stated by 7 MCAR § 1.474 C. 3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

§ 1.475 Experimental Alternative Reporting Requirements. Each hospital meeting the criteria specified in paragraph A of this sec-

Proposed

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

In the Matter of Proposed Rules
Relating to the Minnesota
Hospital Rate Review System

Chapter Twenty-Eight: 7 MCAR § 1.471 - 1.511

§ 1.472 Definitions.

B. "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care~~,~~ exclusive of newborn admissions.

G. "Charges" means the regular amounts charged less expected bad debts, contracted allowances and discounts to patients and/or insurers, prepayment plans and self-insured groups on the patient's behalf~~,~~. ~~irrespective of any discounts, deductions, or other reductions in these charges which, by contract or other agreement, may be applicable.~~ The terms "charges" and "rates" are synonymous for the purposes of these rules. "Gross charges" means "charges" irrespective of any discounts, deductions, or other reductions which by contract or other agreement, may be applicable. The terms "gross charges" and "gross rates" are synonymous for the purpose of these rules.

R. "Outpatient visit" means an acceptance of a patient by a hospital for the purpose of providing outpatient services~~,~~. ~~in a distinct outpatient service center,~~

W. "Revenue(s)" or "income(s)" means the value ~~at the~~ of a hospital's ~~full~~ established charges ~~of~~ for all hospital services rendered to patients~~, regardless of the amounts actually paid to the hospital by or on behalf of patients,~~ less expected and/or incurred bad debts, contracted allowances and discounts granted to patients and/or insurers, prepayment plans and self insured groups. "Gross revenue(s)" or "gross income(s)" means "revenue(s)" or "income(s)" regardless of the amounts actually paid to or received by the hospital.

X. "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

2. Other nursing services (~~special~~ ancillary services), including:

g. Other ~~special~~ ancillary services.

§ 1.474 Report requirements.

A. Annual financial information report. Each hospital shall submit an annual financial information report to the system. This report shall include:

2. a. A detailed statement of income and expenses, including:

(5) Direct gross revenue and gross expense received or incurred from non-hospital operations; and

3. An unadutied copy of the hospital's cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act stated in 20 CFR 405.406(b)~~,~~ and the uniform cost report required under Public Law 95-142, Section 19. ~~This~~ These cost reports shall correspond to the same accounting period as that used in the compilation of data for other requirements for the report of annual financial information.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of Proposed Rule Relating to Charges for Examination Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System.

FINDINGS OF FACT, CONCLUSIONS, AND ORDER.

The Commissioner of Health Adopts the Hearing Examiner's Report in the Matter of Proposed Rules Relating to Charges for Examination Fees of Health Maintenance Organizations and Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System with a number of exceptions.

The following are additions, deletions, or corrections to the Hearing Examiner's Report of November 27, 1978. Each addition, deletion or correction is enumerated to correspond directly to one of the Hearing Examiner's Findings of Fact:

7MCAR § 1.472 - Proposed Amendments to Rate Review System

Section 1.472 Definitions

CORRECTION TO THE SECOND SENTENCE:

"The provisions amended by this rule were items B., ~~G.~~ G., R., W., and X." The error is typographical.

7MCAR § 1.475 - Experimental Alternative Reporting Requirements

Finding 22. Sec. 1.475B. and subparts (1),(2),(3)

CORRECTION TO THE SECOND SENTENCE:

"Under these proposed provisions, the reporting requirements are the same as presently existing rules, but restricting some of the reporting activities which ~~will prove~~ have proven to be more costly...."

Finding 23. Sec. 1.475B.3.e.

CORRECTION AND ADDITION TO THE FOURTH SENTENCE:

"The Department proposed to amend the rule as follows: A statement of the accounts ~~payable~~ receivable in total and of gross revenue by the type of payer."

The correction is typographical. This Sec. (1.475B.3.e.) deals with accounts receivable reporting - see the first sentence in Finding 23 of the Hearing Examiner's Report.. The words in total are being added to avoid any possible confusion. The Department is in concurrence with MHA and believes that receivables can be reported in total and gross revenue by type of payer.

Finding 25. Sec. 1.475D.

CORRECTION TO THE SECOND TO LAST SENTENCE:

"The Department, in opposing the above referenced deletion, stated that empirical data suggested that ~~1.5%~~ 105%...."

The error is typographical.

ADDITION TO THE HEARING EXAMINER'S FINDING:

Insert after the second to last sentence: "However, the Department thoroughly reviewed MHA's suggested language change and finds that its position can be reconciled to MHA's if the following language change were made to 1.475D.1.:

'Aggregate rates and costs and components of aggregate rates and costs have been demonstrated by the hospital to be consistent or inconsistent with the reasonable operating expenses found in 7MCAR § 1.487 [A.1.a.(1),(2),(3),(4),(5),(6); B.(1),(a),(2),(3),(4),(5),(6),(7); A.2.; A.3.; A.4.]. In addition, a maximum of 5% of 7MCAR § 1.487 [A.1.a.(1),(2),(3),(4); b.(1),(a)] shall serve in lieu of 7MCAR § 1.487A.1. [b.(1), (b), (2), (3), (4); and c].'

This language change brings MHA's and MDH's positions in line. It is reasonable in that it recognizes MDH's empirical findings and MHA's concerns about the exclusion of § 1.487A.5.(a)(i)(ii). The proposed change simply takes both positions which differ in approach rather than outcome and refines the proposed rule to blend both outcome and procedure."

Finding 26. Sec. 1.475D.2.

ADDITION TO THE HEARING EXAMINER'S FINDING:

Insert the following between the first and second sentence: "C.D. Ulrich Ltd., a certified public accounting firm in Willmar, indicated in written testimony that the requirement of funding depreciation and the restriction that depreciation must not be used for operating purposes provided under 7MCAR § 1.487A.1.b.(1) should not be imposed on the 5% allowance for hospitals reporting under 7MCAR § 1.475. The 5% alternative allowance cannot and should not be equated with price level depreciation and any hospital required to use invested funds for operations would automatically have a severe shortage of working capital. Therefore, if any arbitrary assignment of the 5% allowance could or should be made in these instances it would probably be to regard the entire 5% allowance as a working capital requirement. He stated that 7MCAR § 1.475D.2. should be deleted. However, the Commissioner adopts the Hearing Examiner's Finding in this case because the proposed rule is consistent with a previously adopted rule, 7MCAR § 1.487 A.1.b., and received no other opposition, especially from hospitals."

Finding 36. Sec. 1.487A.1.(a)(6)

CORRECTION TO THE LIST OF REPRESENTATIVES FROM INTEREST GROUPS:

"Sec. 1.487A.1.(a)(6) and its subparts drew similar criticism from the following representatives of different interest groups: Donald Mill, Minnesota Hospital Association; Dean Lund, Assistant to General Manager of Group Health; ~~E.-Lamsen,-Director-of Providers-Reimbursement-Department,-Blue-Cross/Blue-Shield~~;

David Jones, Fairview Hospital; Terry Klas, Director, North American Life and Casualty Company; and Jean McPherson, Senior Vice President, St. Mary's Hospital, Minneapolis.

ADD THE FOLLOWING AFTER THE LAST SENTENCE:

"E. Lamson, Director of Provider Reimbursement Department, Blue Cross/Blue Shield stated that Blue Cross/Blue Shield concurred with the proposed rule, but that the following should be added to § 1.487A.1.a.(6)(a)(i)

'(dd) Credit and Collection Costs

(ee) Bad Debts'.

In addition, Terry Klas and Dean Lund took exception to the language in 7MCAR § 1.487A.1.a.(6)(iii) found between the parenthesis '(primary consideration should be given to activities that serve the long-range interests of a system wide reduction of hospital costs)'. The Commissioner concurs with Messrs. Klas and Lund and adopts the Hearing Examiner's Findings with the exception of including the parenthetical found in 7MCAR § 1.487A.1.a.(c)(iii). In doing so, the Commissioner recognizes BCBSM's concerns but cannot adopt the suggested additions as rule. While the Department agrees that credit and collection costs and bad debts may contribute to a differential, the Commissioner believes that it is desirable to distribute these costs among the widest range of payers possible. If BCBSM's argumentswere taken to the extreme, the cost of care for nonpayers would be increased because they do not pay, ... ad infinitum. In the final analysis no money would be forthcoming. Distribution of these costs would ensure that

the hospital would recover its costs at the lowest expense to all payers."

Finding 38. Sec. 1.487A.1.(b)(1)

ADDITIONS TO THE HEARING EXAMINER'S FINDINGS:

Add the following after the second to last sentence:

"Blue Cross and Blue Shield of Minnesota, Health Insurance Association of America (HIAA) and the Metro Health Board were in support of the proposed amendment. Both HIAA and the Metro Health Board showed evidence that there is substantial excess capacity in the hospital system and that it would be inappropriate for MDH to propose rules that would allow additional capital."

Finding 39. Sec. 1.487A.1.(b)(1)(b) and (i) and (ii)

ADDITION FOLLOWING THE THIRTEENTH SENTENCE:

"The Metro Health Board concurred with Mr. Klas' position and Blue Cross/Blue Shield was in support of the Department's proposed amendment."

Finding 41. Sec. 1.487A.2.

ADDITION FOLLOWING THE SEVENTH SENTENCE:

"However, MHA did support the proposed change from 'income' to 'funds', but to avoid confusion 7MCAR § 1.487A.2.(b), should contain language listing considerations to be used in the determination of the treatment of unrestricted funds which should include:

1. The hospital's financial condition;

2. Alternative uses which the unrestricted funds are proposed to be put;

3. The hospital's approved long-range plan;

4. The hospital's cost in relation to its peer group; and

5. The magnitude of the unrestricted funds.

"MHA's proposed additions are consistent with the Department's position on the use of unrestricted funds. However, the Department did not propose a substantive change in 7MCAR § 1.487A.2.(b) or a substantial change to the rule and MHA's suggested additional language did not appear in the notice to amend rules published in the State Register. Therefore, MHA's suggestion cannot be adopted at this time, but the Department will consider such an addition at a future date."

ADDITION FOLLOWING THE THIRD TO LAST SENTENCE:

"Both Blue/Blue Shield and the Metro Health Board supported the Department's proposed amdendments."

Finding 42. Sec. 1.487A.2.(a)

ADDITION FOLLOWING THE FOURTH TO LAST SENTENCE:

"Both Blue Cross/Blue Shield and the Metro Health Board supported the amendment as proposed. Much of MHA's argument regarding unrestricted funds and tax levies was superfluous and irrelevant for the purpose of this rules hearing since the term 'tax levies' and sections dealing with tax levies were only specifically included in sections under restricted funds.

Sections dealing with unrestricted funds remain unchanged."

Finding 44. Sec. 1.487A.3.(a), and (b), and (c)

ADDITIONS FOLLOWING THIRD TO LAST SENTENCE:

"Blue Cross/Blue Shield also supported the proposed amendment."

Finding 45. Sec. 1.487A.3.(a)(b)

CORRECTION AND ADDITION:

Delete "drew no comments and"from the last sentence, "These rules ~~drew no comments and~~ are needed and reasonable."

ADD THE FOLLOWING AFTER THE SECOND TO LAST SENTENCE:

"In a written comment C.D. Ulrich Ltd., a certified public accountant, wanted amendment 7MCAR § 1.487A.3.(b) deleted because it would eliminate the reward for efficiency and disregards the important distinction between fixed and variable costs. The Department contends that the fixed-variable cost question is addressed in 7MCAR § 1.487A.3.(c) as are the efficiency incentives. 7MCAR § 1.487A.3.(b) deals with the question of actual revenues in excess of budgeted revenues rather than a reduction of cost as Mr. Ulrich implies."

Finding 46. Sec. 1.487A.3.(c)(1) and (2)

ADDITIONS TO THE SECOND TO LAST SENTENCE:

"The agency opposed any change as did the Metro Health Board. Blue Cross and Blue Shield also supported the agency's language. The agency pointed out that it had proposed amendments to 7MCAR § 1.504., the allowable increase limit, and all difficulties with the allowable increase as an objective measure

of inflation should be directed to those proposed amendments. However, any arguments relating to the separability of costs on the one hand and charges or revenue on the other are inappropriate. Rule 7MCAR § 1.487 establishes a clear relationship between cost and charges/revenues [charge/revenues = f (cost)]. Changes in cost directly related to changes in charges and revenues."

Finding 47. Sec. 1.487A.3.(c)(3)

ADDITION FOLLOWING "BECAUSE" IN THE THIRD TO LAST SENTENCE:

"MHA recommended the deletion of this entire rule because ~~of its belief that a logical inconsistency existed because of the differences in treatment of gains to losses.~~ it states that minor losses that would be non-allowable in the current year may subsequently be recovered from the prior year as a loss carryforward. Moreover, this rule would permanently require the offset of minor gains over financial requirements to be offset against the subsequent years financial requirements and would not allow them to be carried forward in the current year. These logical inconsistencies, argues MHA, make this rule unreasonable. The Department notes that these so called logical inconsistencies work in the favor of hospitals and that MHA's written and oral testimony concerning this rule are inaccurate. 7MCAR § 1.487A.3.a. and b. allow loss and gain carryforwards only after such gains and losses are reconciled to an audit. This means that gains and losses can only come from the prior year to the budget year because current year data is not audited and is partially estimated. In the absence of 7MCAR § 1.487A.3.c.(3) hospitals will have the benefit of all expected gains throughout the budget year and if large losses cause a cash flow problem, they may not be brought forward from the current year, but must wait a full year."

Finding 49. Sec. 1.487C.2.b.(1)(c) and (d)

ADDITION FOLLOWING THE FOURTH TO LAST SENTENCE:

"Both Blue Cross and the Metro Health Board support the proposed amendment. Charges must directly relate to costs."

CORRECTION TO THE THIRD TO LAST SENTENCE:

Substitute the word "review" for the word "setting".

"The Department contends that compliance under these rules for rate ~~setting~~ review must require some constraint by the hospital."

The Department has rate review rather than rate setting authority.

Finding 52. Sec. 1.504F.

CORRECTION TO THE THIRD SENTENCE:

Replace the word "industries" with "indices".

"The blending of the ~~industries~~ indices is necessary for a more appropriate and equitable basis...."

CORRECTION TO THE SECOND TO LAST SENTENCE:

"The single percentage figure shall be so constructed so that it will contain the proportionate contribution of each of the natural expense categories presented in 7MCAR Sec. 1.474a~~.2.(6)~~. A.2.a.(6)."

CONCLUSIONS

All Conclusions of the Hearing Examiner are hereby adopted.

ORDER

NOW THEREFORE, IT IS HEREBY ORDERED that these rules, identified as 7MCAR § 1.372 and amendments to rules 7MCAR §§ 1.472 - 1.509 are adopted pursuant to authority vested in me by Minn. Stat. §§ 62D. 14, subd. b and 62D. 20 as well as Minn. Stat. § 144.703 (1976).

Dated: December 29, 1978

Warren R. Lawson, M.D.
COMMISSIONER OF HEALTH

Subd. 7. No health maintenance organization shall enroll more than 500,000 persons in the state of Minnesota. A violation of this subdivision shall be treated as a violation of the antitrust act, sections 325.8011 to 325.8028.

Subd. 8. No health maintenance organization shall discriminate in enrollment policy against any person solely by virtue of status as a recipient of medical assistance or medicare.

Subd. 9. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that authorized expenses of a health maintenance organization shall include:

(a) cash rebates to enrollees, or to persons who have made payments on behalf of enrollees; or, when approved by the commissioner of health as provided in subdivision 4, direct payments to enrollees for obligations incurred for non-elective emergency or out-of-area services received; or, with prior approval, direct payments to providers for out-of-area, non-elective emergency or referral medical, hospital, or other health services rendered to enrollees;

(b) free or reduced cost health service to enrollees; or

(c) payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. All net earnings shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.29, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

Subd. 10. No health maintenance contract or evidence of coverage entered into, issued, amended, renewed or delivered on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit to an enrollee or other beneficiary by the amount of, or in any proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, as amended subsequent to the date of commencement of such benefit.

Subd. 11. Any health maintenance organization which includes coverage of comprehensive dental services in its comprehensive health maintenance services shall not include the charge for the dental services in the same rate as the charge for other comprehensive health maintenance services. The rates for dental services shall be computed, stated and bid separately. No employer shall be required to purchase dental services in combination with other comprehensive health services. An employer may purchase dental services separately.

[*1973 c 670 s 12; 1974 c 284 s 8,9; 1975 c 323 s 4; 1976 c 296 art 1 s 18; 1977 c 305 s 45*]

62D.13 POWERS OF INSURERS AND NONPROFIT HEALTH SERVICE PLANS. Notwithstanding any law to the contrary, an insurer or a hospital or medical service plan corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group for group coverage under the insurance laws and the nonprofit health service plan corporation act. Under such contracts, the insurer or nonprofit health service plan corporation may make benefit payments to health maintenance organizations for health care services rendered, or to be rendered, by providers pursuant to the health care plan. Any insurer, or nonprofit health service plan corporation, licensed to do business in this state, is authorized to provide the types of coverages described in section 62D.05, subdivision 3.

[*1973 c 670 s 13*]

62D.14 EXAMINATIONS. Subdivision 1. The commissioner of health may make an examination of the financial affairs of any health maintenance organization and its contracts, agreements, or other arrangements with providers as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years.

Subd. 2. The commissioner of health may make an examination concerning the quality of health care services provided to enrollees by any health maintenance organization and providers with whom such organization has contracts, agreements, or

other arrangements pursuant to its health care plan as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years. Provided, that examinations of providers pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees.

Subd. 3. In order to accomplish his duties under this section, the commissioner of health shall have the right to:

(a) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

(b) Audit and inspect any books and records of a health maintenance organization which pertain to services performed and determinations of amounts payable under such contract.

Subd. 4. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee, or any application obtained from any person, shall be confidential and shall not be disclosed to any person except (a) to the extent that it may be necessary to carry out the purposes of sections 62D.01 to 62D.29; (b) upon the express consent of the enrollee or applicant; (c) pursuant to statute or court order for the production of evidence or the discovery thereof; or (d) in the event of claim or litigation between such person and the provider or health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Subd. 5. The commissioner of health shall have the power to administer oaths to and examine witnesses, and to issue subpoenas.

Subd. 6. Reasonable expenses of examinations under this section shall be assessed by the commissioner of health against the organization being examined, and shall be remitted to the commissioner of health for deposit in the general fund of the state treasury.

[*1973 c 670 s 14; 1977 c 305 s 45*]

62D.15 SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY. Subdivision 1. The commissioner of health may suspend or revoke any certificate of authority issued to a health maintenance organization under sections 62D.01 to 62D.29 if he finds that:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62D.03, unless amendments to such submissions have been filed with and approved by the commissioner of health;

(b) The health maintenance organization issues evidences of coverage which do not comply with the requirements of section 62D.07;

(c) The health maintenance organization is unable to fulfill its obligations to furnish comprehensive health maintenance services as required under its health care plan;

(d) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(e) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 62D.06;

(f) The health maintenance organization has failed to implement the complaint system required by section 62D.11 in a manner designed to reasonably resolve valid complaints;

(g) The health maintenance organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(h) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

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Subd. 2. The commissioner of health may approve voluntary reporting and rate review procedures which are substantially equivalent to reporting requirements and rate review procedures adopted by the commissioner of health for reporting and rate reviews conducted pursuant to sections 144.698 and 144.701. The commissioner of health shall, by rule, prescribe standards for approval of voluntary rate review procedures, which standards shall provide for:

(a) The filing of appropriate financial information with the rate review organization;

(b) Adequate analysis and verification of that financial information; and

(c) Timely publication of the review organization's findings and comments prior to the effective date of any proposed rate increase. The commissioner of health shall annually review the procedures approved pursuant to this subdivision.

Subd. 3. Any voluntary, nonprofit rate review organization which conducts a review of the rates of a hospital located in this state shall file a copy of its findings and comments with the commissioner of health within 30 days of completion of the review process, together with a summary of the financial information acquired by the organization during the course of its review.

Subd. 4. Any voluntary, nonprofit rate review organization which receives the financial information required in section 144.698 shall make the information available to the commissioner of health in accordance with procedures prescribed by the commissioner of health.

Subd. 5. If the reporting and rate review procedures of a voluntary, nonprofit rate review organization have been approved by the commissioner of health those reporting and rate reviewing activities of the organization shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 6. For the purposes of this section "rate review organization" means an association or other organization which has as one of its primary functions the peer review of hospital rates.

[*1976 c 296 art 2 s 8; 1977 c 305 s 45*]

144.703 ADDITIONAL POWERS. Subdivision 1. In addition to the other powers granted to the commissioner of health and the commissioner of insurance by law, the commissioner of health and the commissioner of insurance may each:

(a) Adopt, amend, and repeal rules in accordance with chapter 15;

(b) Hold public hearings, conduct investigations, and administer oaths or affirmations in any hearing or investigation.

Subd. 2. Any person aggrieved by a final determination of the commissioner of health or the commissioner of insurance as to any rule or determination under sections 144.695 to 144.703; or 62A.02, subdivision 3; or 62C.15, subdivision 2, shall be entitled to an administrative hearing and judicial review in accordance with the contested case provisions of chapter 15.

[*1976 c 296 art 2 s 9; 1977 c 305 s 45*]

CHILDREN'S CAMPS

144.71 PURPOSE; DEFINITIONS. Subdivision 1. **Health and safety.** The purpose of sections 144.71 to 144.76 is to protect the health and safety of children in attendance at children's camps.

Subd. 2. **Definition.** For the purpose of such sections a children's camp is defined as a parcel or parcels of land with permanent buildings, tents or other structures together with appurtenances thereon, established or maintained as living quarters where both food and lodging or the facilities therefor are provided for ten or more people, operated continuously for a period of five days or more each year for educational, recreational or vacation purposes, and the use of the camp is offered to minors free of charge or for payment of a fee.

Subd. 3. **What not included in definition.** This definition does not include cabin and trailer camps, fishing and hunting camps, resorts, penal and correctional camps, industrial and construction camps, nor does it include homes operated for care or treatment of children and for the operation of which a license is required under the provisions of chapter 257.

[*1951 c 285 s 1; 1974 c 406 s 21*]

Subd. 5. The commissioner of health shall have the right to inspect hospital books, audits, and records as reasonably necessary to verify hospital reports.

[*1976 c 296 art 2 s 4; 1977 c 305 s 45*]

144.699 CONTINUING ANALYSIS. Subdivision 1. The commissioner of health may:

(a) Undertake analyses and studies relating to hospital costs and to the financial status of any hospital subject to the provisions of sections 144.695 to 144.703; and

(b) Publish and disseminate the information relating to hospital costs.

Subd. 2. The commissioner of health shall prepare and file summaries and compilations or other supplementary reports based on the information filed with or made available to the commissioner of health, which reports will advance the purposes of sections 144.695 to 144.703.

[*1976 c 296 art 2 s 5; 1977 c 305 s 45*]

144.70 ANNUAL REPORT. The commissioner of health shall prepare and prior to each legislative session transmit to the governor and to the members of the legislature an annual report of the commissioner of health's operations and activities for the preceding fiscal year as they relate to the duties imposed on the commissioner of health by sections 144.695 to 144.703. This report shall include a compilation of all summaries and reports required by sections 144.695 to 144.703 together with any findings and recommendations of the commissioner of health.

[*1976 c 296 art 2 s 6; 1977 c 305 s 45*]

144.701 INVESTIGATIVE POWER. Subdivision 1. The commissioner of health may initiate reviews or investigations as necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, and that rates are set equitably. The commissioner of health shall prohibit hospitals from discriminating among insurers in its rates.

Subd. 2. In order to properly discharge these obligations, the commissioner of health may review projected annual revenues and expenses of hospitals and comment on them.

Subd. 3. In the interest of promoting the most efficient and effective use of hospitals, the commissioner of health may promote experimental alternative methods of budgeting, cost control, rate determination and payment.

Subd. 4. The commissioner of health shall begin to compile relevant financial and accounting data concerning hospitals in order to have statistical information available for legislative policy making.

Subd. 5. The commissioner of health shall obtain from each hospital a current rate schedule. Any subsequent amendments or modifications of that schedule shall be filed with the commissioner of health at least 60 days in advance of their effective date. The commissioner of health may, by rule, exempt from this requirement rate increases which have a minimal impact on hospital costs. If the hospital has not agreed to submit to a voluntary rate review in accordance with section 144.702, the commissioner of health may hold a public hearing pursuant to chapter 15, on any increase which he determines is excessive and may publicly comment on any increase.

Subd. 6. Each report which is required to be submitted to the commissioner of health pursuant to subdivision 5 and which is not to be reviewed by a voluntary nonprofit rate review organization in accordance with section 144.702 shall be accompanied by a filing fee in an amount prescribed by rule of the commissioner of health. Filing fees shall be set at a level sufficient to cover the costs of any reviews undertaken pursuant to subdivision 5, and may take into consideration the length or complexity of the report being filed. Fees received pursuant to this subdivision shall be deposited in the general fund of the state treasury.

[*1976 c 296 art 2 s 7; 1977 c 305 s 45*]

144.702 VOLUNTARY REPORTING AND RATE REVIEW OF HOSPITAL COSTS. Subdivision 1. A hospital may agree to submit its financial reports to, and be subject to a review of its rates by, a voluntary, nonprofit rate review organization whose reporting and review procedures have been approved by the commissioner of health in accordance with this section.

surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 15.162, subdivision 9.

Subd. 3. The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if he determines the records are necessary to fulfill his duties under Laws 1976, Chapter 325.

[*1976 c 325 s 10; 1977 c 305 s 45*]

144.695 CITATION. Sections 144.695 to 144.703 may be cited as the Minnesota hospital administration act of 1976.

[*1976 c 296 art 2 s 1*]

144.696 DEFINITIONS. Subdivision 1. Unless the context clearly indicates otherwise, for the purposes of sections 144.695 to 144.703, the terms defined in this section have the meanings given them.

Subd. 2. "Commissioner of health" means the state commissioner of health.

Subd. 3. "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.

Subd. 4. "Commissioner of insurance" means the commissioner of insurance.

Subd. 5. "Insurer" means a person selling policies of accident and health insurance pursuant to chapter 62A, or nonprofit health service plan subscriber contracts pursuant to chapter 62C.

[*1976 c 296 art 2 s 2; 1977 c 305 s 45*]

144.697 GENERAL POWERS AND DUTIES OF STATE COMMISSIONER OF HEALTH. Subdivision 1. The commissioner of health may contract with third parties for services necessary to carry out his activities where this will promote economy, avoid duplication of effort, and make best use of available expertise.

Subd. 2. The commissioner of health may apply for and receive grants and gifts from any governmental agency, private entity or other person.

Subd. 3. To further the purposes of sections 144.695 to 144.703, the commissioner of health may create committees from the membership and may appoint ad hoc advisory committees.

Subd. 4. The commissioner of health shall coordinate regulation and inspection of hospitals to avoid, to the extent possible, conflicting rules and duplicative inspections.

[*1976 c 296 art 2 s 3; 1977 c 305 s 45*]

144.698 REPORTING REQUIREMENTS. Subdivision 1. Each hospital, which has not filed the financial information required by this section with a voluntary, nonprofit rate review organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:

(a) A balance sheet detailing the assets, liabilities, and net worth of the hospital;

(b) A detailed statement of income and expenses; and

(c) A copy of its most recent cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act.

Subd. 2. If more than one licensed hospital is operated by the reporting organization, the commissioner of health may require that the information be reported separately for each hospital.

Subd. 3. The commissioner of health may require attestation by responsible officials of the hospital that the contents of the reports are true.

Subd. 4. All reports, except privileged medical information, filed pursuant to this section, section 144.701 or section 144.702, subdivision 3 or 4 shall be open to public inspection.

other arrangements pursuant to its health care plan as often as the commiss
health deems necessary for the protection of the interests of the people of th
but not less frequently than once every three years. Provided, that examina
providers pursuant to this subdivision shall be limited to their dealings with th
maintenance organization and its enrollees.

Subd. 3. In order to accomplish his duties under this section, the comm
of health shall have the right to:

(a) Inspect or otherwise evaluate the quality, appropriateness, and tim
services performed under such contract; and

(b) Audit and inspect any books and records of a health maintenance
tion which pertain to services performed and determinations of amounts pa
der such contract.

Subd. 4. Any data or information pertaining to the diagnosis, trea
health of any enrollee, or any application obtained from any person, shall be
tial and shall not be disclosed to any person except (a) to the extent that
necessary to carry out the purposes of sections 62D.01 to 62D.29; (b) up
press consent of the enrollee or applicant; (c) pursuant to statute or court
the production of evidence or the discovery thereof; or (d) in the event of cl
gation between such person and the provider or health maintenance o
wherein such data or information is pertinent. A health maintenance o
shall be entitled to claim any statutory privileges against such disclosure
provider who furnished such information to the health maintenance orga
entitled to claim.

Subd. 5. The commissioner of health shall have the power to adminis
and examine witnesses, and to issue subpoenas.

Subd. 6. Reasonable expenses of examinations under this section
sessed by the commissioner of health against the organization being ex
shall be remitted to the commissioner of health for deposit in the general
state treasury.

[*1973 c 670 s 14; 1977 c 305 s 45*]

62D.15 SUSPENSION OR REVOCATION OF CERTIFICATE OF A

Subdivision 1. The commissioner of health may suspend or revoke any
authority issued to a health maintenance organization under section
62D.29 if he finds that:

(a) The health maintenance organization is operating significantly
tion of its basic organizational document, its health care plan, or in a ma
to that described in and reasonably inferred from any other information
der section 62D.03, unless amendments to such submissions have been
approved by the commissioner of health;

(b) The health maintenance organization issues evidences of cover
not comply with the requirements of section 62D.07;

(c) The health maintenance organization is unable to fulfill its obli
nish comprehensive health maintenance services as required under i
plan;

(d) The health maintenance organization is no longer financially r
may reasonably be expected to be unable to meet its obligations to en
spective enrollees;

(e) The health maintenance organization has failed to implemen
affording the enrollees an opportunity to participate in matters of policy
under section 62D.06;

(f) The health maintenance organization has failed to implemen
system required by section 62D.11 in a manner designed to reasonab
complaints;

(g) The health maintenance organization, or any person acting w
has advertised or merchandised its services in an untrue, misrepresen
ing, deceptive, or unfair manner;

(h) The continued operation of the health maintenance organiz
hazardous to its enrollees; or

STATE OF MINNESOTA
Commissioner of Health

In the Matter of Proposed Amendments to Rules of the Minnesota Commissioner of Health Governing the Minnesota Hospital Rate Review System

Statement of Need for and Reasonableness of Proposed Amendments

This Statement of Justification is the Commissioner's explanation of the reasoning behind the proposed amendments to the rules including support for the necessity and reasonableness of these proposed rules. The proposed amendments are based upon specific authority in Minnesota Statutes §§ 144.695-144.703. The fundamental principle of these rules is that the Commissioner shall publicly disclose the budgets of hospitals, he shall review and comment upon any proposed increases in hospital rates and he shall monitor the financial condition of hospitals.

Another factor which is pertinent is that hospital rate review, as authorized by the aforementioned statute, is simply a review process; it is not a process as in several other states whereby hospital rates and budgets must conform to the recommendations of the reviewing body. Consequently, the standards for reasonableness contained in the rules and proposed amendments do not constitute strict bases upon which rates must be set; the standards simply suggest what would appear to reflect the reasonable use of funds by a hospital. To guard against overly restrictive future interpretation of the rules and proposed amendments, the standards have purposefully been left as fluid as the Administrative Procedures

Act permits. This flexible construction recognizes that:

(a) Hospital rate review is still in its early stages of development nationally and in the state of Minnesota;

(b) Changing economic conditions and governmental regulations could easily render a highly specific set of standards for assessment useless within a very short period of time; and

(c) The nature of health care delivery is in constant flux and the demands placed upon hospitals vary.

The Commissioner prepared these amendments after a careful review of the program's first year of operation with input from affected parties including insurers (including Blue Cross and Blue Shield of Minnesota, the Minnesota Chapter of the Health Insurance Association of America and HMO's), providers (including representatives from various hospitals and their organizations), health planning groups (including representatives from the State Health Planning and Development Agency and Health Systems Agencies), and Professional Standards Review Organizations. A brief description of the consultation process employed is attached to the justification. Generally speaking these amendments are a precondition to the future successful administration of the rate review program.

This statement of the evidence in support of the Commissioner of Health's proposed amendments will be presented section by section. The sections to be amended are:

7 MCAR § 1.474	Definitions
7 MCAR § 1.474	Report Requirements
7 MCAR § 1.475	Experimental Alternative Reporting Requirements
7 MCAR § 1.487	Investigations, Analysis and Review Standards
7 MCAR § 1.504	Determination of Allowable Increase Limit
7 MCAR § 1.509	Fees

7 MCAR § 1.472

B. "Admissions". The definition of admissions has been altered to reflect standard practice in the hospital industry. A birth is not normally counted as an admission. See Hospital Statistics 1977, page 17 (published by the American Hospital Association) for a supporting reference.

C. "Charges". The definition of charges has been altered to include "net charges" so that the difference between "gross" and "net" could be made in the rules. The definitional destinction is consistent with standard accounting practice.

R. "Outpatient Visit". The language is deleted to increase clarity of the definition. Many services utilized by inpatients are also utilized by outpatients, e.g., laboratory services.

W. "Revenues". the definition of revenues has been altered to include "net revenues" so that the difference between "gross' and "net" could be made in the rules. The definitional distinction is consistent with standard accounting practice.

X. "Revenue Center". The term "ancillary" is being substituted for "special" in 2. and 2.g. as ancillary is the more commonly used terminology.

7 MCAR § 1.474

A. 2. a. (5) The word "gross" was introduced to distinguish between revenues and expenses pre and post deduction for allowances and uncollectibles. This distinction is consistent with the original language and simplifies the appropriate calculation.

3. Public Law 95-142, Section 19 requires all hospitals receiving funds under Title V, XVIII, XIX of the United States Social Security

Act to submit a uniform cost report in conjunction with its Medicare cost report Minnesota Statutes § 144.698 requires hospitals to file their latest Medicare cost report with the Commissioner of Health. The Commissioner considers the report required under P.L. 95-142, Section 19 to be an integral part of the hospital's Medicare cost report.

6. This reporting requirement was deleted from 7 MCAR § 1.474 B. 3. f. and included here. It is more reasonable to require the statement in this section as it is normally part of a hospital's annual financial statements. See Hospital Audit Guide, AICPA. New York, 1976.

7.-8. These reporting requirements were added to bring the rules into conformance with accounting practice. This information is normally part of a hospital's annual financial statements. See Hospital Audit Guide, AICPA. New York, 1976.

B. 2. a. The rationale for this addition is consistent with the change made in 7 MCAR § 1.472 B.

d. See B. 2. a. (immediatly preceeding)

f. See 7 MCAR § 1.474 A. 6.

4. a. (1) See 7 MCAR § 1.474 A. 2. a. (5)

(3) See 7 MCAR § 1.474 A. 2. a. (5)

5. The system does not require hospitals to adopt a uniform accounting system and has not emphasized to any great degree a uniform reporting system even though it would greatly facilitate the review and comment process. The reconciliation is being required so that when a hospital submits information in a format that differs from

that required by the system, the hospital will be protected from unfair comparisons, while at the same time preventing the system from making faulty assessments based upon appearance rather than fact.

C. 4. See 7 MCAR § 1.474 B. 5.

5. See 7 MCAR § 1.474 B. 5.

7 MCAR § 1.475

This rule is bing included so that certain hospitals, specifically small hospitals, can be granted relief, at their option, from the more detailed and costly rate revenue and expense and interim reporting requirements of 7 MCAR § 1.474 B. and C. This experiment, authorized by Minnesota Statutes § 144.701, Subd. 3, recognizes that (1) 85% of total acute care hospital expenditures in Minnesota are made by approximately 60 of the 180 acute care hospitals licensed in the state, (2) "small" hospitals have fewer departments and less division of labor than "large" hospitals, therefore, making detailed departmental accounting less necessary, and (3) "small" hospitals do not usually have the in-house accounting and financial staff required to complete the rate revenue and expense reports detailed in 7 MCAR 1.474 B. requiring them to purchase outside help at a relatively high cost.

A. This rule is included to determine which hospitals will be eligible for the experiment. Eligibility is based on size as defined by hospital gross acute care charges. Eligible hospitals will comprise about 15% of total state gross acute charges, or about 120 of the state's 180 hospitals.

1. This section states the basis upon which a hospital will qualify for the experiment. Total gross acute charges was chosen as the determinator of size or eligibility because the program's orientation is financial review rather than a physical facility review, for example.

2. This rule indicates how the hospitals will be chosen, beginning with the smallest and continually adding hospitals until approximately 15% of total charges is reached.

B. 1. These requirements are exactly the same as a presently existing rule, 7 MCAR §.1.481 C., 7 MCAR § 1.474 B. 1. a, b. and c.

2. These requirements are the same as a presently existing rule, 7 MCAR § 1.474 B.2. with one difference - statistics will be for the hospital as a whole and a maximum of three service centers.

3. These requirements are the same as a presently existing rule, 7 MCAR § 1.474 B.3.a., 7 MCAR § 1.474 A.2.a.(6),7 MCAR § 1.474.B.3.c.,d., with the exception of 7 MCAR § 1.475 B. 3. d. where the number and type of service centers has been limited. This is in recognition of the fact that reporting on activities carried out on levels lower than the three listed may not be fruitful and will prove to be more costly to both the hospital and the reviewing agencies.

C. These requirements are identical with a presently existing rule, 7 MCAR § 1.474 C., and/or 7 MCAR § 1.475 B.

D. All review and comments will be made on the basis of previously adopted rules and/or additions to previously adopted rules found in 7 MCAR § 1.487 C.2.

1. Financial requirements are being altered to include operating expenses (including bad debts) and a "plus factor" not to exceed 5% of operating expenses inclusive of all other operating and non-operating income. This will further reduce reporting requirements for small hospitals,

as the current reporting requirements for plant capital need, working capital, other income, and contractual allowances are substantial and require considerable time and effort. The 5% plus factor is a reasonable approximation of the average level of working capital + (plant capital needs - depreciation) ÷ operating expenses.

2. A previously adopted rule requires the plant capital portion or revenues to be placed in an identifiable fund. Approximately 66% of (plant capital need + working capital) is plant capital need, therefore, 66% of the 5% plus factor should be placed into the plant capital fund.

E. 1. The four year time period was chosen to allow the system and hospitals to accumulate enough experience to evaluate the reporting requirements and still maintain some continuity in reporting from year to year for small hospitals.

2. The evaluation shall begin with enough time to complete the study and adopt permanent rules with regard to reduced reporting requirements for small hospitals.

7 MCAR § 1.487

A. 1. See 7 MCAR § 1.474 A. 2. a. (5)

a. (5) (a) "Gross" see 7 MCAR § 1.474 A. 2. a. (5). "Governmental" has been added to clarify that "contractual allowance" refer only to governmental programs and payers, non-governmental payers are covered under "bad debts", "charity allowances", "cost justified and non-cost justified discounts and/or price differentials".

(iii) This rule is the same as a previously adopted rule. Certain words have been deleted due to a general reorganization of 7 MCAR § 1.487 A. 1. a. (5) (a).

(b) See 7 MCAR § 1.487 A. 1. a. (5) (a) "governmental".

(6) This rule defines "discounts" and/or "price differentials" and distinguishs them from "bad debts", "governmental contractual allowances", and "charity care".

reasonable? need?

(a) This rule defines a "cost justified discount" and/or "price differential" and distinguishes it from a non-cost justified discount and/or differential. See existing rule 7 MCAR § 1.487 A.1.a. (5).

(i)-(iii) In order to help determine if a discount or price differntial is cost justified or not a partial listing of factors to consider has been included. This will give guidance to both hospitals and the system when classifying discounts and/or price differentials. Too much specifity may overly restrict hospitals and payers from entering into mutually beneficial arrangements that can cut costs.

reasonable? need?

(b) This rule defines non-cost justified discounts.

(c) This rule states that both parties, hospitals and payers, should benefit from cost savings. This creates an incentive for payers to undertake cost saving activities.

(i) The discount should not exceed the value of the service rendered, this protects other payers from paying more than "their fair share" and maintains equity among payers as specified in Minnesota Statutes § 144.701.

(ii) It is necessary to specify the conditions under which the discount may be included in financial requirements, for example:

Assume that there are 2 payers, each representing 50% of hospital "A's" utilization and that the hospital has an average cost per adjusted admission of $1000. Furthermore, assume that financial requirements are defined as being equal to allowable operating expenses.

CASE I:

Allowable operating expenses = (admissions) x (average cost per admission) [the average cost per adjusted admission for each payer is equal]. In this case, neither payer has undertaken any activity that would warrant a differential and no cost justified differential should be included in financial requirements.

CASE II:

Allowable operating expenses = (admissions) x (average cost per adjusted admission) [the average cost per adjusted admission for each payer is equal with the exception of $10 for admitting costs].

In this case, average cost per adjusted admission is still equal to $1000, but payer #1's average cost per adjusted admission is $900 and payer #2's is $1010. A cost justified discount is granted to payer #1 and is included in financial requirements, as financial requirements are based upon average cost per adjusted admission:

1. Allowable Operating Expense	$1000 x Admissions
2. Less: Discounts	10 x $\frac{A}{2}$
3. Net Revenues	995 x A
4. Plus: Discounts	10 x $\frac{A}{2}$
5. Financial Requirements	$1000 x A

CASE III:

Conditions are the same as in Case II.

All conditions are the same as in Case II except that financial requirements are based upon the highest cost payer's cost per adjusted admission (payer #2's cost) and cost justified discounts should not be included in financial requirements:

1. Allowable Operating Expenses based on the highest cost payer	$1010 x A
2. Less: Discounts	10 x A
3. Net Revenue: Financial Requirements	$1000 x A

(d) Payers not favored by a discount should not underwrite a discount given to a payer if it is not cost justified. Any such discount should result in the reduction of a hospital's equity.

b. (1) The language "that are capitalized" was added for clarity and does not change the way in which the rule is currently being or will be interpreted.

The language relating to Hill-Burton Free Care expenses was added to rectify a problem with the existing rules. 7 MCAR § 1.487 allows a hospital to include up to 50% of its Hill-Burton Free Care requirement into rates to meet its obligation, but

there is no rule establishing a source of funds to meet the hospital's remaining Hill-Burton obligation. This rule establishes the plant capital fund as the source of funds and is reasonable because it is in keeping with the intent of the original rule in that up to 50% of the Hill-Burton requirement may be explicitly included in rates.

Additional language was added to allow all hospitals to allocate up to 3% of their non-Medicare and non-medicaid expenses to free care. This does not alter financial requirements, but recognizes that not all hospitals have Hill-Burton Free Care obligations and are obliged to render service to the community in the form of free care. Such service will result in a reduction of a hospital's equity. The 3% of non-Medicare and non-medicaid expenses is consistent with Federal Hill-Burton guidelines.

(b) The additions and/or changes in this set of rules are of one of three types:

1) Organizational
2) Grammatical
3) Additional language necessary for the consistent determination of the plant capital portion of financial requirements.

The term "inflation factors" is being replaced with "an amount" for grammatical reasons. A factor is not being added to straight line depreciation; an amount is being added to straight line depreciation.

The language "for each hospital" is being added for clarity.

(i) This rule is exactly the same as an existing rule. The indicated change is in organization.

(ii) This rule is being added to clarify and provide a consistent treatment of the budget year's depreciation expense. It relates to the plant capital component of financial requirements. The index factors used by the system, pursuant to 7 MCAR § 1.487 A. 1. b. (i), are provided by the Marshall Valuation Service (published by the Marshall and Swift Co.) which utilizes a factor of 1 for all prospective years. Therefore, consistency with a presently existing rule, 7 MCAR § 1.487 A. 1. b. (1) (b) requires that the index should be 1. However, a factor of 1 does not recognize any inflation in the budget year, but the use of an index other than 1 would allow hospitals to double count the impact of inflation in the budget year.

The budget year's depreciation expense is made up of two components: 1) the annual depreciation of assets purchased, and still being depreciated, prior to the budget year and 2) assets expected to be purchased. The items to be purchased are carried at the expected purchase price, as are additions to inventory, and are naturally adjusted for inflation. Previously purchased assets are adjusted for inflation retrospectively when the inflation rate is known. The application of a budget year inflation factor, other than 1, will provide a double inflation adjustment for component 2. Therefore, a budget year inflation factor of no greater than 1.04 is being recommended. This will allow adjustment for future inflation without double counting. One and four hundreths (1.04) or less is a conservative estimate of inflation. Under any circumstances, the system shall not allow the factor to exceed 50% of expected inflation. Hospitals will not suffer by this treatment as the difference between the index factor used and actual inflation may be carried forward to the next budget year.

(c) Changes and additions to this rule were made for organizational and grammatical reasons.

2. "Income" is being replaced with "restricted and unrestricted funds" in order to clarify the meaning of income. It was intended that income would be interpreted in its broadest sense - money received from non-patient sources. However, upon occasion "income" has been interpreted by hospitals to mean "interest earned". "Restricted and unrestricted funds" denote types of money received from non-patient sources.

a. The language "tax funds (tax receipts or appropriations received)" is being added for clarity. The rule dealing with restricted funds as an offset to rates has always been interpreted to include all restricted funds without exception and without regard to source. There has been some misunderstanding of the rule, by hospitals, as it applies to tax funds. The term tax funds is being added to the rule so that misunderstandings of the application of the rule to tax funds will be minimized in the future.

(1) "Monies" are being substituted for "income" for the reason explained in 7 MCAR § 1.487 A. 2.

(2) See 7 MCAR § 1.487 A. 2. and 7 MCAR § 1.487 A.2. a. The language relating to debt principal retirement is being added for clarity and is consistent with the plant capital fund use (see 7 MCAR § 1.487 A. 1. b. (1))

(6) This rule is being added for clarity. The concept is that a fund restricted for a specific purpose should be used for that purpose and the cost of the activity should not be included in rates.

3. The rules relating to the section dealing with variations from budgeted revenue and expense has been totally rewritten to accommodate concern expressed by hospitals and the approved alternative rate review or-

ganization with regard to the administrative infeasibility of the rule as it was originally adopted. The new language treats variations in budgeted revenue and expense in a manner that is consistent with the original rule, but allows for a greater degree of flexability for hospitals and reviewers alike in the application of the rule. In lieu of specific fixed variable cost relationships, which have not been shown to be either accurate or inaccurate for Minnesota hospitals, a set of principles are suggested that should guide the application of the rule in the determination of reasonable hospital budgets.

The intent is to neutralize the financial affect of changes from budgeted volume on hospital revenue and expenses, while establishing a financial incentive for hospitals to reduce cost and/or increase productivity.

Loss due to under estimating inflation should be judged against an objective standard of actual inflation. The standard should not be biased by using the actual experience of the hospital which may have made purchases at unreasonably high prices or by using any other hospital or set of hospitals that may be involved in highly favorable purchase arrangements that are foreclosed to the average hospital. Therefore, standard government indexes that are based upon actual national and regional experience should be used as the standard by which inflation is measured.

The actual amount of a loss or gain carry forward should be based upon actual audited experience, but in cases where the loss will cause cash flow difficulties for a hospital estimated information may be used to establish the amount of the loss until audit information is available.

C. 2. b. The system is based upon the review of aggregate rate and, therefore, should comment upon aggregate rates rather than the individual rate for each service or good offered by the hospital.

(1) The amendments to the rule dealing with the bases which may be used to comment that a hospital's existing and prospective rates are reasonable are of the following types:

(a) The addition of aggregate rates and components of aggregate rates to existing rules. This language was added to maintain consistency with the language in 7 MCAR § 1.487 C. 2. b. and to explicitly allow the system to comment on aggregate rates at the hospital and/or service center level. In order for the system to be of value to consumers and hospitals, alike, greater specificity of the components of the aggregate rate (or the service center rates) that are reasonable,when compared to similar hospitals, is required. Data is collected on a service center basis and it is at times appropriate to comment on a service center basis.

(b) The minimal increase should be linked to increses in inflation, still allowing the hospital to recieve full reasonable financial requirements. It is necessary to specify the nature of the minimal increase in terms of a measure of economic inflation so that rate increases reflect increased in the prices of goods and services purchased by the hospital rather than some other measure that is not germane.

(c) See 7 MCAR § 1.487 C. 2. b. (1) (a).

(d) Minnesota Statutes § 144.701 indicates that costs and rates should be related, as such, the system should comment upon a hospital's costs and rates in aggregate and/or by service center.

(e) See 7 MCAR § 1.487 C. 2. b. (1) (b).

(f) This rule is the same as 7 MCAR § 1.487 C. 2. b. (1) (c), but substitutes costs for rates. See 7 MCAR § 1.487 C. a. b. (1) d.

(g) This rule allows the system to comment on the reasnoableness of any loss/gain carry forward that might be included in a budget, pursuant to 7 MCAR § 1.487 A. 3. and the adequacy and accuracy of a hospital's budgeting process.

(h) This rule relates to language in Minnesota Statutes § 144.701 that gives the rate review system the authority to investigate and assure all payers that "rates are set equitably". If service center rates are not reflective of service center costs, certain inequity may exist, i.e., one group of payers may be subsidizing another group.

2. The justification for the amendments to rules (a)-(f) are the same as for 7 MCAR § 1.487 C. 2. b. (1) (a)-(h).

7 MCAR § 1.504

E. "Aggregate rate and average aggregate cost" are being substituted for "charges per inpatient admission" to keep consistency within the rules. The rules are in terms of aggregate rate rather than charges per inpatient admission.

F. the Wholesale Price Index and other indices were added to increase the range of alternatives available to the Commissioner of Health in the construction of the allowable increase limit. Experience indicates that a wider choice of indices is most appropriate and equitable because of the limiting nature of the CPI, many of the products bought by hospitals are at the wholesale level and/or are not an explicit component of CPI or WPI

G. See 7 MCAR § 1.504 F.

2. "Set of" has been added for grammatical reasons.

7 MCAR § 1.509

A. The fee structure is being altered to reflect:

1. The need to generate additional funds to meet the actual cost of operating the program. The experience of the alternative rate review organization (the Minnesota Hospital Association) indicates that the cost of operating the program is approximately $275,000.

2. The new schedule has a built-in inflation adjustment. The fee schedule is tied to revenue which should reflect inflation.

3. The new schedule changes the distribution of payment by putting a greater burden on larger hospitals where there is a greater ability to pay. Also, with the new experimental reporting requirements more time will be spent reviewing large hospitals than small hospitals. As a result, greater program resources will be spent on large hospitals.

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL-Health

Office Memorandum

TO : Lee E. Sheehy
Special Assistant
Attorney General

DATE: January 17, 1979

FROM : John A. Breviu
Special Assistant
Attorney General

PHONE: 5402

SUBJECT: In the Matter of a Proposed Rule Relating to Charges for Examination Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System

I am enclosing, for your review pursuant to Minn. Stat. § 15.0412, subd. 4 (1978), the complete hearing record in the above-entitled matters.

If you have any questions, please feel free to contact me.

JAB:kd

Enclosure

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : Joanne Hinderacker
Special Assistant Attorney General
Department of Administration

DATE: January 25, 1979

FROM : John A. Breviu
Special Assistant Attorney General

PHONE: 5402

SUBJECT: Hospital Rate Review Rules

I understand that Bill Flynn, an attorney representing the Minnesota Hospital Association, may be challenging the above rules during the course of your review. I would appreciate it if you would provide me with a copy of any written arguments he presents to you. I also request the opportunity to respond to those arguments on behalf of the Minnesota Department of Health.

JAB:mt

RECEIVED
JAN 26 1979
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of a Proposed Rule
Relating to Charges for Examination
Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to
the Rules Relating to the Minnesota Hospital
Rate Review System

STATEMENT OF NUMBER
OF PERSONS EXPECTED
TO ATTEND AND LENGTH
OF HEARING

The number of persons expected to attend the hearing in the above-captioned matter is forty.

It is estimated that the length of the hearing will be six hours.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

Dated: 8/23, 1978

for Ellen Z Fifer

WARREN R. LAWSON, M.D.
Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of a Proposed Rule Relating to Charges for Examination Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System

STATEMENT OF EVIDENCE

The Commissioner of Health (hereinafter "Commissioner") will introduce the following evidence at the hearing in the above-entitled matter scheduled for Monday, September 25, 1978, commencing at 9:00 a.m. in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota.

1. Documents attached hereto and made a part hereof evidencing the Commissioner's compliance with procedural requirements for rule making:

(a) Order for Hearing;

(b) Notice of Hearing as mailed;

(c) Affidavit of Receipt of the Secretary of State's List;

(d) Certificate of the Secretary of State;

(e) Affidavit of Mailing of the Notice of Hearing.

2. Documents attached hereto and made a part hereof constituting the Commissioner's affirmative presentation of facts establishing the need for and reasonableness of the proposed rule and evidencing the Commissioner's compliance with substantive requirements for rule making:

(a) Statement of Need and Reasonableness of proposed amendments to Hospital Rate Review rules;

(b) Statement of Need and Reasonableness of proposed Health Maintenance Organization rule.

The following witnesses will represent the Commissioner at the hearing:

Kent Peterson
Chief
Planning and Resources Control Section
Minnesota Department of Health

Fredric Sattler
Director
Hospital Rate Review
Minnesota Department of Health

Diane Harder
Analyst
Minnesota Department of Health

Said witnesses will be available to answer questions as they might relate to the Commissioner's affirmative presentation of facts as set forth through the previously listed and attached documents.

The Statements of Need and Reasonableness attached hereto contain the citations to the Commissioner's statutory

authority to promulgate the proposed Health Maintenance Organization rule and proposed amendments to the Hospital Rate Review rules.

Dated: 8/31, 1978

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

WARREN R. LAWSON, M.D.
Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of Proposed Rule
Relating to Charges for Examination
Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to
the Rules Relating to the Minnesota Hospital
Rate Review System

ORDER FOR HEARING

To effectively implement Minn. Stat. §§ 62D.14, subd. 6 and 62D.20 (1976), relating to Health Maintenance Organizations and Minn. Stat. §§ 144.695-144.703 (1976), relating to Hospital Rate Review, the Minnesota Commissioner of Health deems it necessary to consider adoption of the proposed rule and amendments to 7 MCAR § 1.471-1.511 captioned above pursuant to the authority vested in it by the above-referenced statutes.

NOW, THEREFORE, IT IS ORDERED this 2 day of August, 1978, that a public hearing on the proposed rules captioned above be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Monday, September 25, 1978, commencing at 9:00 a.m., and continuing until all persons or representatives of associations or other interested groups have had an opportunity to be heard.

IT IS FURTHER ORDERED, that notice of said hearing be published in the State Register and be given to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose and to all persons who are presently members of the Minnesota Legislature.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

for Allen Z. Fiser M.D.

WARREN R. LAWSON
Commissioner of Health Deputy Commissioner

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of a Proposed Rule
Relating to Charges for Examination
Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to
the Rules Relating to the Minnesota Hospital
Rate Review System

NOTICE OF HEARING

Notice is hereby given that a public hearing in the above-entitled matters will be held pursuant to Minn. Stat. § 15.0412, subd. 4 (1976), in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Monday, September 25, 1978, commencing at 9:00 a.m.

All interested or affected persons will have an opportunity to participate concerning the adoption of the proposed rule relating to Health Maintenance Organizations and the proposed amendments to 7 MCAR §§ 1.471-1.511 (Hospital Rate Review rules) captioned above. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted by mail to Harry Crump, Hearing Examiner, at Room 300, 1745 University Avenue, St. Paul, Minnesota 55104, telephone (612) 296-8111, either before the hearing or within five (5) working days after the close of the hearing. The hearing record may remain open for a longer period than five working days after the close of the hearing, but not longer than 20 calendar days, if ordered by the Hearing Examiner. All such statements will be entered into and become part of the record. Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand. For those wishing to submit written statements or exhibits, it is requested that at least three (3) copies be furnished. In addition, it is suggested, to save time

and avoid duplication, that those persons, organizations, or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests. The conduct of the hearing shall be governed by the rules of the Office of Hearing Examiners, which are cited in 9 MCAR §§ 2.101-2.112.

A copy of the proposed rule and amendments is attached hereto and made a part hereof.

Copies of the proposed rule and amendments are now available and at least one free copy may be obtained by writing to the Minnesota Department of Health (Attention: Fredric Sattler), 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing.

A Statement of Need explaining the position of the Commissioner of Health relative to the necessity for the proposed rule and amendments and a Statement of Evidence outlining the testimony and evidence which will be introduced by the Commissioner in support of the proposed rule and amendments will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection. The statutory authority of the Commissioner of Health to promulgate and adopt these rules is contained in Minn. Stat. §§ 62D.14, subd. 6 and 62D.20 (1976) relative to Health Maintenance Organizations and in Minn. Stat. § 144.695-144.703 (1976), relative to Hospital Rate Review.

In addition, please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he commences lobbying. Lobbying includes attempting to influence rule making by communicating or urging others to communicate with public officials. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 a year or five (5) hours per month at lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

Notice: Any person may request notification of the date on which the Hearing Examiner's Report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted (or resubmitted) to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Hearing Examiner (in the case of the Hearing Examiner's Report), or to the agency (in the case of the agency's submission or resubmission to the Attorney General).

Dated: August 7, 1978

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

for Ellen Z. Fiper M.D.

WARREN R. LAWSON

Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of a Proposed Rule
Relating to Charges for Examination
Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to
the Rules Relating to the Minnesota Hospital
Rate Review System

AFFIDAVIT OF RECEIPT
OF THE SECRETARY OF
STATE'S LIST

Diane Harder, being duly sworn upon oath, deposes and says:

1. That she is an employee of the Minnesota Department of Health.

2. That on or about the 19th day of July, 1978, an employee of the Minnesota Department of Health called the Minnesota Secretary of State's office and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules or amendments thereto pursuant to Minn. Stat. § 15.0412 subd. 4 (1976).

3. That on the 27th day of July, 1978, in response to the above request, the Secretary of State provided her with such a list, a photocopy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Diane Harder

Diane Harder

Subscribed and sworn to before me

this 28 day of August, 1978.

FREDERICK L. KING
WASHINGTON COUNTY
NOTARY PUBLIC-MINNESOTA
MY COMMISSION EXPIRES FEB. 22, 1984

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of a Proposed Rule
Relating to Charges for Examination
Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to
the Rules Relating to the Minnesota Hospital
Rate Review System

AFFIDAVIT OF MAILING

Shari Driscoll, being first duly sworn, deposes and says:

That on the 22 day of August, 1978, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, as well as to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof.

Shari Driscoll

Shari Driscoll

Subscribed and sworn to before me

this 22 day of August, 1978.

Frederick L. King

FREDERICK L. KING
WASHINGTON COUNTY
NOTARY PUBLIC-MINNESOTA
MY COMMISSION EXPIRES FEB. 22, 1984

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of a Proposed Rule
Relating to Charges for Examination
Fees of Health Maintenance Organizations

and

NOTICE OF HEARING

In the Matter of Proposed Amendments to
the Rules Relating to the Minnesota Hospital
Rate Review System

Notice is hereby given that a public hearing in the above-entitled matters will be held pursuant to Minn. Stat. § 15.0412, subd. 4 (1976), in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Monday, September 25, 1978, commencing at 9:00 a.m.

All interested or affected persons will have an opportunity to participate concerning the adoption of the proposed rule relating to Health Maintenance Organizations and the proposed amendments to 7 MCAR §§ 1.471-1.511 (Hospital Rate Review rules) captioned above. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted by mail to Harry Crump, Hearing Examiner, at Room 300, 1745 University Avenue, St. Paul, Minnesota 55104, telephone (612) 296-8111, either before the hearing or within five (5) working days after the close of the hearing. The hearing record may remain open for a longer period than five working days after the close of the hearing, but not longer than 20 calendar days, if ordered by the Hearing Examiner. All such statements will be entered into and become part of the record. Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand. For those wishing to submit written statements or exhibits, it is requested that at least three (3) copies be furnished. In addition, it is suggested, to save time and avoid duplication, that those persons, organizations, or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests. The conduct of the hearing shall be governed by the rules of the Office of Hearing Examiners, which are cited in 9 MCAR §§ 2.101-2.112.

A copy of the proposed rule and amendments is attached hereto and made a part hereof.

Copies of the proposed rule and amendments are now available and at least one free copy may be obtained by writing to the Minnesota Department of Health (Attention: Fredric Sattler), 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing.

A Statement of Need explaining the position of the Commissioner of Health relative to the necessity for the proposed rule and amendments and a Statement of Evidence outlining the testimony and evidence which will be introduced by the Commissioner in support of the proposed rule and amendments will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection. The statutory authority of the Commissioner of Health to promulgate and adopt these rules is contained in Minn. Stat. §§ 62D.14, subd. 6 and 62D.20 (1976) relative to Health Maintenance Organizations and in Minn. Stat. § 144.695-144.703 (1976), relative to Hospital Rate Review.

In addition, please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he commences lobbying. Lobbying includes attempting to influence rule making by communicating or urging others to communicate with public officials. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 a year or five (5) hours per month at lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

Notice: Any person may request notification of the date on which the Hearing Examiner's Report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted (or resubmitted) to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Hearing Examiner (in the case of the Hearing Examiner's Report), or to the agency (in the case of the agency's submission or resubmission to the Attorney General).

Dated: August 7, 1978

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

/s/ Ellen Z. Fifer, M.D., for
WARREN R. LAWSON
Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

In the Matter of Proposed Rule
Relating to Charges for
Examination Fees of Health
Maintenance Organizations

7 MCAR § 1.372 Other provisions.

G. Fees. Every filing submitted to the Commissioner by a health maintenance organization subject to Minn. Stat. §§ 62D.01 to 62D.29 (the Health Maintenance Act of 1973) shall be accompanied by the following fees:

4. For ~~all other filings, $25.00~~ each examination, $125.00 per eight hour day.

5. For all other filings, $25.00.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

In the Matter of Proposed Rules
Relating to the Minnesota
Hospital Rate Review System

Chapter Twenty-Eight: 7 MCAR § 1.471 - 1.511

§ 1.472 Definitions.

B. "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care, exclusive of newborn admissions.

G. "Charges" means the regular amounts charged less expected bad debts, contracted allowances and discounts to patients and/or insurers, prepayment plans and self-insured groups on the patient's behalf, ~~irrespective of any discounts, deductions, or other reductions in these charges which, by contract or other agreement, may be applicable~~. The terms "charges" and "rates" are synonymous for the purposes of these rules. "Gross charges" means "charges" irrespective of any discounts, deductions, or other reductions which by contract or other agreement, may be applicable. The terms "gross charges" and "gross rates" are synonymous for the purpose of these rules.

R. "Outpatient visit" means an acceptance of a patient by a hospital for the purpose of providing outpatient services. ~~in a distinct outpatient service center~~,

W. "Revenue(s)" or "income(s)" means the value ~~at the~~ of a hospital's ~~full~~ established charges ~~of~~ for all hospital services rendered to patients, ~~regardless of the amounts actually paid to the hospital by or on behalf of patients~~, less expected and/or incurred bad debts, contracted allowances and discounts granted to patients and/or insurers, prepayment plans and self insured groups. "Gross revenue(s)" or "gross income(s)" means "revenue(s)" or "income(s)" regardless of the amounts actually paid to or received by the hospital.

X. "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

2. Other nursing services (~~special~~ ancillary services), including:

g. Other ~~special~~ ancillary services.

§ 1.474 Report requirements.

A. Annual financial information report. Each hospital shall submit an annual financial information report to the system. This report shall include:

2. a. A detailed statement of income and expenses, including:

(5) Direct gross revenue and gross expense received or incurred from non-hospital operations; and

3. An unadutied copy of the hospital's cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act stated in 20 CFR 405.406(b), and the uniform cost report required under Public Law 95-142, Section 19. ~~This~~ These cost reports shall correspond to the same accounting period as that used in the compilation of data for other requirements for the report of annual financial information.

6. A statement of changes in financial position showing the source and application of all funds.

7. A statement(s) of all fund balance(s).

8. All notes and footnotes to the balance sheet, statement of income and expense, statement of changes in financial position, and statement(s) of fund balance(s).

B. Rate revenue and expense report.

2. Statistical information for the rate revenue and expense report shall include:

a. The number of inpatient days excluding nursery days for the hospital, and each appropriate service center.

d. The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and each appropriate service center, excluding nursery bassinets.

3. Financial information for the rate revenue and expense report shall include:

~~f. A statement of changes in financial position showing the source and application of all funds for each period.~~

g. f. A statement of the capital budget of the hospital.

4. The report of rate revenue and expense shall also contain the following information:

a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution. This will be supplemented by a statement of budgeted increases in charges, revenue and aggregate rates for the budget year including these items:

(1) Date(s) on which gross charges, and gross revenue, ~~and aggregate rates~~ will be adjusted.

(3) For each such date, the resulting aggregate dollar and weight average percent of increase in budget year total hospital gross revenues.

5. If a hospital maintains its accounts in a way which necessarily results in detailed statements of income, expense and statistics differing in form and content from those recommended by this rule and 7 MCAR § 1.481 A. 1., the hospital may substitute the information it has available. However, in all such cases the hospital shall submit a detailed reconciliation of the differences between the two sets of information and presentations in conjunction with the rate revenue and expense report.

C. Interim increase reports.

4. Statistical information for each period established by 7 MCAR § 1.474 C. 3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to 7 MCAR § 1.474 B.2., and 5., which shall be recorded for each period stated by 7 MCAR § 1.474 C. 3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

5. Financial information for each period established by 7 MCAR § 1.474 C. 3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to 7 MCAR § 1.474 B. 3. and 5., which shall be recorded for each period stated by 7 MCAR § 1.474 C. 3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

§ 1.475 Experimental Alternative Reporting Requirements. Each hospital meeting the criteria specified in paragraph A of this sec-

tion may file annual Rate Revenue and Expense Reports and interim increase reports according to paragraph B of this section, in lieu of information required under §§ 1.474 B. 2. and 1.474 B. 3.

A. Selection Criteria. Non-state non-federal acute care hospitals licensed in the State of Minnesota are eligible if they belong to the set of hospitals comprising 15% of the total gross acute (inpatient plus outpatient) charges for all non-state non-federal acute care hospitals in the State. Determination of the hospitals to be included in the set of hospitals comprising 15% of total state gross acute charges shall be made as follows:

1. The total gross acute charges used shall be for the prior year, pursuant to 7 MCAR § 1.474 B. 1. a., and shall be adjusted to represent a December 31 fiscal year end.

2. The hospital with the lowest total gross acute charges shall be selected first. The hospital with the second lowest total gross acute charges shall be selected second and its gross acute charges shall be added to the first selected hospital's. The hospital with the third lowest gross acute charges shall be selected third and its total gross acute charges shall be added to the sum of the gross acute charges of the hospitals selected first and second. The procedure shall continue in direct ascending order so as to maximize the number of hospitals included, but the sum of gross patient charges included shall not exceed 15% of the total gross acute charges for all non-state and non-federal acute care hospitals.

B. Rate Revenue and Expense Report.

1. Each hospital shall submit a report of rate, revenue and expense pursuant to 7 MCAR § 1.481 C. This report shall include statistical and financial information for:

a. The prior year as provided by 7 MCAR § 1.474 B. 1. a.

b. The current year as provided by 7 MCAR § 1.474 B. 1. b.

c. The budget year as provided by 7 MCAR § 1.474 B. 1. c.

2. Statistical information submitted in the rate revenue and expense report shall include:

a. The number of inpatient days for the hospital.

b. The number of admissions for the hospital.

c. The average number of full-time-equivalent employees during each accounting period for the hospital. An employee or any combination of employees which is reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employee.

d. The number of beds licensed, the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital.

e. The number of outpatient visits for the hospital.

3. Financial information submitted in the rate revenue and expense report shall include:

a. An interim financial statement as provided by § 1.474 B. 3. a.

b. A statement of expenses for the hospital according to natural classifications of expenses as provided by 7 MCAR § 1.474 A. 2. a. (6).

c. A statement indicating the accounting method used to allocate expenses from among the "non-revenue producing centers" to "revenue producing centers" as provided by 7 MCAR § 1.474 B. 3. c.

d. A statement of total "direct" and "indirect" costs and revenues where applicable for the hospital and for each of the following, both before and after allocation of indirect expenses:

(1) Daily services

(2) Ancillary services

(3) Non-revenue producing services

e. A statement of the accounts receivable by type of purchaser of services.

f. A statement of the capital budget of the hospital.

g. All information as provided by 7 MCAR § 1.474 B. 4. & 5.

C. Interim Increase Reports.

1. Interim increase reports shall be filed as required under 7 MCAR § 1.474 C.1. and 2.

2. Statistical and financial information shall be filed as required under 7 MCAR §§ 1.474 C. 3., 4., 5., and 6., except when in conflict with information required in the rate revenue and expense report as provided by 7 MCAR § 1.475 B. In such circumstances, the information required by 7 MCAR § 1.475 B. shall be the required information.

D. Review and Comment. The review and comment upon all experimental reports reviewed pursuant to 7 MCAR § 1.475 B. and C. shall be conducted and made as stated in 7 MCAR § 1.487 C. 2., with the exceptions of 7 MCAR §§ 1.487 C. 2. b. (1) (c) and 1.487 C. 2. b. (2) (b). The following shall substitute for 7 MCAR §§ 1.487 C. 2. b. (1) (c) and 1.487 C. 2. b. (2) (b):

1. Aggregate rate and costs and components of aggregate rates and costs have been demonstrated by the hospital to be consistant or inconsistant with the operating expenses found in 7 MCAR § 1.487 A. [1. a. (1), (2), (3), (4), (5)(a)(i)(ii); b. (1)(a)(5), (6), (7); 3., 4.] plus a maximum of 5% of reasonable operating expenses in lieu of 7 MCAR § 1.487 A. 1. [b. (1)(b), (2), (3), (4) and c.].

2. Sixty-six percent of the 5% plus factor provided in 7 MCAR § 1.475 D.1. shall be placed in an identifiable depreciation fund and may be used in the manner prescribed in 7 MCAR § 1.487 A. 1. b. and A. 1. b. (i).

E. Aspects of the Experiment.

1. The alternative experimental reporting requirements shall remain in force for a period of four years (four complete reporting cycles) commencing with the effective date of these rules.

2. At the close of the third year of the experiment an evaluation of the alternative reporting requirements shall be made by the Department of Health in conjunction with all approved voluntary, non-profit rate review organizations. The evaluation shall address the following, at a minimum:

a. The adequacy of the data,

b. Impact of the reduced data set on the quality of rate reviews,

c. The appropriateness of the set of hospitals chosen to participate in the experiment; and

d. The appropriateness of adopting the requirements permanently.

§ 1.487 Investigations, Analysis and Review Standards.

A. Bases for judging the reasonable use of finances in a hospital. In all investigations, analyses, and reviews conducted pursuant to Minn. Stat. §§ 144.695-144.703, and these rules, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of these rules, hospitals shall address the contents of their reports to and indicate their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses and reviews following these established bases.

1. Financial Requirements of Hospitals. The gross rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories:

a. Current operating needs related to patient care. In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

(5) Bad debt, charity allowances, and contractual allowances.

(a) Gross Rrates should provide finances necessary to recover losses in gross revenue due to bad debts, charity allowances, and governmental contractual allowances.

(iii) "~~Contractual~~ Governmental contractual allowances," ~~"cost-justified-discounts"-and-"non-cost-justified discounts,"~~ are those discounts from the established gross charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by Title V, Title XVIII and Title XIX of the United States Social Security Act.

~~(aa)-"Governmental-contract-adjustments" are-those-discounts-from-the-established-charges-required-due-to governmental-reimbursement-practices-established-pursuant-to-regulations-authorized-by-such-governmental-programs-as-those-created by-Title-V,-Title-XVIII-and-Title-XIX-of-the-United-States-Social Security-Act;~~

~~(bb)-"Cost-justified-discounts"-or "differentials"-means-those-cash,-trade,-or-quantity-discounts-or differentials-from-the-established-charges.--In-order-to-include the-amount-of-these-discounts-or-differentials-in-rates,-hospitals shall-demonstrate-that-the-value,-as-measured-in-money,-of-services or-other-benefits-for-an-accounting-period-provided-by-certain patients,-groups-of-patients,-or-third-party-payors-to-the-hospital is-equal-to-or-greater-than-the-aggregated-amount,-as-measured-in money,-of-the-differential-or-discount-granted-to-certain-patients, groups-of-patients-or-third-party-payors-for-that-same-accounting period.~~

~~(cc)-Discounts-or-differentials-which are-not-cost-justified-in-a-manner-consistent-with-7-MCAR-§-1.487 A.-1.-a.-(5)(a)(iii)(bb),-above,-shall-not-be-included-in-rates-but shall-be-treated-as-reductions-in-revenue-and-recorded-by-the-hospital-as-such.~~

(b) The losses in revenues due to bad debts, charity allowances, and governmental contractual allowances should be offset by available and applicable income from sources other than patients, as identified by 7 MCAR § 1.487 A. 2., before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs.

(6) "Discounts" and/or "price differentials" are those discounts and/or prices granted and/or charged to certain payors (patients, groups of patients, or third party payors), which result in receipts by a hospital of something less than the average expected dollar amount received for services rendered of comparable type, kind, and quality in the absence of such discounts and/or prices. These discounts and/or price differentials shall be classified as either cost justified or non-cost justified.

(a) "Cost justified discounts" and/or "cost justified price differentials" are discounts and/or price differentials, as measured in dollars, for the services and/or other benefits given to a hospital by a payer during an accounting period. Cost reducing benefits and services that shall be considered in a determination of whether a discount is cost justified include:

(i) Hospital administration;

(aa) Payer admitting requirements,

(bb) Payer accounting and audit requirements,

(cc) Payer billing costs,

(ii) Hospital working capital requirements;

(aa) Cash and prepayment,

(bb) The length of time taken to pay bills; and

(iii) Other cost reducing activities undertaken by specific payers that do not simply and inequitably shift costs from one payer to another (primary consideration should be given to activities that serve the long-range interests of a system-wide reduction of hospital costs).

(b) "Non-cost justified discounts" and/or "non-cost justified price differentials" are all other discounts and/or price differentials that are not cost justified in a manner consistent with 7 MCAR § 1.487 A. 1. a. 6. (a).

(c) "Cost justified discounts" and/or "price differentials" shall be granted to payers for hospital services and may be included in a hospital's financial requirements if:

(i) The amount of the discounts or price differentials as measured in dollars is equal to or less than the value of services or other benefits given to a hospital by a payer during accounting period; and

(ii) The dollar value, per adjusted admission, of the services or other benefits offered to a hospital by a payer is first subtracted from the average cost (which includes the cost saving associated with the service or of benefit given) per adjusted admission for all patients.

(d) "Non-cost justified discounts" and/or "non-cost justified price differentials" shall not be included in a hospital's financial requirements.

b. Plant capital needs. Rates should provide the finances necessary for various plant capital needs. In order to include plant capital needs in rates, the hospital must fund the plant capital requirement and be in receipt of a certificate of need as required by Minn. Stat. §§ 145.71-145.84. Funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

(1) Finances which relate to land, land improvement, building and building equipment and movable equipment shall be placed in an identifiable fund. The use of the fund shall be restricted to debt principal retirement, new plant and equipment (with certificate of need approval if necessary), major repairs (that are capitalized), replacement of capital equipment (with certificate of need approval if necessary), Hill-Burton free-care expenses in excess of those accounted for by 7 MCAR § 1.487 A. 1. a. (5)(a)(iii) and all other free-care (not to exceed 3% of operating expenses net of medicare and medicaid expenses). The annual increment to this fund should be:

(b) Plus ~~inflation-factors~~, an amount annually determined (for each hospital) ~~and~~ to be consistent with the established useful lives of land improvements, buildings, building equipment, and movable equipment. ~~These inflation factors~~ This amount shall be determined ~~by the system on the basis of a price level adjustment~~ as follows: ~~index recognized by independent public appraisers as expressing the annual price level adjustment from historical cost of~~

~~hospital land improvements, buildings, hospital building equipment and movable equipment. The system shall derive these factors from any of the most current indices then available to the system which give specific recognition to the following factors:~~

(i) An index or cumulative index determined by the system and recognized by independent public appraisers as expressing the annual effects of inflation upon historical cost from the year of purchase of hospital land improvements, buildings, hospital building equipment and movable equipment and shall be multiplied by an asset(s) annual depreciation expense.

(ii) The index for the budget year's expected annual depreciation expense shall not exceed 1.04.

(c) The system shall derive these indices from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing land improvements, buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, land improvements, building equipment, and movable equipment.

2. ~~Income~~ Restricted and unrestricted funds from sources other than patients. In all investigations, analyses, and reviews conducted pursuant to these rules, the system shall recognize that hospitals have sources of ~~income~~ funds other than patients which are intended to be or may be used for the reduction of its rates. In meeting the reporting requirements of these rules, hospitals shall disclose the

extent of which ~~this income is~~ these funds are used to offset costs and to provide service in such a manner as to reduce gross rates charged patients. This income includes:

a. Restricted endowment funds, specific purpose funds, tax funds (tax receipts or appropriations received) and gifts.

(1) ~~Income~~ Monies from endowment funds, or and/or gifts, restricted by donors or monies generated by taxes ~~restricted by donors~~ to provide for services for designated patients should be used to reduce the payment for those services.

(2) ~~Income~~ Monies from endowment funds, or and/or gifts restricted by donors or monies generated by taxes to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, (this may include debt principal retirement) as appropriate.

(3) Monies from endowment funds, and/or gifts restricted by donors or monies generated by taxes to provide for operating expenses should be used to reduce payments for operating expenses.

b. Unrestricted funds from non-patient sources. Unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital. Exceptions to this rule may be granted if the hospital can show that alternative uses of these funds are to the economic benefit of current patients and/or are in the best interests of the community served.

~~3. Variations from budgeted volumes of activity and service: Changes in the aggregate rate may be necessary due to variations from budgeted volumes of activity and service. The financial requirements of a hospital for a budget year should reflect adjustments in volumes of activity and service realized during the prior and current years.~~

~~a. If a hospital over projects its volume in a service center, in the next year its financial requirements should be increased by an amount equal to the ratio of fixed to total costs for that service center multiplied by the income loss due to unrealized activity.~~

~~b. If a hospital under projects its volume in a service center, in the next year its financial requirements should be reduced by the ratio of fixed to total costs of that service center multiplied by the income loss due to unrealized activity.~~

~~c. The system proposes three alternative procedures for identifying the costs related to increased volume or reduction in expenses anticipated resulting from decreases in volume as compared to original budget forecast.~~

~~(1) Alternative 1. The system will establish different fixed to variable expense ratios for different peer groups of hospitals. The ratios will vary from 80%/40% and shall be applied to hospitals in a manner consistent with the hospital's size and complexity of services. The fixed to variable expense ratio will be applied to total patient admissions adjusted for outpatient activity, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.~~

~~(2) Alternative 2. In the event that an individual hospital identifies that its fixed to variable expense ratio differs significantly in aggregate total from that established by the system, that hospital may submit supporting data to the system requesting a fixed to variable ratio different than that adopted for its peer group. In such cases, the system may approve a fixed to~~

~~variable-expense-ratio-other-than-that-established-under-7-MCAR § 1.487 A. 3. c. (1). Under this alternative, the fixed-to-variable ratio would be applied to adjusted patient admissions, with the adjustment based on the ratio of outpatient revenues to inpatient revenues. Revenue and rate adjustment based on volume variance within the provisions of Alternative 1 and 2 can be made on aggregate average annual rates per adjusted patient admissions. These rates, based on total approved budget, are identified at the time of the budget review.~~

~~(3) Alternative 3. In the event that a hospital has identified that its operating expenses by service center depart drastically from the fixed-to-variable expense ratio at the aggregate level, such a hospital may submit supporting data to the system establishing a different fixed-to-variable expense ratio for each service center. In such instances, the volume variances would be measured according to the unit of service established for each service center, and the expense adjustment allowance would be based on the ratio of fixed-to-variable expenses for each service center, rather than on the aggregate overall average expenses and per adjusted admission.~~

3. Variations from budgeted revenue and expense. Changes in aggregate rates may be necessary due to variations from budgeted volume and mix of services, and assumptions about future input prices. The financial requirements of a hospital for a budget year should reflect variations from budgeted revenue and expense as depicted by actual experience in the current and prior years.

a. If actual reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b., as reconciled to an audit, are in excess of actual reasonable revenues, as reconciled to an audit, pursuant to 7 MCAR § 1.487 C. 2. b., by a greater margin than was previously budgeted in the year in question, then the excess may be included in the forthcoming budget year's reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b.

b. If actual reasonable revenues pursuant to 7 MCAR § 1.487 C. 2. b., as reconciled to an audit, are in excess of actual reasonable financial requirements, as reconciled to an audit, pursuant to 7 MCAR § 1.487 C. 2. b., for the year in question, then the excess may be used to offset the forthcoming budget year's reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b.

c. When adjusting the forthcoming year's budgeted reasonable financial requirements pursuant to 7 MCAR § 1.487 C. 2. b. for the conditions described in 7 MCAR §§ 1.487 3. a. and 1.487 3. b.:

(1) Hospitals should not benefit from unanticipated gains resulting from under estimates of projected reasonable revenues, and/or volume, and/or over estimates of the costs of services delivered pursuant to 7 MCAR § 1.487 C. 2. b., however, hospitals should benefit from productivity increases that reduce the reasonable cost of delivered and/or offered services pursuant to 7 MCAR § 1.487 C. 2. b.

(2) Hospitals should not be penalized for incurring unanticipated losses resulting from over estimates of reasonable volume, and/or revenue, and/or under estimates of the reasonable costs of services delivered (when compared to the allowable increase limit

adjusted for actual inflation for the relevant period), however, hospitals should not carry forward losses that result from conditions that should have been averted and/or decreases in productivity.

(3) If current year estimates of unanticipated losses exceed .005 times the hospital's operating budget, then that amount in excess of the loss estimated in the budget year may be carried forward to the forthcoming budget year. The estimated loss carried forward from the budget year must be reconciled to an audit in a subsequent filing (when the budget year becomes the prior year).

C. Review of reports.

2. Review of rate revenue and expense reports and interim increase reports.

b. Comment. The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public prior to the implementation of proposed budgets or aggregate rates. The comment shall state that a hospital's existing and proposed aggregate rates are reasonable or are in question.

(1) Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(a) Aggregate Rrates and components of aggregate rates are similar to the average of the aggregate rates and components of aggregate rates in effect in the prior year for other hospitals in a peer group;

(b) Prospective aggregate rates and components of prospective aggregate rates represent a minimal increase which is consistent with ~~the principles of the bases for judging~~ the allowable increase limit established by 7 MCAR § ~~1.487 A.~~ 1.504;

(c) Aggregate rates and components of aggregate rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by 7 MCAR § 1.487 A.

(d) Aggregate costs and components of aggregate costs are similar to the average of the aggregate costs and components of aggregate costs incurred by other hospitals in a peer group during the prior year;

(e) Prospective aggregate costs and components of prospective aggregate costs represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504 and components of the allowable increase limit that corresponds to natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6).

(f) Aggregate costs and components of aggregate costs have been demonstrated by the hospital to be necessary and consistent with the priniciples for judging established by 7 MCAR § 1.487 A.;

(g) Total prior and current year's actual aggregate rates and costs are similar to prior and current year's budgeted aggregate rates and costs;

(h) Actual and budgeted costs and revenues for each service center are similar.

(2) Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(a) Aggregate Rrates and components of aggregate rates deviate from the average of the aggregate rates and components of aggregate rates then in effect in the prior year for other hospitals in a peer group;

(b) ~~Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by 7 MCAR § 1.487 A.~~ Prospective aggregate rates and components of prospective aggregate rates do not represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504;

(c) Rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles of the bases for judging established by 7 MCAR § 1.487 A.;

(d) Aggregate costs and components of aggregate costs are not similar to the average of the aggregate costs incurred for other hospitals in a peer group during the prior year;

(e) Prospective aggregate costs and components of prospective aggregate costs do not represent a minimal increase which is consistent with the allowable increase limit established in 7 MCAR § 1.504 and components of the allowable increase limit that corresponds to natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6).;

(f) Aggregate costs and components of aggregate costs have not been demonstrated by the hospital to be necessary and consistent with the principles for judging established by 7 MCAR § 1.487 A.;

(g) Total prior and current year's actual aggregate rates and costs are not similar to prior and current year's budget aggregate rates and costs;

(h) Actual and budgeted costs and revenues for each service center are not similar.

§ 1.504 Commissioner of Health determination of allowable increase limit.

E. Form. The quarterly allowable increase limit is a single percentage figure which is applicable to the average ~~charges per inpatient admission~~ aggregate rate and average aggregate cost for the hospital.

F. Basis. This single percentage figure is based upon the averaged ~~monthly~~ quarterly Consumer and/or Wholesale Price ~~Index~~ Indices, and/or relevant components of the Consumer, Wholesale Price or other appropriate economic indices representing natural expense categories presented in 7 MCAR § 1.474 A. 2. a. (6), as published by the Division of Labor Statistics, U.S. Department of Commerce, stated as percent changes, for relevant previous quarters preceding the establishment of a quarterly allowable increase limit.

G. Compensation. Should quarterly allowable increase limits prospectively established by the Commissioner according to these rules allow increases in aggregate rates in excess or less than any actual increases in the Consumer and/or Wholesale Price ~~Index~~ Indices, or relevant components of these indices the Commissioner may compensate for this excess by:

2. Adding or reducing by a reasonable proportion of that difference the next set of quarterly allowable increase limits to be established by the Commissioner.

§ 1.509 Fees.

A. Rate revenue and expense report fee. On each occasion which a hospital submits a rate revenue and expense report to the Commissioner of Health as distinct from a voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

~~If the Number of Licensed Acute Care Beds of the Hospital Is:~~	~~Then the Filing Fee Is:~~
~~6 to 24~~	~~$ 385.00~~
~~25 to 49~~	~~$ 495.00~~
~~50 to 99~~	~~$ 710.00~~
~~100 to 149~~	~~$ 930.00~~
~~150 to 199~~	~~$1,150.00~~
~~200 to 249~~	~~$1,370.00~~
~~250 to 299~~	~~$1,590.00~~
~~300 to 349~~	~~$1,810.00~~
~~350 to 399~~	~~$2,025.00~~
~~400 to 449~~	~~$2,250.00~~
~~450 to 499~~	~~$2,470.00~~
~~500 or over~~	~~$2,685.00~~

Hospital Gross Revenue	Filing Fee Is:
Under $2,500,000	.0005 Times Gross Revenue or $200 (which ever is less) to a Maximum of $800
$2,500,000 - $19,999,999	.0004 Times Gross Revenue to a Maximum of $5,500
$20,000,000 +	.0003 Times Gross Revenue to a Maximum of $7,500

EXHIBIT A

STATE OF MINNESOTA
COUNTY OF RAMSEY

In The Matter Of A Proposed Rule Relating to Charges for Examination Fees of Health Maintenance Organizations

and

In the Matter of Proposed Amendments to the Rules Relating to the Minnesota Hospital Rate Review System

CERTIFICATE

I hereby certify that the attached 488 labels, 9 sheets constitute the complete list of persons, associations, and other interested groups who as of 11:30 o'clock A.M, this 27th day of July, 1978, have requested pursuant to M.S. 1976, 15.0412, that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

Secretary of State

Joan Anderson Growe

By Cheri L. Mattson

EXHIBIT A

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AHOLA DEBRA
616 LINCOLN AVE APT 307
ST PAUL MN
55102

ALBERT,AA CALDER CORP
366 JACKSON ST
ST PAUL MN
55101

ALLIN M KARLS
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MPLS MN
55414

ALLENDORF MARSHALL
220 GRAIN EX 400 S 4TH
MPLS MN
55415

ALLERS JOHN
1501 W 80TH ST SUITE210
BLOOMINGTON MN
55431

AMER CAMPING ASSN
3639-21/2 ST N.E.
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55418

AM INST PROF GEOLOGISTS
2201 PRINCETON AVE
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55105

ANCHOR BLOCK COMPANY
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ST PAUL MN
55165

ANDERSON DEBRA
1115 E RIVER ROAD
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55414

ANDERSON HERBERT
418 8TH ST. SO.
VIRGINIA MN
55792

ANDERSON HAROLD
P.O. BOX 3047
MANKATO MN
56001

ANDERSON JAMES
7703 NORMANDALE RD
MPLS MN
55435

ANDERSON MARY
4425 RUTLEDGE AVE
EDINA MN
55436

ANDERSON STANFORD P
14600 MINNETONKA BLVD
MINNETONKA MN
55343

ANTHONY DICK WDSM RADIO
230 E SUPR ST
DULUTH MN
55102

ANTI-TRUST DIV.ATTY GEN.
160 STATE OFF BLDG
ST PAUL MN
55155

ARNOLD ROBERT MESPA
41 SHERBURNE
ST PAUL MN
55103

ARROWHEAD ECONOMIC OP AGE
CO S BRUSTUN BOX 1066
VIRGINIA MN
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ARROWHEAD REG. DEV COMM.
211 W 2ND ST
DULUTH MN
55802

ARROWHEAD REGIONAL DEV COMM
200 ARROWHEAD PLACE
DULUTH MN
55802

ASH GEORGE
3040 OTTAWA STREET
ST LOUIS PARK MN
55416

ASMUSSEN,DENNIS,MPIRG
3036 UNIV AVE SE
MPLS MN
55414

ASSOCIATED GEN CONTROF MN
48 E 8TH STREET
ST PAUL MN
55101

ASSN OF MINN COUNTIES
55 SHEREURNE AVE #203
ST PAUL MN
55103

ASSN RESIDENCES FOR RETARDED
459 RICE SUITE 301
ST PAUL MN
55103

BABCOCK LOCHER NELSON ET AL
118 E MAIN ST
ANOKA MN
55303

BADALICH JOHN P
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SC ST PAUL MN
55075

BARATTO DIVINE M
1192 BUSH ST
ST PAUL MN
55106

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BEMIDJI STATE COLLEGE

118 E MAIN ST
ANOKA MN
55303

2025 THOMPSON AVE
SC ST PAUL MN
55075

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BARTHOLOW HAROLD E FIRE CHF
2400 LOG AVE N W
COON RAPIDS MN
55433

BECK PAT
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ST PAUL MN
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BEGALKA D REV
212 N ELK ST
BELLE PLAINE MN
56011

BEMIDJI STATE COLLEGE
PLACEMENT BUR.J.C.BRADY
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BENDA GEORGE
RURAL ROUTE 1
ALPHA MN
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BERGERUD ALF
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MPLS MN
55402

BERGSETH THOMAS
1011 NICOLLET MALL
MPLS MN
55403

BEST FLANAGAN ET AL
4040 IDS CENTER
MPLS MN
55402

BEUTEL ROBERT
2200 SILVER LAKE RD
NEW BRIGHTON MN
55112

BINGHAM KE CRIM JUSTICE COUN
351CITY HALL ANNEX
ST PAUL MN
55102

BLADIN PAPER CO W J LICKE
115 1ST ST SW
GRAND RAPIDS MN
55744

BLOMQUIST BARRY L

NORTH BRANCH MN
55056

BLOOMINGTON CITY CLERK
2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
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BOWMAN & BRUNS ATTN P MASON
1616 PIONEER BLDG
ST PAUL MN
55101

BREHL JAMES W
332 HAMM BLDG
ST PAUL MN
55102

BRICK PHILIP D
807 SELLWOOD BLDG
DULUTH MN
55802

BRIGGS & MORGAN - B F FRIEL
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2850METRO DR. SUITE 504
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BROOKS WILLIAM F JR
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MPLS MN
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BROWN D M GOODRIDGE PUB S
IND DIST #561
GOODRIDGE MN
56725

BROWN H D
4921 KINGSBERRY LANE
MINNETONKA MN
55343

BRUBACHER RICHARD COMM ADM
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BRUNING C.R.DEPT.CLINIC.EXP.
BURTON HALL
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BUR.ENGR.IND.DIV. MR.KIBIGER
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55407

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MPLS MN
55402

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COTTAGE GROVE MN
55016

CARLSON VERNE E
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WILLMAR MN
56201

CARRISON DALE K
MANKATO STATE COLLEGE
MANKATO MN
56001

CHAMBER OF COMMERCE
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ELY MN
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CHERCHES CHRIS CITY MGR
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55104

CHRISTIANSEN FREDRIK
RM 505 CAPITOL SQ BLDG
ST PAUL MN
55155

CHRYSALIS CENTER FOR WOMEN
2104 STEVENS AVE S
MPLS MN
55404

CITY CLERK
386 CITY HALL
ST PAUL MN
55102

CITIZENS LEAGUE
530 SYNDICATE BLDG
MPLS MN
55402

CITY OF ROBBINSDALE
C LARSON 4221 LAKE RD
ROBBINSDALE MN
55422

CLARKSON J.B.
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MINNEAPOLIS MN
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2307 STANDISH ST
ST PAUL MN
55108

CLAWSON CONNIE
HELP CT 317-17TH AV SE
MPLS MN

C LARSON 4221 LAKE RD
ROBBINSDALE MN
55422

COLEMAN NICHOLAS
208 STATE CAPITOL
ST PAUL MN
55155

CONCORDIA COLLEGE
DEAN
MOORHEAD MN
56560

CROW WING CO PLANNING & ADV
COURT HOUSE
BRAINERD MN
56401

DAILEY THOMAS ECONOMICS LAB
370 WABASHA ST
ST PAUL MN
55102

DAYTON CHAS SIERRA CLUB
800 MIDLAND BANK BLDG
MPLS MN
55401

DISPATCH PIONEER PRESS
PRESS RM STATE CAPITOL
ST PAUL MN
55101

DUNN OLIVER PLUMBERS LOC 15
708 SO 10TH ST
MPLS MN
55404

E CENTRAL REG. DEV. COMM
COURTHOUSE 18 N VINE ST
HINCKLEY MN
55037

EICHTEN DANIEL
3794 HAZEL
WHITE BEAR LK MN
55110

EMERICK RICHARD A
1900 IDS CENTER
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55402

ERNEST K LEHMANN & ASSOC.
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55706

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CHASKA MN
55318

CONSUMER SERVICES DEPT COMM
5TH FLR METRO SQ BLDG
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55101

CUSHMAN J S DAYTON HUDSON
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MPLS MN
55402

DANKERS, KENNETH
1200 WEST FOURTH STREET
RED WING MN
55066

DEVELOP DISABILITIES PROGRAM
STATE PLAN 101 CAP SQ
ST PAUL MN
55155

DORSEY MARQUART
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MPLS MN
55402

DUPONT MIKE
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INTL FALLS MN
56649

ESSE KENNETH
4801 W 50TH ST
EDINA MN
55424

ST PAUL MN
55108

COLLIN LAURENCE
RT 2
ISANTI MN
55040

COUNTY ATTYS COUNCIL
40 NO MILTON ST STE 106
ST PAUL MN
55104

DANIELSON RODNEY L
418 AUDITORIUM
ST PAUL MN
55102

DICKINSON MRS JOANNE
BOX 1065
MARSHALL MN
56258

DOUGLAS BELL ET AL
2212 AM.NATL BK BLDG
ST PAUL MN
55102

DZUGAN KEN ST PAUL PLANNING
421 WABASHA ST
ST PAUL MN
55102

ECKLUND WM EELLHABER-LARSON
W 1080 1ST NATL BANK
ST PAUL MN
55101

ELDRED R W ARMOUR & CO
UNION STOCK YARDS
SO ST PAUL MN
55075

ENV SERV-GEN RESOURCE CORP
6340 INDUSTRIAL DR
HOPKINS MN
55343

ETHICS COMM
RM 410 STATE OFF BLDG
ST PAUL MN
55155

FAEGRE & BENSON ATTN LIBR
2300 NW BANK BLDG
MPLS MN
55402

MPLS MN

COMMUNITY DESIGN CENTER
118 E 26TH ST
MPLS MN
55404

CRAVEN NORMAN
10637 THOMAS AVE S
BLOOMINGTON MN
55431

DAHLKE LOIS M
118 S EAGLE ST
BELLE PLAINE MN
56011

DAWSON JEAN MN GOV'T REP
ROOM B12 CAPITOL
ST PAUL MN
55155

DIEHL JOHN
26 KENWOOD PKWY
ST PAUL MN
55105

DOW CHEMICAL
47 BLDG
MIDLAND MI
48640

EDEVOLD RUTH
PO BOX 248
BEMIDJI MN
56601

ELMER EDWIN W
2901 PLEASANT AVE
MPLS MN
55408

ERDMAN ROGER TENNANT CO
701 N LILAC DR
MPLS MN
55441

EVANS CHAS.L. PRENTICE-H
ENGELWOOD CLIFFS
NEW JERSEY

FARMERS ELEVATOR ASSN
852 GRAIN EXCH BLDG
MPLS MN
55415

BRITT MN
55706

MPLS MN
55402

MPLS MN
55415

FARRELL FRANK BUR NOR
RM 1180 176 E 5TH ST
ST PAUL MN
55101

FARSETH PAUL FOOD STAMPS PRO
WELFARE DEPT 690 N ROBT
ST PAUL MN

FELHABER R S
W 1ST NATL BANK BLDG
ST PAUL MN
55101

FILTER LOREN
BOX 36
BRITT MN
55701

FINLEY JAMES F
920 MINN BLDG
ST PAUL MN
55101

FINNEGAN J.R.
55 E. 4TH
ST.PAUL MN
55101

FITZGERALD DR BOB
3007 LYNDALE AVE SO
MPLS MN
55408

FITZPATRICK LEO
8138 HENSLOWE AVE S
COTTAGE GROVE MN
55016

FLEMING FREDERICK A
1860 HIGHLAND PARKWAY
ST PAUL MN
55116

FLADLAND CLINT MN L&P BUR
795 RAYMOND AVE
ST PAUL MN
55114

FORBES GORDON MINN RRS ASSN
203 HANOVER 480 CEDAR
ST PAUL MN
55101

FORSBERG AGR SERV
518 SUMMIT AVE
NEW ULM MN
56073

FOX w.E. LINDQUIST & VENNUM
4200 IDSCTR 80 S.8TH ST
MINNEAPOLIS MN
55402

FRANKLIN ROBERT B MPLS TRIB
426 PORTLAND
MPLS MN
55415

FREDIN CONRAD M
811 FIRST NATL BK BLDG
DULUTH MN
55802

FREDLUND MRS PHYLLIS
RR 4 BOX 37
CANBY MN
56220

FREDRIKSON BYRON ET AL
47TH FLR IDS CENTER M
PLS MN
55402

FRIESEN MILLER A
RMR 80 624 13TH ST S
VIRIGINIA MN
55792

FRISON FRANK NECA
RM 305 200 SO ROBERT
ST PAUL MN
55107

GALVIN M J JR
W2162 1ST NATL BK BLDG
ST PAUL MN
55101

GARDNER HDW - R A JOHNSON
515 WASHINGTON AVE N
MPLS MN
55401

GEBERT K L
220 GRAIN EXCH
MPLS MN
55415

GEO A HORMEL & CO LAW DE
PO BOX 800
AUSTIN MN
55912

GIEL DAVID
RM B-28 STATE CAPITOL
ST PAUL MN
55155

GLEESON MICHAEL
909 SOC SC BLDG U OF M
MPLS MN
55455

GLEN. HILLS HOSP.R.VAN HAUER
3901 GOLDEN VALLEY RD.
MPLS. MN
55422

GODIN RALPH J
3824 47TH AVE SO
MPLS MN
55406

GOLDBERG PROF MELVIN
W4 MITCHELL COL OF LAW
ST PAUL MN
55105

GOODMAN DF TEL CABLE TV
302 E SUPERIOR
DULUTH MN
55802

GRAHAM THOS H
854 MIDLAND BK BLDG
MPLS MN
55401

GRANATH MARVIN -HONEYWELL
2701 4TH AVE SO
MPLS MN
55408

GREATER MET AREA HOSPITALITY
5152 CEDAR AVE S
MPLS MN
55417

GREEN DEL CITY MGR
BLOOMINGTON CITY HALL
BLOOMINGTON MN
55431

GREEN GARY J
41 SHERBURNE AVE
ST PAUL MN
55102

GREEN JANET
9773 N SHORE DR
DULUTH MN
55804

GRUMMERT REV DONALD
1435 ADAMS ST
MPLS MN
55413

GUSTAFSON DAN-LABOR TEMPLE
312 CENTRAL
MPLS MN
55414

GUSTAFSON WALLACE
BOX 567
WILLMAR MN
56201

H B FULLER CO
2400 KASOTA AVE
ST PAUL MN
55108

HALLBERG LEE & MCCABE
4927 34TH AVE S
MPLS MN
55417

HANFT PHILIP M
1200 ALWORTH BLDG
DULUTH MN
55802

HANSON WARREN A SKELGAS
PO BOX 1650
TULSA OK
74102

HAROLD J WESTIN CONSTRUCTORS
45 E 8TH ST
ST PAUL MN
55101

HARRY RICK
RT 1 BOX 138
KETTLE RIVER MN
55757

HAUN DR J W GEN MILLS
PO BOX 1113
MPLS MN
55440

HAYES, THOMAS W
700 SELLWOOD BLG
DULUTH MN
55812

ST PAUL MN
55101

KETTLE RIVER MN
55757

MPLS MN
55440

DULUTH MN
55812

HART PATRICK V
112 E LIBERTY BOX 3271
MANKATO MN
56001

HARTFELDT WILL
434 HAMM BLDG
ST PAUL MN
55102

HAVEN ROBT TWIN TN TREATMENT
1706 UNIV AVE
ST PAUL MN
55104

HEAD & TRUHN
1007 SOO LINE BLDG
MPLS MN
55402

HEADWATERS REG DEV. COMM
BOX 564 MENTAL HEALTH
BEMIDJI MN
56601

HEALTH MANPOWER C LARSON
717 DELAWARE ST SE
MPLS MN
55440

HEANEY BILL
30 W SUPERIOR ST
DULUTH MN
55802

HEARING EX.OFF. M GREENBE
1745 UNIV AVE
ST PAUL MN
55104

HEIM PAUL M
3944 IDS CENTER 80 S 8
MPLS MN
55402

HEISENFELT WM
BOX 516
BEMIDJI MN
56601

HELTZER JAMES DAYTON HUDSON
777 NICOLLET MALL
MPLS MN
55402

HENDRICKSON A WM
100 FREEMAN DRIVE
ST PETER MN
56082

HENDRICKSON MRS VIRGINIA
3324 COUNTRY WOOD DR
BURNSVILLE MN
55337

HINRICHSEN PATRICK
MANKATO FREE PRESS
MANKATO MN
56001

HOLEY GEORGE
1509 SW SIXTH STREET
FARIBAULT MN
55021

HOLMES EUSTIS ET AL
4610 IDS CENTER
MPLS MN
55402

HOPKINS W.D. DIR.MISSCA
3915 GOLDEN VALLEY ROAD
GOLDEN VALLEY MN
55422

HORNER WALDORF - KAZIUKEWICZ
PO BOX 3260
ST PAUL MN
55165

HOLT JOHN
517 4TH ST NW
FARIBUALT MN
55021

HOULE MELVIN
881 W HWY 96
SHOREVIEW MN
55112

HOUSE APPROPRIATIONS COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HULSTRAND ANDERSON & LARSON
PO BOX 130
WILLMAR MN
56201

HUMAN RIGHTS
200 CAPITOL SQ BLDG
ST PAUL MN
55101

HUSEBYE, CRAIG J.
5036 FRANCE S.
EDINA MN
55410

HUTCHISON R.M. ANOKA CO.COMP
COURT HOUSE
ANOKA MN
55303

HYLAND DEAN
1501 W 50TH ST
MPLS MN
55419

IMAGE
BOX 3215
ST PAUL MN
55165

IMS PAUL

ECHO MN

INGEBRIGTSEN DR K H
23 SE 4TH ST
MPLS MN
55414

INGVALSON VERN MN.FARM BU
1976 WOODDALE BOX 43370
ST PAUL MN
55164

INS FED OF MINN
902 SOO LINE BLDG
MPLS MN
55402

INTERSTATE POWER RW STEELE
1000 MAIN ST
DUBUQUE IA
52001

IVERSON DR JOS DEPT ED
ST OLAF COLLEGE
NORTHFIELD MN
55057

IZAAK WALTON MN DIV
111 E FRANKLIN RM-210
MPLS MN
55404

JAIN NIRMAL ENIV PROCESS
1220 GLENWOOD AVE
MPLS MN
55405

JENOS INC
525 LAKE AVE SO
DULUTH MN
55801

JENSEN ARTHUR,CITY CLK
2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
55431

JENSEN CARL A
127 E MAIN ST
SLEEPY EYE MN
56085

JENSEN MRS GAYNOLD
111 WEST 107TH ST
MPLS MN
55420

JOHANSEN BUS SERV INC
19 DAYTON RD
CHAMPLIN MN
55316

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

JOHNSON CLARENCE IBEW LU
3615 37TH AVE S
MPLS MN
55406

JOHNSON G ROBERT
4344 IDS CENTER
MPLS MN
55402

JOHNSON LEROY
9939 BLUEBIRD ST NW
COON RAPIDS MN
55433

JOHNSON M.D. FRUNDT & FRUNDT

BLUE EARTH MN
56013

JOHNSON LANCE J
265 S LAFAYETTE RD
ST PAUL MN
55107

KAHLE RICHARD W

KAVANEY RICHARD

MPLS MN
55402

CCON RAPIDS MN
55433

BLUE EARTH MN
56013

ST PAUL MN
55107

JONES C NORTHSIDE RES REDEV
1900 OLSON MEMORIAL HWY
MPLS MN
55411

KABLE RICHARD W

BETHEL MN
55006

KAVANEY RICHARD
1220 NORTHERN FED BLDG
ST PAUL MN
55102

KEABLE MIKE
909 6TH AVE N
ST CLOUD MN
56301

KEENAN RICHARD J
4444 IDS BLDG
MPLS MN
55402

KJERVIK DIANE
4302 POWEL HALL U OF M
MPLS MN

KLOSTER MARION PEAVEY CO
730 2ND AVE S
MPLS MN
55402

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNOPP TIMOTHY
COLLEGE FORESTRY U OF M
ST PAUL MN
55108

KNUTSON DR KEITH,BIOLOGY DPT
ST CLOUD STATE
ST CLOUD MN
56301

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KELLER MR & MRS ERWIN A
1568 DULUTH ST
ST PAUL MN
55108

KEPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

KRAMER ERNEST W
717 DELAWARE ST SE
MPLS MN
55440

KROEGER CHARLES
122 NW 7TH STREET
FARIBAULT MN
55021

KROHLOKKEN J E
10048 NORD RD
BLOOMINGTON MN
55437

KROON H CLIFTON
210 E WALNUT
MANKATO MN
56001

KVB ENGINEERING INC
600 S CO RD 18
MPLS MN
55426

LABELLE JUANITA MRS
5816 AQUILA AVE NO
NEW HOPE MN
55428

LAKE SUPERIOR INDUSTRIAL BUR
828 FIRST AM. BK. BLDG.
DULUTH MN
55802

LANAHAN E F - SIBLEY CO
184 E 6TH ST
ST PAUL MN
55101

LANGVIN DAVID
7500 80TH ST S
COTTAGE GROVE MN
55016

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LARSON C L
3800 MINNEHAHA AVE SO
MPLS MN
55406

LARSON HANS P DIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LEAGUE MN MUNIC
300 HANOVER 480 CEDAR
ST PAUL MN
55101

LEAGUE WOMEN VOTERS OF MINN
555 WABASHA
ST PAUL MN
55102

LEG.REF.LIB-Z. DEWITT
RM 111 STATE CAPITOL
ST PAUL MN
55155

LEVEY JESS MET STATE UNIV
METRO SQ RM 121
ST PAUL MN
55101

LEAVEY THOS
829 22ND AVE SE
MPLS MN
55414

LEWIS DR.G.W JR.
ABBOTT 110 E 18TH ST
MPLS MN
55403

LIBBEY LEONARD
BOX 17011 NOKOMIS STA
MPLS MN
55417

LINDALL & JONATHAN DEVELOP.
VILLAGE ONE CENTER
CHASKA MN
55318

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

LOWE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

LUTH SOC SERVICE OF MN
2414 PARK AVE
MPLS MN
55404

LYNCH DONALD SIBLEY CO
184 E 6TH ST
ST PAUL MN
55102

MACLIN ALAN ASST ATTY GEN
720 AMERICAN CENTE BLDG
ST PAUL MN
55101

MAHOF RICK CARTER
2850 METRO DR SUITE 431
BLOOMINGTON MN
55420

MALECKI JAMES
1 SO STATE ST
NEW ULM MN
56073

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANKATO STAT STUDENT SENATE
CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO STATE STUDENT ASSN
BOX 58 MANKATO COLLEGE
MANKATO MN
56001

MANTHEY T J PICKANDS MATH
1100 SUPERIOR AVE
CLEVELAND OH
44114

444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO MN
56001

CLEVELAND OH
44114

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MAYO FOUNDATION G ORWOLL
200 FIRST AVE NW
ROCHESTER MN
55901

MCCLURG EUNICE
1061 109TH AVE NE
BLAINE MN
55434

MCDONALD PHILIP M
2077 SELBY AVE
ST PAUL MN
55104

MCFADDEN G H DISPATCH-PRESS
55 E 4TH ST
ST PAUL MN
55101

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MCNEILLY GREG MNDSVIEW ED
41 SHERBURNE AVE
ST PAUL MN
55103

MET. WASTE CONTOL COMM.
350 METRO SQ BLG
ST PAUL MN
55101

MEIEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

MET TFR MEN ASSN A ROSENTHAL
1821 UNIV AVE
ST PAUL MN
55104

METROPOLITAN COUNCIL LIBR
300 METRO SQUARE
ST PAUL MN
55155

MEYER HERBERT
10824 ZENITH AVE S
BLOOMINGTON MN
55431

MIDLAND GLASS-HD SPURLING
PO BOX 69
SHAKOPEE MN
55379

MILLER M ADMIN AGENCIES DIV
G19K STATE ADM BLDG
ST PAUL MN
55155

MILLER PAUL J PHARMACY SE
ST MARYS HOSP
ROCHESTER MN
55901

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MINN ASPHALT PAVEMENT ASS
555 WABASHA RM 209
ST PAUL MN
55102

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERATIVES
4901 W 77TH ST
MPLS MN
55435

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN ASSN VOL SOC SERVICE
1821 UNIV SUITE 389
ST PAUL MN
55114

MINN ASSN WATERSHED DIST'S

ADA MN
56510

MINN CHAP ASSOC BLDRS-CONTRS
7204 W 27TH ST
MPLS MN
55426

MINN COMM FOR HANDICAPPED
METRO SQ 492 7TH & ROBT
ST PAUL MN
55101

MINN COMMUNITY DEVELOP SE
512 ROSSMOR BLDG
ST PAUL MN
55101

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINNESOTA FARMERS UNION
1717 UNIVERSITY AVE
ST PAUL MN
55104

MINN FOOD RETAILERS ASSN
555 WABASHA
ST PAUL MN
55101

MINN GOV ENG COUNCIL
2400 SHERWOOD HILL RD
MINNETONKA MN
55343

MINN HEREFORD-LJ SCHAFER

BUFFALO LAKE MN
55314

MINN. HOTEL & MTR. ASSN
2001 UNIVERSITY AVE
ST PAUL MN

MINN HWYS MANAGEMENT SERVICE
407 HWY BLDG
ST PAUL MN
55101

MINN LAND USE COMMITTEE
4344 IDS CENTER
MPLS MN
55402

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINN.MTR.TRANSP. .J.N.DENN
1821 UNIV.
ST.PAUL MN
55104

MINN PETROLEUM COUNCIL
1020 NORTHERN FED BLDG
ST PAUL MN
55102

MINN POLLUTION CONTROL AG
1935 W CO RD B2
ROSEVILLE MN
55113

MINN POULTRY & HATCHERY ASSN
BOX 158
MADELIA MN
56062

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN
55104

MINN RETAIL FED INS
131 METRO SP
ST PAUL MN
55101

MINN RETAIL HARDWARE ASSN
3233 EXCELSIOR BLVD 313
MPLS MN
55416

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE BD PHARMACY
717 DELAWARE ST SE #351
MPLS MN
55414

MINN STATE EMP UNION COUN
236 E PLATO BLVD
ST PAUL MN
55107

3313 EXCELSIOR BLVD 313
MPLS MN
55416

100 MINN FED BLDG
MPLS MN
55402

MPLS MN
55414

ST PAUL MN
55107

MINN STATE MEDICAL ASSOC
STE 900 AM NATL BK BLDG
STPAUL MN
55101

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MINN TEAMSTERS CREDIT UNION
2021 HENN AVE E
MPLS MN
55413

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN.TURKEY GROWERS ASSN
2383 UNIV AVE
ST PAUL MN
55114

MINN VETERANS MED ASSN
2175 W HWY 36
ROSEVILLE MN
55113

MINN WATER RESOURCES BD
RM 206 555 WABASHA ST
ST PAUL MN
55102

MINN-WISC BOUNDARY AREA C
600 2ND ST
HUDSON WI
54016

MN AUTOMOBILE DEALERS ASSN
277 UNIV AVE
ST PAUL MN
55103

MN. ASN.C&IND H.D.PETERSON
480 CEDAR ST.
ST.PAUL MN
55101

MN AFL-CIO L.O. LASHOMB
175 AURORA
ST PAUL MN
55103

MN.BD OF NURSING
717 DELAWARE ST SE
MPLS MN
55414

MN ELECTRICAL ASSN
3100 HUMBOLT SO
MPLS MN
55408

MN GRAPHIC DESIGNERS ASSO
PO BOX 24272
MPLS MN
55424

MN PUB INT RESEARCH GROUP
3036 UNIV AVE SE
MPLS MN
55414

MN SOC SERV ASS J HOOD
614 PORTLAND
ST PAUL MN
55102

MN ST PHARMACEUTICAL ASSN
2449 UNIVERSITY AVE
ST PAUL MN
55114

MN STATE SER BLIND-K NATARDY
1745 UNIVERSITY AVE
ST PAUL MN
55104

MIXA FRANK LK MNTKA CONS DIS
402 E LAKE ST
WAYZATA MN
55391

MOFFITT R C
RM 301 M MPLS CITYHALL
MPLS MN
55415

MOOD R BLOOMINGTON HLTH DEPT
13200 PENN SO
BLOOMINGTON MN
55431

MORTON BUILDINGS INC
R #1
FOLEY MN
56329

MOSS DR JEROME
125 PEIK 159 PILLSBURY
MPLS MN
55455

MOSTCA
PO BOX J
PERHAM MN
56573

MOTOR VEHICLE MFRS ASSN
411 MAIN ST (215)
ST PAUL MN
55102

MPIRG
BOX 45 ST MARYS COLLEGE
WINONA MN
55987

MPLS ASSN RETARDED CITIZENS
3100 W LAKE ST
MPLS MN
55416

MPLS CITY ATTORNEY
325M CITY HALL
MPLS MN
55415

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MPLS TRIBUNE CITY DESK
425 PORTLAND AVE
MPLS MN
55415

MT OLIVET ROLLING ACRES
R 1 BOX 576
EXCELSIOR MN
55331

MURPHY DIANA E
4200 IDS-LINDQUIST VENN
MPLS MN
55402

MURPHY PATRICK SSR INC
BOX 996 COURTHOUSE STA
ARLINGTON VA
22216

MURPHY PATRICK DUFFY
1440 SUMMITT AVE
ST PAUL MN
55105

NASS GEO V HENN CO GEN HO
5TH AND PORTLAND AVE
MPLS MN
55415

NATL CAR RENTAL ATT D MITZEL
5501 GREEN VALLEY DR
MPLS MN
55437

NATL COUNCIL JEWISH WOMEN
4330 CEDAR LK RD
MPLS MN
55416

NATL FAMILY INS CO
2147 UNIV AVE
ST PAUL MN
55114

NCEC INC C/O DR DAHLBERG
CONCORDIA COLLEGE
MOORHEAD MN
56560

NELSON HOWARD I

LINDSTROM MN
55045

NELSON JOHN
4809 180TH ST N
HUGO MN
55038

NEREN MADONNA
376 NEAL AVE S
AFTON MN
55001

NEUMAN RALPH W
RT 2 BOX 125
EMBARRASS MN
55732

NO SUB MONTESSORI-S SADDLER
2487 HELEN COURT
NO ST PAUL MN
55109

NORTH CENTRAL ELEC ASSN
PO BOX 202
BATTLE LAKE MN
56515

NURSING HOME ADMRS BD EXAMRS
RM 340 717 DELAWARE SE
MPLS MN
55414

NURSING HOME RES ADV CO.
111 E FRANKLIN S210
MPLS MN
55404

NO ST PAUL MN
55109

BATTLE LAKE MN
56515

MPLS MN
55414

MPLS MN
55404

NW BELL TEL CO LEGAL DEPT
224 S 5TH ST RM 2000
MPLS MN
55402

NW COUNTRY ELEVATOR ASSN
802 GRAIN EXCH BLDG
MPLS MN
55415

NW REG. DEV. COMM
425 WOODLAND AVE
CROOKSTON MN
56716

NYQUIST DEAN A
3707 53RD PL N
BROOKLYN CTR MN
55429

O'BRIEN J.DENNIS
1100 1ST NATL.BANK BLDG
MINNEAPOLIS MN
55402

O'CONNELL RAY
MN GAS CO 733 MARQ AVE
MPLS MN
55402

OFFICE OF THE GOVERNOR
130 STATE CAPITOL
ST PAUL MN
55101

OLOFSON ARTHUR MBO & MAINC
927 SOO LINE BLDG
MPLS MN
55402

OLSON KATHLEEN
192 SEYMOUR AVE SE
MPLS MN
55414

OTTER TAIL POWER CO.
215 S. CASCADE ST.
FERGUS FALLS MN
56537

PARKER SANDY
7480 CHANHASSEN ROAD
EXCELSIOR MN
55331

PATTISON ORVIS
BOX 645
WILLMAR MN
56201

PAYNE COL ALVIN

DEGRAFF MN
56233

PAYNE WM B
2400 FIRST NATL BK BLDG
MPLS MN
55402

PETERSEN DOUG ESIDE NEIGHBOR
HOOD SERV 1929 2ND STNE
MPLS MN
55418

PETERSON MYRON D
ROUTE 2 BOX 99
SACRED HEART MN
56285

PFEIFER AND SHULTZ, INC
1433 UTICA AVE S
MPLS MN
55416

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STAPLES MN
56479

REGION NINE DEV. COMM.
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56001

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3M CENTER
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STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA DEPARTMENT OF HEALTH

RECEIVED
OFFICE OF HEARING EXAMINERS

In the Matter of Proposed Rules Relating to Charges for Examination Fees of Health Maintenance Organizations

Statement of Need and Reasonableness

New proposed rule § 1.372 G is authorized by Minn. Stat. § 62D.14, Subd. 6, which reads as follows:

> "Reasonable expenses of examination under this section shall be assessed by the board against the organization being examined, and shall be remitted to the board for deposit in the general fund of the state treasury."

The process of conducting examinations was developed by staff of the Department of Health between 1974 and 1976. During this learning process, we felt that it was improper to charge a fee for a "developmental" examination. The attached examination process and examination report format have now been developed and the HMO Unit has conducted several exams with this process and format. We are therefore using a tested examination system and there should be no further delay of assessment of expenses.

The method and amount of assessment was determined from experiences during our uniform exam process and report. We feel that the "per examiner day" rate is the most accurate and administratively feasible method of assessment. The assessment would be made regardless of whether the examiner was on-site at the HMO or doing research elsewhere. If the examiner devotes less than the full day to the task of examination, proportional assessment will be made. For example, if four hours were devoted to an examination on a particular day, only one-half of the $125.00 assessment would be charged.

The rate of assessment was determined using FY-1979 budget information and time study results from the "trial" examinations conducted during the period of July 1, 1977 to March 1, 1978. The salary expenses listed on the next page are effective March 1, 1978. The travel and office expenses (use of state car, reimburseable meals, telephone, supplies, etc) reflect the overall proportion of personnel expenses to travel and office expenses in the HMO Unit for FY-1979. The proportion has been 5 to 1, salary expenses compared to travel and office expenses.

	Hourly Rate	Average Hours Per Exam Day	
Personnel			
Examiner	$7.70	8	$61.60
Typist	$5.25	4	$23.00
Supervisor	$12.00	1.6	$19.20
			$103.80
Travel and Office Expenses (20% of Personnel)			$20.76
Total Examination Expenses per 8 Hour Day			$124.56

Therefore, $125.00 is a reasonable rate to charge per day of examiner time involved in HMO examination. This rate has been the experience during the several examinations previously performed. Using this proposed rule, the following would be a typical assessment against an organization being examined:

	Hours by Each Examiner	
Day #1	8 hours	$125.00
Day #2	4 hours	62.50
Day #3-#6	4 x 8 hours	500.00
Day #7	6 hours	93.75
		$781.25

Examination Process

A. 1. Notify HMO approximately six weeks prior to examination. The notification shall contain:

   a. Dates of Exam
   b. Process involved
   c. List of materials necessary (prior to Exam and on date of onsite inspection)

2. Two weeks prior to the examination the examiner shall have the following material:

   a. Financial Statements
      i. Balance Sheets
      ii. Income (Operating) Statements for year and previous year
      iii. Changes in Financial Position

   b. List of Phone Numbers of:
      i. Board members
      ii. Plan administrator
      iii. Membership services person
      iv. Medical records person
      v. Actuary
      vi. Health education person
      vii. Selected providers of the Plan

   c. Medical protocol and medical audit procedures
   d. Map of hospitals and outlets
   e. Listing of Plan personnel and percent of time used for Plan activities
   f. Copayment schedules
   g. Clinic schedules
   h. Protocol of preventive care and description
   i. Description of health education
   j. List of mandated employers
   k. Resumes of Plan managers and medical director

3. The examiner shall review all data to complete portions of examination questionnaire and to develop interviewing questions.

B. 1. The financial statements are to be analyzed for:

   a. Working capital position
   b. Cash flow problems
   c. Trends of financial position -- deficit/growth
   d. Calculations of current ratios to measure working capital improvement
   e. Debt capacity ratios
   f. Adequacy of the rates for generating revenue
   g. Measurement of the form of assets and liabilities
   h. Calculation of the deficit per member per month

2. Review rates for the groups for the previous years

    a. Summarize for the rating portion of the examination
    b. Evaluate hospital and other rating components using the annual report summaries
    c. Use utilization data to determine the appropriateness of utilization of the various rate components
    d. Analyze the components use of staff

3. Review provider contracts -- are they current?

    a. What is the risk-sharing provision?
    b. What financial arrangements are in effect?
    c. What is the mechanism for claims or payments?
    d. What percentage of the providers business consists of the HMO members?

4. Review the Bylaws for statutory compliance and for prior approval. Note any descrepancies for clarification.

5. Review the certificate of coverage for:

    a. Benefits list
    b. Clear, concise and complete?
    c. Complaint procedure
    d. A determination of the amount of benefits above the minimum, i.e., is it compatible with the Plan's position?
    e. Department approval
    f. Compare certificate with master contracts

6. Review membership of the Board of Directors

    a. Are consumer members forty percent of the Board?
    b. What committees exist?

7. Utilization review

    a. Contact PSRO regarding Plan hospitals
    b. Utilization and medical audits on public and private patients?
    c. JCAH accreditation?

8. Review accessibility and availability of both hospital and primary care outlets.

9. Evaluate open enrollment either from annual report or conversation.

10. Evaluate reasonableness of copayments.

11. Cost of hospitalization

    a. Evaluate LOS
       $/day
       $/stay
       Discharges/1000
       Days/1000
       and rank
    b. What direction is this moving?
    c. What about current utilization?
    d. How does this compare with past performance?

12. Prior to the examination, contact ten to twenty consumers of the Plan to elicit opinions of the HMO.

13. Develop detailed list of questions for Plan providers and staff. Contact enrollee groups for their input and complaints.

C. Examination

1. Interview key board members:

    a. Administrator
    b. Medical Director
    c. Membership Services Person
    d. Providers
    e. Accountant
    f. Marketing Person
    g. Utilization review person

2. Review all complaints in files

    a. Contact unresolved complainants
    b. Identify major problem areas

3. Examine insurance policies
4. Examine medical records for referral patterns and continuity of care, as well as for completeness
5. Examine all master contracts for compliance with certificates and MHD approval
6. Examine minutes of Board meetings, as well as those of Executive, Utilization Review, etc. Committees
7. Examine provider contracts and compare for non-approved contract changes
8. Examine open enrollment documentation
9. Examine conversion contract or arrangements for clearness, conciseness and completeness
10. Examine lists of potential markets
11. Examine lists of membership and group penetration
12. Contact major groups to determine satisfaction and their participation on the Board
13. Review financial conditions in light of utilization and payment for services
14. Examine facilities
15. Discuss future plans

D. Draft report using identified format.

E. Send draft to HMO for corrections of factual data and comments.

F. Incorporate appropriate comments and finalize and then, send to Plan and its Board.

G. Review findings with the Board.

EXAMINATION REPORT FORMAT

1. Description of Plan if initial examination.

   If follow-up exam, then summary with notation of changes in operations. Description shall include:

   a. Board of Directors and and role of Board and Committees.
   b. Organization of providers, i.e., how service is provided.
   c. Personnel.
   d. Marketing problems and projections (include federal qualification).

2. Financial Affairs.

   A. Position

      a. Include review of recent auditor's report.
      b. Form of Assets and Liabilities (e.g., cash, accounts receivable, accounts payable, etc.)
      c. Present financial position compared with past (back to the date of the previous examination).
      d. Working Capital Analysis:
         i. Sources of working capital.
         ii. Changes in working capital.
         iii. Current Ratios.
         iv. Uses of working capital.
         v. Future sources of working.
      e. Debt Capacity.
      f. Financial Responsibility.

   B. Full Financial Risk

      a. The form of passing the risk to providers.
      b. Use of stop-loss insurance.
      c. Consistent with statutes.

   C. Adequacy of Charges

      a. Describe rate-making process if different from previous examination.
      b. Break rating into components. Determine appropriateness and reasonableness.
         i. Identify per member per month (pmpm) cost of each component.
         ii. Compare with other HMOs.

3. Quality Assurance.

A. Acceptability-Enrollee Satisfaction

1a. Examine the log of complaints and the written summaries regarding these situations.
b. Identify the complaint mechanism and its description in the certification of coverage.
c. Identify the key areas in which complaints occur.
d. Is there another mechanism for incorporating enrollee opinions? How effective is it (are they)?
2a. Examine Board for statutory make-up by consumer members (forty percent).
b. Describe any changes since previous examination.

B. Quality Controls

1. Provider selection -- if any changes.
2a. Utilization Review. Are there any changes in the review procedures?
2b. What are the results of this mechanism?
c. Contact regional PSRO for hospital compliance with standards.
3. Medical Audits -- note any changes.
4. Internal Peer Review -- note any changes.
5. Medical Records -- cite any changes.
6. Licensure of Facilities -- Check on this.

C. Accessibility and Availability

1. Hospital location and hours -- note changes.
2. Primary Care Outlets -- note changes.
3. Ancillary Services -- note changes.
4. Waiting Time -- note changes.
5. Open Enrollment -- examine proof of notice and enrollment mechanisms.

D. Affordability

1. Premium rates -- exhibit past years rates and note any change in assumptions.
2. Copayments
   a. Examine amount of copayments received and compare with charges for reasonability for:
      -emergency room
      -mental health
      -drugs
      -other
3. Cost of Hospitalization
   a. Detail hospital utilization statistics, rank, and compare with performance since last exam.

b. Compare with current data if available.
c. Comment on validity/accuracy.
d. Identify trends and make recommendations on short areas.

4. Utilization of Services and Cost.

A. Examine use of Primary Care.
B. Emergency Rooms.
C. Ancillary Services.

D. Mental Health/Chemical Dependency.
E. Referrals.
F. Benefit Plan.

5. Examine for appropriateness -- changes since past examinations. What can be done to reduce utilization. Causes of high utilization. Review Mechanisms stated in application; does present practice conform? Miscellaneous Statutory Areas.

A. Provider Contracts
1. Have the contracts changed since previous exam?
2. Are they reasonable?
3. Have changes been approved by MHD?
4. Explain risk-sharing and its affect.
5. Detail the percent of provider clients which are HMO members.

B. Bylaws
1. Examine Bylaws for changes or which were not filed and/or for omission of provisions not consistent with Minn. Stat. or 7 MCAR. Give deadline for compliance.

C. Statistics
Are the statistics which are required by the HMO Act available? How accurate are they?

D. Financial Disclosure
Examine Plan personnel for conflicts of interest.
Describe staff changes.

E. Insurance
Inspect for compliance with State law: malpractice, stoploss, and out-of-area.

F. Protection for Members
If the Plan is in the red, then the Plan shall have provisions to protect the members in the event of failure.

G. Preventive Care
What is being provided?
Who controls it?

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the proposed rules relating to Charges for Examination Fees of Health Maintenance Organizations and Amendments to Rules Relating to the Minnesota Hospital Rate Review System and all related documents and that, based on such examinations and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed.

Dated: January 16, 1979

John A. Breviu

JOHN A. BREVIU
Special Assistant
Attorney General

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

IN THE MATTER OF PROPOSED RULE RELATING TO CHARGES FOR EXAMINATION FEES OF HEALTH MAINTENANCE ORGANIZATIONS

and

IN THE MATTER OF PROPOSED AMENDMENTS TO THE RULES RELATING TO THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM.

REPORT OF THE CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on September 25, 1978, before Harry Seymour Crump, a Hearing Examiner of the State Office of Hearing Examiners, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, Subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. § 15.052, Subd. 3, was issued to the Department of Health on November 27, 1978; and

WHEREAS, the Department of Health has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, Subd. 4; and

WHEREAS, the Department of Health has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. § 15.052, Subd. 4, and Rule HE 110; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Department of Health has met all requirements of Minn. Stat. § 15.0412, Subd. 4.

NOW, THEREFORE, upon receipt of this Report, the Department of Health has the responsibility of submitting the complete hearing record and the rules as adopted by the Department to the Attorney General, notifying all persons who requested to be informed that the hearing record has been submitted to the Attorney General, and publishing in the State Register, all pursuant to Minn. Stat. § 15.0412, Subd. 4.

Dated this 15th day of January, 1979.

DUANE R. HARVES
Chief Hearing Examiner