

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File #641

ADMIN 1009 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : GEORGE R. PETTERSEN, M.D.
Commissioner of Health

DATE: 10/24/80

Attn: JOHN A. BREVIU

FROM : H. THEODORE GRINDAL HTG
Special Assistant
Attorney General

PHONE: 297-3471

SUBJECT: Rules as Approved In the Matter of Proposed Amendments to Rules of the Minnesota Commissioner of Health Governing the Minnesota Hospital Rate Review System.

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Note that they have NOT been filed with the State Register; this must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of the stamps of the Attorney General and Secretary of State to the last page of the rules;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages of the rules in the approved set.

Directly following the approved rules is a complete set of required documents and transcript which must be retained with the rules by you or your agency.

If you have any questions in this regard, please contact me.

HTG/bw
Encl.
cc: Duane Harves
Susan Robertson

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

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

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULES

The Commissioner of Health Adopts the Hearing Examiner's Report in the Matter of Proposed Rules Relating to the Minnesota Hospital Rate Review System with a number of exceptions.

The following are additions or corrections to the Hearing Examiner's Report of July 30, 1980. Each addition or correction is numerated to correspond directly to one of the Hearing Examiner's Findings of Fact:

7 MCAR § 1.505 B - Commissioner of Health Establishment

Finding 11 a - Add the following paragraph after the last sentence of 11 a.

After carefully considering all of the comments and testimony, the Commissioner of Health has determined that it would be appropriate to adopt a single statewide percentage figure for all hospitals rather than adopting a rule that would divide hospitals into two groups and allow for the establishment of two percentage figures. This position is being adopted due to the apparent lack of support enjoyed by the proposed rule, i.e., two sets of hospitals, and the comments submitted by hospitals indicating support for a single statewide figure. These comments which were sent by hospitals of all sizes, large and small, imply that a single statewide figure applicable to all hospitals would not be inequitable. Therefore, 7 MCAR § 1.505 B.3. shall be deleted from the proposed rules in its entirety.

Finding 11 e - Correct the following in the last sentence of Finding 11 e.1:

> "The rule provides a numerical set of bounds, i.e., 0.0 to .036, however, grounds for the selection of a figure between 0.0 and ~~.086~~ .036 should also be provided."

The above corrects a typographical error in the Hearing Examiner's Report.

Finding 11 e - Correct the following in the first sentence of Finding 11 e.2:

"The grounds for selection of a ~~figurae~~ figure...."

The above corrects a typographical error in the Hearing Examiner's Report.

Finding 14 - Add the following paragraph after the last sentence of Finding 14:

The amendments to 7 MCAR § 1.505 E required by the adoption of a "one-set", "single-rate" methodology are as follows:

2. An abbreviated projected operating statement ~~for hospitals in Set II, as described in 7 MCAR §1.5[illegible] B.3.b.1.~~ shall include the following data for the prior, current and budget years:

~~a. A natural expense summary consisting of total institutional expenses for:~~

~~(1) Salaries and wages;~~

~~(2) Employee benefits;~~

~~(3) Medical Fees;~~

~~(4) Raw food;~~

~~(5) Drugs;~~

~~(6) Medical Supplies;~~

~~(7) Other Supplies;~~

~~(8) Utilities;~~

~~(9) Repairs and Maintenance;~~

~~(10) Rental Expense;~~

~~(11) Insurance;~~

~~(12) Interest;~~

~~(13) Depreciation - buildings and fixed equipment;~~

~~(14) Depreciation - movable equipment;~~

~~(15) Other expense;~~

a. ~~b.~~ Total acute care hospital operating expense.

b. ~~c.~~ Total institutional patient charges.

c. ~~d.~~ Total acute care hospital patient charges.

d. ~~e.~~ Total acute care hospital inpatient charges.

e. ~~f.~~ Total acute care hospital outpatient charges.

f. ~~g.~~ An expense analysis consisting of acute care:

(1) Direct costs for:

(a) Daily hospital services,

(b) Ancillary service,

(c) Non-revenue producing centers.

(2) Costs after allocation of non-revenue producing centers costs to:

(a) Daily hospital services,

(b) Ancillary service.

g. ~~h.~~ An acute care hospital statistical summary consisting of:

(1) Number of patient days (excluding nursery),

(2) Number of nursery days,

(3) Number of total patient days,

(4) Number of admissions,

(5) Average length of stay.

(6) Occupancy - licensed beds,

(7) Occupancy - staffed and set-up beds,

(8) Number of outpatient and emergency room visits.

h. ~~i.~~ An acute care hospital full time equivalent summary consisting of salary and numbers of full-time equivalent personnel for:

(1) Daily hospital services,

(2) Ancillary services,

(3) Non-revenue producing centers,

(4) Total hospital,

(5) Total institution.

i.~~j.~~ An acute care bed summary consisting of:

(1) Number of licensed beds,

(2) Number of physically present beds,

(3) Number of staffed and set-up beds.

j.~~k.~~ Depreciation Fund

(1) Beginning Balance,

(2) Ending Balance.

~~3. An abbreviated projected operating statement for hospitals in Set I, as described in 7 MCAR §1.505 B.1.a., shall include all data elements found in 7 MCAR §1.505 B.2.b,c,d,e,f,g,h,i,j,k.~~

3.~~4.~~ The information provided on the abbreviated projected operating statement shall support the hospital's claim that it will achieve an increase in gross acute care charges less than that established by the Commissioner of Health pursuant to 7 MCAR §1.505 B.

The required data elements chosen to apply to all hospitals are those that were initially proposed for the small hospital set due to the fact that by their numbers small hospitals are dominant.

NOW, THEREFORE, IT IS ORDERED that the rule amendments identified as 7 MCAR §§ 1.742.G; 1.474.A.9; 1.505 are adopted the 8 day of September, 1980.

George R. Pettersen M.D.

George R. Pettersen, M.D.
Commissioner of Health

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : Ted Grindal
Special Assistant
Attorney General

DATE: October 23, 1980

FROM : John A. Breviu
Special Assistant
Attorney General

PHONE: 341-7272

SUBJECT: Hospital Rate Review Rules

This memo confirms our telephone conversation of October 23, 1980. You are authorized to correct certain typographical errors contained in the above rules. Those errors are as follows:

p. 6 - 505 C., fourth line, misspelling of "overall."

p. 7 - 505 E.2.c., misspelling of "hospital."

Thank you for bringing these errors to my attention.

JAB:sd

cc: Fred Sattler

RECEIVED
OCT 24 1980
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

Amendments to Rate Review Rules as adopted by the Commissioner of Health.

Rules as Adopted.

- AG copy

AMENDMENTS TO RULES

1. 7 MCAR §1.472

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. 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," "gross acute care charges," and "gross rate" are synonymous for the purpose of these rules.

2. 7 MCAR §1.474 A.9.

Each hospital claiming exempt status pursuant to Minnesota Statutes 144.7021 and 7 MCAR §1.505 shall include or append a clearly identifiable statement(s) of annual gross acute care charges.

3. 7 MCAR §1.505 Acceptable Increases in Hospital Gross Acute Care Charges: Exemptions from Hospital Rate Review.

A. Each hospital that anticipates an increase in budget year gross acute care charges which is less than the acceptable increase determined by the Commissioner of Health may claim and shall be granted, an exemption from the filing of a rate revenue and expense report as required by 7 MCAR §1.481 C. and as described in 7 MCAR §1.474 B. and the review and comment provisions of 7 MCAR §1.487 C.2., upon filing an abbreviated projected operating statement as described in 7 MCAR §1.505 E.2.

B. Commissioner of Health Establishment:

1. The Commissioner of Health shall establish at the beginning of each quarter of the fiscal year (July 1, October 1, January 1, April 1), a percentage figure representing an acceptable increase in gross acute care charges for the succeeding six quarters (eighteen months).

a. Each hospital being reviewed by the Commissioner of Health pursuant to Minnesota Statutes §144.701 shall be notified of each quarterly established acceptable increase in and adjustments to the acceptable increase in gross acute care charges pursuant to 7 MCAR §1.505 D.

b. Each voluntary non-profit rate review organization approved pursuant to 7 MCAR §1.496 shall be notified of each quarterly established acceptable increase in and adjustments to the acceptable increase in gross acute care charges and shall in turn notify each of the hospitals electing to be reviewed by said organization.

2. Basis. The single percentage figure established by the Commissioner of Health shall be the algebraic sum of the following percentages:

a. An estimate of the forthcoming annual rate of change in the average total cost of all goods and services to hospitals. This estimate shall be determined by summing the weighted change in price of each of the natural expense classifications described in 7 MCAR §1.474 A.2.f. The weights shall be the proportionate contributions of each of these natural expense classifications to hospitals' total cost. The estimate shall explicitly recognize the expected overall level of price change in the state's economy and shall be derived from expected annual changes in the Consumer and/or Producer Price Indices and/or relevant components of the Consumer and/or Producer Price and/or other similar economic indices published by an agency of the Federal or State Governments.

b. An estimate of the rate of change in the dollar value of the forthcoming annual statewide change in: HE p.4

1) the average mix of patients utilizing hospitals, and

2) the average intensity of services received by patients during hospital stays or visits as is consistent with the delivery of medical care which is of generally accepted quality and efficiency. The estimate shall not be less than zero nor more than .036.

For the purposes of this section:

1) "Mix" means the types of illnesses, injuries, and conditions treated in hospitals.

2) "Intensity of services" means the styles and methods of treating illness, injuries, and conditions in hospitals.

c. An estimate of the forthcoming annual rate of change in the statewide number of hospital adjusted admissions per 1,000 population as is consistent with the delivery of medical care which is of generally accepted quality and efficiency.

C. Conformity

1. Each exempted hospital, by the close of the third quarter of its fiscal year, shall assess its likely conformity with its most re-

cently filed abbreviated projected operating statement. If the anticipated actual increase in gross acute care charges, to be reported pursuant to 7 MCAR §1.474 A.9., for an exempt hospital is in excess of the acceptable increase in gross acute care charges under which exemption was claimed pursuant to 7 MCAR §1.505 A., as adjusted pursuant to 7 MCAR §1.505 D., then that hospital shall file a rate revenue and expense report for the coming budget year pursuant to 7 MCAR §1.474 B. and 7 MCAR §1.481 C.

2. If an exempt hospital estimates that it is likely to conform with its most recently filed abbreviated projected operating statement and does not file a rate revenue and expense report pursuant to 7 MCAR §1.505 C.1. and it is subsequently found that the actual increase in gross acute care charges was more than .00125 in excess of the acceptable increase in gross acute care charges under which exemption was claimed pursuant to the 7 MCAR §1.505 A., as adjusted pursuant to 7 MCAR §1.505 D., then that hospital shall file a rate revenue and expense report pursuant to 7 MCAR §1.481 C. no later than 150 days after the close of the fiscal year in question.

D. Adjustments to the acceptable change. Each figure in 7 MCAR §1.505 B. shall be adjusted and updated at the close of the third quarter after its establishment according to the criteria specified in 7 MCAR §1.505 B.2.a. and shall reflect actual changes in the overall price change level throughout the state's economy. The updated figure shall be used when judging conformity to 7 MCAR §1.505 C.1.

E. Abbreviated Projected Operating Statement.

1. Each hospital claiming exempt status shall file an abbreviated projected operating statement no later than the commencement of its fiscal year or up to sixty days prior to the commencement of its fiscal year. Pursuant to Minnesota Statutes §144.701, Subd. 5. no change in rates may be made until sixty days have elapsed from the date of filing.

2. An abbreviated projected operating statement shall include the following data for the prior, current and budget years:

   a. Total acute care hospital operating expense.
   b. Total institutional patient charges.
   c. Total acute care hospital patient charges.
   d. Total acute care hospital inpatient charges.
   e. Total acute care hospital outpatient charges.
   f. An expense analysis consisting of acute care:
      1) Direct costs for:
         a) Daily hospital services,
         b) Ancillary service,
         c) Non-revenue producing centers.
      2) Costs after allocation of non-revenue producing centers costs to:
         a) Daily hospital services,
         b) Ancillary service.
   g. An acute care hospital statistical summary consisting of:
      1) Number of patient days (excluding nursery),

2) Number of nursery days,

3) Number of total patient days,

4) Number of admissions,

5) Average length of stay,

6) Occupancy - licensed beds,

7) Occupancy - staffed and set-up beds,

8) Number of outpatient and emergency room visits.

h. An acute care hospital full-time equivalent summary consisting of salary and numbers of full-time equivalent personnel for:

1) Daily hospital services,

2) Ancillary services,

3) Non-revenue producing centers,

4) Total hospital,

5) Total institution.

i. An acute care bed summary consisting of:

1) Number of licensed beds,

2) Number of physically present beds,

3) Number of staffed and set-up beds.

j. Depreciation Fund

1) Beginning Balance,

2) Ending Balance.

3. The information provided on the abbreviated projected operating statement shall support the hospital's claim that it will achieve an increase in gross acute care charges less than that established by the Commissioner of Health pursuant to 7 MCAR §1.505 B.

APPROVED AS TO FORM AND LEGALITY
Oct 23 1980
WARREN SPANNAUS, ATTORNEY GENERAL
BY [signature]
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
OCT 24 1980
Joan Anderson Growe
Secretary of State
2:38 PM

Our File #641

Permanent Rule X

Temporary Rule _____

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 10/13 DUE DATE 10/23

Resubmitted and Received _____

a. Returned to Agency w/o Filing w/Secretary of State _____
b. Approved _____ Date Sent Back to Agency _____

- -

1. Rules as Adopted ✓
2. Rules as Proposed ✓
3. Certificate of Board's Authorizing Resolution, where applicable N/A
4. Order for Hearing ✓
5. Notice of Hearing ✓ 4.27.80
   Sufficiency ✓
6. Secretary of State's List ✓ (one copy only)
7. Certificate of Acquisition of Secretary of State's List ✓
8. Secretary of State's Certification of Delivery of Secretary of State's List to Agency ✓
9. Affidavit of Mailing ✓
   At least 30 days prior to hearing ✓ 5.19.80
10. Publication in State Register ✓ copy not submitted but see HEP 2
    At least 30 days prior to hearing ✓ 5.19.80
11. Statement of Need and Evidence ✓
12. Hearing Examiner's Report ✓
13. Agency's Findings of Fact ✓ combined with #15 - Order Adopting
14. Certificate of Board's Resolution Adopting Rules, where applicable N/A
15. Order Adopting ✓
16. Report of Chief Hearing Examiner ✓
17. Order Approving Incorporation by Reference, where applicable N/A
18. Certificate of Compliance with Rulemaking Procedures ✓
19. Copy of Notice of Intent to Solicit Outside Opinion, where applicable ✓ copy of SR not submitted but see Attachment A, exhibit I to Statement of Need
20. Petition by Public, where applicable N/A

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

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

AFFIDAVIT OF MAILING

Patti Engel, being first duly sworn, deposes and says:

That on the 14 day of May, 1980, at the City of Minneapolis, County of Hennepin, State of Minnesota, he 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.

Patti A. Engel

Subscribed and sworn to before
me this 29th day of May, 1980.

Beverly Conerton

BEVERLY CONERTON
NOTARY PUBLIC-MINNESOTA
HENNEPIN COUNTY
My Comm. Expires Jan. 2, 1986

STATE OF MINNESOTA
COUNTY OF RAMSEY

CERTIFICATE

In the matter of the Proposed ~~Adoption~~ Amendments to ~~x~~Rules of the Commissioner ~~Division~~ of Health Governing ~~the Minnesota Hospital Rate Review System~~

I hereby certify that the attached 357 labels 9 sheets constitute the complete list of persons, associations, and other interested groups who as of 2:30 o'clock P.M, this 5th day of May, 1980, 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 Donna Scott

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

BEFORE THE 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

AFFIDAVIT OF RECEIPT OF THE SECRETARY OF STATE'S LIST

Fredric Sattler, being first duly sworn upon oath, deposes and says:

1. That he is an employee of the Minnesota State Department of Health.

2. That he contacted 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 (1978).

3. That on the 5th day of May, 1980, in response to the above request, the Secretary of State provided him with such a list, a photocopy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Fredric L. Sattler

Subscribed and sworn to before me
this 29th day of May, 1980.

Beverly Conerton

BEVERLY CONERTON
NOTARY PUBLIC-MINNESOTA
HENNEPIN COUNTY
My Comm. Expires Jan. 2, 1986

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

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

ORDER FOR HEARING

To effectively implement Minn. Stat. § 144.703 (1978) and Minn. Stat. § 144.7021 (Supp. 1979), the Minnesota Commissioner of Health deems it necessary to consider adoption of the proposed amendments captioned above pursuant to the authority vested in him by the above-referenced statutes.

NOW, THEREFORE, IT IS ORDERED this 29 day of April, 1980, that a public hearing on the proposed rules captioned above be held in Room 105, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on June 27, 1980, commencing at 9:30 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

George R. Petersen M.D.

GEORGE R. PETTERSEN, M.D.
Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

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

NOTICE OF HEARING

A public hearing concerning the proposed amendments to the rules captioned above will be held in Room 105, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on June 27, 1980, commencing at 9:30 a.m. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. 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 to Peter Erickson, Hearing Examiner, Room 300, 1745 University Avenue, Saint Paul, Minnesota 55104, telephone (612) 296-8108, either before the hearing or within five (5) working days after the close of the hearing. The Hearing Examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. All such statements will be entered into and become part of the record. For those wishing to submit written statements or exhibits, it is requested that at least two (2) 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 rule hearing procedure is governed by Minn. Stat. §§ 15.0411, 15.0417, and 15.052, and by 9 MCAR §§ 2.010-2.112 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the Hearing Examiner.

Twenty-five (25) days prior to the hearing, a Statement of Need and Reasonableness will be available for review at the agency and at the Office of Hearing Examiners. This Statement of Need and Reasonableness will include all of the evidence which the agency intends to present at the hearing to justify both the need for and the reasonableness of the proposed rule. However, additional evidence may be submitted in response to questions raised by interested persons. You are therefore urged to both review the Statement of Need and Reasonableness before the hearing and to attend the hearing. Copies of the Statement of Need and Reasonableness may be obtained from the Office of Hearing Examiners at a minimal charge.

A copy of the proposed rules is attached hereto and made a part hereof. The statutory authority of the Commissioner of Health to adopt these rules is contained in Minn. Stat. § 144.703 (1978) and Minn. Stat. § 144.7021 (Supp. 1979).

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.

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10A.01, subd. 11, (Supp. 1979) as any individual:

(a) Engaged for pay or other consideration or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year for the purpose of

attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, Saint Paul, Minnesota 55155, telephone: (612) 296-5615.

Dated: Apr 29, 1980

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Petersen MD

GEORGE R. PETTERSEN, M.D.
Commissioner of Health

STATEMENT OF COMPLIANCE WITH

RULE MAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the proposed 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 Rule Making Procedures have been followed.

Dated: October 10, 1980

JOHN A. BREVIU
Special Assistant
Attorney General

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL- Health

Office Memorandum

TO : Judith Wehrwein
Administration

DATE: October 13, 1980

FROM : John A. Breviu
Special Assistant
Attorney General

PHONE: 341-7272

SUBJECT: Amendments to Rules Relating to the Minnesota Hospital Rate Review System

I believe I forgot to include a Statement of Compliance with Rule Making Procedures in the packet which was recently sent to you regarding the above-referenced rules. Accordingly, I am enclosing an original and one copy of the Statement for your records.

JAB:ejg

Enclosure

RECEIVED
OCT 16 1980
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : Jerry Anderson
Special Assistant
Attorney General
Administration Department

DATE: October 2, 1980

FROM : John A. Breviu
Special Assistant
Attorney General

PHONE: 341-7272

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

I have enclosed an original and two copies of the entire hearing record for your review in the above-referenced matter pursuant to Minn. Stat. § 15.0412.

The record includes the following:

1. Order of the Chief Hearing Examiner;

2. Findings of Fact, Conclusions, and Order of the Commissioner of Health;

3. Rules as Adopted by the Commissioner;

4. Rules as Proposed (post-hearing changes are marked in red);

5. Report of the Hearing Examiner;

6. Letters received following the Hearing;

7. Rules Hearing Register;

8. Statement of Need and Reasonableness;

9. Notice of Intent to Obtain Information on Proposed Rules from Non-Agency Sources, as published in the State Register on July 2, 1979, and materials received following the above Notice (attachment A of Statement of Need and Reasonableness);

10. Order for Hearing;

11. Notice of Hearing as mailed;

12. Affidavit of Receipt of the Secretary of State's List;

13. Certificate of the Secretary of State plus attached Secretary of State's List;

PRINTED ON RECYCLED PAPER

14. Affidavit of Mailing of the Notice of Hearing;

15. Statement of Number of Persons Expected to Attend and Length of Hearing; and

16. Tape of the June 27, 1980, Hearing.

As I indicated above, the post-hearing changes in the rules have been marked in red. The primary change involves elimination of the "two-set" concept of hospitals as originally proposed. You will notice that the Hearing Examiner's report concluded that the record would show need for and reasonableness of either the two-set or single percentage concept and left to the department the decision of which policy to follow.

JAB:sd

Enclosures

HL[redacted]-80-050-PE

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

IN THE MATTER OF PROPOSED AMENDMENTS TO RULES GOVERNING THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM.	ORDER OF THE CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on June 27, 1980, before Peter C. Erickson, a Hearing Examiner of the State Office of Administrative Hearings, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Report of the Hearing Examiner made pursuant to Minn. Stat. § 15.052, subd. 3, was issued to the Department of Health on July 30, 1980; 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 9 MCAR § 2.110; 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 Order, 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 25th day
of September, 1980.

DUANE R. HARVES
Chief Hearing Examiner

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 and Reasonableness

This Statement of Need and Reasonableness 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 authority to propose these rules is contained in Minnesota Statutes §144.7021 (1979). The fundamental purpose of these rules is to exempt hospitals meeting a specific criterion from the hospital rate review process, to establish an alternative to the rate revenue and expense report, (i.e., the abbreviated projected operating statement referenced in 7 MCAR §1.505 E), and to establish the methodology upon which the value of the criterion will be determined.

These amendments were prepared after a careful review of the statutory language and with input from affected parties including insurers and payers (e.g., Blue Cross and Blue Shield of Minnesota, the Minnesota Chapter of the Health Insurance Association of America and Minnesota Department of Public Welfare), providers (e.g., the Minnesota Hospital Association, representatives from various hospitals), health planning groups (e.g., representatives from the State Health Planning and Development Agency and Health Systems Agencies) and professional accounting groups. A brief description of the consultation process employed is attached to this statement. (See Attachment A)

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

7 MCAR §1.472	Definitions
7 MCAR §1.474	Report Requirements
7 MCAR §1.505	Acceptable Increases in Hospital Gross Acute Care Charges: Exemptions from Hospital Rate Review. (A new section to be added)

7 MCAR §1.472

G. "Charges." The words "gross acute care charges" has been added to the definition of charges because it appears without definition in the statutory amendment, Minnesota Statutes §144.7021. "Gross acute care charges" is synonymous with "gross charges" for the purpose of these rules, since the rate review program's statutory authority is limited to the review of acute care financial and statistical information. (See Minn. Stats. §144.695, Subdivision 3.) This is a clarification and represents no substantive change from the existing definition.

7 MCAR §1.474 A.9.

This rule is necessary because Minnesota Statutes §144.7021 requires each exempt hospital to "include a separate statement of its total hospital gross acute care charges" as part of its income statement.

The rule is reasonable because it meets the statutory requirements of Minnesota Statutes §144.7021, while providing hospitals and hospital auditors with maximum format and presentation flexibility. Format and presentation flexibility is desirable. The Department of Health received a letter from Mr. Rodney S. Rasmusson, C.P.A., of Robert C. Engelhart & Co., indicating the need for formating flexibility. He stated that, "it would be improper to include this [the statement of hospital gross acute care charges] in the audited financial

statements of the institution and suggest that a separate certification might be more appropriate." He went on to suggest that it would not be "...proper for the State government to mandate the form of audit reports." The rule as written adequately reflects Mr. Rasmusson's concerns, while retaining the ability of the Commissioner to obtain the required data.

7 MCAR §1.505

A. This rule is necessary and reasonable because it states the purposes of 7 MCAR §1.505 and the conditions and responsibilities of hospitals claiming exemption under Minnesota Statutes §144.7021.

Minnesota Statutes §144.702 authorizes the Commissioner of Health to approve of alternative voluntary rate review organizations to review and comment on hospitals' proposed budgets. The Minnesota Hospital Association has been approved as such an organization and in fact reviews, with one exception, the budgets of all of the hospitals subject to the provisions of Minnesota Statutes §§144.695-144.703. It is, therefore both logical and practical that the approved voluntary rate review organization notify the hospitals that it is reviewing.

B. This rule sets forth:

1. The form that the acceptable increase in gross acute care charges may take, how often it will be established and what periods it will cover, and who shall notify hospitals of its value.
2. The factors that must be considered by the Commissioner of Health when he/she establishes the acceptable increases.

3. The method to be used to divide hospitals into two sets for the purposes of determining exempt status.

This rule is necessary and reasonable for the following reasons:

1. The figure representing an acceptable increase for the succeeding eighteen months will be published at quarterly intervals so as to coincide with the budgeting practices of hospitals. Hospitals' fiscal years begin at varying times throughout the calendar year and the budgeting process usually begins six months prior to the beginning of the fiscal year. By making the acceptable increase figure for the coming year known early in the budgeting cycle, two objectives can be met: 1) hospitals can use the figure as a budgeting guide; and 2) hospitals will have ample time to assess the likelihood of exemption and prepare an appropriate filing, i.e., a rate revenue and expense report or an abbreviated projected operating statement.
2. The figure should represent, to the extent possible, those factors that influence the level of hospitals' gross acute care charges. The major driving force behind hospital price changes are changes in the prices of the goods and services purchased by hospitals. In the absence of sources of non-patient related revenue, e.g., gifts, grants, etc., hospitals' prices should reflect changes in the prices of the goods and services they purchase. The approach that is being proposed to estimate changes in the prices of goods and services purchased by hospitals is the same as the approach previously adopted by the Commissioner of Health and is currently being used by the Department. (See MDH Rule 7 MCAR §1.504 F.)

MDH Rule 7 MCAR §1.504 F. provides the basis for the Commissioner's computation of the expected impact inflation will have on hospital expenses. The actual method employed by the Commissioner to establish the expected impact of inflation on hospital expense can be found in the attached report prepared by members of the faculty of the Unversity of Minnesota's Graduate School of Business Administration.

Hospitals can be thought of as mult-product firms where the products require the use of different resources and/or the use of the same resources in differing proportions. Additionally, the mix of products produced and production technology may change year to year. In order to deal with this phenomenon, the quantity component of gross acute care charges should be divided into a pure volume component, i.e., the number of adjusted admissions, and a component that accounts for changes in product mix and production technology. The second component is generally known as a mix and intensity factor. Research indicated that the average change in mix and intensity nationally has been approximately 3.6% per year between 1970 and 1978. (See Freeland, M., C. Anderson, C. Schendler, "National Hospital Input Price Index," Health Care Financing Review. Department of Health Education and Welfare (Summer 1979)). The use of the long-term average increase in mix and intensity, 3.6%, is quite liberal for two reasons:

a) The number was computed by deflating the growth in expenses per admission with the residual being called increases in mix and

intensity. However, the residual value is actually the net of the following factors: i) increases in mix and intensity; ii) changes in employee productivity; iii) changes in managerial efficiency; and iv) errors in the measurement of the deflator. At this time, little work has been done to estimate the direction of the bias caused by factors i-iv, but Freeland, et. al. perceive as a result of their research, that

> the average [increase in mix and intensity]... is directly influenced by governmental and industry policies.... In April 1977 the Carter Administration announced a program to contain hospital costs and the hospital industry responded with the Voluntary Effort to control costs. Data from 1978 [3.4%] show that the rate of real growth is again below the long-term average, perhaps due to the threat of mandatory controls (p. 41).

This information coupled with the knowledge that the vast majority of hospitals in the country during the 1970-1978 period had few spending restraints except for the period during which the Economic Stabilization Program was in effect, might lead one to suspect that the long-run average is biased upward. If hospitals were subject to the same economic constraints, as other business entities, e.g., price competition, then the long-run average would be lower because there would be strong managerial incentives to more stringently control the growth in the numbers and types of production inputs that account for much of the increase in intensity.

The remaining component of quantity considers the rate of change in the number of adjusted admissions throughout the state irrespective of illness or condition . This approach is consistent with the common practice in the hospital industry.

3. When establishing the figure, the Commissioner should consider the way in which the three factors driving changes in hospital gross acute

care charges affect the various types of hospitals in the state. In this regard, Minnesota Statutes §144.701, Subdivision 3, authorize the Commissioner to act in the following way:

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

The Commissioner believes that there is a fundamental difference between large and small hospitals (Set I is made up of small hospitals, Set II is made up of large hospitals) and those differences can affect the rate of change in gross acute care charges. There are approximately 175 hospitals in the state that are subject to the provisions of Minnesota Statutes §§144.695-144.703. Sixty large hospitals account for about 85% of total state-wide hospital charges, while 120 hospitals account for the remaining 15%. The 60 larger hospitals are generally treating more seriously ill patients who require a different mix of resources. Therefore, the rate of change of the mix and intensity factor may be different for larger hospitals than for small hospitals.

Additionally, the number of adjusted admissions is more stable in large than in small hospitals. Large fluctuations in the number of adjusted admissions from year to year will likewise cause relatively large fluctuations in gross acute care charges. These two factors suggest that it would be appropriate for the Commissioner to have the ability to consider and recognize the varying effects that different rates of change of the quantity component of gross acute care charges will have on large and small hospitals. The method being used to establish the two sets of hospitals is identical to the one being used to establish large and small hospital sets in MDH rule 7 MCAR §1.475 A.

The set of hospitals in each group should be evaluated every 5 years to be sure that each hospital is placed in the appropriate group. Over a period of time it might be found that the certain hospitals in set II should be in set I and vice versa. This can occur because the rate of change in acute care charges can vary from hospital to hospital. A five year period was chosen as the interval to evaluate each set because it is long enough to allow for clear shifts in rank, but not so short as to cause unnecessary instability in the groups.

C. This rule is necessary because Minnesota Statutes §144.7021, Subdivision 2 requires that when an

> ...exempted hospital exceeds the figure established by the Commissioner, it shall promptly file a rate review request pursuant to section 144.701 or 144.702.

This rule sets forth the procedure an exempted hospital is to use to determine if it actually exceeded the figure established by the Commissioner and when it shall file a rate revenue and expense report.

The rule is reasonable for the following reasons:

1) Under normal circumstances, when a hospital does not claim an exemption under Minnesota Statutes §144.7021, it will file a rate revenue and expense report up to 60 days prior to the beginning of its fiscal year with the review normally taking place prior to or shortly after the start of the fiscal year. The timing of the review is important for two reasons: a) a review prior to the start of or very early in the fiscal year gives the hospital an indication of the reasonableness of its revenue and expense projections with enough lead time to make changes if necessary, and b) MDH rule 7 MCAR §1.781.C.1. requires

hospitals to file rate revenue and expense reports up to 60 days prior to, but no later than the close of their fiscal years. The adoption of this rule would facilitate the review of the hospital in question by having its rate revenue and expense report filed in the normal cycle if it is clear that the hospital's increase in gross acute care charges will be in excess of the figure established by the Commissioner. Furthermore, this rule will reduce a potential administrative redundancy for both hospitals and rate review organizations. Take the following case: A hospital claims exempt status in year 1 and then finds that it will exceed the figure established by the Commissioner. The budget for year 2 indicates that the hospital's expected increase for year 2 will also exceed the Commissioner's figure. The latter will necessitate the filing of a rate revenue and expense report for year 2 which also contains information for year 1. Hence the filing requirements of both situations, i.e., the year 1 nonconformity and year 2 rate review, can be met with one filing.

2) This rule gives a hospital that will be close to the Commissioner's figure the opportunity to close its books for the year before determining its conformity. A small margin for error is recognized and if the hospital's increase in gross acute care charges is in excess of the Commissioner's figure by more than .00125, it then must file a full rate revenue and expense report.

One hundred fifty days after the close of a hospital's fiscal year is believed to be enough time to file a rate revenue and expense report, if necessary, because the audit report which will be used to determine conformity is normally completed 120 days after the close of the fiscal year.

The margin for error of .00125 (12.5% of 1.00%) is proposed because it represents an allowance that is neither so large as to encourage a hospital to be overly optimistic in its estimates of actual performance, nor so small as to discourage a hospital from waiting until its books are closed prior to filing a full rate revenue and expense report if its actual increase in gross acute care charges is close to the figure set by the Commissioner.

D. This rule is necessary and reasonable because the major component of the Commissioner's figure is an estimate of inflation, and estimates can be in error. A hospital should not be considered out of conformance because of that error. The proposed method for recognizing estimating errors in this rule is currently in use by the Department and has been previously found necessary and reasonable. (See MDH rule 7 MCAR §1.487 A.3.c.)

MDH rule 7 MCAR §1.487 A.3.c. establishes a mechanism that protects hospitals from being unduly penalized from under estimates of inflation and protects the rate payer from over estimates of inflation by the Commissioner. The mechanism allows for a comparison of the projected inflation rate with actual inflation as measured by indices or components of indices published by the Division of Labor Statistics, U.S. Department of Commerce.

E. This rule is necessary because Minnesota Statutes §144.7021, Subdivision 1 requires hospitals claiming exempt status to file an abbreviated projected operating statement. Since the abbreviated projected operating statement is filed in lieu of a rate revenue and expense report and must be put to much the same purpose, i.e., the calculation of group averages and the

assertainment of reasonableness, the time of filing should be the same as is required of rate revenue and expense reports.

Minnesota Statutes §144.7021, Subdivision 3 states that,

> The available abbreviated projected operating statements of hospitals which are exempted from rate review under this section shall be used in making determinations of the reasonableness of all hospitals' projected increases in revenues and expenses.

The information being asked for in this rule is consistent with this subdivision of the Statute. In support of this statement, a set of the "Summary Exhibits" used during the rate review process is attached. Note Exhibits I and III of Attachment B that compares various aspects of the hospital undergoing review to other similar hospitals. The data necessary to make peer group comparisons is contained in the abbreviated projected operating statement.

Minnesota Department of Health Consultation Process with Interested Parties During the Drafting of Rules 7 MCAR §1.505

The following is a description of the process employed by the Department of Health to confer with affected parties during the development of these rules:

I. A notice of the Commissioner's intent to solicit outside opinion concerning a proposed rule relating to hospitals and providing for exemption from rate review for certain hospitals was published in the State Register on July 2, 1979. (See Exhibit I)

II. A meeting to discuss the proposed rules was held between the Department of Health and the Minnesota Hospital Association staff, on July 23, 1979.

III. Three letters of comment were received by the Department in late July. (See Exhibit II)

IV. A memo and the first draft of the proposed rules was sent to 27 "interested parties" on September 19, 1979. Inviting them to a meeting on October 9, 1979 to discuss the draft rules. (See Exhibit III)

V. A meeting was held with Minnesota Hospital Association staff on November 7, 1979, to discuss issues of hospital reporting requirements which arose during the October 9 meeting.

VI. The Minnesota Hospital Association communicated its position on hospital reporting requirements in a December 10, 1979 letter to the Department. (See Exhibit IV)

VII. On February 6, 1980, representatives of the Health Department met with the Minnesota Hospital Association's rate review policy committee for the purpose of reviewing the proposed rules. As a result of concerns raised by the policy committee about the possible magnitude of the acceptable increase in gross acute care charges, the Department altered the proposed rules to accomodate two different acceptable increases, one for large hospitals and one for small hospitals, when and if appropriate.

VIII. A second revised draft of the proposed rules was sent to interested parties, on March 10, 1980. The Department received a few informal comments on this draft from the Minnesota Hospital Association. (See Exhibit V)

IX. A final review of the rules was held with the rate review policy committee, on April 9, 1980.

Exhibit I

Department of Health

Hospital Rate Review

Notice of Intent to Solicit Outside Opinion Concerning a Proposed Rule Relating to Hospitals and Providing for Exemption from Rate Review for Certain Hospitals.

Notice is hereby given that the Minnesota Department of Health is considering adoption of a rule which would:

1. establish an acceptable increase in hospital gross acute care charges (all hospitals whose projected increases in gross acute care charges fall under the acceptable increase established by the Commissioner of Health would be exempt from the rate review process for that year);

2. establish the elements to be included in the abbreviated projected operating statement which must be filed by exempt hospitals; and

3. other technical aspects of Minnesota Statutes § 144.7021.

All interested or affected persons or groups may submit information on this subject. Written or oral information and comment should be addressed to:

Mr. Fredric L. Sattler, Director
Hospital Rate Review Program
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440
(612) 296-5572

All statements of information and comment must be received by July 31, 1979. Any written material received by this date will become part of the record of any hearing held on this subject.

June 11, 1979

Fredric L. Sattler, Director

Hospital Rate Review Program

Exhibit II a

Robert G. Engelhart & Co.
Certified Public Accountants
MINNEAPOLIS • ST. PAUL, MINNESOTA
TELEPHONE 612 • 890-4400

GENERAL OFFICE
151 W. BURNSVILLE PARKWAY
BURNSVILLE, MINNESOTA 55337
MAILING ADDRESS
P. O. BOX 20-453
MINNEAPOLIS, MINNESOTA 55420

July 25, 1979

Mr. Fredric L. Sattler
Hospital Rate Review Program
Minnesota Department of Health
717 Delaware Ave. S.E.
Minneapolis, MN 55414

Dear Mr. Sattler:

We have read with interest the Conference Committee Report on H.F. No. 260 which relates to the rate review process. We note that under (144.7021)(EXEMPT HOSPITALS) Subd. 2., reference is made to the income statement in the exempt hospital's financial report required by section 144.698. We presume that the financial report referred to is the audited financial statements of the institution. We note that Subdivision 2 calls for a separate statement of total hospital gross acute care charges.

We believe it would be improper to include this in the audited financial statements of the institution and suggest that a separate certification might be more appropriate. The terminology "as part of the income statement" has raised this question in our minds.

We do not feel it proper for the State government to mandate the format of audit reports.

If you have any questions regarding this or wish to discuss the matter with us, please contact me.

Sincerely,

ROBERT G. ENGELHART & CO.

Rodney S. Rasmusson
Certified Public Accountant

RSR:lo
cc: Mr. Thomas E. Rubbelke

Exhibit II b

RECEIVED
JUL 31 1979
DIVISION OF
HEALTH SYSTEMS

minnesota hospital association

serving nonprofit hospitals and nursing homes

July 31, 1979

Mr. Frederick L. Sattler
Director, Hospital Rate Review Program
Minnesota Department of Health
717 Delaware St. S.E.
Minneapolis, Minnesota 55414

Dear Fred,

In response to your request for information and comments pertaining to the "proposed rule relating to hospitals and providing for exemption from Rate Review for certain hospitals", I am filing the following comments:

1. I feel that any good econometric model will predict increases in the hospitals' natural expense categories; however, this does not include two important factors that affect hospital gross costs. Mix and intensity plus volume must be considered when attempting to predict increases in hospital costs or charges. By not including mix and intensity, a large regional or teaching hospital's higher cost of operation would not be taken into consideration. These hospitals generally function as referral hospitals and offer a more varied and intense service. It should also be noted that because the hospital offers this type of service, its patients tend to be more acute. Many of the costs associated with running a hospital are fixed and do not change with the volume of patients served. By not including volume in predicting hospital costs you run the risk of understating costs if volume increases and overstating costs if volume decreases. Taken altogether, the hospitals' natural expense categories, plus mix and intensity, plus changes in volume, we should have a "best guess" of future increases in hospital costs, therefore charges.

   The "best guess" promulgated as an acceptable increase in hospital gross acute care charges should be released as a quarterly rate. This would be similar to the method presently used by the MHD to establish the allowable increase limit (7MCAR 1.504; B 1&2; C).

2. The elements contained in the abbreviated projected operating statement should be sufficient to meet the information needs of both using agencies, MRRP and MDH. I feel that the following items are the minimum acceptable. The elements are taken from the MRRP abbreviated form set dated April 1979.

2333 UNIVERSITY AVENUE SOUTHEAST • MINNEAPOLIS, MINNESOTA 55414 • PHONE (612) 331-5571

- natural expense summary
- financial requirements summary
- revenue summary
- statistical summary
- net receivable summary
- hospital FTE summary
- hospital bed summary

As you can see this includes much of the form set. It may prove more economical in the long run to have the hospitals submit the required information on the abbreviated form set. An important addition, from the form set, would be the depreciation fund analysis. Monitoring a hospital's funded depreciation would allow the program to insure this financial requirement is being met. Hospitals are presently required to submit an MRRP form set (full or abbreviated), audited financial statement, and the latest Medicare report. Under Minnesota state statute 144.7021, those hospitals falling below the established acceptable increase in gross acute care charges will only file the abbreviated projected operating statement, audited financial statement, and the latest Medicare report. Within the abbreviated projected operating statement, the hospital must state that its gross acute care charges will not exceed the percentage promulgated by the Commissioner. The amount of time necessary to complete the abbreviated form set will not be that much greater than an abbreviated projected operating statement. Allowing the program the necessary latitude in determining the method of reporting would satisfy the state statute and not increase the number of reports presently filed by the hospital.

3. Monitoring compliance with the established acceptable increase in gross acute care charges will be difficult. Only on a retrospective audit can compliance be confirmed. This doesn't fit the present prospective model the MRRP has had since the beginning. In order to fairly treat all hospitals that are under rate review, I feel that specific rules must be established in reporting price increases. The rules should address filing a rate review request, time limit for reporting a deviation from the hospital's total gross acute care charges, and submitting the abbreviated operating statement.

   A hospital that determines, through its budget process, that the acceptable percentage increase in gross acute care charges will be exceeded, should notify the program and file a rate review request within 60 days of this notice. Additionally, as under the allowable increase limit (7MCAR §1.481,c,4,b), the hospital should notify the system any time it increases its rates.

   The abbreviated operating statement should be filed under the same restrictions as the annual financial information (7MCAR §1.481 B).

4. The easiest and most expeditious method of making these changes to the rules would be, as you pointed out, to add a specific new section to the rules. I feel that this will be exceptable if several items within the present rules are addressed for consistency.

   a) 7MCAR §1.472G - definition of gross charges

b) 7MCAR §1.472U - definition of aggregate rate

c) 7MCAR §1.504 - allowable increase limit

Much of the information shown above is a reiteration of our conversation on July 23, 1979. I should explain that I have a specific reason for being both redundant and elementary in my examples. As we progress toward the actual hearing process it will be very important for both MHA and MHD to verbalize their positions. I hope that we can continue to have an open dialogue and solve problems as they surface. I would like to receive a copy of your first draft of the proposed rule, this will allow me to point out any technical issues prior to the next official steps. I would also like to take this opportunity to thank you for being open and candid during our meeting on this subject. If you have any questions or comments, please feel free to call.

Sincerely,

Vernal F. Silvernale
Hospital Rate Review Advocate
Division of Health Economics

VFS:jll

cc: Steve Rogness, Brian McInerney, Tom Rubbelke

Exhibit II C

RECEIVED
JUL 31 1979
DIVISION OF
HEALTH SYSTEMS

minnesota hospital association

SERVING nonprofit hospitals and nursing homes

July 31, 1979

Mr. Frederick Sattler
Director Hospital Rate Review
Minnesota Department of Health
717 Delaware Street S.E.
Minneapolis, Minnesota 55414

Dear Fred,

Thank you for affording us the opportunity to discuss the industry's assessments and concerns with the most recent amendment to the review and comment statute. As we indicated, the Association is committed to working with the Department to ensure an orderly and equitable implementation of the law.

As you requested, both Mr. Silvernale and I are filing in written form those comments we made in our July 23rd meeting. There appear to be several areas which the Department will have to address during this round of rulemaking and which are of particular concern to the state's hospitals. Specifically they are:

- the periodic establishment of an acceptable increase figure by the Commissioner
- the percentage figure itself
- the definition of gross acute care charges
- the content of the abbreviated projected operating statement
- the prompt filing of a rate review request pursuant to an individual institution's exceeding the figure established by the Commissioner

The bulk of Mr. Silvernale's comments will be directed to the periodic establishment of the acceptable increase figure and the content of the abbreviated projected operating statement. My suggestions/concerns will focus on the remaining issues.

As we are both aware, the Commissioner is required to promulgate an acceptable increase in hospital gross acute care charges. The methodologies for predicting industry behavior for any time period are diverse - both in their content and their ability to accurately predict. For example, the models used by the Department and the Minnesota Rate Review Program to predict allowable increase limits are not inconsiderably different. Yet despite both methods' differing assessments of the behavior of individual expense classifications, the aggregate percentage increases

predicted by both models have been remarkably close. The current models do not, however, address aggregate changes in revenue that result from changes in mix, intensity and volume. The Association would prefer that the increase promulgated by the Commissioner be an inflation quideline. However, we recognize that such an action would be inconsistent with the language and the intent of the statute.

Consequently the Association proffers the following suggestion:

- that any regulatory elucidation of the method of determining the acceptable increase in gross acute care charges be generic and include considerations of mix, intensity and volume changes

To that extent, the Association is committed to involving both staff and members in dialogue with the Department to arrive at a reasonable and equitable method of determining the likely acceptable increase in gross acute care charges. If necessary, the Association is committed to an exploration of a memorandum of agreement between the MRRP and the Department. We are sensitive to the difficulties that might arise if such an agreement could not be achieved.

Secondly, the Association is concerned with the definition, in rules, of the term "gross acute care charges". While we realize the Department's reasons for necessarily including volume, mix and intensity components to the definition, we would suggest a modification to the definition which might benefit the consumers of Minnesota. We encourage the Department to exclude outpatient revenues from the definition of acute care charges. Such a procedure would, of course, exclude from the limitation of the percentage acceptable increase those institutional revenues associated with other than (generally speaking) inpatient acute care. Such an "unbundling" could result in an expansion of institutional involvement in providing community programs, outreach, etc. by virtue of allowing a pricing latitude not subject to program scrutiny. Any possible expansion into non-acute inpatient services could well be in accord with individual hospital plans as well as with the desires of local planning bodies. We stress that this suggestion is in an embryonic form. We will involve our members in a more detailed discussion of its feasibility subject to an assessment by the Department that such a definitional modification is possible.

Thirdly, we share your commitment to simplifying any review process the state's hospitals undergo. We appreciate that an attempt by the agency to enforce the prompt notification by a hospital, when it exceeds its original estimate to remain within the acceptable increase figure, could become a bureaucratic nightmare. We feel that there is a process that could enable the Department to fulfill its obligations and not encumber individual hospitals. It is:

- that each institution participating in this amended process file, within thirty days of the end of each fiscal quarter, a statement affirming (denying) its ability to stay within the limit established by the Commissioner

- that any institution exceeding the acceptable increase figure for two consecutive fiscal quarters file, within ninety days, the prospective budgetary information for the coming fiscal year. The panel decision would affirm the reasonableness of the financial requirements for the prospective year.

This suggestion is also embryonic and deserves much more detailed investigation. Coupled with the periodicity of the percentage increase promulgated by the Commissioner (and any update), this provision of the statute could prove the most troublesome to implement.

Finally, we would like to re-inforce our recommendation that any regulation deriving from this amendment to the law be segregated from the body of regulation currently in effect. As you indicated, to do otherwise would be a difficult task which could likely result in more than a modicum of confusion.

We would like to further discuss with you the Department's concerns, the industry's concerns and any other suggestions that may have been provided by interested parties during the comment period. Please advise me if the morning of August 13th is clear on your calendar.

Sincerely,

Brian

Brian F. McInerney
Director, Division of Health Economics

BFM:jll

cc: Steve Rogness, Tom Rubbelke

Exhibit III

minnesota department of health
717 s.e. delaware st. minneapolis 55440
(612) 296-5221

MEMORANDUM

TO: John Dilley, State Health Planning and Development Agency

Eric Monson, Agassiz Health Systems Agency

Felix Serelickas, Health Systems Agency of Western Lake Superior

Bruce Briggs, Min-Dak Health Systems Agency

Gerald Wantulok, Central Minnesota Health Systems Agency

Malcolm Mitchell, Metropolitan Health Board

Bjorn Larsen, Minnesota Health Systems Agency Six

Conrad Smith, Southeastern Minnesota Health Systems Agency

Carl Gustafson, Foundation for Health Care Evaluation

Gregory A. Pillette, Profession Services Quality Council of Minnesota

Brian McInerney, Minnesota Hospital Association

Tom Bubbelke, Minnesota Hospital Association

Vern Silvernail, Minnesota Hospital Association

Gary Appel, Council of Community Hospitals

Ernie Larson, Blue Cross Blue Shield of Minnesota

Terry Klus, Health Insurance Association of America

Lu Molberg, West Metro Trustee Council

Jim Lee, ABT Associates

Rodney S. Rasmusson, Robert G. Engelhart, and Co.

Kathy Lamp, House Research

Brian Osberg, Administrative Assistant, House Health and Welfare Committee

Debbie Huskins, Senate Staff

Larry Fredrickson, Senate Staff

Robert Trumpin, Minnesota Society of Certified Public Accountants

Donald Mills, Bethesda Lutheran Hospital

Roger Jorgenson, Hospital Financial Managers Association

Tom Jolicoeur, Department of Public Welfare

FROM: Fred Sattler, Director, Hospital Rate Review
Minnesota Department of Health

DATE: September 19, 1979

RE: (1) Proposed Rules Relating to Annual Exemptions from the Rate Review Process for Certain Hospitals

(2) Hospital Statistics for Budget Year 1979

During the Spring of 1979, the Minnesota Legislature passed and the Governor signed a bill amending the statute authorizing the Commissioner of Health to review and comment upon hospital rates and costs. Enclosed you will find a copy of the amendment and a first draft of the rules which will be used to administer the statutory amendment.

The proposed rules are divided into three major sections:

1. An amendment to current rate review rule 7MCAR §1.472G., the definition of "charges"

2. An addition to current rate review rule 7MCAR §1.474 A., "reporting requirements".

3. A new section, 7MCAR §1.505 "Acceptable Change in Hospital Gross Acute Care Charges," to be added to the set of rate review rules.

There will be a meeting at the Minnesota Department of Health:

Room: 408
Time: 1:00 p.m. - 3:00 p.m.
Date: October 9, 1979

Also enclosed are hospital summary statistics for Budget Year 1979. These statistics represent both individual hospital and statewide anticipated financial and statistical pictures for hospitals whose fiscal years end in 1979. These data were extracted from Rate Revenue and Expense Reports submitted to the Department by the Minnesota Hospital Association.

If you have any questions concerning either the proposed rules or the summary statistics, please do not hesitate to contact either Diane Harder or myself. We can be reached at (612) 296-5573 or 296-5572.

FLS:km

Enc.s

Exhibit IV

minnesota hospital association

serving nonprofit hospitals and nursing homes

December 10, 1979

DEC 1 2 1979

Mr. Fredric Sattler
Hospital Rate Review System
Minnesota Department of Health
717 Delaware Street SE
Minneapolis, MN 55414

Dear Fred:

In response to your request at our November 7, 1979, meeting, this is to inform you that the Minnesota Rate Review Program will ask that the reporting requirements of hospitals exempted under S.F. 60 include depreciation fund balance data for the prior year. This information could be collected either through completion of the relevant portion of ABBREVIATED MRRP FORM O, or through an addition to hospital financial statements.

I would like to suggest that this change be incorporated in the draft rules rather than argue for a change at the hearing. It is not anticipated either by the Program or MHA, that this additional requirement would be contested at the hearing.

The Program considers this additional data necessary to determine compliance with funding of charged depreciation and price level in years in which the hospital may not have been exempted. As you know, the Program requires that hospitals be accountable for such funds, as required by the rate review rules, and such a compliance check is an integral part of the hospital review process.

Please call me at your convenience if you have any questions.

Sincerely,

Carl Schwensohn

Carl Schwensohn
Senior Financial Analyst &
Acting Manager, Rate Review

kq
cc: Steve Rogness
Jim Cox
Chuck Ego
Donald Mills
Brian McInerney

2333 UNIVERSITY AVENUE SOUTHEAST • MINNEAPOLIS, MINNESOTA 55414 • PHONE (612) 331-5571

Exhibit V

minnesota department of health
717 s.e. delaware st. minneapolis 55440
612 296 5221

M E M O R A N D U M

TO: John Dilley, State Health Planning and Development Agency

Eric Monson, Agassiz Health Systems Agency

Felix Sereicikas, Health Systems Agency of Western Lake Superior

Bruce Briggs, Min-Dak Health Systems Agency

Gerald Wantulok, Central Minnesota Health Systems Agency

Malcolm Mitchell, Metropolitan Health Board

Bjorn Larsen, Minnesota Health Systems Agency Six

John Boustead, Southeastern Minnesota Health Systems Agency

Carl Gustafson, Foundation for Health Care Evaluation

Gregory A. Pilette, Professional Services Quality Council of Minnesot

Brian McInerney, Minnesota Hospital Association

Carl Schwensohn, Minnesota Hospital Association

Vern Silvernale, Minnesota Hospital Association

Gary Appel, Council of Community Hospitals

Ernie Lamson, Blue Cross and Blue Shield of Minnesota

Terry Klas, Health Insurance Association of America

Lu Molberg, West Metro Trustee Council

Jim Lee, ABT Associates

Rodney S. Rasmusson, Robert G. Engelhart, and Co.

Kathy Lamp, House Research

Brian Osberg, Administrative Assistant, House Health and Welfare Committee

Debbie Huskins, Senate Staff

an equal opportunity employer

Larry Fredrickson, Senate Staff

Robert Trumpis, Minnesota Society of Certified Public Accountants

Donald Mills, Bethesda Lutheran Hospital

Roger Jorgenson, Hospital Financial Managers Association

Tom Jolicoeur, Department of Public Welfare

FROM: Fredric L. Sattler, Director
Hospital Rate Review Program
Minnesota Department of Health

DATE: March 10, 1980

SUBJECT: Second Draft of Proposed Rules for Certain Hospitals Exempt from Rate Review

As promised some months ago, I am forwarding to you the second draft of the proposed rules we reviewed in September, as well as a copy of a letter I recently received from the Minnesota Hospital Association.

I have made two changes that were not discussed during our meeting, one replaces the two year average compound rate of change with a single year rate of change. In the long-run, the single year rate of change will cause less confusion and it more accurately reflects the language in the statute.

The other, establishes two sets of hospitals, large and small, for which an acceptable increase is to be established and reduces the reporting requirements for the small hospital set.

I am not planning on calling another meeting to review this draft, but I would like to hear from you if you have any problems with it. If I find that your comments require major changes, I will call another meeting.

I would like to hear from you by March 21, 1980 so that I can publish the proposed rules in the State Register early in April.

FLS:pe

Enclosures

Date _____ Hospital _____ Location _____

Exhibit I

Key — Part One: PRIMARY SCREEN ANALYSIS — Key

COST SCREENS: TWO YEAR TREND COMPARED TO GROUP MEAN

	Prior Year	% Change	Current Year	% Change	Budget Year	Compounded % Change
1. Hospital Adjusted Cost Per Stay	Total hospital operating expenses (A57 or 79/M18) divided by adjusted admissions					
2. Peer Group*	Line 45, Summary of Hospital Indicators					
3. Variance Per Stay	Line 1 - line 2					
4. Total Variance	Line 3 X Adjusted admissions					
5. Hospital Adjusted Cost Per Day	Total hospital operating expenses (A57 or 79/M18) divided by adjusted patient days					
6. Peer Group	Line 72, Summary of Hospital Indicators					
7. Variance Per Day	Line 5 - line 6					

ADJUSTED PATIENT DAYS = PAT. DAYS (E50/M26) X RECIPROCAL OF INPATIENT REVENUE DIVIDED BY TOTAL HOSPITAL REVENUE

ADJUSTED ADMISSIONS = ADMISSIONS (E51/M29) X RECIPROCAL OF INPATIENT REVENUE DIVIDED BY TOTAL HOSPITAL REVENUE

RATE SCREENS: TWO YEAR TREND COMPARED TO GROUP MEAN

8. Hospital Aggregate Rate	Total Hospital Patient Charges (A75 or 101/M28) divided by adjusted admissions					
9. Peer Group	Line 55, Summary of Hospital Indicators					
10. Variance Per Adj. Adm.	Line 8 - line 9					
11. Total Variance	Line 10 X Adjusted Admissions					
12. Hospital Aggregate Rate	Same as Line 8					
13. Allowable Interim Increase	See Rate Review Monitors for two year allowable interim increase for appropriate fiscal yea*					
14. Variance Per Adjusted Admission	Line 12 - line 13					

15. Total Revenue Increase — PY to CY _____ % (% change, PY to CY A75 or 101/M28) — CY to BY _____ % (% change, CY to BYA A75 or 101/M28)

16. Requested Price Increase — PY to CY _____ % (See cover sheet, formset.) — CY to BY _____ % (See cover sheet, formset. % change, CY to BYB, A75 or 101/M2

* Multiply PY aggregate rate(hospital) times allowable interim rate increase PY to CY, enter in CY column, line 13
Multiply CY aggregate rate (hospital) times allowable interim rate increase CY to BY, enter in BY column, line 13

The PY column for lines 13 and 14 will be blank.

Date _____

Exhibit I

Part Two: STATISTICS

Key

Hospital _____
Location _____

	Prior Year	% Change	Current Year	% Change	Budget Year
1. Acute Beds	E65/Q35				
2. Nursery	E66/Q39				
3. Non-Acute	E67/Q40				
4. % Occupancy-Licensed	E54/N31				
Peer Group	Line 15, Summary of Hospital Indicators				
5. % Occupancy-Staffed and Setup	E55/N32				
Peer Group	Disclosure of Minnesota Hospital Indicators (most recent). Not available on Summary.				
Variance as a %	Hospital occupance - Peer group divided by peer group				
6. Patient Days	E50/N26				
Peer Group	Summary of Hospital Indicators, line 1,				
7. Adjusted Patient Day	See Exhibit I, Primary Screens for calculation				
Peer Group	Summary of Hospital Indicators, line 11,				
8. Admissions	E51/N29				
Peer Group	Summary of Hospital Indicators, line 12				
9. Adjusted Admissions	See Exhibit I, Primary Screens				
Peer Group	Summary of Hospital Indicators, line 13				
10. Average Length of Stay	E53/N30				
Peer Group	Summary of Hospital Indicators, line 14				

11. Change in ALOS from PY to Cy due to _____ Information obtained from hospital.

12. Change in ALOS from PY to CY due to _____ Information obtained from hospital.

Date _____ **Key Exhibit I** Hospital _____ Location _____

Part Three: SECONDARY SCREEN ANALYSIS

DEPARTMENTAL CLASSIFICATIONS: HOSPITAL COMPARED TO GROUP MEAN

	Prior Year	% Change	Current Year	% Change	Budget Year
ROUTINE DIRECT COSTS					
1. Hospital Per Adjusted Admission	C23/N2 Routine Direct Costs divided by Adjusted Admissions				
2. Peer Group	Summary of Hospital Indicators, line 91				
3. Variance	Line 1 - line 2				
4. Hospital Per Adjusted Patient Day	Routine Direct Costs (C23/N2) divided by Adjusted Patient Days				
5. Peer Group	Summary of Hospital Indicators, line 97				
6. Variance	Line 4 - line 5				
ANCILLARY DIRECT COSTS					
7. Hospital Per Adjusted Admission	Ancillary Direct Costs (C50/N3) divided by Adjusted Admissions				
8. Peer Group	Summary of Hospital Indicators, line 92				
9. Variance	Line 7 - line 8				
10. Hospital Per Adjusted Patient Day	Ancillary Direct Costs (C50/N3) divided by Adjusted Patient Days				
11. Peer Group	Summary of Hospital Indicators, line 98				
12. Variance	Line 10 - line 11				
GENERAL AND ADMINISTRATIVE DIRECT COSTS					
13. Hospital Per Adjusted Admission	Total Allocated Hospital Costs (C163 - 51/N21 - 6) divided by Adj. Admissions				
14. Peer Group	Summary of Hospital Indicators, line 93.				
15. Variance	Line 13 - line 14				
16. Hospital Per Adjusted Patient Day	Total Allocated Hospital Costs (C163 - 51/N21 - 6) divided by Adj. Pat. Days				
17. Peer Group	Summary of Hospital Indicators, line 99.				
18. Variance	Line 16 - line 17.				

Date _____

Exhibit I

Hospital _____
Location _____

Part Three: SECONDARY SCREENS, CONTINUED

NATURAL EXPENSE CLASSIFICATIONS: HOSPITAL COMPARED TO GROUP MEAN

	Prior Year	% Change	Current Year	% Change	Budget Year
1. Salaries					
Peer Group					
2. Employee Benefits					
Peer Group					
3. Medical Fees					
Peer Group					
4. Raw Food					
Peer Group					
5. Drugs					
Peer Group					
6. Medical Supplies					
Peer Group					
7. Other Supplies					
Peer Group					
8. Utilities					
Peer Group					
9. Repairs and Mainteance					
Peer Group					
10. Rental Expense					
Peer Group					
11. Insurance					
Peer Group					
12. Interest Expense					
Peer Group					
13. Building Depreciation					
Peer Group					
14. Equipment Depreciation					
Peer Group					
15. Other Expense					
Peer Group					

These are calculated as natural expenses per unit, either per adjusted patient days or adjusted admissions. Natural expenses on Form A, lines 1 - 55 and on Form M, lines 1 - 16 for the abbreviated formset.

Natural expenses are divided by the appropriate units and compared to the peer group means found on the Summary of Hospital Indicators, lines 30 - 44 per adjusted admission and lines 57 - 71 per adjusted patient day.

Remember that the peer group means are for hospital only. If hospital operating expenses (Line A70 or M18) are not equal to total institution operating expenses (Line A56 or 57 or M17), an adjustment factor needs to be used.

This adjustment factor is equal to: TOTAL HOSPITAL PATIENT REVENUE (B50/M12)
TOTAL INSTITUTION REVENUE (B56)

For the abbreviated formsets, the total institution revenue will have to be obtained from the audited financial statements in the prior year and a ratio obtained. The same ratio will then have to serve as an approximation for all three years unless the formset preparer has listed this information on a worksheet.

Date _____

Exhibit II

Hospital _____
Location _____

VOLUME ADJUSTED TREND ANALYSIS

NATURAL COST CLASSIFICATIONS: COMPARISON OF ACTUAL TO BUDGET

	Prior Year	% Change	Current Year	% Change	Budget Year	% Change
1. Salaries/FTE						
Budget Factor						
Variance	THESE VALUES ARE TRASNFERRED FROM THE EXHIBIT II WORKSHEET, WHICH HAS EQUATIONS FOR CALCULATION.					
2. Employee Benefits/FTE						
Budget Factor						
Variance						
3. Medical Fees/Adjusted Day						
Budget Factor						
Variance						
4. Rawfood/Meal						
Budget Factor						
Variance						
5. Drugs/Prescription						
Budget Factor						
Variance						
6. Medical Supplies/Adjusted Day						
Budget Factor						
Variance						
7. Other Supplies/Adjusted Day						
Budget Factor						
Variance						
8. Utilities/Square Foot						
Budget Factor						
Variance						

Exhibit II

VOLUME ADJUSTED TREND ANALYSIS

NATURAL COST CLASSIFICATIONS: COMPARISON OF ACTUAL TO BUDGET, CONTINUED

	Prior Year	% Change	Current Year	% Change	Budget Year	% Change
9. Repairs and Maintenance/Square Foot						
Budget Factor						
Variance						
10. Rental Expense						
Budget Factor						
Variance						
11. Insurance						
Budget Factor						
Variance						
12. Interest						
13. Building Depreciation						
14. Equipment Depreciation						
15. Other Expense/Adjusted Day						
Budget Factor						
Variance						
16. Total Unfavorable Variances	TOTAL ALL POSITIVE	VARIANCES FOR EACH COLUMN.				

Date _____

Exhibit III

Hospital _____
Location _____

Key

SALARY AND FULL TIME EQUIVALENT ANALYSIS

Key

Part One: SALARIES

	Prior Year	% Change	Current Year	% Change	Budget Year
1. TOTAL SALARIES	P31/D101 Total hospital salaries.				
ROUTINE SALARIES					
2. Hospital-Per Adjusted Admission	Daily hospital service salaries (D13/P21) divided by adjusted admissions				
Peer Group	Summary of Hospital Indicators, line 88				
3. Hospital-Per Adjusted Day	Daily hospital service salaries (D13/P21) divided by adjusted patient days				
Peer Group	Summary of Hospital Indicators, line 94)				
4. Hospital-Per FTE	Daily hospital service salaries (D13/P21) divided by daily service FTES (D13/P2				
Peer Group	Summary of Hospital Indicators, line 85.				
ANCILLARY SALARIES					
5. Hospital-Per Adjusted Admission	Hospital ancillary salaries (D50/P22) divided by adjusted admissions				
Peer Group	Summary of Hospital Indicators, line 89				
6. Hospital-Per Adjusted Day	Hospital ancillary salaries (D50/P22) divided by adjusted patient days				
Peer Group	Summary of Hospital Indicators, line 95				
7. Hospital-Per FTE	Hospital ancillary salaries (D50/P22) divided by ancillary FTEs (D50/P22)				
Peer Group	Summary of Hospital Indicators, line 86				
GENERAL AND ADMINISTRATIVE SALARIES					
8. Hospital-Per Adjusted Admission	G & A salaries (D101 - 5/P31 - 21 - 22) divided by adjusted admissions				
Peer Group	Summary of Hospital Indicators, line 90				
9. Hospital-Per Adjusted Day	G & A salaries (D101 - 5/P31 - 21 - 22) divided by adjusted patient days				
Peer Group	Summary of Hospital Indicators, line 96				
10. Hospital-Per FTE	G & A salaries (D101 - 5/P31 - 21 - 22) divided by G & A FTEs (same line)				
Peer Group	Summary of Hospital Indicators, line 87				
11. Average Salary Per FTE	Total hospital salaries (D101/P31) divided by total hospital FTEs (same line)				
12. Peer Group	Summary of Hospital Indicators, line 84				
13. Variance Per FTE	Line 11 - line 12.				
14. Total Variance	Line 13 times total hospital FTEs				

Date _____

Exhibit III

Hospital _____
Location _____

SALARY AND FULL TIME EQUIVALENT ANALYSIS

Key ~

Part Two: FULL TIME EQUIVALENT ANALYSIS

Key ~

	Prior Year	% Change	Current Year	% Change	Budget Year
1. FTEs Per Adjusted Occupied Bed	Total hospital FTEs (D101/P31) divided by adj. pat. days times 365 (or 366				
2. Peer Group	Summary of Hospital Indicators, line 19				
3. Variance Per Adjusted Occupied Bed	Line 1 minus line 2				
4. Total FTE Variance	Line 2 X adjusted pat days divided by 365 (or 366) days, subtract from to hosp. F				
5. Total Salary Variance	Line 4 X Average salary plus average empl. benefits per FTE				
6. FTE's Per Adjusted Admission	Total hospital FTEs divided by adjusted admissions				
7. Peer Group	Summary of Hospital Indicators, not available				
8. Variance Per Adjusted Admission	Line 6 minus line 7				
9. Total FTE Variance	Line 7 x adj. admissions, subtract from total hosp. FTEs (D101/P31)				
10. Total Salary Variance	Line 9 times average salary plus average empl. benefits per FTE				
ROUTINE MANHOURS OF CARE					
11. Hospital-Per Day	Total daily hosp. service FTEs (D13/P21) X 2080 divided by patient days (E /N2				
Peer Group	Summary of Hospital Indicators, line 20				
ANCILLARY MANHOURS OF CARE					
12. Hospital-Per Day	Total ancillary FTEs (D50/P22) X 2080 divided by Patient Days (E50/N26)				
Peer Group	Summary of Hospital Indicators, line 28				
GENERAL AND ADMIN. MANHOURS OF CARE					
13. Hospital-Per Day	G & A FTEs (D101 - 51/P31 - 21 - 22) X 2080 divided by patient days (E50/N				
Peer Group	Summary of Hospital Indicators, line 29				
14. Total FTE's	Total hospital FTEs (D101/P31)				
15. Total Patient Days	Total hospital patient days (E50/N26)				
16. Total Adjusted Days	See earlier calculation				
17. Total Admissions	Total inpatient admissions (E51/N29)				
18. Total Adjusted Admissions	See earlier calculation				

Total FTE's

'80 submission
79 submission
78 submission

Budget Year _____
Current Year _____ BY
Prior Year _____ CY BY

FTEs Per Adjusted Occupied Bed

Budget Year _____
Current Year _____ _____
Prior Year _____ _____ _____

Date _____

Exhibit IV

Hospital _____
Location _____

ANALYSIS OF ACCOUNTS RECEIVABLE AND WORKING CAPITAL

NET DAYS CHARGES IN NET PATIENT RECEIVABLES	Prior Year	% Change	Current Year	% Change	Budget Year
1. Hospital	Net days charges in accounts receivables (I-1, line 52/P13)				
2. Peer Group	Summary of Hospital Indicators, line 104				
3. Variance	Line 1 - line 2				
If Net Days Charges are at the Group _____ Level in the BY the Working Capital Requirement Would Change by $_____	For abbreviated formset net Medicare receivables can be calculated as on form I-1, long forms.				
Net Days Charges According to Payor:					
4. Medicare	I-1 line 9				
5. Medicaid	I-1, line 19				
6. Blue Cross	I-1, line 29				
7. Other Insurers	Form I-1, line 39				
8. Self Pay	I-1, line 47				
WORKING CAPITAL COMPOSITION TRENDS					
Net Accounts Receivable/CA					
Inventories/CA					
Prepaid Expenses/CA					
Other Current Assets/CA					
Trade Accounts Payable/CL	THESE TREND INDICATORS CALCULATED AS LISTED				
Salaries Payable/CL					
Other Current Liabilities/CL					
HOSPITAL FINANCIAL RATIOS					
RECEIVABLE RATIOS:					
9. Allowance for Uncollectibles / Gross Receivables	CALCULATED AS LISTED				
10. Bad Debts Expense / Total Operating Revenue	CALCULATED AS LISTED				
11. Total Patient Revenue / Net Accounts Receivable	CALCULATED AS LISTED				
LIQUIDITY					
1. Days Cash					
2. Quick Ratio					
PROFITABILITY					
3. Net Take-Down					
4. Net Gain					
DEBT AND TURNOVER					
5. Debt Ratio					
6. Asset Turnover					

This set represents the proposed amendments to the rate review rules that went to hearing. Post hearing changes are indicated in red.

April 21, 1980

PROPOSED RULES

RECEIVED
MAY 14 1980
OFFICE OF HEARING EXAMINERS

1. 7 MCAR §1.472

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. 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," "gross acute care charges," and "gross rate" are synonymous for the purpose of these rules.

2. 7 MCAR §1.474 A.9.

Each hospital claiming exempt status pursuant to Minnesota Statutes 144.7021 and 7 MCAR §1.505 shall include or append a clearly identifiable statement(s) of annual gross acute care charges.

3. 7 MCAR §1.505 Acceptable Increases in Hospital Gross Acute Care Charges: Exemptions from Hospital Rate Review.

A. Each hospital that anticipates an increase in budget year gross acute care charges which is less than the acceptable increase determined by the Commissioner of Health may claim and shall be granted, an exemption from the filing of a rate revenue and expense report as required by 7 MCAR §1.481 C. and as described in 7 MCAR §1.481 C. and the review and comment provisions of 7 MCAR §1.487 C.2., upon filing an abbreviated projected operating statement as described in 7 MCAR §1.505 E.2.

B. Commissioner of Health Establishment:

1. The Commissioner of Health shall establish at the beginning of each quarter of the fiscal year (July 1, October 1, January 1, April 1), a percentage figure for each set of hospitals described in 7 MCAR §1.505 B.3., representing an acceptable increase in gross acute care charges for the succeeding six quarters (eighteen months).

a. Each hospital being reviewed by the Commissioner of Health pursuant to Minnesota Statutes §144.701 shall be notified of each quarterly established acceptable increase in and adjustments to the acceptable increase in gross acute care charges pursuant to 7 MCAR §1.505 D.

b. Each voluntary non-profit rate review organization approved pursuant to 7 MCAR §1.496 shall be notified of each quarterly established acceptable increase in and adjustments to the acceptable increase in gross acute care charges and shall in turn notify each of the hospitals electing to be reviewed by said organization.

2. Basis. The single percentage figure established by the Commissioner of Health shall be the algebraic sum of the following percentages:

a. An estimate of the forthcoming annual rate of change in the average total cost of all goods and services to hospitals. This estimate shall be determined by summing the weighted change in price of each of the natural expense classifications described in 7 MCAR §1.474 A.2.f. The weights shall be the proportionate contributions of each of these natural expense classifications to hospitals' total cost. The estimate shall explicitly recognize the expected overall level of price change in the state's economy and shall be derived from expected annual changes in the Consumer and/or Producer Price Indices, and/or relevant components of the Consumer and/or Producer Price and/or other similar economic indices published by ~~the Bureau~~ an agency

the Federal + State Governments.
of ~~Labor Statistics, United States Department of Commerce.~~

rate of change in the
b. An estimate of the dollar value of the forthcoming annual statewide ~~rate of~~ change in:

1) the average mix of patients utilizing hospitals, and

2) the average intensity of services received by patients during hospital stays or visits

as is consistent with the delivery of medical care which is of generally accepted quality and efficiency. The estimate shall not be less than zero nor more than .036.

For the purposes of this section:

1) "Mix" means the types of illnesses, injuries, and conditions treated in hospitals.

2) "Intensity of services" means the styles and methods of treating illness, injuries, and conditions in hospitals.

c. An estimate of the forthcoming annual rate of change in the statewide number of hospital adjusted admissions per 1,000 population as is consistent with the delivery of medical care which is of generally accepted quality and efficiency.

~~3. For purposes of 7 MCAR §1.505, hospitals shall be divided into two sets, as of the effective date of these rules and every 5 years thereafter, as follows:~~

~~a. Set I shall be composed of hospitals whose~~

combined total gross acute care charges (inpatient plus outpatient) comprise 15% of total gross acute care charges (inpatient plus outpatient) for all non-state, non-federal acute care hospitals. Determination of the hospitals to be included in this set shall be made as follows:

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

2) The hospital with the lowest total gross acute care charges shall be selected first. The hospital with the second lowest total gross acute care charges shall be selected second and its gross acute care charges shall be added to the charges of the first selected hospital. The hospital with the third lowest gross acute care charges shall be selected third and its total gross acute care charges shall be added to the sum of the gross acute care 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 acute care charges included shall not exceed 15%

of the total gross acute care charges for all non-state and non-federal acute care hospitals subject to the provisions of Minnesota Statutes §§144.695-144.703.

b. Set II shall be composed of all non-state, non-federal acute care hospitals subject to the provisions of Minnesota Statutes §§144.695-144.703 and not included in Set I as described in 7 MCAR §1.505 B.3.a.

C. Conformity

1. Each exempted hospital, by the close of the third quarter of its fiscal year, shall assess its likely conformity with its most recently filed abbreviated projected operating statement. If the anticipated actual increase in gross acute care charges, to be reported pursuant to 7 MCAR §1.474 A.9., for an exempt hospital is in excess of the acceptable increase in gross acute care charges under which exemption was claimed pursuant to 7 MCAR §1.505 A., as adjusted pursuant to 7 MCAR §1.505 D., then that hospital shall file a rate revenue and expense report for the coming budget year pursuant to 7 MCAR §1.474 B. and 7 MCAR §1.481 C.

2. If an exempt hospital estimates that it is likely to conform with its most recently filed abbreviated

projected operating statement and does not file a rate revenue and expense report pursuant to 7 MCAR §1.505 C.1. and it is subsequently found that the actual increase in gross acute care charges was more than .00125 in excess of the acceptable increase in gross acute care charges under which exemption was claimed pursuant to the 7 MCAR §1.505 A., as adjusted pursuant to 7 MCAR §1.505 D., then that hospital shall file a rate revenue and expense report pursuant to 7 MCAR §1.481 C. no later than 150 days after the close of the fiscal year in question.

D. Adjustments to the acceptable change. Each figure in 7 MCAR §1.505 B. shall be adjusted and updated at the close of the third quarter after its establishment according to the criteria specified in 7 MCAR §1.505 B.2.a. and shall reflect actual changes in the overall price change level throughout the state's economy. The updated figure shall be used when judging conformity to 7 MCAR §1.505 C.1.

E. Abbreviated Projected Operating Statement.

1. Each hospital claiming exempt status shall file an abbreviated projected operating statement no later than the commencement of its fiscal year or up to sixty days prior to the commencement of its fiscal year . Pursuant to Minnesota statutes §144.701, Subd.5. no change in rates

may be made until sixty days have elapsed from the date of filing.

2. An abbreviated projected operating statement ~~for hospitals in Set II, as described in 7 MCAR §1.505 B.3.b.1.~~ shall include the following data for the prior, current and budget years:

~~a. A natural expense summary consisting of total~~ institutional expenses for:

(1) Salaries and wages,

(2) Employee benefits,

(3) Medical Fees,

(4) Raw food,

(5) Drugs,

(6) Medical Supplies,

(7) Other Supplies,

(8) Utilities,

(9) Repairs and Maintenance,

(10) Rental Expense,

(11) Insurance,

(12) Interest,

(13) Depreciation - buildings and fixed equipment,

(14) Depreciation - movable equipment,

(15) Other expense.

a. ~~b.~~ Total acute care hospital operating expense.

b. ~~c.~~ Total institutional patient charges.

c. ~~d.~~ Total acute care hospital patient charges.

d. ~~e.~~ Total acute care hospital inpatient charges.

e. ~~f.~~ Total acute care hospital outpatient charges.

f. ~~g.~~ An expense analysis consisting of acute care:

(1) Direct costs for:

(a) Daily hospital services,

(b) Ancillary service,

(c) Non-revenue producing centers.

(2) Costs after allocation of non-revenue producing centers costs to:

(a) Daily hospital services,

(b) Ancillary service.

g. ~~h.~~ An acute care hospital statistical summary consisting of:

(1) Number of patient days (excluding nursery),

(2) Number of nursery days,

(3) Number of total patient days,

(4) Number of admissions,

(5) Average length of stay,

(6) Occupancy - licensed beds,

(7) Occupancy - staffed and set-up beds,

(8) Number of outpatient and emergency room visits.

h. ~~i.~~ An acute care hospital full time equivalent summary consisting of salary and numbers of full-time equivalent personnel for:

(1) Daily hospital services,

(2) Ancillary services,

(3) Non-revenue producing centers,

(4) Total hospital,

(5) Total institution.

i. ~~j.~~ An acute care bed summary consisting of:

(1) Number of licensed beds,

(2) Number of physically present beds,

(3) Number of staffed and set-up beds.

j. ~~k.~~ Depreciation Fund

(1) Beginning Balance,

(2) Ending Balance.

~~3. An abbreviated projected operating statement for hospitals in Set I, as described in 7 MCAR §1.505 B.1.a., shall include all data elements found in 7 MCAR §1.505 B.2.b,c,d,e,f,g,h,i,j,k.~~

3. ~~4.~~ The information provided on the abbreviated projected operating statement shall support the hospital's claim that it will achieve an increase in gross acute care charges less than that established by the Commissioner of Health pursuant to 7 MCAR §1.505 B.

STATE OF MINNESOTA)
(ss.
COUNTY OF RAMSEY)

AFFIDAVIT OF SERVICE

Eileen A. Gaiovnik, being first duly sworn, deposes and says that on the 30th day of July, 1980, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Report of the Hearing Examiner, HLTH-80-050-PE

unstamped, by placing in the designated tray to be collected by messenger for delivery to the central mailing station as required by Minn. Stat. § 16.54 (1974), a true and correct copy thereof on all persons at the addresses shown on the attached mailing list.

Eileen A. Gaiovnik

Subscribed and sworn to before me this
30th day of July, 1980.

Susan C. Wojcik

SUSAN C. WOJCIK
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Commission Expires April 26, 1986

Mr. Fredric Sattler, Director
Hospital Rate Review
Department of Health
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Minneapolis, Minnesota - 55440

Mr. John A. Breviu
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STATE OF MINNESOTA
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Planning & Resources Control Section
JUL 31 1980

July 30, 1980

Mr. Fred Sattler
Director of Hospital Rate Review
Department of Health
717 Delaware Street SE
Minneapolis, Minnesota 55440

Re: In the Matter of Proposed Amendments to Rules Governing the Minnesota Hospital Rate Review System. Docket No. HLTH-80-050-PE.

Dear Mr. Sattler:

Enclosed and served upon you by mail, please find the Report of the Hearing Examiner in the above-entitled matter. Also enclosed is the official record, including the tapes of the proceedings, Tape Nos. 1797 and 1798.

Yours very truly,

Peter C. Erickson

PETER C. ERICKSON
Hearing Examiner

Telephone: 612/296-8118

PCE:sw
Encs.

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

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

REPORT OF THE HEARING EXAMINER

The above-entitled matter came on for hearing before Hearing Examiner Peter C. Erickson of the State Office of Hearing Examiners at 9:30 a.m. on Friday, June 27, 1980 in Room 105 of the Department of Health Building, Minneapolis, Minnesota.

John A. Breviu, Special Assistant Attorney General, appeared on behalf of the Department of Health. Fredric Sattler, Director of Hospital Rate Review, testified in support of the proposed rules on behalf of the Department. The hearing continued until all interested groups or persons had had an opportunity to be heard concerning the adoption of the proposed rules.

Pursuant to Minn. Stat. § 15.0412, subd. 4 (1978), this Report shall be available for review to all affected individuals upon request for at least five days. Thereafter, the Commissioner of Health shall, if he proposes to adopt the rules as originally proposed or amended, submit a copy of the Order Adopting Rules, a copy of any additional agency findings, a copy of the rules as originally proposed, and a copy of the rules as adopted to the Chief Hearing Examiner for review pursuant to Minn. Stat. § 15.052, subd. 4 (1978). The submission to the Chief Hearing Examiner shall precede review by the Attorney General. The Chief Hearing Examiner shall complete his review and submit his report to the Commissioner on the issues of substantial changes in the rule and compliance with Minn. Stat. § 15.0412 (1978) within ten calendar days. The Commissioner will 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.

Based upon all the records and proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

1. On April 22, 1980, 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.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.

2. On May 19, 1980, a Notice of Hearing and a copy of the proposed rules were published at 4 State Register 1804.

3. On May 14, 1980, 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 May 30, 1980, 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 list.
(e) The Secretary of State's Certificate and list.
(f) The Statement of Need and Reasonableness.
(g) All materials received following a Notice of Intent to Solicit Outside Opinion published at 3 State Register 2307 (July 2, 1979).
(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.

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 Wednesday, July 9, 1980 for the receipt of written comments and statements.

6. Statutory authority to promulgate the proposed rules is contained in Minn. Stat. §§ 144.7021 (1979 Supp.) and 144.703 (1978).

7. At hearing, the Department corrected typographical errors which were contained in the State Register publication of the proposed rules as follows:

a. 7 MCAR § 1.505 A. - . . . expense report as required by 7 MCAR § 1.481 C. and as described in 7 MCAR § ~~1.481 C.~~ 1.474 B. and the review and comments . . . OK p.3

b. 7 MCAR § 1.505 E.3. - . . . all data elements found in 7 MCAR § 1.505 ~~B.~~E. 2.b., c., d., e., f., g., h., i., j., k. deleted from final form.

8. The amendment proposed to 7 MCAR § 1.472 G. defines the term "gross acute care charges" as it appears without definition in the statutory amendments to Minn. Stat. § 144.7021.

9. The amendment proposed to 7 MCAR § 1.474 A.9. requires each exempt hospital to include a statement of gross acute care charges as part of its income statement. This requirement is mandated by Minn. Stat. § 144.7021 (1979 Supp).

10. Proposed 7 MCAR § 1.505 A. sets forth the purposes of § 1.505 and the conditions and responsibilities of hospitals claiming exemption under Minn. Stat. § 144.7021 (1979 Supp.).

11. Proposed 7 MCAR § 1.505 B. states the responsibility of the Commissioner of Health to establish acceptable increases in gross acute care charges for each set of hospitals, the factors that must be considered in setting the rate increases, and the method to be used to divide hospitals into two sets for the purpose of determining exempt status.

a. The Minnesota Hospital Association (hereinafter "Association" or "MHA") contends that the intent of Minn. Stat. § 144.7021 (1979 Supp.) is the "promulgation of a single, statewide percentage figure by the Commissioner and the testing of all hospitals against that single screen." See, written testimony of MHA dated June 27, 1980. The Association argues that the Statement of Need and Reasonableness does not articulate the difference between the two sets of hospitals nor does it demonstrate that any difference is causally related to the rate of increase in gross acute care charges. The MHA recommends that all references in the rules to two sets of hospitals be stricken and that the Commissioner promulgate a single, statewide acceptable percentage increase for all hospitals. The Canby Community Hospital and Senior Haven Home, Canby, Minnesota; the Naeve Hospital Association, Albert Lea, Minnesota; the Mercy

Hospital and Nursing Home, Moose Lake, Minnesota; the Riverview Hospital Association, Crookston, Minnesota; the Kittson Memorial Hospital, Hallock, Minnesota; and the Miller-Dwan Hospital, Duluth, Minnesota, each submitted comments opposing the "two-set" concept and favoring a single percentage rate for all hospitals.

The Statement of Need and Reasonableness supports the hosital groupings as follows:

> The commissioner believes that there is a fundamental difference between large and small hospitals (Set I is made up of small hospitals, Set II is made up of large hospitals) and those differences can affect the rate of change in gross acute care charges. There are approximately 175 hospitals in the state that are subject to the provisions of Minnesota Statutes §§ 144.695-144.703. Sixty large hospitals account for about 85% of total state-wide hospital charges, while 120 hospitals account for the remaining 15%. The 60 larger hospitals are generally treating more seriously ill patients who require a different mix of resources. Therefore, the rate of change of the mix and intensity factor may be different for larger hospitals than for small hospitals.
>
> Additionally, the number of adjusted admissions is more stable in large than in small hospitals. Large fluctuations in the number of adjusted admissions from year to year will likewise cause relatively large fluctuations in gross acute care charges. These two factors sugsgest that it would be appropriate for the Commissioner to have the ability to consider and recognize the varying effects that different rates of change of the quantity component of gross acute care charges will have on large and small hospitals. The method being used to establish the two sets of hospitals is identical to the one being used to establish large and small hospital sets in MDH rule 7 MCAR § 1.475 A.

Subsequent to hearing, the Department stated in written comments that, "If, as MHA suggests, hospitals believe that it [dividing hospitals into two sets based upon size] will cause inequities, then the Commissioner does not object to withdrawing the proposed rule."

Minn. Stat. § 144.7021 (1979 Supp.), provides that the Commissioner shall "establish a percentage figure"; however, the Examiner does not read this language as mandating that only <u>one</u> figure be established. To group hospitals into two separate sets is a policy decision which the Department of Health has authority to utilize, if need and reasonableness can be shown. The Examiner finds that the record does contain enough supporting evidence to sustain the need for and reasonableness of the "two-set", "two-rate" system as proposed. However, if after a thorough review of the comments and testimony, the Department should favor a one-set, single-rate approach, the record will also support that proposal. In addition, though, several other amendments would have to be made to § 1.505 E. if the second approach is adopted.

see F. of F. "2-set concept is deleted.

b. The MHA proposes to amend § 1.505 B.2.a. by including other economic indices which might prove to be more reasonable and appropriate rather than only those published by the Bureau of Labor Statistics, United States Department of Commerce. The Department concurred with those concerns and suggested that the rule be amended as follows:

". . . published by an agency of the Federal or State Governments."

As amended, the Examiner finds the proposed rule to be both needed and reasonable.

OK p.4

c. The MHA proposes to clarify the intent of § 1.0505 B.2.b. as follows:

"An estimte of the rate of change in the dollar value of the forthcoming annual state-wide ~~rate of~~ change in: . . ."

ok. p. 5

The Department concurred in this proposed amendment. As amended, the Examiner finds the rule to be both needed and reasonable.

d. The MHA argued that the use of a population-based indicator as contained in § 1.505 B.2.c. artificially distorts any percentage increase or decrease in adjusted admissions. This argument was made at the hearing; however, after Mr. Sattler described in more detail how the calculation would be made by the Department, MHA opposition was withdrawn. The posthearing comments submitted by the Department also reflect this understanding.

e. The MHA contends that the use of the language, "as is consistent with the delivery of medical care which is of generally accepted quality and efficiency," to qualify components of the percentage increase allows too much discretion on the part of the Department as to which quality and efficiency criteria it may choose to employ. Absent the inclusion of criteria, the MHA reacommends that this language be deleted in part so that it would read:

". . .as is consistent with the delivery of medical care."

The Department argues that the language as proposed is necessary and reasonable for the following reasons:

1. It is necessary to provide parameters which bound the terms which will be summed to produce the percentage figure that the Commissioner will establish for reasons similar to those pointed out in the preceding discussion of 7 MCAR § 1.505 B.2.a. The rule provides a numerical set of bounds, i.e., 0.0 to .036, however, grounds for the selection of a figure between 0.0 and .086 should also be provided.

2. The grounds for selection of a figurae are quality and efficiency. Quality and efficiency are many times thought of as opposing forces, which could be used to bound the Commissioner's choice of a figure, i.e., excessive spending is many times justified in the name of quality and, likewise, necessary quality can be sacrificed in the name of efficiency.

3. Quality is an appropriate bound because the sustained choice of an unreasonably low figure over a period of time could adversely affect quality and/or contribute to the establishment of false expectations, on the part of the public, about the level of increase in spending necessary to maintain or increase quality health care.

4. Efficiency is an appropriate bound because an assurance of hospital operating efficiency is one of the primary rationalizations of the hospital rate review program. The Commissioner would be remiss if he/she knowingly set a figure that encouraged and condoned inefficiency.

5. The language of the statutory amendment speaks in terms of the Commissioner establishing ". . . a percentage figure for an acceptable increase in hospital gross acute care charges." (Minnesota Statutes § 144.7021). In the Commissioner's view, the figure should be "acceptable" in terms of allowing for necessary quality and the promotion of the efficient delivery of medical care in hospitals.

6. The "generally accepted" language proposed also acts as a conceptual bound on the Commissioner's ability to select a figure. "Generally accepted" restricts his/her choices to those levels of quality and efficiency that are and have been achieved, rather than an arbitrary or theoretically determined level of quality and efficiency.

The Examiner finds that the language as proposed is both needed and reasonable. Although the Department will have great latitude to determine what is quality and efficient medical care, the same latitude must also be read into the MHA proposal. The Department is entrusted by the State Legislature to make subjective judgments of this nature. The criteria of "generally accepted quality and efficiency" is not so vague or arbitrary as to invalidate the rule.

12. Proposed 7 MCAR § 1.505 C. sets forth the procedure to be used by an exempted hospital to file a rate revenue and expense report if it exceeded the figure established by the Commissioner. The filing is mandated by Minn. Stat. § 144.7021, subd. 2 (1979 Supp.).

13. Proposed 7 MCAR § 1.505 D. provides that the percentage figures determined by the Commissioner shall be adjusted in accordance with increases in the cost-of-living. This mechanism protects hospitals from initial under-estimations of inflation factors.

14. Proposed 7 MCAR § 1.505 E. sets forth the requirements for filing and content of an abbreviated projected operating statement. Minn. Stat. § 144.7021, subd. 1 (1979 Supp.) requires that all hospitals claiming exempt status file such a statement. As stated in Finding 11.a., § 1.505 E. will have to be amended if the Department chooses to adopt a "one-set", "single-rate" methodology. So amended - note deletions

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

CONCLUSIONS

1. The Department of Health gave due, timely and adequate legal notice of the hearing. All relevant, substantive and procedural requirements of law or rule have been met.

2. The Department of Health has documented its statutory authority to promulgate the proposed rules.

3. The Department of Health has demonstrated the need for and the reasonableness of the proposed rules, as amended herein, by an affirmative presentation of facts. The Department should further review this record to determine whether a single-rate or two-rate methodology is most appropriate. As the Examiner has stated herein, the need for and reasonableness of either method can be shown by this record. It is the responsibility of the Department to make this policy decision.

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

RECOMMENDATION

That the Department of Health adopt the proposed rules as amended herein.

Dated this 30 day of July, 1980.

Peter C. Erickson

PETER C. ERICKSON
Hearing Examiner