limitation contained in Minnesota Statutes, section 475.53, subdivision 1. The levy of taxes required by Minnesota Statutes, section 475.61 to pay the principal of and interest on the bonds shall not be subject to any levy limitations, or be included in computing or applying any levy limitation applicable to the city.

Sec. 2. **EFFECTIVE DATE.**

This act is effective the day after the filing of a certificate of local approval by the governing body of the city of Cologne in compliance with Minnesota Statutes, section 645.021, subdivision 3.

Approved March 24, 1986

CHAPTER 420—S.F.No. 2147

An act relating to health and human services; requiring the commissioner of health to monitor transitional care; authorizing use of swing beds by patients transferred from hospitals; requiring transportation services involving the use of a stretcher to meet life support transportation licensing standards; changing the computation of inpatient hospital rates; modifying the preadmission screening program; changing financial statement certification requirements for nursing homes that are phasing out of the medical assistance program; providing for refunds of excess charges; establishing requirements for medical assistance rate appeals procedures for intermediate care facilities; requiring a study of geographic groupings of nursing homes; establishing a task force on long-term care health planning; requiring a refund for private pay residents; amending Minnesota Statutes 1984, sections 144.801, subdivision 4; 174.29, subdivision 1; and 251.011, subdivision 4; and Minnesota Statutes 1985 Supplement, sections 144.562, subdivision 3; 256.969, subdivision 2; 256B.091, subdivisions 2, 4, 5, and 8; 256B.48 subdivision 1b and by adding a subdivision; and 256B.501, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 144.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1985 Supplement, section 144.562, subdivision 3, is amended to read:

Subd. 3. **APPROVAL OF LICENSE CONDITION.** The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision:

(a) The hospital must meet the eligibility criteria in subdivision 2.

(b) The hospital must be in compliance with the medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 405.1041.

(c) The hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the

duration of medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(d) The hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

(e) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(f) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

Sec. 2. **[144.564] MONITORING OF SUBACUTE OR TRANSITIONAL CARE SERVICES.**

Subdivision 1. **HOSPITAL DATA.** The commissioner of health shall monitor the provision of subacute or transitional care services provided in hospitals. All hospitals providing these services must report statistical data on the extent and utilization of these services on forms supplied by the commissioner. The data must include the following information: the number of admissions to and discharges from subacute or transitional care beds, charges for services in these beds, the length of stay and total patient days, admission origin and discharge destination, and other information required by the commissioner to assess the utilization of these services. For purposes of this subdivision, subacute or transitional care services is care provided in a hospital bed to patients who have been hospitalized and no longer meet established acute care criteria, and care provided to patients who are admitted for respite care.

Subd. 2. **NURSING HOME DATA.** Nursing homes which provide services to individuals whose length of stay in the facility is less than 42 days shall report the data required by subdivision 1 on forms supplied by the commissioner of health.

Subd. 3. **ANNUAL REPORT.** The commissioner shall monitor the provision of services described in this section and shall report annually to the legislature concerning these services, including recommendations on the need for legislation.

Sec. 3. Minnesota Statutes 1984, section 144.801, subdivision 4, is amended to read:

Subd. 4. "Life support transportation service" means transportation and treatment which is rendered or offered to be rendered preliminary to or during transportation to, from, or between health care facilities for ill or injured persons, or expectant mothers. The term includes all transportation involving the use of a stretcher, unless the person to be transported is not likely to require life support transportation service and medical treatment during the course of transport.

Sec. 4. Minnesota Statutes 1984, section 174.29, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** For the purpose of sections 174.29 to 174.31 "special transportation service" means motor vehicle transportation provided on a regular basis by a public or private entity or person that is designed exclusively or primarily to serve individuals who are elderly, handicapped, or disabled and who are unable to use regular means of transportation but do not require life support transportation service, as defined in section 144.801, subdivision 4. Special transportation service includes but is not limited to service provided by specially equipped buses, vans, taxis, and volunteers driving private automobiles.

Sec. 5. Minnesota Statutes 1984, section 251.011, subdivision 4, is amended to read:

Subd. 4. **OAK TERRACE NURSING HOME.** Any portion or unit of Glen Lake Sanatorium not used for the treatment of tuberculosis patients may be used by the commissioner of human services for the care of geriatric patients, under the name of Oak Terrace Nursing Home.

The commissioner of administration may lease any portion or unit of Oak Terrace Nursing Home for the purpose of providing food and shelter for the homeless.

Sec. 6. Minnesota Statutes 1985 Supplement, section 256.969, subdivision 2, is amended to read:

Subd. 2. **RATES FOR INPATIENT HOSPITALS.** Rates paid to inpatient

hospitals shall be based on a rate per admission until the commissioner can begin to reimburse hospitals for services under the medical assistance and general assistance medical care programs based upon a diagnostic classification system appropriate to the service populations. On July 1, 1984, the commissioner shall begin to utilize to the extent possible existing classification systems, including medicare. The commissioner may incorporate the grouping of hospitals with similar characteristics for uniform rates upon the development and implementation of the diagnostic classification system. Prior to implementation of the diagnostic classification system, the commissioner shall report the proposed grouping of hospitals to the senate health and human services committee and the house health and welfare committee. Effective August 1, 1985, the computation of the base year cost per admission and the computation of the relative values of the diagnostic categories must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs and days beyond that point. Claims paid for care provided on or after August 1, 1985, may be adjusted to reflect a recomputation of rates. The commissioner shall reconstitute the diagnostic categories to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the state register and a 30 day comment period. After May 1, 1986, acute care hospital billings under the medical assistance and general assistance medical care programs must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments with inpatient hospitals that have individual patient lengths of stay in excess of 30 days regardless of diagnosis-related group. For purposes of establishing interim rates, the commissioner is exempt from the requirements of chapter 14. Medical assistance and general assistance medical care reimbursement for treatment of mental illness shall be reimbursed based upon diagnosis classifications. The commissioner may selectively contract with hospitals for services within the diagnostic classifications relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to utilize a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital.

Sec. 7. Minnesota Statutes 1985 Supplement, section 256B.091, subdivision 2, is amended to read:

Subd. 2. **SCREENING TEAMS; ESTABLISHMENT.** Each county agency designated by the commissioner of human services to participate in the program shall contract with the local board of health organized under sections 145.911 to 145.922 or other public or nonprofit agency to establish a screening team to assess the health and social needs of all applicants prior to admission to a nursing home or a boarding care home licensed under section 144A.02 or sections 144.50 to 144.56, that is certified for medical assistance as a skilled nursing facility, intermediate care facility level I, or intermediate care facility level II. Each local screening team shall be composed of a public health nurse from the local public health nursing service and a social worker from the local com-

munity welfare agency. Each screening team shall have a physician available for consultation and shall utilize individuals' attending physicians' physical assessment forms, if any, in assessing needs. The individual's physician shall be included on the screening team if the physician chooses to participate. If a person who has been screened must be reassessed for purposes of assigning a case mix classification because admission to a nursing home occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team. If the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions but not in making the screening team's recommendations under subdivision 3, clause (e). If the assessment procedure or screening team recommendation results in a delay of the individual's discharge from the acute care facility, the facility shall not be denied medical assistance reimbursement or incur any other financial or regulatory penalty of the medical assistance program that would otherwise be caused by the individual's extended length of stay; 50 percent of the cost of this reimbursement or financial or regulatory penalty shall be paid by the state and 50 percent shall be paid by the county. Other personnel as deemed appropriate by the county agency may be included on the team. The county agency may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team with regard to individuals discharged from the facility and in those cases the discharge planners may participate in making recommendations under subdivision 3, clause (e). No member of a screening team shall have a direct or indirect financial or self-serving interest in a nursing home or noninstitutional referral such that it would not be possible for the member to consider each case objectively.

Individuals not eligible for medical assistance who are being transferred from a hospital to a nursing home may be screened by only one member of the screening team in consultation with the other member. The interagency board for quality assurance, with the participation of members of screening teams, shall identify other circumstances when it would be appropriate for only one member of a screening team to conduct the nursing home preadmission screenings. The committee shall report its recommendations to the legislature in January, 1987.

Sec. 8. Minnesota Statutes 1985 Supplement, section 256B.091, subdivision 4, is amended to read:

Subd. 4. **SCREENING OF PERSONS.** Prior to nursing home or boarding care home admission, screening teams shall assess the needs of all applicants, except (1) patients transferred from other nursing homes; (2) patients who, having entered acute care facilities from nursing homes, are returning to nursing home care; (3) persons entering a facility described in section 256B.431, subdivision 4, paragraph (b); (4) individuals not eligible for medical assistance whose length of stay is expected to be 30 days or less based on a physician's certification, if the facility notifies the screening team upon admission and provides an update to the screening team on the 30th day after admission; (5) individuals

who have a contractual right to have their nursing home care paid for indefinitely by the veteran's administration; or ~~(4)~~ (6) persons entering a facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing. The cost for screening ~~persons~~ applicants who are receiving medical assistance ~~or who would be eligible for medical assistance within 180 days of nursing home or boarding care home admission,~~ must be paid by ~~state, federal, and county money. Other persons shall be assessed by a screening team upon payment of a fee approved by the commissioner.~~ the medical assistance program. The total screening cost for each county for applicants who are not eligible for medical assistance must be paid monthly by nursing homes and boarding care homes participating in the medical assistance program in the county. The monthly amount to be paid by each nursing home and boarding care home must be determined by dividing the county's estimate of the total annual cost of screenings allowed by the commissioner in the county for the following rate year by 12 to determine the monthly cost estimate and allocating the monthly cost estimate to each nursing home and boarding care home based on the number of licensed beds in the nursing home or boarding care home. The monthly cost estimate for each nursing home must be submitted to the nursing home and the state by the county no later than February 15 of each year for inclusion in the nursing home's payment rate on the following rate year. The commissioner shall include the reported annual estimated cost of screenings for each nursing home or boarding care home as an operating cost of that nursing home in accordance with section 256B.431, subdivision 2b, clause (g). For all individuals regardless of payment source, if delay-of-screening timelines are not met because a county is late in screening an individual who meets the delay-of-screening criteria, the county is solely responsible for paying the nursing home rate for the resident days that exceed the delay-of-screening timelines until the screening is completed. Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

Sec. 9. Minnesota Statutes 1985 Supplement, section 256B.091, subdivision 5, is amended to read:

Subd. 5. **APPEALS.** Appeals from the screening team's recommendation shall be made pursuant to the procedures set forth in section 256.045, subdivisions 2 and 3. ~~An appeal shall be automatic if the individual's physician does not agree with the recommendation of the screening team.~~

Sec. 10. Minnesota Statutes 1985 Supplement, section 256B.091, subdivision 8, is amended to read:

Subd. 8. **ALTERNATIVE CARE GRANTS.** The commissioner shall provide grants to counties participating in the program to pay costs of providing alternative care to individuals screened under subdivision 4 and nursing home residents who request a screening. Prior to July of each year, the commissioner shall allocate state funds available for alternative care grants to each local agency. This allocation must be made as follows: half of the state funds available for alternative care grants must be allocated to each county according to the total number of adults in that county who are recipients age 65 or older who are reported to the department by March 1 of each state fiscal year and half of the state funds available for alternative care grants must be allocated to a county according to that county's number of medicare enrollments age 65 or older for

the most recent statistical report. Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home admission or continued stay if alternative care were not available; (2) who are receiving medical assistance or who would be eligible for medical assistance within 180 days of admission to a nursing home; (3) who need services that are not available at that time in the county through other public assistance; and (4) who are age 65 or older.

The commissioner shall establish by rule, in accordance with chapter 14, procedures for determining grant reallocations, limits on the rates for payment of approved services, including screenings, and submittal and approval of a biennial county plan for the administration of the preadmission screening and alternative care grants program. Grants may be used for payment of costs of providing care-related supplies, equipment, and services such as, but not limited to, foster care for elderly persons, day care whether or not offered through a nursing home, nutritional counseling, or medical social services, which services are provided by a licensed health care provider, a home health service eligible for reimbursement under Titles XVIII and XIX of the federal Social Security Act, or by persons employed by or contracted with by the county board or the local welfare agency. The county agency shall ensure that a plan of care is established for each individual in accordance with subdivision 3, clause (e)(2), and that a client's service needs and eligibility is reassessed at least every six months. The plan shall include any services prescribed by the individual's attending physician as necessary and follow up services as necessary. The county agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program and shall provide documentation in each individual's plan of care and to the commissioner that the most cost effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The county agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care grants program and that the agency allowed potential providers an opportunity to be selected to contract with the county board. Grants to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.

The commissioner shall establish a sliding fee schedule for requiring payment for the cost of providing services under this subdivision to persons who are eligible for the services but who are not yet eligible for medical assistance. The sliding fee schedule is not subject to chapter 14 but the commissioner shall publish the schedule and any later changes in the State Register and allow a period of 20 working days from the publication date for interested persons to comment before adopting the sliding fee schedule in final forms.

The commissioner shall apply for a waiver for federal financial participation to expand the availability of services under this subdivision. The commissioner shall provide grants to counties from the nonfederal share, unless the commis-

sioner obtains a federal waiver for medical assistance payments, of medical assistance appropriations. A county agency may use grant money to supplement but not supplant services available through other public assistance or service programs and shall not use grant money to establish new programs for which public money is available through sources other than grants provided under this subdivision. A county agency shall not use grant money to provide care under this subdivision to an individual if the anticipated cost of providing this care would exceed the average payment, as determined by the commissioner, for the level of nursing home care that the recipient would receive if placed in a nursing home. The nonfederal share may be used to pay up to 90 percent of the start-up and service delivery costs of providing care under this subdivision. Each county agency that receives a grant shall pay ten percent of the costs.

The commissioner shall promulgate emergency rules in accordance with sections 14.29 to 14.36, to establish required documentation and reporting of care delivered.

Sec. 11. Minnesota Statutes 1985 Supplement, section 256B.48, subdivision 1b, is amended to read:

Subd. 1b. **EXCEPTION.** Notwithstanding any agreement between a nursing home and the department of human services or the provisions of this section or section 256B.411, other than subdivision 1a of this section, the commissioner may authorize continued medical assistance payments to a nursing home which ceased intake of medical assistance recipients prior to July 1, 1983, and which charges private paying residents rates that exceed those permitted by subdivision 1, paragraph (a), for (i) residents who resided in the nursing home before July 1, 1983, or (ii) residents for whom the commissioner or any predecessors of the commissioner granted a permanent individual waiver prior to October 1, 1983. Nursing homes seeking continued medical assistance payments under this subdivision shall make the reports required under subdivision 2, except that on or after December 31, 1985, the financial statements required need not be audited by or contain the opinion of a certified public accountant or licensed public accountant, but need only be reviewed by a certified public accountant or licensed public accountant. In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing home under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing home.

Sec. 12. Minnesota Statutes 1985 Supplement, section 256B.48, is amended by adding a subdivision to read:

Subd. 7. **REFUND OF EXCESS CHARGES.** Any nursing home which has charged a resident a rate for a case-mix classification upon admission which is in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission, must refund the amount of charge in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission. Refunds must

be credited to the next monthly billing or refunded within 15 days of receipt of the classification notice from the department of health. Failure to refund the excess charge shall be considered to be a violation of this section.

Sec. 13. Minnesota Statutes 1985 Supplement, section 256B.501, subdivision 3, is amended to read:

Subd. 3. **RATES FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of intermediate care facilities for persons with mental retardation or related conditions. The procedures shall be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of residents in efficiently and economically operated facilities. In developing the procedures, the commissioner shall include:

(a) cost containment measures that assure efficient and prudent management of capital assets and operating cost increases which do not exceed increases in other sections of the economy;

(b) limits on the amounts of reimbursement for property, general and administration, and new facilities;

(c) requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles; ~~and~~

(d) incentives to reward accumulation of equity; and

(e) appeals procedures that satisfy the requirements of section 256B.50 for appeals of decisions arising from the application of standards or methods pursuant to Minnesota Rules, parts 9510.0500 to 9510.0890, 9553.0010 to 9553.0080, and 12 MCAR 2.05301 to 2.05315 (temporary).

In establishing rules and procedures for setting rates for care of residents in intermediate care facilities for persons with mental retardation or related conditions, the commissioner shall consider the recommendations contained in the February 11, 1983, Report of the Legislative Auditor on Community Residential Programs for the Mentally Retarded and the recommendations contained in the 1982 Report of the Department of Public Welfare Rule 52 Task Force. Rates paid to supervised living facilities for rate years beginning during the fiscal biennium ending June 30, 1985, shall not exceed the final rate allowed the facility for the previous rate year by more than five percent.

Sec. 14. **GEOGRAPHIC GROUPINGS STUDY.**

By February 1, 1987, the director of the state planning agency, in consultation with the commissioner of human services, shall report to the legislature on the appropriateness of current geographic groupings for reimbursement of nursing home operating costs. The report shall contain recommendations for legislative action which address the following: nursing home input prices and regional

variation in costs; and alternative methods for recognizing regional variations in the cost of doing business including approaches used by other states with comparable nursing home reimbursement systems.

Sec. 15. **TASK FORCE ON LONG-TERM CARE HEALTH PLANNING.**

Subdivision 1. **CREATION.** There is created a task force on long-term care health planning. The nine-member task force appointed by the governor shall include: two members from the legislative commission on long-term care; two representatives from the Minnesota nursing home trade associations; two members from long-term care consumer groups, and one representative each of the commissioners of health and human services. The director of the state planning agency or a designee shall chair and convene the task force.

Subd. 2. **DUTIES.** The task force on long-term care health planning shall conduct a study and report to the legislative commission on long-term care and to the legislature by January 15, 1987. In the study and report, the task force shall:

(1) propose a statewide plan for orderly and rational development of additional long-term care facilities;

(2) examine the need to amend the moratorium law to permit replacement or reconfiguration of beds provided no new beds are added to the system unless necessary;

(3) examine current classification of the intermediate care facilities class two (ICF II) as to the possibility of reclassification or upgrading; and

(4) address the need to modernize and renovate long-term care facilities built in 1950 to 1960 to improve energy efficiency and the quality of life in those older facilities.

Subd. 3. **TASK FORCE EXPIRATION DATE.** The task force on long-term care health planning expires January 15, 1987.

Sec. 16. **REFUND REQUIRED.**

Any current or previous nursing home provider obligated pursuant to a written agreement or otherwise to refund to a private paying resident, the resident's legal representative, or the resident's successor in interest, excess charges made in violation of section 256B.48, subdivision 1, clause (a), since July 1, 1976, shall refund the excess charges plus interest to the private paying resident, the resident's legal representative, or the resident's successor in interest before July 1, 1986. Unless otherwise specified in a written agreement with the commissioner of human services, the amount of excess charges to be refunded shall be equal to the difference between the prospective desk audit rate, before appeal resolutions, established by the commissioner and the actual amount charged to each private paying resident. The interest refunded shall be equal to the greater of the actual interest earned by the provider or six percent per annum. However, where a current or previous nursing home provider has notified a resident,

the resident's legal representative, or the resident's successor in interest, that the resident is due a refund and the refund is unclaimed, or if the resident, the resident's legal representative, or the resident's successor in interest cannot be located, the provider is exempt from any cause of action for civil damages. A private paying resident, the resident's legal representative, or the resident's successor in interest, has a cause of action for civil damages against the current or previous nursing home provider for the provider's failure to refund the excess charges and interest owing in violation of this section. The damages shall be three times the excess charges and interest payment that results from the violation, together with costs and disbursements, including reasonable attorney's fees or their equivalent. For prospective desk audit rates established prior to July 1, 1983, which are under appeal as of March 1, 1986, the provider must refund: (1) at the prospective desk audit rate; or (2) at the amount not in dispute with notice that an additional refund based on the rate after appeal may be forthcoming upon resolution of an appeal. Any nursing home withholding all or part of a refund based on its pending rate appeal shall, by July 1, 1986, submit to the commissioner for each appeal a specification of each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the nursing home believes is correct, the authority in statute or rule upon which the nursing home relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner, unless the above information has already been submitted to the commissioner. Any amounts still owing the resident, the resident's legal representative, or the resident's successor in interest, after the appeal is settled must be refunded within 30 days of the resolution of the appeal. Interest shall continue on the amount not immediately refunded, and shall be equal to the greater of the actual interest earned by the provider or six percent per annum.

Sec. 17. **TRANSFER.**

$880,000 is transferred from the preadmission screening and alternative care grants account to the medical assistance account.

Sec. 18. **EFFECTIVE DATE.**

Sections 3, 4, 6 to 13, and 16 are effective the day following enactment. Section 1 is effective May 1, 1986, and sections 2, 5, 14, 15, and 17 are effective July 1, 1986.

Approved March 24, 1986