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STATE OF MINNESOTA

STATE REGISTER

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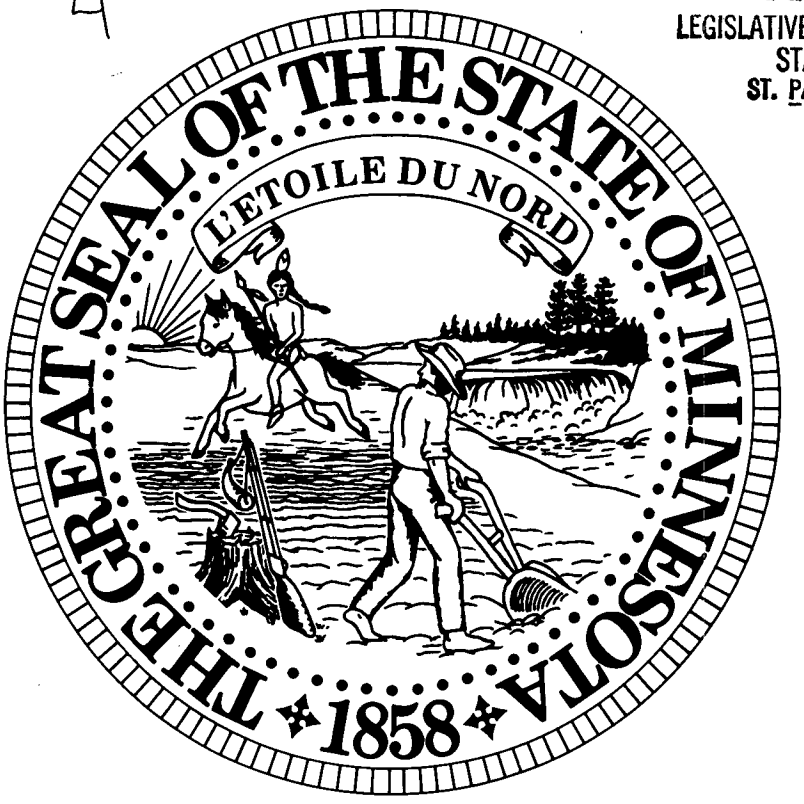

Monday 1 December 1986

VOLUME 11, NUMBER 22

Pages 965-1020

STATE REGISTER

Judicial Notice Shall Be Taken of Material Published in the *State Register*

The *State Register* is the official publication of the State of Minnesota, containing executive orders of the governor, proposed and adopted rules of state agencies, official notices to the public, state and non-state public contracts, grants, supreme court and tax court decisions, and a monthly calendar of cases scheduled to be heard by the state supreme court.

Volume 11 Printing Schedule and Submission Deadlines

Vol. 11 Issue Number	*Submission deadline for Executive Orders, Adopted Rules and **Proposed Rules	*Submission deadline for State Contract Notices and other **Official Notices	Issue Date
22	Monday 17 November	Friday 21 November	Monday 1, December
23	Friday 21 November	Monday 1 December	Monday 8 December
24	Monday 1 December	Monday 8 December	Monday 15 December
25	Monday 8 December	Monday 15 December	Monday 22 December

*Deadline extensions may be possible at the editor's discretion; however, none will be made beyond the second Wednesday (12 calendar days) preceding the issue date for rules, proposed rules and executive orders, or beyond the Wednesday (5 calendar days) preceding the issue date for official notices. Requests for deadline extensions should be made only in valid emergency situations.

**Notices of public hearings on proposed rules and notices of intent to adopt rules without a public hearing are published in the Proposed Rules section and must be submitted two weeks prior to the issue date.

Instructions for submission of documents may be obtained from the *State Register* editorial offices, 504 Rice Street, St. Paul, Minnesota 55155, (612) 296-4273.

The *State Register* is published by the State of Minnesota, Department of Administration, Documents Division, 117 University Avenue, St. Paul, Minnesota 55155, pursuant to Minn. Stat. § 14.46. Publication is weekly, on Mondays, with an index issue in September. In accordance with expressed legislative intent that the *State Register* be self-supporting, the subscription rate has been established at $130.00 per year, postpaid to points in the United States. Second class postage paid at St. Paul, Minnesota. Publication Number 326630. (ISSN 0146-7751) No refunds will be made in the event of subscription cancellation. Single issues may be obtained at $3.50 per copy.

Subscribers who do not receive a copy of an issue should notify the *State Register* Circulation Manager immediately at (612) 296-0931. Copies of back issues may not be available more than two weeks after publication.

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FOR LEGISLATIVE NEWS

Publications containing news and information from the Minnesota Senate and House of Representatives are available free to concerned citizens and the news media. To be placed on the mailing list, write or call the offices listed below:

SENATE

Briefly-Preview—Senate news and committee calendar; published weekly during legislative sessions.

Perspectives—Publication about the Senate.

Session Review—Summarizes actions of the Minnesota Senate.

Contact: Senate Public Information Office
Room 231 State Capitol, St. Paul, MN 55155
(612) 296-0504

HOUSE

Session Weekly—House committees, committee assignments of individual representatives; news on committee meetings and action. House action and bill introductions

This Week—weekly interim bulletin of the House.

Session Summary—Summarizes all bills that both the Minnesota House of Representatives and Minnesota Senate passed during their regular and special sessions.

Contact: House Information Office
Room 175 State Office Building, St. Paul, MN 55155
(612) 296-2146

CONTENTS

NOTICE

How to Follow State Agency Rulemaking Action in the *State Register*

State agencies must publish notice of their rulemaking action in the *State Register*. If an agency seeks outside opinion before promulgating new rules or rule amendments, it must publish a **NOTICE OF INTENT TO SOLICIT OUTSIDE OPINION** also.

The PROPOSED RULES section contains:

- Proposed new rules (including notice of hearing and/or notice of intent to adopt rules without a hearing).
- Proposed amendments to rules already in existence in the Minnesota Rules.
- Proposed emergency rules.
- Withdrawal of proposed rules (option; not required).

The ADOPTED RULES section contains:

- Notice of adoption of new rules and rule amendments adopted without change from the previously published proposed rules. (Unchanged adopted rules are not republished in full in the *State Register* unless requested by an agency.)
- Adopted amendments to new rules or rule amendments (adopted changes from the previously published proposed rules).
- Notice of adoption of emergency rules.
- Adopted amendments to emergency rules (changes made since the proposed version was published).
- Extensions of emergency rules beyond their original effective date.

The OFFICIAL NOTICES section includes (but is not limited to):

- Notice of intent to solicit outside opinion before promulgating rules.
- Additional hearings on proposed rules not listed in original proposed rules calendar.

ALL ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES published in the *State Register* and filed with the Secretary of State before April 8, 1985 are published in the *Minnesota Rules 1985*. ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES filed after April 8, 1985 are included in a supplement published in Spring, 1986. Proposed and adopted EMERGENCY (formerly called TEMPORARY) RULES appear in the *State Register* but are generally not published in the *Minnesota Rules* due to the short-term nature of their legal effectiveness. Those that are long-term may be published.

The *State Register* publishes partial and cumulative listings of rule in the MINNESOTA RULES AMENDMENTS AND ADDITIONS list on the following schedule:

Issues 1-13, inclusive
Issues 14-25, inclusive
Issue 26, cumulative for 1-26
Issues 27-38, inclusive
Issue 39, cumulative for 1-39
Issues 40-51, inclusive
Issue 52, cumulative for 1-52

MINNESOTA RULES AMENDMENTS AND ADDITIONS

NOTE: This listing includes all proposed and adopted rules printed in this issue except emergency rules and errata for this issue. Please see those sections for the appropriate rule numbers.

EXECUTIVE ORDERS

Executive Order No. 86-13

Providing for Assistance to Officials of Aitkin, Minnesota

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, the Sheriff of Aitkin County has requested assistance in the search for and rescue of a lost seventeen year old boy; and

WHEREAS, the size and terrain of the search area are beyond the capabilities of local resources;

NOW, THEREFORE, I hereby order that:

1. The Adjutant General of Minnesota order to active duty on or after November 2, 1986, in service of the State, such elements and equipment of the military forces of the State as required and for such period of time necessary to ensure the safety of our citizens.

2. Cost of subsistence, transportation, fuel, and pay and allowances of said individuals shall be defrayed from the General Fund of the State as provided for by Minnesota Statutes, Section 192.49, Subdivision 1, Section 192.51, and Section 192.52.

PURSUANT TO Minnesota Statutes, Section 4.035, this Order shall be effective retroactive to November 2, 1986, and shall remain in effect until such date as elements of the military forces of the State are no longer required.

IN TESTIMONY WHEREOF I have set my hand this seventh day of November, 1986.

RUDY PERPICH
Governor

PROPOSED RULES

Pursuant to Minn. Stat. of 1982, §§ 14.22, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register*. The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules; and
4. that the rule may be modified if the modifications are supported by the data and views submitted.

If, during the 30-day comment period, 25 or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of §§ 14.14-14.20, which state that if an agency decides to hold a public hearing, it must publish a notice of intent in the *State Register*.

Pursuant to Minn. Stat. §§ 14.29 and 14.30, agencies may propose emergency rules under certain circumstances. Proposed emergency rules are published in the *State Register* and, for at least 25 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Health

Proposed Permanent Rules Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

Notice of Hearing

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held at the Minnesota Veterans' Home Auditorium, Building 15, 5101 Minnehaha Avenue, Minneapolis, Minnesota 55417, on January 7 & 8, 1987, commencing at 9:00 a.m. and continuing until all interested or affected parties have an opportunity to participate. 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.

The hearing on these rules will be part of a hearing on Minnesota Department of Human Services Proposed Rules parts 9549.0050 to 9549.0059. The Department of Human Services Rules will implement a case mix reimbursement system for long term care facilities. All references to parts 9549.0050 to 9549.0059 found in these rules are to the rules as proposed.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the proposed rules. Written material not submitted at the time of the hearing, which

is to be included in the hearing record may be mailed to Jon L. Lunde, Administrative Law Judge, Office of Administrative Hearings, 400 Summit Bank Building, 310 South Fourth Avenue, Minneapolis, Minnesota 55415; telephone (612) 341-7645, either before the hearing or within five working days after the public hearing ends.

The Administrative Law Judge may, at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period, the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons that the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record.

Upon the close of the hearing record, the Administrative Law Judge will write a report as provided for in Minnesota Statutes, section 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.01 to 14.56, and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

These rules, parts 4656.0010 to 4656.0090 require the Department of Health to conduct annual resident assessments in accordance with procedures established by 42 Code of Federal Regulations (C.F.R.), sections 456.600 to 456.614. The rules also incorporate by reference specific pages of the November 1986 versions of the Facility Manual for Completing Case Mix Requests for Classification and the Inspection of Care Instruction Manual: With Procedures for Completing Case Mix Requests for Classifications, as well as the Guideline for Isolation Precautions in Hospitals. These documents are available for review at the Ford Law Library at 117 University Avenue, St. Paul, Minnesota 55155, and through the minitex interlibrary loan system. In addition, the rules establish procedures for the classification of residents in nursing homes and boarding care homes participating in the Medical Assistance Program, provide a mechanism for reconsidering Department of Health Classifications, establish a process for auditing resident assessments referred by nursing homes or boarding care homes, and require facilities to provide death, discharge, change of payment source, and transfer information to the Department of Health every 30 days.

The Department's authority to adopt the proposed rules is contained in Minnesota Statutes, sections 144.072, subdivision 1, and 256B.502. The Department estimates that the total cost to local public bodies will not exceed $100,000 in either of the two years immediately following adoption of these rules. Therefore, no fiscal note is required under subdivision 1 of Minnesota Statutes, section 14.11.

The Department of Health is exempt from Minnesota Statutes, section 14.115, Small Business Considerations in Rulemaking, by virtue of subdivision 7(c) of that statute.

Copies of the proposed rules are now available, and one free copy may be obtained by writing to Gary A. Goetzke, Health Resources Division, Minnesota Department of Health, 717 Delaware Street S.E., P.O. Box 9441, Minneapolis, Minnesota 55440.

Additional copies will be available at the hearing. If you have any questions on the content of the rule, contact Gary A. Goetzke, at the address listed above, or at (612) 623-5627.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge'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. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified, you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument that the agency anticipates presenting at the hearing to justify both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings, and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10a, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, 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 travel expenses and membership dues, in any year, for the

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purpose of atttempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

b) who spends more than $250, not including 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, St. Paul, Minnesota 55155, telephone (612) 296-5615.

Dated: 17 November 1986

Sister Mary Madonna Ashton, Commissioner
Minnesota Department of Health

Rules as Proposed (all new material)

4656.0010 SCOPE.

Parts 4656.0010 to 4656.0090 establish procedures for the assessment of the appropriateness and quality of care and services furnished to medical assistance sponsored residents of facilities certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p, as amended through December 31, 1984, under Minnesota Statutes, section 144.072. Parts 4656.0010 to 4656.0090 also establish procedures for the assessment of private paying residents in certified nursing homes and boarding care homes, under Minnesota Statutes, section 144.0721, and for the classification of medicaid sponsored and private paying residents in certified nursing homes and boarding care homes, under Minnesota Statutes, section 144.0722. Procedures for determining the operating cost payment rates for all certified nursing homes and boarding care homes are found in rules of the Department of Human Services, parts 9549.0050 to 9549.0059 as proposed at *State Register,* volume 11, pages 988 to 1004 and as subsequently adopted.

4656.0020 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 4656.0010 to 4656.0090, the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the department's quality assurance and review program and used for performing resident assessments.

Subp. 3. **Certified.** "Certified" means authorized to participate in the medical assistance program under United States Code, title 42, sections 1396-1396p as amended through July 18, 1984. Before certification, facilities must be licensed by the state under parts 4655.0090 to 4655.9900, and must also meet any additional requirements established by certification standards under the Social Security Act.

Subp. 4. **Department.** "Department" means the Minnesota Department of Health.

Subp. 5. **Guideline for Isolation Precautions in Hospitals.** "Guideline for Isolation Precautions in Hospitals" means the six guidelines written by Julia S. Garner, RN, and Bryan P. Simmons, MD, reprinted by the United States Department of Health and Human Services, Public Health Service, Center for Disease Control, from Infection Control July/August 1983 (Special Supplement); 4 (suppl): pp. 245-325. The guidelines are incorporated by reference. They are available at the Ford Law Library, 117 University Avenue, Saint Paul, MN 55155. This material is not subject to frequent change.

Subp. 6. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatments and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Subp. 7. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 8. **Resident.** "Resident" means an individual residing in a facility certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p as amended through July 18, 1984, unless otherwise provided in parts 4656.0010 to 4656.0090.

Subp. 9. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 as proposed at *State Register*, volume 11, pages 999 to 1001 and as subsequently adopted.

Subp. 10. **Resident plan of care.** "Resident plan of care" for residents of nursing homes means the patient care plan specified in part 4655.6000. Resident plan of care for residents in boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Subp. 11. **Resident record.** "Resident record" means the entire record of a resident compiled by the nursing home or boarding care home. The resident record must include the following:

A. the admission record;

B. the medical plan of care;

C. the resident plan of care;

D. documentation from services providing care to the resident;

E. reports of any diagnostic testing, consultation, and other services;

F. a copy of any transfer data provided to another health care facility; and

G. a discharge summary.

4656.0030 ANNUAL RESIDENT ASSESSMENT.

Subpart 1. **Inspection of care requirements.** The department shall annually assess the appropriateness and quality of care and services provided to medical assistance sponsored residents in every certified facility, and to private paying residents in certified nursing homes and boarding care homes. Assessments must be conducted in accordance with the inspection of care requirements established by Code of Federal Regulations, title 42, sections 456.600 to 456.614, as amended through December 31, 1984. However, provisions relating to recommendations for changes in the level of care provided shall not apply to private paying residents.

Subp. 2. **Assessment process.** A registered nurse shall complete an assessment form for each resident, in accordance with procedures established in the Inspection of Care Instruction Manual, with Procedures for Completing Case Mix Requests for Classification published by the Minnesota Department of Health. Pages 8 to 29 of the November 1986 version of the manual are incorporated by reference. This manual is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155. This material is not subject to frequent change. The completed assessment form must reflect the resident's needs at the time of the assessment. The assessment process includes observation of the resident, review of the medical record, and when necessary, staff interviews.

CASE MIX REIMBURSEMENT CLASSIFICATIONS

4656.0040 CLASSIFICATION OF ASSESSMENTS COMPLETED BY REVIEW TEAMS.

Within 15 working days of receiving assessment documents submitted under part 4656.0030, the department shall classify each resident of a certified nursing home or boarding care home into one of the resident classes prescribed by part 9549.0058, subpart 1, item F, as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, and mail a written notice of the classification to the resident and to the facility. The written notice must specify that the resident or the resident's authorized representative and the facility have the right to review the department's documents supporting the classification and to request a reconsideration of the classification.

4656.0050 REVIEW AND CLASSIFICATION OF FACILITY AND PREADMISSION SCREENING ASSESSMENTS.

Subpart 1. **Assessment instructions.** Assessment forms which are completed in accordance with part 9549.0059, as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted must be completed by using the procedures established in the Facility Manual for Completing Case Mix Requests for Classification published by the Minnesota Department of Health. Pages 10 to 23 of the November 1986 version of the manual are incorporated by reference. This manual is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155. This material is not subject to frequent change.

Subp. 2. **Classification or notification of incomplete assessments.** Within 15 working days of receiving a request for classification submitted under part 9459.0059 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, the department shall classify the resident into one of the resident classes established under part 9549.0058 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, or notify the individual completing the assessment or the facility furnishing the documentation of the need to submit additional information necessary for determining the classification.

Subp. 3. **Requests requiring additional information.** When additional information requested under subpart 2 has been submitted and the department has determined that the request for classification is complete and accurate, the department shall classify the

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resident into one of the resident classes established under part 9549.0058 as proposed at *State Register*, volume 11, page 988 to 1004 and as subsequently adopted, and mail a written notice of the classification to the resident and to the resident's facility within 15 working days.

Subp. 4. **Classification notice.** Classification notices provided under this part must include the resident's classification, as well as a statement which informs the resident, the resident's authorized representative, and the facility of the right to review the department's documents supporting the classification and to request a reconsideration of the classification.

4656.0060 FACILITY RESPONSIBLE FOR DISTRIBUTING CLASSIFICATION NOTICES.

Within five days of receipt of the notice, the facility must provide the resident or the person responsible for the resident's payment with every classification notice mailed to the facility by the department under parts 4656.0040 and 4656.0050. If the resident's classification has changed, the facility must include the current rate for the new classification with the classification letter.

4656.0070 REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION.

Subpart 1. **Reconsideration permitted.** The facility, the resident, or the resident's authorized representative may request that the department reconsider the classification.

Subp. 2. **Request for reconsideration.** A reconsideration request must be in writing and submitted to the department within ten working days of receiving the notice of the resident's classification. Requests must be accompanied by written documentation to support the claim that the resident's needs at the time of the assessment were different from those needs identified in the assessment, or that the needs identified in the assessment require a different resident classification from the classification assigned by the department. The facility shall provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation must be provided within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. If a facility requests the reconsideration of a resident's classification, the facility must provide written notice to the resident or the person responsible for the resident's payment on the date the request is submitted to the department. The notice to the resident or the person responsible for the resident's payment must contain the information provided to the department that supports the request for reconsideration.

Subp. 3. **Review of requests and notification.** The department shall review the requests for reconsideration, affirm or modify the resident's classification, and notify the resident and the facility by letter of the classification within 20 working days.

Subp. 4. **Status of initial classification.** The resident classification established by the department must be the classification that applies to the resident while the request for reconsideration is pending.

Subp. 5. **Additional information.** The department reserves the right to request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

4656.0080 AUDITS OF ASSESSMENTS OF NURSING HOME RESIDENTS.

Subpart 1. **Audit types.** The department shall audit the accuracy of resident assessments performed under parts 9549.0050 to 9549.0059 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, through desk audits and on-site review of residents and their records. The department shall reclassify a resident it determines to have been incorrectly classified.

Subp. 2. **Unannounced audits.** The department is authorized to conduct unannounced on-site audit reviews.

Subp. 3. **Access to records.** Facilities shall grant the department access during regular business hours, to examine the medical records relating to the resident assessments selected for audit under this part. For the purpose of clarifying or substantiating these records, the department may also speak to facility staff and physically observe the resident. Refusal to grant the department access to examine and clarify or substantiate the medical records shall be grounds for a correction order.

Subp. 4. **Documentation time frame.** The department shall consider the following documentation, as relevant to the audit process:

A. documentation recorded in the resident record up to four days after the date the resident returns from the hospital, but only as the documentation relates to the resident's condition at the time the resident is assessed under part 9549.0059, subpart 4 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted;

B. documentation recorded in the resident record up to nine days after the date the resident is admitted to the nursing home, but only as the documentation relates to the resident's condition at the time the resident is assessed under part 9549.0059, subpart 1 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted; and

C. documentation recorded in the resident record up to the time the resident is assessed under parts 9549.0059, subpart 2 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, and part 4656.0030.

Subp. 5. **Routine audits procedures.** Facilities will be routinely audited at least once per calendar year in accordance with the following procedures:

A. The department shall select for audit either ten percent or ten, whichever is greater, of the assessments submitted in accordance with part 9549.0059, subpart 2, as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, or ten percent or ten, whichever is greater, of the assessments submitted during the previous four months in accordance with part 9549.0059, subparts 1 and 4 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted.

B. If more than 20 percent of the assessments audited under item A contain errors that could result in a change of classification, the auditors shall remain on-site and audit a second sample equal in size and selected from the same types of assessments as in item A.

C. If more than 20 percent of the assessments audited under item B contain errors that could result in a change of classification, the facility shall be subject to an additional audit of up to 100 percent of the assessments.

Subp. 6. **Special audits.** The department may conduct special audits whenever it deems such audits necessary.

Subp. 7. **Notice to facility.** No exit interview will be conducted at the facility to discuss the preliminary findings of the department. Within 15 working days of completing the audit process, the department shall mail the written results of the audit to the facility, along with a written notice to the resident and to the facility which contains the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the department's documents supporting the classification and to request a reconsideration of the classification.

4656.0090 DEATH, DISCHARGE, CHANGE OF PAYMENT SOURCE, AND TRANSFER INFORMATION.

Every month, certified facilities shall provide updated information to the department relating to the deaths, discharges, changes in payment source when the resident payment goes from private pay to medicaid sponsored, and transfers that occurred within the facility the previous month. This information must be provided on forms developed by the department.

Department of Human Services

Proposed Rules Relating to Hospital Medical Assistance Reimbursement

Notice of Intent to Adopt a Rule without a Public Hearing

Notice is hereby given that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 256.969 and Laws of Minnesota, 1986, Chapter 420, section 6.

All persons have 30 days or until 4:30 p.m. on December 31, 1986 in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Juli Menssen
Director, Hospital Rates
444 Lafayette Road, 4th floor
St. Paul, MN 55101
Telephone: (612) 296-9939

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

Parts 9500.1090 to 9500.1155 became effective in August, 1985, Implementation of those parts has shown the Department of

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Human Services that some of those parts need to be amended to compensate hospitals more equitably, to clarify rule language, and to correct technical and grammatical errors.

The proposed amendments to parts 9500.1090 to 9500.1155 apply to hospital administrators and other persons interested in inpatient hospital reimbursement rates under Medical Assistance and General Assistance Medical Care.

The amendments that will have the most impact on hospital rates include the partitioning of rates into rates for the care of persons who are eligible for Medical Assistance (MA) because they are also eligible for Aid to Families with Dependent Children (AFDC) and for the care of all other MA recipients; the inclusion of cost outliers up to their trim points and day outliers up to their trim points plus 40 per cent of costs beond the trim point in the calculation of relative values; settling pass-through costs by using actual experience for the budget year; and the inclusion of Medicare crossover claims in the calculation of the disproportionate population adjustment and redetermination of the disproportionate population adjustment using actual data.

The amendments also include definitions of new terms used in the amendments.

A free copy of the rule is available upon request from Juli Menssen. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Juli Menssen upon request.

Adoption of these rules will increase aggregate local public body spending by over $100,000 in either of the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. See the fiscal note attached to this notice which contains the estimated total cost to all local public bodies and an explanation of how the cost was calculated. An additional copy of the fiscal note is available to the public from Julie Menssen upon request.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Juli Menssen.

Leonard W. Levine, Commissioner
Dept. of Human Services

Fiscal Note for 1986 Amendments to Minnesota Rules, Parts 9500.1090 to 9500.1155 Inpatient Hospital Reimbursements

INTRODUCTION

The following describes the net change in state and local spending resulting from amendments to Minnesota Rules, parts 9500.1100 to 9500.1155. Many amendments are housekeeping amendments, such as language changes to improve clarity and grammatical changes, and have no effect on state or local spending. In the interest of brevity fiscal impacts for housekeeping amendments are not discussed below. If an amendment is not discussed below, therefore, it can be assumed that amendment will have no fiscal impact.

9500.1090 PURPOSE AND SCOPE

Description of amendment/s: Amendments to this part partition inpatient hospital reimbursements into reimbursements for persons who receive medical assistance because they are eligible for AFDC and all other persons who receive medical assistance.

Method used to calculate change in state and local spending: Past department reimbursements show that medical assistance payments for hospital services to AFDC recipients are much lower than medical assistance payments for hospital services to all other recipients of medical assistance. Therefore, when the costs to serve both populations are averaged to determine reimbursements, the higher cost of serving non-AFDC medical assistance recipients results in a disproportionately high amount of reimbursements for medical assistance/AFDC recipients. A hospital that has served a large percentage of the medical assistance/AFDC recipients will receive lower reimbursements per admission as a result of the amendments and a hospital that has served a relatively small percentage of medical assistance/AFDC recipients will receive higher reimbursements per admission.

Projected net change in state or local spending: The department knows that amounts of reimbursements to individual hospitals will change. But the exact change in total reimbursement amounts will not be known until the amendments are implemented. Because in the past the Department has averaged the two populations and now is partitioning the payments into two separate rates the net affect of partitioned rates on State and local expenditures will be negligible.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES AND 9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION

Description of amendments: Amendments to parts 9500.1110 and 9500.1115 allow inclusion of cost outliers up to their trim points and day outliers up to their trim points plus 40 percent of costs beyond the trim point in the calculation of relative values.

These amendments to these parts make up the substantive portion of the amendments from a fiscal perspective. Other amendments will have negligible fiscal impacts.

Method used to calculate change in state and local spending: The revisions to Part 9500.1110 will intensify the revision to Part 9500.1115 since these two parts describe components to the reimbursement formula. In general, a hospital payment is calculated by multiplying a base rate per admission, by a health care cost index, and by an appropriate statewide relative value. The product is summed with a pass-through cost amount. These amendments will cause the hospital-specific base rate to change as well as the relative values. A change to one factor may be either magnified or mitigated by a change in another factor. Experience in prospective payment reimbursement provides a basis for assessing the fiscal impact of the amendments to parts 9500.1110 and 9500.1115.

Projected net change in state and local spending: The inclusion of outliers into the determination of the base year cost per admission will necessarily increase the base year cost per admission because by definition outlier cases are higher cost admissions and thus will push up the allowable base year cost per admission.

Changes to the relative values as a result of including outlier cases will have a varying impact on the hospital reimbursement. Since the relative value magnifies the base year cost per admission the effect on a particular hospital will depend on the change in the base year cost, the change in the relative values, and the relative distribution of each hospital's claims within the diagnostic category. Thus, changes to Parts 9500.1110 and 9500.1115 may increase or decrease individual claim payment amounts such that some hospitals may receive additional money while other hospitals may owe the department. Because of the changes to the various components, the exact fiscal impact of the amendments would have to be determined through the use of a specially designed computer simulation. The resources for such a simulation are unavailable, however projections indicate that the expenditures are within the amounts budgeted for fiscal year 1986 and 1987. In effect these amendments are budget neutral against all current appropriations for this biennium. The following data shows the increases in expenditures over the current expenditures for state fiscal years 1986, 1987, and 1988:

		FY 1986		FY 1987 (Thousands of Dollars)		Fy 1988
MEDICAL ASSISTANCE						
Inp. Hosp. Costs / Current Level (Actual '86; Projected '87-'88)		123,443		130,919		138,394
% Increase	x	9.7%	x	9.7%	x	9.7%
9 Mos. / 12 in '86	x	0.75				
Projected Increase		9,011		12,743		13,470
State Share %	x	0.4210	x	0.4193	x	0.4155
State Share Increase		3,794		5,343		5,597

		FY 1986		FY 1987 (Thousands of Dollars)		FY 1988
GENERAL ASSISTANCE MEDICAL CARE						
Inp. Hosp. Cost / Current Level (Actual '86; Projected '87-'88)		34,822		33,366		42,902
% Increase	x	7.9%	x	7.9%	x	7.9%
9 Mos. / 12 in '86	x	0.75				
Projected Increase		2,072		2,647		3,404
State Share %	x	0.90	x	0.90	x	0.90
State Share Increase		1,865		2,382		3,063

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9500.1125 DETERMINATION OF CATEGORIAL RATE PER ADMISSION SUBPART 4

Description of amendments: Pass through costs consist of the following costs: depreciation, rents and leases, property taxes, property insurance, interest, and malpractice insurance. As per the rule, the hospital estimates these costs for the forthcoming rate year. These amendments allow the department to more accurately settle pass through costs because they allow the department to apply actual utilization rates by ancillary and routine costs centers to total pass through costs.

Method used to calculate change state and local spending: It is not possible to calculate the fiscal impact of this amendment because changes in reimbursement due to pass-through cost settlement depends on the hospital's ability to forecast their pass-through costs. It is expected that some hospitals will over budget these costs while other hospitals will under budget these costs.

Projected net change in state or local spending: The net effect of these amendments on all hospitals in aggregate is expected to be a very small decrease to no decrease in reimbursements. In fact, pass through settlements may vary from year to year.

500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT

Description of amendment/s: Amendments to this part clarify that Medicare crossover claims are included in the calculation of the ratio. Further these amendments will allow the department to redetermine the ratio based on actual data for the rate year.

Method used to calculate change in state and local spending: Changes in spending due to these amendments will depend on whether hospital utilization by MA, GAMC, and Medicare crossover recipients changed significantly as a percent of total hospital patient load from the base year, 1981. If there has been a significant change, these amendments will allow the Department to reflect these changes in reimbursements.

Projected net change in state or local spending: The fiscal impact of these amendments is expected to be extremely small as a percent of total reimbursement.

EFFECT ON MEDICAL ASSISTANCE ADMINISTRATIVE EXPENDITURES

The adoption of these amendments will not increase or decrease the personnel requirements of the Department of Human Services or any local government.

EFFECT ON LOCAL AGENCY EXPENDITURES

Based on the same methodology used above to calculate the fiscal impact on state expenditures the estimated increase in aggregate local agency expenditures will be over $100,000 for each of the two years following the adoption of the amendments. The estimated aggregate increased expenditures for local agencies will be $1.5 million for State fiscal year 1986, $2.1 million for state fiscal year 1987, and $2.3 million for state fiscal year 1988.

Rules as Proposed

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for ~~all~~ the hospitals that participate in and are reimbursed by medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 5, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

9500.1100 DEFINITIONS.

Subpart 1. to 3. [Unchanged.]

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to ~~9505.5020 [Emergency]~~ 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy families with dependent children.

Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission ~~which~~ that is adjusted for case mix ~~and which~~, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. [Unchanged.]

Subp. 7. **Appeals board.** "Appeals board" means the board ~~which~~ that advises the commissioner on a hospital's request for adjustments to ~~a categorical rate per admission, rate per admission, or a rate per day~~ reimbursements made under the prospective reimbursement system.

Subp. 8. [Unchanged.]

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. to 11. [Unchanged.]

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the [(adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (~~DRG's~~ DRGs) under medicare with adjustments as follows:

Diagnostic Categories	DRG Numbers Within the Diagnostic Category

A. to JJ. [Unchanged.]

Subp. 21. [Unchanged.]

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards of practice accepted by the medical community.

Subp. 22. to 24. [Unchanged.]

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. to 29. [Unchanged.]

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in ~~parts 9505.0530 [Emergency] and~~ part 9505.0540 ~~[Emergency]~~ cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. to 33. [Unchanged.]

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. to 38. [Unchanged.]

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to ~~9505.5020 [Emergency]~~ 9505.5030 and 9505.5105.

Subp. 40. [Unchanged.]

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or ~~some~~ a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission ~~which~~ that occurs within seven days of a discharge~~, whose diagnostic category or a related diagnostic category is the same as that identified for that discharge~~ of the same recipient.

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Subp. 43. [Unchanged.]

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. [Unchanged.]

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission ~~for all admissions,~~ excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all ~~other~~ the diagnostic categories on a statewide basis.

Subp. 46. [Unchanged.]

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in ~~part 9505.5030 [Emergency]~~ parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. [Unchanged.]

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing Administration (HCFA) Form 2552, 1981 revision, Worksheet A, column 7, line 84. ~~Health Care Financing Administration Form 2552, 1981 revision is incorporated by reference. The form is published by Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, Saint Paul, Minnesota 55164. The form is available through the minitex interlibrary loan system.~~ The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. [Unchanged.]

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. to C. [Unchanged.]

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined ~~in~~ from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio ~~as identified in Worksheet C determined in~~ from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(3) and (4) [Unchanged.]

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all computations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. and G. [Unchanged.]

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's diagnostic category day outlier trim point divided by the day

outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X \ldots \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the diagnostic category day outlier trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital ~~cost~~ costs for all admissions ~~excluding outliers~~ less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions ~~excluding~~ including outliers;

~~I.~~ K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic category ~~excluding outliers~~ less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category ~~excluding~~ including outliers; and

~~J.~~ L. determine the relative value for each diagnostic category by dividing item ~~I~~ K by item ~~H~~ J.

Subp. 2. and 3. [Unchanged.]

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. [Unchanged.]

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers ~~as determined~~ in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, ~~item G~~ items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital ~~excluding~~ including outliers;

D. adjust item C for case mix as follows:

(1) [Unchanged.]

(2) multiply ~~each~~ the hospital's number of base year ~~admission excluding~~ admissions within each diagnostic category including outliers by the relative value of ~~the~~ that diagnostic category ~~assigned to that admission~~,

(3) [Unchanged.]

(4) divide the sum from subitem (3) by the number of base year admissions ~~excluding~~ including outliers, and

(5) [Unchanged.]

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, ~~each~~ the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total Medical Assistance non-AFDC admissions. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days ~~prior to~~ before the start of each hospital's budget year and must include the following information:

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	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
~~A.~~ (1)	Depreciation			
~~B.~~ (2)	Rents and leases			
~~C.~~ (3)	Property taxes			
~~D.~~ (4)	Property insurance			
~~E.~~ (5)	Interest			
~~F.~~ (6)	Malpractice insurance			
~~G.~~ (7)	Total Pass-Through Costs (~~Items A to F~~ Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to ~~items A to F~~ item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to medicare. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/medicaid cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. **Determination of budget year pass-through cost per admission.** The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs			
B.	Pass-through costs as specified in subpart 1, item ~~G~~ A, subitem (7), multiplied by item A			
C.	Number of ~~base year~~ Medical Assistance admissions including outliers			
D.	Pass-through cost per admission (item B divided by item C)			

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission~~)~~ multiplied by ~~(~~budget year HCI~~)~~ and multiplied by ~~(~~the relative value of the appropriate diagnostic category), plus ~~(~~budget year pass-through cost per admission~~)~~]

Subp. 4. **Pass-through cost ~~per admission~~ adjustment.** After the end of each budget year, the commissioner shall redetermine the ~~categorical rate per admission. The commissioner shall substitute actual pass-through costs as determined by medicare for budgeted pass-through costs in subpart 2, item B for that year. If the adjustment indicates an overpayment to a hospital, that hospital shall pay to the commissioner the overpayment within 60 days of the written notification from the commissioner. If the adjustment indicates an underpayment to a hospital, the commissioner shall pay that hospital the underpayment within 60 days of written notification from the commissioner~~ budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column

1 by column 5 for each routine service type. This computation produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as computed in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This computation produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. Compute the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This computation produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs computed in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted per-admission pass-through cost used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated. This computation produces the actual value of the pass-through cost payments made during the year.

G. Subtract the actual value of the medical assistance pass-through cost payments during the completed year (computed at item F) from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be payed by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the 61st day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [See Repealer.]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall ~~use medicare to~~ determine the recapture of depreciation due to a change in the ownership of a hospital ~~and~~ that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner. ~~Interest charges must be assessed according to part 9500.1125, subpart 5.~~

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. [Unchanged.]

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Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.** The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission~~,~~; out-of-area categorical rate per admission~~, or the~~; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. and 5. [Unchanged.]

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	[~~(~~Medicare deductibles~~)~~, plus ~~(~~Medicare coinsurance~~)~~, ~~plus (amounts for services covered by medical assistance but not by medicare)~~] less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse ~~hospitals who discharge transfers and who admit transfers~~ both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[~~(~~The product of the adjusted base year cost per admission~~)~~ multiplied by the budget year HCI and multiplied by ~~(~~the relative value of the appropriate diagnostic category~~)~~, divided by ~~(~~the ~~geometric~~ arithmetic mean length of stay of the diagnostic category) and multiplied by ~~(~~the number of days of inpatient hospital services~~)~~], plus ~~(~~budget year pass-through cost per admission ~~)~~]

In no case of a transfer may a hospital receive a ~~transfer~~ reimbursement that exceeds the applicable categorical rate per admission, ~~out-of-area~~ or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless ~~the transfer~~ that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, ~~out of area~~ the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a transferred recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to the other hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if ~~appropriate~~ eligible. The combined stay of the admission and readmission shall be used to determine qualification for outlier payment. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission. ~~A~~ An admission and subsequent readmission to a different hospital shall be reimbursed ~~as a transfer~~ as specified ~~in~~ under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with ~~a~~ the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA ~~hospitals~~

hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the ~~geometric~~ arithmetic mean length of stay for the diagnostic category;

(3) [Unchanged.]

(4) subtract the ~~number of days of inpatient hospital services at two standard deviations~~ day outlier trim point for the appropriate diagnostic ~~categories A to N and P to H under part 9500.1100, subpart 20 or the number of days of inpatient hospital services at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20, as determined under part 9500.1110, subpart 1, item G~~ category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) [Unchanged.]

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) [Unchanged.]

(3) subtract the cost at three standard deviations for diagnostic ~~categories A to N, and P to H~~ category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item G from the adjusted cost from subitem (2); and

(4) multiply the amount determined in subitem (3) by 60 percent for diagnostic ~~categories A to N, and P to H~~ category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, ~~the~~ a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse out-of-area hospitals based on the lesser of billed charges or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted ~~allowable~~ base year cost per admission in effect on the first day of a calendar year for each hospital statewide by ~~the~~ that hospital's HCI and by the number of admissions in ~~each~~ that hospital's base year, ~~excluding~~ including outliers;

B. sum the products in item A;

C. divide the sum from item B by the sum of all admissions for all hospitals statewide, ~~excluding~~ including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base year, ~~excluding~~ including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, ~~excluding~~ including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission = [(statewide budget year adjusted base year cost per admission~~)~~ multiplied by ~~(~~the relative value of the appropriate diagnostic category), plus ~~(~~statewide budget year pass-through cost per admission~~)~~]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

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A. Multiply the adjusted ~~allowable~~ base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, ~~excluding~~ including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of ~~all~~ the admissions for all MSA hospitals statewide, ~~excluding~~ including outliers, to determine the statewide ~~adjusted~~ allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission must be determined according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart ~~5~~ 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per Admission for MSA Hospitals Statewide ~~Which~~ That Do Not Have ~~Admission~~ Admissions In The Base Year = [(adjusted base year cost per admission for MSA hospitals statewide~~)~~ multiplied by the budget year HCI and multiplied by ~~(~~the relative value of the appropriate diagnostic category) plus ~~(~~budget year pass-through cost per admission~~)~~]

F. [Unchanged.]

Subp. 12. [Unchanged.]

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Determination of disproportionate population adjustment.** The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions according to the ~~following~~ schedule~~:~~ below.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are ~~Medical Assistance~~ MA and ~~General Assistance Medical Care~~ GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. [Unchanged.]

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

Subpart 1. to 4. [Unchanged.]

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. to 5. [Unchanged.]

Subp. 5a. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. [Unchanged.]

REPEALER. Minnesota Rules, part 9500.1125, subpart 5 is repealed.

Department of Human Services

Proposed Permanent Rules Relating to Inpatient Hospital Reimbursement Under Medical Assistance and General Assistance Medical Care

Notice of Public Comment Period

Pursuant to Laws of Minnesota, 1986, chapter 420, section 6, subdivision 2, as amended by Laws of Minnesota, 1986, 1st Special Session, chapter 3, article 2, section 51, "The commissioner may 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". Revision of the Diagnostic Categories is exempt from Minnesota Statutes, chapter 14 rulemaking requirements. The State Department of Human Services gives notice that it intends to amend diagnostic categories established at Minnesota Rules, part 9500.1100, subpart 20, as follows:

Rules as Proposed

9500.1100 DEFINITIONS.

Subpart 1. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (DRG's) under medicare with adjustments as follows:

	Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A.	to M. [Unchanged.]	
N.	Pregnancy, Childbirth, and the Puerperium	~~(370, 374, 375~~ 376-384)
O.	to BB. [Unchanged.]	
CC.	Caesarean ~~section without comorbidities and complications~~ sections	(370-372)
DD.	Vaginal delivery with complicating diagnosis or operating room procedures	(372,374-375)
EE.	Vaginal delivery without complicating diagnosis or operating room procedures and Normal newborns	(373), (391)
FF.	to JJ. [Unchanged.]	

Subp 21. to 50. [Unchanged.]

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Department of Human Services

Proposed Permanent Rules Relating to Nursing Home Operating Cost Payment Rate Determination

Notice of Hearing

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in the Veterans Home, Auditorium/ Chapel, Building 15, 5101 Minnehaha Avenue South, Minneapolis, Minnesota 55417 on January 7 and 8, 1987 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. 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.

These rules will be heard in conjunction with parts 4656.0010 to 4656.0090, which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4646.0010 to 4656.0090 found in these rule parts are references to the rules as proposed.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Jon Lunde, Administrative Law Judge, Office of Administrative Hearings, 400 Summit Bank Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7645, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge, may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Judge will write a report as provided for in Minnesota Statutes, section 14.50. The rule hearing is governed by Minnesota Statutes, section 14.01 to 14.56 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, parts 9549.0050 to 9549.0059 affect the operating costs payment rate nursing homes licensed under Minnesota statutes, chapter 144A or boarding care facilities licensed under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program.

The purpose of the proposed rule parts is to implement a case mix reimbursement system which establishes operating cost payment rates for the nursing homes based on the condition and needs of the residents in each nursing home. Under the proposed rule parts a statewide uniform classification system is used to classify residents into 11 resident classes. Payments to nursing homes are made based on the resident classes.

Ongoing assesssment of residents' needs is required to determine to which of the 11 resident classes each resident belongs. These assessments are conducted on admission, every six months and after hospitalization. An additional assessment is required 30 to 35 days after a resident returns to the nursing home after hospitalization.

A schedule of 11 prospective payment rates is established for each nursing home. For purposes of establishing these prospective payment rates, operating costs are divided into two parts: total care related operating costs, which include case mix and other care related costs; and other operating costs.

Separate rate limitations are applied to each part of the operating costs and an efficiency incentive is established for other operating costs. In establishing the rate limitations, nursing homes are grouped by geographic location. Additional distinctions are made based on type of facility.

This rule parts contain standard scope and definition sections and specific provisions governing:

A. establishment of geographic groups;

B. determination and allocation of fringe benefits and payroll taxes, food costs, and dietician consulting fees;

C. determination of allowable historical operating cost per diems;

D. determination of operating cost adjustment factors and limits;

E. indexing of limits;

F. determination of operating cost payment rates including:

(1) application of limits;

(2) determination of efficiency incentives;

(3) eligibility for and determination of a one time adjustment;

G. determination of interim and settle-up operating cost payment rates;

H. establishment of resident classes and class weights;

I. assessment of residents;

J. resident access to assessments and documents.

Minnesota Rules, parts 9549.0010 to 9549.0080, govern the determination of payment rates for nursing homes licensed under Minnesota statutes, chapter 144A or boarding care facilities licensed under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The proposed amendments to these rule parts affect part 9549.0060, subpart 11, item C, subitem (3) which governs the calculation of the single bedroom rate, and part 9549.0060, subpart 13, item B, subitem (2) which governs how property-related payment rates will be established during the phase-in of the rental formula when the nursing home's number of capacity days changes.

The agency's authority to adopt the parts 9549.0050 to 9549.0059 is contained in Minnesota Statutes, section 256B.41, subdivision 1 and Minnesota Statutes, section 256B.431, subdivision 6. The agency's authority to adopt the amendment to parts 9549.0010 to 9549.0080 is contained in Minnesota Statutes, section 256B.41, subdivision 1 and Minnesota Statutes, section 256B.502.

The system established under rule parts 9549.0050 to 9549.0059 is approximately budget neutral. The rule parts will not result in additional state or county spending beyond the amount appropriated by the legislature. The amendments to rule parts 9549.0010 to 9549.0080 also will not result in additional state or county spending.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to Mary Ann Bredesen, Department of Human Services, Space Center, 444 Lafayette Road, 6th Floor, St. Paul, Minnesota 55101.

A copy of the rule may also be viewed at any of the 87 county welfare agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule parts 9549.0050 to 9549.0059, contact Pamela Parker at 297-3209. If you have any questions on the content of the amendments to rule parts 9549.0010 to 9549.0080, contact Charles Osell at 297-3463.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge'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. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10A, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, 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 travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or uring others to communicate with public officials; or

(b) who spends more than $250, not including 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.

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The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Dated: 14 November 1986

Leonard W. Levine, Commissioner
Dept. of Human Services

Rules as Proposed (all new material)

DEPARTMENT OF HUMAN SERVICES

NURSING HOME PAYMENT RATE DETERMINATION

9549.0050 SCOPE.

Parts 9549.0050 to 9549.0059 establish procedures for determining the operating cost payment rates for all nursing homes participating in the medical assistance program. Parts 9549.0050 to 9549.0059 are effective for rate years beginning on or after July 1, 1987. Procedures for assessment and classification of residents by the Department of Health in accordance with parts 9549.0050 to 9549.0059 are found in parts 4656.0010 to 4656.0090 as proposed at *State Register*, Volume 11, pages 970 to 975 and as subsequently adopted.

9549.0051 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9549.0050 to 9549.0059, the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the Department of Health Quality Assurance and Review Program under parts 4656.0010 to 4656.0090 as proposed at *State Register*, Volume 11, pages 970 to 975 and as subsequently adopted and used for performing resident assessments.

Subp. 3. **Base year.** "Base year" means the reporting year ending September 30, 1984.

Subp. 4. **Case mix index.** "Case mix index" means the sum of the results obtained by multiplying the number of residents in each resident class in each nursing home by the weights listed in part 9549.0058.

Subp. 5. **Case mix operating costs.** "Case mix operating costs" means the operating costs listed in part 9549.0040, subpart 5, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category under part 9549.0053.

Subp. 6. **Case mix score.** "Case mix score" means the case mix index divided by the total number of residents in the nursing home.

Subp. 7. **Discharge.** "Discharge" means a termination of placement in the nursing home that is documented in the discharge summary signed by the physician. For the purposes of this definition, discharge does not include:

A. a transfer within the nursing home unless the transfer is to a different licensure level; or

B. a leave of absence from the nursing home for treatment, therapeutic, or personal purposes when the resident is expected to return to the same nursing home.

Subp. 8. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Subp. 9. **Other care-related operating costs.** "Other care-related operating costs" means the operating costs listed in part 9549.0040, subpart 6, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the dietician consulting fees calculated under part 9549.0053.

Subp. 10. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, excluding the cost of food and dietician consulting fees, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories under part 9549.0053.

Subp. 11. **Productive nursing hours.** "Productive nursing hours" means all on-duty hours of nurses, aides, orderlies, and attendants. This term does not include the on-duty hours of the medical records personnel or the director of nursing for facilities with more than 60 licensed beds. Vacation, holidays, sick leave, classroom training, and lunches are not included in productive nursing hours.

Subp. 12. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 13. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058.

Subp. 14. **Resident plan of care.** "Resident plan of care" for residents of nursing homes not licensed as boarding care homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents of nursing homes licensed as boarding

care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Subp. 15. **Short length of stay facility.** "Short length of stay facility" means a nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. For the purpose of this definition the commissioner shall calculate average length of stay for the nursing home by dividing actual resident days in the skilled level of care for which the nursing home can bill, by the total number of discharges from the skilled level of care during the reporting year.

Subp. 16. **Standardized resident days.** "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class listed in part 9549.0058. Standardized resident days must be determined under part 9549.0054, subpart 2.

9549.0052 ESTABLISHMENT OF GEOGRAPHIC GROUPS.

Subpart 1. **Classification process.** The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts 2 to 4.

Subp. 2. **Group 1.** All nursing homes in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 3. **Group 2.** All nursing homes in counties other than the counties listed under subparts 2 and 4 must be placed in geographic group 2.

Subp. 4. **Group 3.** All nursing homes in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

9549.0053 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND DIETICIAN CONSULTING FEES.

Subpart 1. **Fringe benefits and payroll taxes.** Fringe benefits and payroll taxes must be allocated to case mix, other care-related costs, and other operating costs according to items A to D.

A. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under part 9549.0040, subpart 5.

B. Fringe benefits and payroll taxes must be allocated to other care-related costs in the same proportion to salaries reported under part 9549.0040, subpart 6.

C. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under part 9549.0040, subparts 1, 2, 3, 4, and 7.

D. For any nursing home that cannot separately report each salary component of an operating cost category, the commissioner shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to subitems (1), (2), and (3).

(1) The commissioner shall sum the allowable salaries for all nursing homes separately reporting allowable salaries in each cost category, by cost category and in total.

(2) The commissioner shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

(3) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (2) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for the nursing home under this item.

Subp. 2. **Determination of food costs.** The commissioner shall determine the costs of food to be included in other care-related costs according to items A and B.

A. For any nursing home separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing home that cannot separately report the cost of food under part 9549.0040, subpart 1, the commissioner

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shall determine the average ratio of food costs to total dietary costs for all nursing homes that separately reported food costs. The nursing home's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing home.

Subp. 3. **Determination of dietician consulting fees.** The commissioner shall determine the dietician consulting fees to be included in other care-related costs according to items A and B.

A. For any nursing home separately reporting dietician consulting fees, the dietician consulting fees shall be the allowable dietician consulting fees reported under part 9549.0040, subpart 1.

B. For any nursing home that has not separately reported dietician consulting fees, the commissioner shall determine the average cost per licensed bed of allowable dietician consulting fees for all nursing homes that separately reported dietician consulting fees. The nursing home's total number of licensed beds must be multiplied by the average cost per bed to determine the dietician consulting fees for the nursing home.

9549.0054 DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COSTS PER DIEMS.

Subpart 1. **Review and adjustment of costs.** The commissioner shall annually review and adjust the operating costs reported by the nursing home during the reporting year preceding the rate year to determine the nursing home's actual allowable historical operating costs. The review and adjustment must comply with the provisions of parts 9549.0010 to 9549.0080.

Subp. 2. **Standardized resident days for rate years beginning on or after July 1, 1987.** For rate years beginning on or after July 1, 1987, each nursing home's standardized resident days must be determined in accordance with items A and B.

A. The nursing home's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class listed in part 9549.0058.

B. The amounts determined in item A must be summed to determine the nursing home's standardized resident days for the reporting year.

Subp. 3. **Allowable historical case mix operating cost standardized per diem.** The allowable historical case mix operating cost standardized per diem must be computed by dividing the allowable historical case mix operating cost by the standardized resident days determined in subpart 2.

Subp. 4. **Allowable historical other care-related operating cost per diem.** The allowable historical other care-related operating cost per diem must be computed by dividing the allowable historical other care-related operating costs by the number of resident days in the nursing home's reporting year.

Subp. 5. **Allowable historical other operating cost per diem.** The allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the number of resident days in the nursing home's reporting year.

9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. **Annual adjustment factors.** The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care-related operating costs must be established according to subitems (1) to (7).

(1) The components and indices specified in the following table must be used to establish the case mix and other care-related operating cost adjustment factor. These indices are incorporated by reference as specified in subpart 4.

CASE MIX AND CARE-RELATED COMPONENTS AND INDICES

Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers.
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies.
Food	.1183	Producer Price Index for consumer foods.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (7).

(1) The components and indices specified in the following table must be used to establish the other operating cost adjustment factor. These indices are incorporated by reference as specified in subpart 4.

OTHER OPERATING COSTS COMPONENTS AND INDICES

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central states (20 percent).
Salaries	.5864	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

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(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

Subp. 2. **Base year limits.** For each geographic group established in part 9549.0052 the base year operating costs limits must be determined according to items A to E. No redetermination of the base year operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix operating cost per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care-related operating cost per diems for the base year. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care-related per diems for the base year by dividing the allowable historical other care-related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facilty. For a short length of stay facility, the allowable historical other care-related operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

C. The total care-related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B. The total care-related operating cost limit for a short length of stay facility must be 125 percent of the total care-related operating cost limit. A nursing home licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 is exempt from the total care-related operating cost limit.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes, that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative. For the purpose of computing the amount of disallowed general and administrative cost, the nursing home's professional liability and property insurance must be excluded from the general and administrative cost category.

E. The other operating costs limits must be determined in accordance with subitems (1) to (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

(1) For each geographic group in part 9549.0052, the commissioner shall group all hospital attached nursing homes, short length of stay facilities, and nursing homes licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600.

(2) The other operating cost limit for hospital attached nursing homes in each geographic group in part 9549.0052 must be 105 percent of the median of the array of the allowable historical other operating cost per diem for each nursing home in the group established under subitem (1) in the base year.

(3) The other operating cost limit for all short length of stay facilities and nursing homes licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 in each geographic group in part 9549.0052 must be 105 percent of the limit established in subitem (2).

(4) For each geographic group in part 9549.0052, the commissioner shall group all nursing homes not included in subitem (1).

(5) The other operating cost limit for each group established in subitem (4) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing home in the group for the base year.

Subp. 3. **Indexed limits.** For a rate year beginning on or after July 1, 1987, the total care related operating cost limits and the other operating cost limits must be determined under items A and B.

A. The total care related operating cost limits must be determined under subitems (1) and (2).

(1) The composite price index for case mix and other care related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care related operating cost limits.

B. The total other operating costs limits must be determined under subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

Subp. 4. **Incorporations by reference.** The indices specified in items A to D are incorporated by reference and are available through the Minitex interlibrary loan system. They are subject to frequent change.

A. The index for average hourly earnings of employees in nursing and personal care facilities is published monthly in "Employment and Earnings," Bureau of Labor Statistics, United States Department of Labor. Standard Industrial Code 805 (SIC 805) is the code used for employees in nursing and personal care facilities in this publication.

B. The Employment Cost Index for Service Workers and the Employment Cost Index for wages and salaries of professional and technical workers are published monthly in "Current Wage Developments," Bureau of Labor Statistics, United States Department of Labor.

C. The Consumer Price Index for nonprescription medical equipment and supplies and the Consumer Price Index for maintenance and repair commodities are published in the "Monthly Labor Review," Bureau of Labor Statistics, United States Department of Labor.

D. The Producer Price Index for consumer foods, the Producer Price Index for natural gas, and the Producer Price Index for commercial power in west north central states are published monthly in "Producer Prices and Price Indexes," Bureau of Labor Statistics, United States Department of Labor.

9549.0056 DETERMINATION OF OPERATING COST PAYMENT RATE.

Subpart 1. **Nonadjusted case mix and other care-related payment rate.** For each nursing home, the nonadjusted case mix and other care-related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem established in part 9549.0054, subpart 3, must be multiplied by the weight for each resident class listed in part 9549.0058.

B. The allowable historical other care-related operating cost per diem established in part 9549.0054, subpart 4, must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group established in part 9549.0055, subpart 2, item C, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted case mix and other care-related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group established in part 9549.0055, subpart 2, item C, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted case mix and other care-related payment rate must be set at the limit.

Subp. 2. **Adjusted prospective case mix and other care-related payment rate.** For each nursing home, the adjusted prospective case mix and other care-related payment rate for each resident class must be the nonadjusted case mix and other care-related

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payment rate multiplied by the case mix and other care-related adjustment factor determined in part 9549.0055, subpart 1, item A. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in reduced by the amount of the efficiency incentive, if any, must be added to the adjusted prospective case mix and other care-related payment rate.

Subp. 3. **Nonadjusted other operating cost payment rate.** The nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem determined in part 9549.0054, subpart 5, is below the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem determined in part 9549.0054, subpart 5, is at or above the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted other operating cost payment rate must be set at that limit.

Subp. 4. **Adjusted prospective other operating cost payment rate.** The adjusted prospective other operating cost payment rate must be determined according to items A to E.

A. Except as provided in item B, if the nursing home's nonadjusted other operating cost payment rate is below the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, and the nonadjusted other operating cost payment rate in subpart 3 up to a maximum of two dollars per resident day.

B. For any short length of stay facility and any nursing home licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 that is under the limits established in part 9549.0055, subpart 2, item E, subitem (3), as indexed in part 9549.0055, subpart 3, the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055, subpart 2, item E, subitem (2), as indexed in part 9549.0055, subpart 3, and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars per resident day.

C. If the nursing home's nonadjusted other operating cost payment rate is at or above the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item B, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, except as provided in subpart 7.

D. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in must be added to the adjusted prospective other operating cost payment rate.

E. The nursing home's efficiency incentives as determined in item A or B must not be changed as a result of field audit adjustment.

Subp. 5. **Total operating cost payment rate.** The nursing home's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care-related payment rate determined in subpart 2 and the adjusted other operating cost payment rate determined in subpart 4.

Subp. 6. **One-time adjustment.** Items A to F set forth the procedure to be applied to establish a one-time adjustment to the nursing home's case mix operating costs per diem for the period October 1, 1986, to September 30, 1987.

A. To qualify for a one-time adjustment to the case mix operating costs per diem, the nursing home or portion of the nursing home for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing home must not have received an interim or settle-up payment rate during the reporting year ending September 30, 1985.

B. To apply for the one-time adjustment to case mix operating costs per diem, the nursing home must have submitted a written request to the commissioner on or before July 31, 1986. The written request must include the information required in subitems (1) to (3).

(1) Documentation indicating that based on the productive nursing hours and standardized resident days for the reporting period, ending September 30, 1985, the nursing home cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing home cannot use other available resources, including any efficiency incentives effective July 1, 1986, to increase productive nursing hours to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(2) A list of the number and type of staff positions including annual hours worked, and related fringe benefits and payroll taxes for the reporting years ending September 30, 1984 and September 30, 1985.

(3) A written nursing plan describing how the nursing home will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing home receives a one-time adjustment. The plan must include the number and types of staff to be added to the current staff complement and the projected cost of the salary and related fringe benefits and payroll taxes for the additional staff. The plan must also specify any other increases in case mix operating costs.

C. The commissioner of human services and the commissioner of health shall review the documentation submitted by the nursing home under item B to determine if the nursing home meets the criteria in subitems (1) to (5).

(1) The nursing home meets the criteria in item A.

(2) The nursing home has submitted the documentation required in item B.

(3) The nursing home provided less than a minimum of 0.95 productive nursing hours per standardized resident day for the reporting period ending September 30, 1985.

(4) The nursing home cannot meet the minimum of 0.95 productive nursing hours per standardized resident day by reallocating staff and costs including efficiency incentives.

(5) The nursing home's allowable historical case mix and other care-related operating cost per diem plus the one-time adjustment is less than the case mix and other care-related operating cost limit.

D. If the request meets the criteria in item C, the commissioner shall make a one-time adjustment to the nursing home's payment rate. The one-time adjustment must be determined according to subitems (1) to (9) and must not exceed the amount computed in subitem (3).

(1) The nursing home's productive nursing hours per standardized resident day for the reporting period ending September 30, 1985, must be subtracted from 0.95 and the result must be multiplied by the nursing home's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing home's nursing cost per hour must be determined by dividing the nursing home's total allowable historical case mix operating costs by the nursing home's total productive nursing hours for the reporting period ending September 30, 1985.

(3) The amount determined in subitem (1) must be multiplied by the amount determined in subitem (2) to determine the total maximum nursing costs required to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(4) If the amount requested in the nursing hours plan submitted under item B is less than the amount in subitem (3) the difference must be subtracted from the amount in subitem (3).

(5) The amount determined in subitem (4) must be divided by the nursing home's standardized resident days for the reporting period ending September 30, 1985, to compute the maximum standardized case mix per diem costs to be allowed under this subpart.

(6) Any efficiency incentive included in the nursing home's total operating costs payment on July 1, 1986, must be subtracted from the amounts in subitem (5).

(7) Any further reduction that the commissioner determines would be possible by reallocating the nursing home's staff and costs must be subtracted from the amount computed in subitem (6).

(8) The amount computed in subitem (7) must be multiplied by the weight for each resident class contained in part 9549.0058, subpart 2.

(9) The amount computed in subitem (8) must be added to the adjusted prospective case mix and other care-related payment rates for each corresponding resident class.

E. The one-time adjustment determined in item D, subitem (9) shall be implemented beginning October 1, 1986. No portion of the adjustment may be used to provide services that are not case mix operating costs according to part 9549.0051, subpart 5. The commissioner shall perform a fiscal review of the nursing home's cost report submitted for the reporting period ending September 30, 1987, and of any additional documentation required by the commissioner to determine if the nursing home provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing home has implemented the provisions of the plan specified in item B. The commissioner shall consult with the commissioner of health to verify compliance with any applicable care-related licensing or certification standards. Based on the results of the fiscal review and the information provided by the commissioner of health, the commissioner shall implement either subitem (1), (2), or (3).

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(1) If the nursing home has failed to implement the plan required in item B, the commissioner shall recover the total amount paid under this subpart in accordance with part 9549.0070, subpart 4 and shall disallow any increases in costs incurred by the nursing home under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing home has implemented or partially implemented the plan specified in item B and the actual case mix operating costs incurred during the reporting year ending September 30, 1987, are below the payment made under this subpart, the commissioner shall reduce the adjustment to the nursing home's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home until June 30, 1988.

(3) If the actual costs of implementing the plan specified in item B, subitem (3) incurred during the reporting period ending September 30, 1987, exceed the payments made under this subpart there shall be no retroactive cost settle-up. The adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home at the same level until June 30, 1988.

F. The nursing home must record the costs associated with this subpart separately from other nursing home costs until the commissioner's fiscal and compliance review under item E establishes that the nursing home has implemented the plan required in item B and has provided at least 0.95 productive nursing hours per standardized resident day during the reporting period ending September 30, 1987. To prevent duplicate payments, the case mix operating costs associated with this subpart are nonallowable until after the commissioner has reviewed and approved the costs under item E. If the commissioner approves the costs, the additional case mix operating costs incurred under this subpart are allowable costs and must be included in the computation of the allowable historical case mix operating cost per diem for the rate year beginning July 1, 1988.

Subp. 7. **Phase-in of rates.** Nursing home rate limits shall be phased-in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

9549.0057 DETERMINATION OF INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES.

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing home must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle-up operating cost payment rates for a newly constructed nursing home, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059, except that:

A. The nursing home must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase-in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle-up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

(2) The commissioner shall use the standardized resident days in subitem (1) in determining the allowable historical

case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle-up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase-in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine-month period in item C must be determined under parts 9549.0050 to 9549.0059.

E. A newly-constructed nursing home or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle-up total operating cost payment rate is determined under this subpart.

9549.0058 RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident or applicant must be assessed according to items A to E based on the information on the assessment form completed in accordance with part 9549.0059.

A. A resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. A resident or applicant assessed as dependent in fewer than four of the ADLs in item A must be defined as Low ADL. A resident or applicant assessed as dependent in four through six of the ADLs in item A must be defined as Medium ADL. Each resident or applicant assessed as dependent in seven or eight of the ADLs in item A must be defined as High ADL.

C. A resident or applicant must be defined as special nursing if the resident or applicant meets the criteria in subitems (1) and (2):

(1) the resident or applicant is assessed to require tube feeding; or

(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

(a) oxygen and respiratory therapy;

(b) ostomy/catheter care;

(c) wound or decubitus care;

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(d) skin care;

(e) intravenous therapy;

(f) drainage tubes;

(g) blood transfusions;

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. The publication is available through the Minitex interlibrary loan system and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952);

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is two or more for behavior on the assessment form.

Subp. 2. **Resident classes.** The commissioner shall establish resident classes according to items A to K. The resident classes must be established based on the definitions in subpart 1.

A. A resident must be assigned to class A if the resident is assessed as:

(1) Low ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

B. A resident must be assigned to class B if the resident is assessed as:

(1) Low ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

C. A resident must be assigned to class C if the resident is assessed as:

(1) Low ADL; and

(2) defined special nursing.

D. A resident must be assigned to class D if the resident is assessed as:

(1) Medium ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

E. A resident must be assigned to class E if the resident is assessed as:

(1) Medium ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

F. A resident must be assigned to class F if the resident is assessed as:

(1) Medium ADL; and

(2) defined special nursing.

G. A resident must be assigned to class G if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) not defined special nursing; and

(4) not defined behavioral condition.

H. A resident must be assigned to class H if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) defined behavioral condition; and

(4) not defined special nursing.

I. A resident must be assigned to class I if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) not defined neuromuscular condition.

J. A resident must be assigned to class J if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) defined neuromuscular condition or scoring three or four on behavior.

K. A resident must be assigned to class K if the resident is assessed as:

(1) High ADL; and

(2) defined special nursing.

Subp. 3. **Class weights.** The commissioner shall assign weights to each resident class established in subpart 2 according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

J. Class J, 3.53;

K. Class K, 4.12.

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9549.0059 RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing home applicants and newly admitted residents.** Each nursing home applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's class. The assessment must be conducted according to the procedures in items A to I.

A. The county preadmission screening team or hospital screening team under contract with the county must assess all nursing home applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.091, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.091, except as provided in subitems (1) and (2).

(1) The public health nurse of the county preadmission screening team or the registered nurse case manager shall assess a nursing home applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) An applicant whose admission to the nursing home is for the purpose of receiving respite care services need not be reassessed more than once every six months for the purpose of computing resident days under part 9549.0054, subpart 2, if the applicant has been classified by the Department of Health within the prior six-month period. In this case, the resident class established by the Department of Health within the prior six-month period may be the resident class of the applicant. A resident must not receive more than one assessment per respite care stay.

B. Except as provided in item A, subitem 2, the nursing home must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.091, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.091. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing home that is licensed differently than the section the resident previously was placed in or a resident who has been transferred from another nursing home.

C. Except as provided in item D, the assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing home.

D. Any resident who is required to be assessed by the preadmission screening team under item A or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing home must be assessed by the nursing home. The nursing home must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

E. Each assessment that the nursing home is required to perform must be completed by a registered nurse. The registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QA&R procedures of the Department of Health including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.

G. Within five working days following the assessment, the preadmission screening team or hospital screening team under contract with the county must send the completed assessment form to the Department of Health, and provide a copy to the nursing home.

H. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing home as a request for classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for applicants or newly admitted residents must be effective on the date of the person's admission to the nursing home.

Subp. 2. **Semiannual assessment by nursing homes.** Semiannual assessments of residents by the nursing home must be completed in accordance with items A to D.

A. A nursing home must assess each of its residents no earlier than 162 days and no later than 182 days after the date of the most recent annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall assess each resident according to QA&R procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse performing the assessment shall sign the assessment form.

C. Within five working days of the completion of the nursing home's semiannual resident assessments, the nursing home must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, the residents' plans of care, and the nursing home's daily census for the date on which

the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing home must provide additional information to the Department of Health if the Department of Health requests the information in order to determine a resident's classification.

D. Any change in resident class due to a semiannual assessment must be effective on the first day of the month following the date of the completion of the semiannual assessments.

Subp. 3. **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health's QA&R team will be effective as of the first day of the month following the date of completion of the Department of Health's assessments.

Subp. 4. **Assessment upon return to the nursing home from a hospital.** Residents returning to a nursing home after hospitalization must be assessed according to items A to D.

A. A nursing home must assess any resident who has returned to the same nursing home after a hospital admission. The assessment must occur no more than five working days after the resident returns to the same nursing home.

B. In addition to the assessment required in item A, residents who have returned to the same nursing home after hospital admission must be reassessed by the nursing home no less than 30 days and no more than 35 days after return from the hospital unless the nursing home's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to QA&R procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assesssment, the nursing home must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing home after a hospital admission. This request must include the assessment form and the resident's medical plan of care. Upon request, the nursing home must furnish the Department of Health with additional information needed to determine a resident's classification.

D. Any change in resident class due to an assessment provided under item A must be effective on the date the resident returns to the nursing home from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first of the month following the assessment.

Subp. 5. **Change in resident class due to audits of assessments of nursing home residents.** Any change in resident class due to a reclassification required by part 4656.0050 as proposed at *State Register*, Volume 11, pages 970 to 975 and as subsequently adopted must be retroactive to the effective date of the assessment audited.

Subp. 6. **False information.** If the nursing home knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in part 9549.0041, subpart 15.

Subp. 7. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under part 4656.0070 as proposed at *State Register*, Volume 11, pages 970 to 975 and as subsequently adopted.

Subp. 8. **Change in resident class due to request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4656.0070 as proposed at *State Register*, Volume 11, pages 970 to 975 and as subsequently adopted is pending.

B. Any change in a resident class due to a reclassification under part 4656.0070 as proposed at State Register, Volume 11, pages 970 to 975 and as subsequently adopted must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. 9. **Resident access to assessments and documentation.** The nursing home must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing home resident or the resident's authorized representative according to items A to D.

A. The nursing home must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing home. The nursing home may include a notice that the nursing home has chosen to appeal the rates under part 9549.0080.

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B. The nursing home must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Department of Health within five days of the receipt of the classification letter. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

D. The nursing home must provide each nursing home resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative.

Department of Human Services

Proposed Permanent Rules Relating to Nursing Home Payment Rate Determination

Rules as Proposed

9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.

Subpart 1 to 10. [Unchanged.]

Subp. 11. **Capacity days.** The number of capacity days is determined under items A to C.

A. and B. [Unchanged.]

C. The commissioner shall waive the requirements of item B if a nursing home agrees in writing to subitems (1) to (3).

(1) and (2) [Unchanged.]

(3) The nursing home shall agree not to charge any private paying resident in a single bedroom a payment rate that exceeds the ~~total payment rate established in part 9549.0070, subpart 1 by more than ten percent~~ amount calculated under units (a) to (e).

(a) The nursing home's average case mix score for the reporting year must be determined by dividing the nursing home's standardized resident days by the nursing home's resident days.

(b) The nursing home's average case mix operating cost payment rate must be determined by multiplying the nursing home's average case mix score in unit (a) by the nursing home's adjusted prospective case mix operating cost payment rate for its resident class A.

(c) The nursing home's average total payment rate must be determined by adding together the nursing home's average case mix operating cost payment rate, adjusted prospective care related payment rate, adjusted prospective other operating cost payment rate, real estate taxes and special assessment payment rate, and property-related payment rate.

(d) The nursing home's maximum single bedroom adjustment must be determined by multiplying its average total payment rate calculated under unit (c) by ten percent.

(e) The nursing home's single bedroom adjustment which must not exceed the amount computed in unit (d) must be added to each total payment rate established in part 9549.0070, subpart 1 to determine the nursing home's single bedroom rates.

Subp. 12. [Unchanged.]

Subp. 13. **Determination of the property-related payment rate.** The commissioner shall determine the property-related payment rate according to items A to H.

A. [Unchanged.]

B. The allowable historical property-related per diem shall be established according to subitems (1) and (2).

(1) [Unchanged.]

(2) For rate years beginning after June 30, 1986, the historical property-related cost per diem shall be the property-related payment rate established for the previous rate year unless the nursing home's capacity days change. If the nursing home's capacity days change from one reporting year to the next for any reason including a change in the number of licensed nursing home beds, a change in the election for computing capacity days as provided in subpart 11, or a change in the number of days in

the reporting year, the historical property related per diem must be recalculated using the capacity days for the reporting year in which the change occurred.

C. to H. [Unchanged.]

Subp. 14. [Unchanged.]

ADOPTED RULES

The adoption of a rule becomes effective after the requirements of Minn. Stat. § 14.14-14.28 have been met and five working days after the rule is published in *State Register*, unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption and a citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strikeouts and new language will be underlined. The rule's previous *State Register* publication will be cited.

An emergency rule becomes effective five working days after the approval of the Attorney General as specified in Minn. Stat. § 14.33 and upon the approval of the Revisor of Statutes as specified in § 14.36. Notice of approval by the Attorney General will be published as soon as practicable, and the adopted emergency rule will be published in the manner provided for adopted rules under § 14.18.

Board of Accountancy

Adopted Permanent Rules Relating to License Nonrenewals

The rules proposed and published at *State Register*, Volume 11, Number 8, pages 331-332, August 25, 1986 (11 S.R. 331) are adopted as proposed.

Department of Human Services

Adopted Permanent Rules Relating to Chemical Dependency Care for Public Assistance Recipients

The rules proposed and published at *State Register*, Volume 10, Number 52, pages 2546-2556, June 23, 1986 (10 S.R. 2546) are adopted with the following modifications:

Rules as Adopted

9530.6600 CHEMICAL DEPENDENCY CARE FOR PUBLIC ASSISTANCE RECIPIENTS; GENERAL PROVISIONS.

Subpart 1. **Applicability.** Parts 9530.6600 to 9530.6655 establish criteria that counties shall apply to determine the appropriate level of chemical dependency care for a client seeking treatment for chemical dependency and abuse problems which requires the expenditure of public funds for treatment. Parts 9530.6600 to 9530.6655 do not apply to court commitments under Minnesota Statutes, chapter 253B, or section 526.10.

9530.6605 DEFINITIONS.

Subp. 9. **Client.** "Client" means an individual who is eligible for chemical dependency treatment funded under Minnesota Statutes, chapters 246, 256B, 256D, and 256E, and who has requested chemical dependency assessment services or for whom chemical dependency assessment services have been requested from a county.

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Subp. 18. **Inappropriate and harmful use.** "Inappropriate and harmful use" means use of a chemical which exceeds social or legal standards of acceptability, the outcome of which is characterized by three or more of the following:

A. weekly use to intoxication;

B. inability to function in a social setting without becoming intoxicated;

C. driving after consuming sufficient chemicals to be considered legally impaired under Minnesota Statutes, section 169.121, whether or not an arrest takes place;

D. excessive spending on chemicals that results in an inability to meet financial obligations;

E. loss of friends due to behavior while intoxicated; or

F. chemical use that prohibits one from meeting work, school, family, or social obligations.

9530.6610 COMPLIANCE PROVISIONS.

Subpart 1. **Assessment responsibility.** The county shall provide a chemical use assessment as provided in part 9530.6615 for all ~~eligible persons~~ clients who seek treatment or for whom treatment is sought for chemical abuse or dependency. ~~Except as provided in subpart 4,~~ The assessor shall complete an assessment summary on a form prescribed by the commissioner for each ~~eligible person~~ client assessed for chemical dependency treatment services. The form shall be maintained in the client's case record.

Organizations contracting with the department to provide a prepaid health plan that includes the provision of chemical dependency services to enrollees, and that utilizes funds authorized under Minnesota Statutes, chapters 256B and 256D, shall provide a chemical use assessment for enrollees who seek treatment or for whom treatment is sought as provided in part 9530.6615, and shall place enrollees in accordance with the criteria established in parts 9530.6625 to 9530.6650.

Subp. 2. **County records.** The commissioner shall ensure compliance with parts 9530.6600 to 9530.6655 by requiring each county to have available for review records that include the following information:

A. documentation of compliance with parts 9530.6600 to 9530.6655 for all clients seeking treatment for chemical abuse or dependency, including copies of placement policies and procedures;

B. documentation of the qualifications of assessors in accordance with the standards established under part 9530.6615, subpart 2; and

C. documentation of a plan for eight hours of in-service training or continuing education concerning or related to assessment skills ~~and~~, treatment resources, or unique assessment and treatment needs of special populations for all assessors on an annual basis.

~~Subp. 3. Consequence of inappropriate placement. After July 1, 1987, payment shall not be made for chemical dependency treatment services provided to clients who have not been assessed by the county as being in need of that level of service according to items A and B.~~

~~A. Reimbursement will be made from funds authorized under Minnesota Statutes, chapters 256B, 256D, and 256E only for the level of service found to be appropriate as a result of an assessment performed in compliance with parts 9530.6600 to 9530.6655.~~

~~B. A client placed in a state hospital to receive care and treatment for chemical abuse or dependency shall be assessed and placed according to parts 9530.6600 to 9530.6655.~~

Subp. ~~4~~ 3. **County designee.** The county may contract with public, nonprofit, or proprietary agencies or individuals identified in Minnesota Statutes, section 256E.08, subdivision 4, for the provision of assessments by a qualified assessor. An assessor under contract with the county shall have no direct shared financial interest or referral relationship resulting in shared financial gain with a treatment provider identified under part 9530.6600, subpart 2.

Subp. ~~5~~ 4. **County designee variance.** The county may request a variance from the commissioner to approve a county designee that does not meet the criteria under subpart ~~4~~ 3 if the conditions under item A or B exist. The request for a variance must be submitted in writing and must document that the conditions in item A or B exist.

A. A culturally specific service provider, or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference is available in the county and the service provider employs a qualified assessor.

B. The county does not employ a sufficient number of qualified ~~assessor~~ assessors and the only qualified ~~assessor~~ assessors available in the county ~~has~~ have a direct shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider.

A county designee providing assessments under a variance granted under subpart ~~6~~ 5 shall not place clients in treatment. The county designee shall gather information required under part 9530.6620 and provide the local agency with the documentation required under part 9530.6615, subpart 4, items A to D. The local agency must make all placement decisions for clients assessed by a county designee under a variance.

Subp. ~~6~~ 5. **Review of variance request; notification.** The commissioner shall review a variance request submitted by a county. If the county has demonstrated that a condition under subpart ~~5~~ 4, item A or B exists, the commissioner shall approve the request. A variance requested and granted under subpart ~~5~~ 4, item B, shall not extend for more than 12 months from the date of approval. If the commissioner denies a requested variance, the commissioner shall notify the county within 30 days of receipt of the variance request of the reasons for the denial.

9530.6615 CHEMICAL USE ASSESSMENTS.

Subpart 1. **Assessment mandate.** The county shall provide a chemical use assessment for each client seeking treatment or for whom treatment is sought for chemical dependency or chemical abuse problems before the client is placed in a program identified in part 9530.6600, subpart 2. The assessment must be done in a language understandable to the client and must be completed within the time limits specified under part 9550.0070. The county shall provide interpreters for the hearing impaired and foreign language interpretive services when necessary.

Subp. 2. **Staff performing assessment.** Chemical use assessments must be conducted by qualified staff of the county or their designee in a manner that complies with parts 9530.6600 to 9530.6655. An individual is qualified to perform chemical use assessments if he or she annually completes a minimum of eight hours of in-service training or continuing education, documented under part 9530.6610, subpart 2, item C, and meets the criteria in one of the items listed below:

A. The individual ~~is certified as a chemical dependency practitioner or chemical dependency counselor by the Institute for Chemical Dependency Professionals of Minnesota, Inc.~~ has successfully completed 30 hours of classroom instruction on chemical dependency assessments, has successfully completed one year of work experience in chemical dependency assessments, either as an intern or as an employee, and has successfully completed two additional years of work experience in chemical dependency assessments or treatment before July 1, 1987.

C. The individual has at least a baccalaureate degree in social work, nursing, sociology, human services, or psychology, has successfully completed 30 hours of classroom instruction on chemical dependency assessments, and has successfully completed a one year internship or one year of work experience in chemical dependency assessments.

Subp. 3. **Method of assessment.** The method of assessment must include a personal interview with the client in order to make a finding about the extent of the problem with chemical use. It must also include collateral contacts and a review of relevant records or reports regarding the client consistent with confidentiality and data privacy provisions in Minnesota Statutes, chapter 13; sections 144.343 and 254A.09; and Code of Federal Regulations, title 42, sections 2.1 to 2.67-1. If an assessor is unable to make collateral contacts, the assessor must include in the client's case record an explanation of why collateral contacts were not made.

9530.6620 PLACEMENT INFORMATION.

Subpart 1. **Level of care determination.** The information in items A to I must be considered when determining the level of care for a client~~:~~. If a treatment provider identifies additional information that indicates that a client has not been placed in the most appropriate level of care, the treatment provider shall, in compliance with confidentiality and data privacy provisions in Minnesota Statutes, chapter 13; sections 144.343 and 254A.09; and Code of Federal Regulations, title 42, sections 2.1 and 2.67-1, provide the county with the additional information for the county to consider in determining whether the placement was made at the appropriate level of care and whether an alternative placement must be made.

9530.6650 EXCEPTIONS TO PLACEMENT CRITERIA.

Subpart 1. **General exceptions.** Clients may be placed in a program even though they do not meet the criteria established under parts 9530.6625 to 9530.6650 if one of the following exceptions applies:

D. the client is placed by ~~juvenile court or probate~~ a committing court ~~commitment~~ as defined in Minnesota Statutes, section 253B.02, subdivision 4; or

EFFECTIVE DATE. Parts 9530.6600 to 9530.6655 are effective January 1, 1987, unless otherwise specified.

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OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Ethical Practices Board

Notice of 1987 Campaign Expenditure Limits

In accordance with Minn. Stat. §§ 10A.25 and 10A.255, the following are nonelection year campaign expenditure limits for 1987, by office sought or held: Governor and Lt. Governor, $283,643; Attorney General, $47,274; Secretary of State, State Treasurer, State Auditor (each), $23,637; State Senator, $7,092; and State Representative, $3,546.

Minnesota Housing Finance Agency

Notice of Hearing on Bond Issue

The Minnesota Housing Finance Agency will hold a public hearing at 1:00 p.m. on Tuesday, December 23, 1986, at the Minnesota Housing Finance Agency, in St. Paul, Minnesota for the purpose of taking public testimony regarding its proposed issuance of single family mortgage revenue bonds in a principal amount not exceeding $55,000,000.

The proceeds of the Bonds will make available approximately $53,000,000 in lower interest mortgage loans to certain homebuyers of single family owner/occupied residences located throughout the State of Minnesota, which homebuyers qualify under the Agency's Program and Federal Law.

Additional information relating to the Agency's Program and the Bonds may be obtained from Minnesota Housing Finance Agency, 400 Sibley Street, Suite 300, St. Paul, Minnesota 55101, Attn: John Silvis.

James Solem
Executive Director

Department of Human Services Chemical Dependency Program and Mental Health Program Divisions

Notice of Legislative Hearing on the Federal Alcohol, Drug Abuse and Mental Health Block Grant, and the Availability of a Statement Describing the Intended Use of Alcohol and Drug Abuse Funds from the Alcohol, Drug Abuse, and Mental Health Block Grant-Federal Fiscal 1987

Notice is hereby given that the Health and Human Services Subcommittee of the Senate Finance Committee and the Human Services Division of the House Appropriations Committee will conduct a joint public hearing on the use of the Federal Alcohol, Drug Abuse and Mental Health Block Grant. The hearing will be held December 9, 1986 at 10:00 AM in Room 120, State Capitol.

Notice is also given that the Department of Human Services has available a Description of Intended Use for the alcohol and drug abuse funds available to the State of Minnesota from the Federal Fiscal Year 1987 Alcohol, Drug Abuse and Mental Health Block Grant. This description is being made available to the public for comment in accord with Part B, Section 1915(d) of Title IX, Omnibus Budget Reconciliation Act of 1981.

All interested or affected persons or groups are invited to comment. Copies of the description are available from:

Sheila Vadnais
Chemical Dependency Program Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155
(612) 296-4618

Comments on the proposed plan may be directed to the same address and phone number. Oral requests and comments will be received during normal business hours.

Department of Labor and Industry Prevailing Wage Division

Notice of Certified Prevailing Wage Rates for Commercial Construction

On December 1, 1986 the commissioner will certify prevailing wage rates for commercial construction projects in the following Minnesota counties: Anoka, Benton, Big Stone, Carver, Chippewa, Chisago, Dakota, Douglas, Grant, Hennepin, Isanti, Kanabec, Kandiyohi, McLeod, Meeker, Mille Lacs, Morrison, Pine, Pope, Ramsey, Scott, Sherburne, Stearns, Stevens, Swift, Todd, Traverse, Washington and Wright.

A copy of the determined wage rates for Minnesota counties may be obtained by contacting the State Register and Public Documents Division, 117 University Avenue, St. Paul, Minnesota 55155. The charges for the cost of copying and mailing are $.50 for the first county and $.30 for any subsequent copies of the same or other counties. For all 87 counties the charge is $25.00. A sales tax of 6% must be added to all orders.

A check or money order payable to the State of Minnesota must accompany each request.

Steve Keefe, Commissioner
Department of Labor and Industry

Department of Labor and Industry Prevailing Wage Division

Notice of Correction to Prevailing Wage Rates in Fillmore and Olmsted Counties for Highway Heavy Construction Projects

Due to an error of omission, revisions have been made to prevailing wage rates certified October 1, 1986 for highway and heavy construction projects in Fillmore and Olmsted counties.

The revised rates may be obtained by contacting the State Register and Public Documents Division, 117 University Avenue, St. Paul, Minnesota 55155.

Steve Keefe, Commissioner
Department of Labor and Industry

Department of Transportation

Notice to Consulting Engineers — Registered Civil and Structural

The Minnesota Department of Transportation (Mn/DOT) anticipates retaining Bridge Design Consultants to design and prepare construction plans for a limited number of bridges of average complexity during 1987.

Applicants must have an office in Minnesota staffed to handle the work. Recent experience in the production of bridge plans for the State Highway System, the County State Aid Highway System, or equivalent, is required.

Eligible design firms desiring to be considered as design contractors are asked to submit a brochure or resume giving qualifications and experience to D. J. Fleming, State Bridge Engineer, 610D Transportation Building, Mn/DOT, St. Paul, Minnesota 55155. Identify personnel to conduct the work and detail their training and experience. Brochures and resumes will be received until 4:00 P.M., December 19, 1986. Applicants may be requested to interview at the Mn/DOT Building in St. Paul.

Names of selected firms will be retained on file with Mn/DOT for consideration during 1987.

Department of Transportation

Petition of the City of Andover for a Variance from State Aid Administrative Requirements for the determination of the Maintenance Monies

Notice is hereby given that the City Council of the City of Andover has made a written request to the Commissioner of Transportation pursuant to Minnesota Rules § 8820.3300 for a variance from requirements for establishing their 1986 Maintenance Allocation.

The request is for a variance from Minnesota Rules for State Aid Operations § 8820.1400, adopted pursuant to Minnesota Statutes Chapter 161 and 162, so as to permit the City of Andover to increase their 1986 Maintenance Allotment by $41,431.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

If a written objection is received within 20 days from the date of this notice in the *State Register*, the variance can be granted only after a contested case hearing has been held on the request.

Dated: 21 November 1986

Richard P. Braun
Commissioner of Transportation

Department of Transportation

Petition of the City of St. Paul for a Variance from State Aid Standards for Design Standards

Notice is hereby given that the City Council of the City of St. Paul has made a written request to the Commissioner of Transportation pursuant to Minnesota Rules § 8820.3300 for a variance from minimum standards for a reconstruction project on Lexington Parkway from 125′ South of Montana Avenue to Larpenteur Avenue.

The request is for a variance from Minnesota Rules for State Aid Operations § 8820.9912 adopted pursuant to Minnesota Statutes Chapter 161 and 162, so as to permit a roadway width of 36′ with no parking permitted instead of the required width of 52′ with no parking permitted.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

If a written objection is received within 20 days from the date of this notice in the *State Register*, the variance can be granted only after a contested case hearing has been held on the request.

Dated: 21 November 1986

Richard P. Braun
Commissioner of Transportation

Department of Transportation

Petition of the City of St. Paul for a Variance from State Aid Standards for Design Standards

Notice is hereby given that the City Council of the City of St. Paul has made a written request to the Commissioner of Transportation pursuant to Minnesota Rules § 8820.3300 for a variance from minimum standards for a reconstruction project on Sixth Street between Hope Street and Cypress Street.

The request is for a variance from Minnesota Rules for State Aid Operations § 8820.9919 adopted pursuant to Minnesota Statutes, Chapter 161 and 162, so as to permit a street width of 42′ with no parking allowed and a design speed of 15 miles per hour instead of the required street width of 46′ with no parking allowed and a design speed of 30 miles per hour.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

If a written objection is received within 20 days from the date of this notice in the *State Register*, the variance can be granted only after a contested case hearing has been held on the request.

Dated: 21 November 1986

Richard P. Braun
Commissioner of Transportation

STATE CONTRACTS

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency must make reasonable effort to publicize the availability of any services contract or professional and technical services contract which has an estimated cost of over $2,000.

Department of Administration procedures require that notice of any consultant services contract or professional and technical services contract which has an estimated cost of over $10,000 be printed in the *State Register*. These procedures also require that the following information be included in the notice: name of contact person, agency name and address, description of project and tasks, cost estimate, and final submission date of completed contract proposal. Certain quasi-state agencies are exempted from some of the provisions of this statute.

Commodities contracts with an estimated value of $5,000 or more are listed under the Procurement Division, Department of Administration. All bids are open for 7-10 days before bidding deadline. For bid specifics, time lines, and other general information, contact the appropriate buyers by calling 296-6152. If the appropriate buyer is not available, contact Harvey Leach or Barbara Jolly at 296-3779.

Department of Administration: Procurement Division

Contracts and Requisitions Open for Bid

Call 296-6152 for Referral to Specific Buyers.

Commodity for Bid	Bid Closing Date at 2 pm	Department or Division	Delivery Point	Requisition #
U.P.M. Bituminous Mix	Dec. 1, 1986	Transportation	Morris	79-450 B
Spectrophotometer	Dec. 1, 1986	State University	St. Cloud	26-073-19264
Fiber Optics Power Meter	Dec. 1, 1986	State University	St. Cloud	26-073-19195
Furnish & Install Automatic Van Lift—Rebid	Dec. 1, 1986	Jobs & Training	St. Paul	21-607-41431
Methanol Alcohol	Dec. 2, 1986	Transportation	Various	Various
Ammonia	Dec. 2, 1986	Various	Various	Various
Dump Trucks	Dec. 2, 1986	Transportation	Various	Sch. 1130
Dental Lab Work	Dec. 2, 1986	Correctional Facility	Stillwater & Oak Park	Various
Oscilloscope	Dec. 2, 1986	Transportation	St. Paul	79-000-72465
Delco Remy Service Parts	Dec. 2, 1986	Transportation and Natural Resources	Various	Price Contract
Repair Aircraft	Dec. 2, 1986	Transportation: Aeronautics	St. Paul	79-000-72403
Upgrade of CPT System	Dec. 2, 1986	State University	St. Cloud	26-073-19221
Aggregates	Dec. 2, 1986	Transportation	Owatonna	79-650 A
Used Van	Dec. 2, 1986	Jobs & Training	St. Paul	21-605-49663
Computer Software	Dec. 2, 1986	Community College	Bloomington	27-156-10090
Computer Cable	Dec. 2, 1986	State University	Mankato	26-071-17112
Generators	Dec. 2, 1986	Transportation	Various	79-382-0128 etc.
Bending & Forming Machines	Dec. 3, 1986	Administration: Plant Mgmt.	St. Paul	02-307-51238
Display System	Dec. 3, 1986	Energy & Economic Devel.	St. Paul	22-400-01401
Sand Spreaders	Dec. 3, 1986	Transportation	St. Paul	79-382-01162
Adaptive Equip. for Van	Dec. 3, 1986	Jobs & Training	West St. Paul	21-606-70446
Genuine Parts for John Deere Ind. Tractors, Wheel Loaders, Motor Graders & Mowers	Dec. 3, 1986	Various	Various	Price Contract
Spectrophotometer	Dec. 4, 1986	State University	Winona	26-074-11192
Emergency Lights	Dec. 4, 1986	Public Safety	St. Paul	07-500-39583
Automation System	Dec. 4, 1986	School for the Arts	St. Paul	25-000-00165
Shower Room Units	Dec. 4, 1986	MN Academy for the Deaf	Faribault	37-001-70376
Snow Removal Contract	Dec. 5, 1986	Iron Range Resources & Rehabilitation Board	Eveleth	Price-Contract
Radio Comm. Equip.	Dec. 5, 1986	Public Safety	St. Paul	07-600-39592
Stainless Steel Tableware	Dec. 5, 1986	Various State Agencies	Various	Price-Contract
Galvanized Metalware	Dec. 5, 1986	Various State Agencies	Various	Price-Contract

State Designer Selection Board

Request for Proposal for University of Minnesota—Transportation/Office Building

TO REGISTERED PROFESSIONALS IN MINNESOTA:

The State Designer Selection Board has been requested to select designer University of Minnesota/Minneapolis Campus—Transportation/Office Building Design firms who wish to be considered for this project should submit proposals on or before 4:00 P.M., December 23, 1986, to George Iwan, Executive Secretary, State Design Selection Board, Room G-10, Administration Building, St. Paul, Minnesota 55155-1495.

The proposal must conform to the following:

1. Six copies of the proposal are required.

2. All data must be on 8½" x 11" sheets, soft bound; the proposal shall not consist of more than 20 faces.

3. The cover sheet of the proposal must be clearly labeled with the project number, as listed in number 7 below, together with the designer's firm name, address, telephone number, and the name of the contact person.

4. **Mandatory Proposal contents in sequence:**

a) Identity of firm and an indication of its legal status, i.e. corporation, partnership, etc. If the response is from a joint venture, this information must be provided for firms comprising the joint venture.

b) Names of the persons who would be directly responsible for the major elements of the work, including consultants, together with brief descriptions of their qualifications. If desired, identify roles that such persons played in projects which are relevant to the project at hand.

c) A commitment to enter the work promptly, if selected, by engaging the consultants, and assigning the persons named in 4b above along with adequate staff to meet the requirements of work.

d) A list of State and University of Minnesota current and past commissions under contract or awarded to the prime firm(s) submitting this proposal during the three (3) years immediately preceding the date of this request for proposal. The prime firm(s) shall list and total all fees associated with these projects whether or not the fees have been received or are anticipated. In addition, the prime firm(s) shall indicate the amount of fees listed which were paid directly to engineers or other speciality consultants employed on the projects listed pursuant to the above.

e) A section containing graphic material (photos, plans, drawings, etc.) as evidence of the firm's qualification for the work. The graphic material must be identified. It must be work in which the personnel listed in "c" have had significant participation and their roles must be clearly described. It must be noted if the personnel named were, at the time of the work, employed by other than their present firms.

The proposal shall consist of no more than twenty (20) faces. Proposals not conforming to the parameters set forth in this request will be disqualified and discarded without further examination.

5. **Statutory Proposal Requirements**

In accordance with the provisions of Minnesota Statutes, 1981 Supplement, Section 363.073; for all contracts estimated to be in excess of $50,000.00, all responders having more than 20 full-time employees at any time during the previous 12 months must have an affirmative action plan approved by the Commissioner of Human Rights before a proposal may be accepted. The proposal will not be accepted unless it includes one of the following:

a) A copy of the firm's current certificate of compliance issued by the Commissioner of Human Rights; or

b) A statement certifying that firm has a current certificate of compliance issued by the Commissioner of Human Rights; or

c) A statement certifying that the firm has not had more than 20 full-time employees in Minnesota at any time during the previous 12 months; or

d) A statement certifying that the firm has an application pending for a certificate of compliance.

6. Design firms wishing to have their proposals returned after the Board's review must follow one of the following procedures:

a) Enclose a self-addressed stamped postal card with the proposals. Design firms will be notified when material is ready to be picked up. Design firms will have two (2) weeks to pick up their proposals, after which time the proposals will be discarded; or

b) Enclose a self-addressed stamped mailing envelope with the proposals. When the Board has completed its review, proposals will be returned using this envelope.

In accordance with existing statute, the Board will retain one copy of each proposal submitted.

Any questions concerning the Board's procedures or their schedule for the project herein described may be referred to George Iwan at (612) 296-4656.

7) PROJECT—12-86

Transportation/Office Building
University of Minnesota
Minneapolis, Minnesota

The University of Minnesota is seeking an architect to design a Transportation/Office Building at the Minneapolis Campus.

The total cost of this is estimated at $4,100,000.00. The funding will come from University funds. Facility Program documents are being finalized.

Below is a brief description of the project:

The University of Minnesota plans to construct a new transportation/office building located on the East Bank of the Minneapolis campus. The new three story facility will consist of approximately 57,000 gsf with an enclosed vehicle storage area of approximately 10,000 gsf. The estimated construction cost is approximately $3,460,000.00. The major components of the project costs of:

—First Floor—(19,000 gsf)

- Transportation Services offices
- Office Equipment Rental offices
- Campus Mail facilities/loading dock
- Parking Services facilities

—Second and Third Floor—(38,000 gsf)

- Unassigned office space to be initially designed as "shell" space

—Parking/Service Yard

- 25 secured indoor spaces (10,000 gsf)
- 10 visitor
- 2 official
- 2 handicapped
- staff contract parking

The site, located north of Williams Arena, is bounded by 4th Street S.E., Oak Street S.E., 5th Street S.E. and 19th Street S.E. Two existing buildings will remain on the site with an addition removed from one. The proposed new University transit way (partially elevated) will cut across the northwest corner of the site. Site utilization will be an important part of the project. Yard service and storage areas are required for the new facility and one of the existing buildings.

Questions regarding this project may be referred to Clinton N. Hewitt at 625-7355.

Richard F. Whiteman, Chairman
State Designer Selection Board

State Designer Selection Board

Request for Proposal for Coffman Memorial Union—University of Minnesota

TO REGISTERED PROFESSIONALS IN MINNESOTA:

The State Designer Selection Board has been requested to select designer for the Coffman Memorial Union—Ground Floor Renovation at the University of Minnesota/Minneapolis Campus. Design firms who wish to be considered for this project should submit proposals on or before 4:00 P.M., December 23, 1986, to George Iwan, Executive Secretary, State Designer Selection Board, Room G-10, Administration Building, St. Paul, Minnesota 55155-1495.

The proposal must conform to the following:

1. Six copies of the proposal will be required.
2. All data must be on 8½" x 11" sheets, soft bound.

3. The cover sheet of the proposal must be clearly labeled with the project number, as listed in number 7 below, together with the designer's firm name, address, telephone number and the name of the contact person.

4. **Mandatory Proposal contents in sequence:**

a) Identity of firm and an indication of its legel status, i.e. corporation, partnership, etc. If the response is from a joint venture, this information must be provided for firms comprising the joint venture.

b) Names of the persons who would be directly responsible for the major elements of the work, including consultants, together with brief descriptions of their qualifications. If desired, identify roles that such persons played in projects which are relevant to the project at hand.

c) A commitment to enter the work promptly, if selected, by engaging the consultants, and assigning the persons named 4b above along with adequate staff to meet the requirements of work.

d) A list of State and University of Minnesota current and past commissions under contract or awarded to the prime firm(s) submitting this proposal during the three (3) years immediately preceding the date of this request for proposal. The prime firm(s) shall list and total all fees associated with these projects whether or not the fees have been received or are anticipated. In addition, the prime firm(s) shall indicate the amount of fees listed which were paid directly to engineers or other specialty consultants employed on the projects listed pursuant to the above.

e) A section containing graphic material (photos, plans, drawings, etc.) as evidence of the firm's qualification for the work. The graphic material must be identified. It must be work in which the personnel listed in "c" have had significant participation and their roles in which the personnel listed in "c" have had significant participation and their roles must be clearly described. It must be noted if the personnel named were, at the time of the work, employed by other than their present firms.

The proposal shall consist of no more than twenty (20) faces. Proposals not conforming to the parameters set forth in this request will be qualified and discarded without further examination.

5. **Statutory Proposal Requirements:**

In accordance with the provisions of Minnesota Statutes, 1981 Supplement, Section 363.073; for all contracts estimated to be in excess of $50,000.00, all responders having more than 20 full-time employees at any time during the previous 12 months must have an affirmative action plan approved by the Commissioner of Human Rights before a proposal may be accepted. The proposal will not be accepted unless it includes one of the following:

a) A copy of your firm's current certificate of compliance issued by the Commissioner of Human Rights; or

b) A statement certifying that firm has a current certificate of compliance issued by the Commissioner of Human Rights; or

c) A statement certifying that the firm has not had more than 20 full-time employees in Minnesota at any time during the previous 12 months; or

d) A statement certifying that the firm has an application pending for a certificate of compliance.

6. Design firms wishing to have their proposals returned after the Board's review must follow one of the following procedures:

a) Enclose a self-addressed stamped postal card with the proposals. Design firms will be notified when material is ready to be picked up. Design firms will have two (2) weeks to pick up their proposals, after which time the proposals will be discarded; or

b) Enclose a self-addressed stamped mailing envelope with the proposals. When the Board has completed its review, proposals will be returned using this envelope.

In accordance with existing statute, the Board will retain one copy of each proposal submitted.

Any questions concerning the Board's procedures or their schedule for the project herein described may be referred to George Iwan at (612) 296-4656.

7) PROJECT—11-86
Coffman Memorial Union
Ground Floor Renovation
University of Minnesota
Minneapolis, Minnesota

The University of Minnesota is seeking an architect to design the Coffman Memorial Union—Ground Floor Renovation at the University of Minnesota/Minneapolis Campus.

The total cost of this project is estimated at $850,000.00 which includes fees, furnishings and equipment.

Funding for the Project will come from Internal University funds.

Below is a brief description of the Project:

The University of Minnesota plans to renovate much of the Ground Floor of Coffman Memorial Union located on the Minneapolis campus. The project consists of the remodeling of approximately 43,000 gsf in two phases, summer of 1987 and summer of 1988. The estimated construction cost is approximately $640,000.00. The major components of the project consist of:

- The **"Little Brown Jug"** (a food service area)—Access, serving and seating areas to be remodeled/upgraded with current serving technologies and decor (approximately 10,700 gsf, Phase I, 1987).
- **"The In"** (a food service area)—To be remodeled into a submarine sandwich shop (approximately 1,600 gsf, Phase I, 1987).
- The **"Gopher Court"** (a commons type space)—To be renovated to improve circulation and to update decor (approximately 11,000 gsf, Phase II, 1988).
- The **"Parlor"** (containing two specialty food service areas)—To be remodeled/upgraded (approximately 3,700 gsf, Phase II, 1988).
- The **"Great Hall"** (a ballroom and meeting room)—To be renovated to improve circulation and flexibility (approximately 15,700 gsf, Phase II, 1988).
- Plans need to be developed for improving access to the Basement (Phase II, 1988).
- Interior design ability and experience is important.
- A food service consultant will be retained by the University to provide detailed equipment bid documents, serving layouts, and labor productivity consultation.

Questions regarding this project may be referred to Clinton N. Hewitt at 625-7355.

Richard F. Whiteman, Chairman
State Designer Selection Board

Department of Health

Request for Proposals for Producing Four Video Documentaries

The Center for Nonsmoking and Health of the Minnesota Department of Health is seeking proposals from agencies or individuals interested in competing for a contract for producing four high-quality video documentaries. The videos produced would be based on existing footage of an interview with a 47-year-old Minnesotan named Elain Knox-Wagner, who had lung cancer and wanted, before she died, to share with others the price they may pay for smoking.

The contractor for this project will produce one broadcase-quality, 28-minute videotape documentary and three shorter (10- to 15-minute) topical versions. The contractor will be expected to film three or more additional interviews, which may involve some out-of-state travel. Applicants must demonstrate the creative, technical, administrative, and fiscal capability to complete this project.

The anticipated amount of this contract is not more than $23,000.00, not including travel costs. The estimated starting date is February 23, 1987 with an estimated end date of May 29, 1987.

Agencies or individuals interested in bidding for this contract should request a copy of the Request for Proposal from:

Darlene Zirk
Center for Nonsmoking and Health
Minnesota Department of Health
717 S.E. Delaware St.
P.O. Box 9441
Minneapolis, MN 55440
612/623-5272

The deadline for submitting proposals is 4:30 p.m., Monday, January 12, 1987. Eligible applicants will be asked to participate in an interview with a review committee, and to show two or more examples of their previous video productions, preferably in the health or human services area. The selection of a contractor from those who have submitted proposals will be announced on January 26, 1987.

NON-STATE PUBLIC CONTRACTS

The *State Register* also serves as a central marketplace for contracts let out on bid by the public sector. The *Register* meets state and federal guidelines for statewide circulation of public notices. Any tax-supported institution or government jurisdiction may advertise contracts and requests for proposals from the private sector.

It is recommended that contracts and RFPs include the following: 1) name of contact person; 2) institution name, address, and telephone number; 3) brief description of project and tasks; 4) cost estimate; and 5) final submission date of completed contract proposal. Allow at least three weeks from publication date (four weeks from date article is submitted for publication). Surveys show that subscribers are interested in hearing about contracts for estimates as low as $1,000. Contact the editor for further details.

Metropolitan Council of the Twin Cities Area

Invitation for Sealed Bids to Print the *METRO MONITOR*

The Metropolitan Council, 300 Metro Square Bldg., St. Paul 55101, is requesting sealed bids to print the METRO MONITOR.

Specifications for printing the publication can be obtained by contacting Nadine Farrington, publications unit, at 291-6478.

Sealed bids will be accepted by the Metropolitan Council until 4 p.m. Dec. 8, 1986. The Council's purchasing officer will open the sealed bids publicly in the Council offices at 10 a.m. Dec. 9.

All sealed bids shall be marked "Bids to print Metro Monitor—to be opened on Dec. 9, 1986." Bids shall be mailed or delivered to Nadine Farrington, Communications Department, Metropolitan Council, 300 Metro Square Bldg., St. Paul 55101.

The Metropolitan Council reserves the right to reject any or all bids, and to waive any minor irregularity or deviation from the specifications.

Dated: 18 November 1986

Sandra S. Gardebring, Chair

Metropolitan Council of the Twin Cities Area

Request for Proposals for Evaluating the Metropolitan Housing Authority's Internal Operations

The Metropolitan Council is seeking proposals from qualified firms for assistance in evaluating its Metropolitan Housing Authority's (HRA) internal operations. The consultant will review the HRA's administrative structure, staffing level, processing procedures and work methods and propose cost-effective changes to increase the productivity and efficiency of program operations while maintaining or increasing the service delivery level, consistent with federal program requirements.

Copies of the Request for Proposals may be obtained by requesting same from: Mr. John R. Harrington, Metropolitan Council, 300 Metro Square Building, St. Paul, MN 55101.

Proposals are to be submitted to the Metropolitan Council by 3:00 p.m. January 2, 1987. Inquiries regarding this request should be directed to Mr. Harrington (612) 291-6324.

SUPREME COURT DECISIONS

Decisions Filed Friday 21 November 1986

Compiled by Wayne O. Tschimperle, Clerk

C7-85-1357, C7-85-1665, C9-85-1666 In the Matter of the Welfare of: L.Z., C.R.P. and S.L.P. Court of Appeals.

For the offense of habitual truancy, the child must (1) be absent from school for the requisite number of days, (2) without a lawful excuse, and (3) by his or her own choice or neglect.

School attendance records are admissible as a business records exception, over hearsay and confrontation clause objections, to show the child was absent on a particular day, what excuse, if any, was offered by the parent, or if no parental excuse was offered; the records are not admissible to show the child was "absenting himself" but this can be shown by other evidence such as the child's admission to school authorities.

The evidence in two of the cases is sufficient to sustain the finding of habitual truancy; in the case of the third juvenile, the evidence is insufficient.

Affirmed in part and reversed in part. Simonett, J.

C1-85-1645 Vera L. Wagner, et al. v. Thomas J. Obert Enterprises, petitioner, Appellant. Court of Appeals.

The trial court did not err in submitting primary assumption of risk to the jury in this roller-skating accident case.

The trial court erred by admitting a doctor's notes on accident causation as an admission of a party, but, because the doctor would have and did testify, the error was harmless.

Plaintiffs waived any objection to admission of an accident report. Admission of photographs of "Skate At Your Own Risk" signs was within the trial court's discretion.

Reversed. Simonett, J.

C9-84-1253 Knutson Construction Company, petitioner, Appellant v. St. Paul Fire and Marine Insurance Company, et al, United States Fire Insurance Company, Northbrook Excess and Surplus Insurance Company, Integrity Insurance Company, et al. Court of Appeals.

Building damage sustained by an owner as a result of a breach of a construction contract due to faulty workmanship or the use of defective materials by a general contractor, who had exclusive responsibility for the construction of the building, or its subcontractors, is a business risk to be borne by the general contractor and not by a comprehensive general liability insurer which had issued a policy containing a completed operations and broad form property damage endorsement.

Affirmed. Kelley, J.

C1-85-1967 State of Minnesota v. David Brian Sutherlin, Appellant. Ramsey County.

Defendant received a fair trial and was properly convicted of two counts of first-degree murder.

Affirmed. Coyne, J.

ERRATA

Office of the Secretary of State

Annual Compilation of State Agencies: Notices of Vacancies (Application and Appointment Procedure)

ADVISORY COUNCIL ON PLUMBING CODE AND EXAMINATIONS

Correction to notice published in Volume 11, Number 18, Page 786.

Membership should read as follows:

APPOINTMENTS PENDING

ADVISORY COUNCIL ON PLUMBING CODE AND EXAMINATIONS: 717 Delaware St. S.E., Mpls 55440; (612)623-5328; (M.S. § 326.41; 6/30/83).

Examines and licenses plumbers; recommends revisions and amendments to the plumbing code and licensing rules. Seven

members, appointed by the Commissioner of Health, include 1 journeyman plumber, 1 master plumber, and a representative of the commissioner. Bi-annual meetings at the Department of Health, 717 Delaware St. S.E., Mpls.; members receive expenses.

CURRENT MEMBERS:

*Bellin, Milton; 3828 Kipling Ave S, St Louis Pk 55416; (612)623-5517; Hennepin; (83/11-87/01); CD03; LD44B; M.
*Mallory, Robert; Walker 56484; (218)547-1684; Cass; (83/01-87/01); CD07; LD04; M; W.
*Schwab, Douglas; 370 Oakcrest Ln, Roseville 55113; (612)298-4786; Ramsey; (83/01-87/01); CD04; LD63B; M; DFL; W.
Hendrickson, Sivert; 2005 Sumac Ln, Burnsville 55337; (612)435-5392; Dakota; (84/01-88/01); CD02; LD53B; M; IR; W.
Lichliter, Ralph Jr; 4075 Ensign Ave N, Mpls 55427; (612)546-6153; Hennepin; (84/01-88/01); CD05; LD43; M; DFL; W.
Mindrum, Joseph; 90 Crocus Pl, St Paul 55102; (612)222-7047; Ramsey; (84/01-88/01); CD04; LD65A; M.
Nelsen, Charles; 1823 16 1/2 St NW, Rochester 55901; (507)282-8128; Olmsted; (84/01-88/01); CD01; LD33A; M; W.

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The Spirit of Winter Camping—A wilderness guide to cold weather camping. How to have fun safely. Code No. 19-67. ~~$5.99~~ $5.39.

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