CHAPTER 256

HUMAN SERVICES

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

[For text of subd 1, see M.S.2000]

Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

(1) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(a) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(b) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(c) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(d) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(e) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017;

(f) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds; and

(g) enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to the extent necessary for the tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

(2) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(3) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of

the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the state board of control.

(4) Administer and supervise all noninstitutional service to handicapped persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise handicapped. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(5) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(7) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(8) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as mentally retarded. For children under the guardianship of the commissioner whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(9) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

(10) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(11) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experi-

mental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(a) The secretary of health and human services of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity.

(b) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

(13) According to federal requirements, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(14) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the following manner:

(a) One-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due.

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

(15) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(16) Have the authority to make direct payments to facilities providing shelter to women and their children according to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shelter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(17) Have the authority to establish and enforce the following county reporting requirements:

(a) The commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements,

the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced.

(b) The county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner.

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

(d) A county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance.

(e) The final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period.

(f) The commissioner may not delay payments, withhold funds, or require repayment under paragraph (c) or (e) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under paragraph (c) or (e), the county board may appeal the action according to sections 14.57 to 14.69.

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

(18) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample for the foster care program under title IV-E of the Social Security Act, United States Code, title 42, in direct proportion to each county's title IV-E foster care maintenance claim for that period.

(19) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department.

(20) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

(21) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount

of the rebate shall be equal to the basic rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8(c)(1). This basic rebate shall be applied to single-source and multiple-source drugs. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(22) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

(23) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(24) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(25) Incorporate cost reimbursement claims from First Call Minnesota and Greater Twin Cities United Way into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement received is appropriated to the commissioner and shall be disbursed to First Call Minnesota and Greater Twin Cities United Way according to normal department payment schedules.

(26) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

[For text of subds 3 and 4, see M.S.2000]

Subd. 4a. **Technical assistance for immunization reminders.** The state agency shall provide appropriate technical assistance to county agencies to develop methods to have county financial workers remind and encourage recipients of aid to families with dependent children, Minnesota family investment program, the Minnesota family investment plan, medical assistance, family general assistance, or food stamps whose assistance unit includes at least one child under the age of five to have each young

child immunized against childhood diseases. The state agency must examine the feasibility of utilizing the capacity of a statewide computer system to assist county agency financial workers in performing this function at appropriate intervals.

[For text of subds 5 to 17, see M.S.2000]

Subd. 18. **Immigration status verifications.** (a) Notwithstanding any waiver of this requirement by the secretary of the United States Department of Health and Human Services, effective July 1, 2001, the commissioner shall utilize the Systematic Alien Verification for Entitlements (SAVE) program to conduct immigration status verifications:

(1) as required under United States Code, title 8, section 1642;

(2) for all applicants for food assistance benefits, whether under the federal food stamp program, the MFIP or work first program, or the Minnesota food assistance program;

(3) for all applicants for general assistance medical care, except assistance for an emergency medical condition, for immunization with respect to an immunizable disease, or for testing and treatment of symptoms of a communicable disease; and

(4) for all applicants for general assistance, Minnesota supplemental aid, MinnesotaCare, or group residential housing, when the benefits provided by these programs would fall under the definition of "federal public benefit" under United States Code, title 8, section 1642, if federal funds were used to pay for all or part of the benefits.

(b) The commissioner shall comply with the reporting requirements under United States Code, title 42, section 611a, and any federal regulation or guidance adopted under that law.

Subd. 19. **Grants for case management services to persons with HIV or AIDS.** The commissioner may award grants to eligible vendors for the development, implementation, and evaluation of case management services for individuals infected with the human immunodeficiency virus. HIV/AIDS case management services will be provided to increase access to cost effective health care services, to reduce the risk of HIV transmission, to ensure that basic client needs are met, and to increase client access to needed community supports or services.

History: *2001 c 178 art 1 s 2; 1Sp2001 c 9 art 2 s 6; art 3 s 8; art 10 s 1,66*

256.022 CHILD MALTREATMENT REVIEW PANEL.

Subdivision 1. **Creation.** The commissioner of human services shall establish a review panel for purposes of reviewing investigating agency determinations regarding maltreatment of a child in a facility in response to requests received under section 626.556, subdivision 10i, paragraph (b). The review panel consists of the commissioners of health; human services; children, families, and learning; and corrections; the ombudsman for crime victims; and the ombudsman for mental health and mental retardation; or their designees.

Subd. 2. **Review procedure.** (a) The panel shall hold quarterly meetings for purposes of conducting reviews under this section. If an interested person acting on behalf of a child requests a review under this section, the panel shall review the request at its next quarterly meeting. If the next quarterly meeting is within ten days of the panel's receipt of the request for review, the review may be delayed until the next subsequent meeting. The panel shall review the request and the final determination regarding maltreatment made by the investigating agency and may review any other data on the investigation maintained by the agency that are pertinent and necessary to its review of the determination. If more than one person requests a review under this section with respect to the same determination, the review panel shall combine the requests into one review. Upon receipt of a request for a review, the panel shall notify the alleged perpetrator of maltreatment that a review has been requested and provide an approximate timeline for conducting the review.

(b) Within 30 days of the review under this section, the panel shall notify the investigating agency and the interested person who requested the review as to whether

the panel agrees with the determination or whether the investigating agency must reconsider the determination. If the panel determines that the agency must reconsider the determination, the panel must make specific investigative recommendations to the agency. Within 30 days the investigating agency shall conduct a review and report back to the panel with its reconsidered determination and the specific rationale for its determination.

Subd. 3. **Report.** By January 15 of each year, the panel shall submit a report to the committees of the legislature with jurisdiction over section 626.556 regarding the number of requests for review it receives under this section, the number of cases where the panel requires the investigating agency to reconsider its final determination, the number of cases where the final determination is changed, and any recommendations to improve the review or investigative process.

Subd. 4. **Data.** Data of the review panel created as part of a review under this section are private data on individuals as defined in section 13.02.

History: *1Sp2001 c 9 art 11 s 3*

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICE MATTERS.

[For text of subd 1, see M.S.2000]

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245A, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; (8) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; or (9) except as provided under chapter 245A, an individual disqualified under section 245A.04, subdivision 3d, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (8) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside or rescinded under section 245A.04, subdivision 3b, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant,

recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4), (8), or (9) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under clause (8) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (8) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

The scope of hearings involving claims to foster care payments under clause (5) shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(b) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services included in the amended community social services plan developed under section 256E.081, subdivision 3, if the county agency has met the requirements in section 256E.081.

(d) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

[For text of subd 3a, see M.S.2000]

Subd. 3b. **Standard of evidence for maltreatment and disqualification hearings.** The state human services referee shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557. For purposes of hearings regarding disqualification, the state human services referee shall affirm the proposed disqualification in an appeal under subdivision 3, paragraph (a), clause (9), if a preponderance of the evidence shows the individual has:

(1) committed maltreatment under section 626.556 or 626.557, which is serious or recurring;

(2) committed an act or acts meeting the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or

(3) failed to make required reports under section 626.556 or 626.557, for incidents in which:

(i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment; and

(ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment

occurred, and that the subject was responsible for the maltreatment. If the disqualification is affirmed, the state human services referee shall determine whether the individual poses a risk of harm in accordance with the requirements of section 245A.04, subdivision 3b.

The state human services referee shall recommend an order to the commissioner of health, children, families, and learning, or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. Except as provided under section 245A.04, subdivisions 3b, paragraphs (e) and (f), and 3c, in any licensing appeal under chapter 245A and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive.

[For text of subd 3c, see M.S.2000]

Subd. 4. **Conduct of hearings.** (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4), (8), and (9), either party may subpoena the private data relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4), (8), or (9), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more than 90 days imprisonment or a fine of not more than $700, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), (8), and (9), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

[For text of subds 4a to 10, see M.S.2000]

History: *2001 c 178 art 2 s 6; 1Sp2001 c 9 art 14 s 26-28*

256.476 CONSUMER SUPPORT PROGRAM.

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability. The program shall:

(1) make support grants or exception grants described in subdivision 11 available to individuals or families as an effective alternative to existing programs and services, such as the developmental disability family support program, personal care attendant services, home health aide services, and private duty nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person or the person's legal representative, after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board or, for counties not participating in the consumer grant program by July 1, 2002, the commissioner, to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, environmental modifications, or assistance purchased by the person or the person's family. Examples of supports include respite care, assistance with daily living, and assistive technology. For the purpose of

this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the developmental disability family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the department of health or human services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving home and community-based services under United States Code, title 42, section 1396h(c); personal care attendant and home health aide services under section 256B.0625; a developmental disability family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) The commissioner may limit the participation of recipients of services from federal waiver programs in the consumer support grant program if the participation of these individuals will result in an increase in the cost to the state.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

(b) Support grants to a person or a person's family will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person or the person's family to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service plan, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person or the person's family. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person or the person's family shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, if any, or the person's family. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from specific programs or services, such as the developmental disability family support program and personal care assistant services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the developmental disability family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each individual or individual's family cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

[For text of subd 6, see M.S.2000]

Subd. 7. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 8. **Commissioner responsibilities.** The commissioner shall:

(1) transfer and allocate funds pursuant to subdivision 11;

(2) determine allocations based on projected and actual local agency use;

(3) monitor and oversee overall program spending;

(4) evaluate the effectiveness of the program;

(5) provide training and technical assistance for local agencies and consumers to help identify potential applicants to the program; and

(6) develop guidelines for local agency program administration and consumer information.

[For text of subds 9 and 10, see M.S.2000]

Subd. 11. **Consumer support grant program after July 1, 2001.** (a) Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) for individuals whose program of origination is medical assistance home care under section 256B.0627, the maximum allowable monthly grant levels are calculated by:

(i) determining the nonfederal share of the average service authorization for each home care rating;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to the average service authorization level of each home care rating;

(iv) adjusting the result for any authorized rate increases provided by the legislature; and

(v) adjusting the result for the average monthly utilization per recipient; and

(2) for persons with programs of origination other than the program described in clause (1), the maximum grant level for an individual shall not exceed the total of the nonfederal dollars expended on the individual by the program of origination.

(b) Persons receiving consumer support grants prior to July 1, 2001, may continue to receive the grant amount established prior to July 1, 2001.

(c) The commissioner may provide up to 200 exception grants, including grants in use under paragraph (b). Eligible persons shall be provided an exception grant in priority order based upon the date of the commissioner's receipt of the county request. The maximum allowable grant level for an exception grant shall be based upon the nonfederal share of the average service authorization from the most recent fiscal year for each home care rating category. The amount of each exception grant shall be based upon the commissioner's determination of the nonfederal dollars that would have been expended if services had been available for an individual who is unable to obtain the support needed from the program of origination due to the unavailability of qualified service providers at the time or the location where the supports are needed.

History: *1Sp2001 c 9 art 3 s 9-15*

256.482 COUNCIL ON DISABILITY.

[For text of subds 1 to 7, see M.S.2000]

Subd. 8. **Sunset.** Notwithstanding section 15.059, subdivision 5, the council on disability shall not sunset until June 30, 2003.

History: *2001 c 161 s 45; 1Sp2001 c 9 art 13 s 21*

256.741 CHILD SUPPORT AND MAINTENANCE.

Subdivision 1. **Public assistance.** (a) The term "direct support" as used in this chapter and chapters 257, 518, and 518C refers to an assigned support payment from an obligor which is paid directly to a recipient of TANF or MFIP.

(b) The term "public assistance" as used in this chapter and chapters 257, 518, and 518C, includes any form of assistance provided under the AFDC program formerly codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter 256, MFIP under chapter 256J, work first program under chapter 256K; child care assistance provided through the child care fund under chapter 119B; any form of medical assistance under chapter 256B; MinnesotaCare under chapter 256L; and foster care as provided under title IV-E of the Social Security Act.

(c) The term "child support agency" as used in this section refers to the public authority responsible for child support enforcement.

(d) The term "public assistance agency" as used in this section refers to a public authority providing public assistance to an individual.

[For text of subds 2 to 4, see M.S.2000]

Subd. 5. **Cooperation with child support enforcement.** After notification from a public assistance agency that an individual has applied for or is receiving any form of public assistance, the child support agency shall determine whether the party is cooperating with the agency in establishing paternity, child support, modification of an existing child support order, or enforcement of an existing child support order. The public assistance agency shall notify each applicant or recipient in writing of the right to claim a good cause exemption from cooperating with the requirements in this section. A copy of the notice must be furnished to the applicant or recipient, and the applicant or recipient and a representative from the public authority shall acknowledge receipt of the notice by signing and dating a copy of the notice. The individual shall cooperate with the child support agency by:

(1) providing all known information regarding the alleged father or obligor, including name, address, social security number, telephone number, place of employment or school, and the names and addresses of any relatives;

(2) appearing at interviews, hearings and legal proceedings;

(3) submitting to genetic tests including genetic testing of the child, under a judicial or administrative order; and

(4) providing additional information known by the individual as necessary for cooperating in good faith with the child support agency.

The caregiver of a minor child must cooperate with the efforts of the public authority to collect support according to this subdivision. A caregiver must notify the public authority of all support the caregiver receives during the period the assignment of support required under subdivision 2 is in effect. Direct support retained by a caregiver must be counted as unearned income when determining the amount of the assistance payment, and repaid to the child support agency for any month when the direct support retained is greater than the court-ordered child support and the assistance payment and the obligor owes support arrears.

[For text of subds 6 and 7, see M.S.2000]

Subd. 8. **Refusal to cooperate with support requirements.** (a) Failure by a caregiver to satisfy any of the requirements of subdivision 5 constitutes refusal to cooperate, and the sanctions under paragraph (b) apply. The IV-D agency must determine whether a caregiver has refused to cooperate according to subdivision 5.

(b) Determination by the IV-D agency that a caregiver has refused to cooperate has the following effects:

(1) a caregiver is subject to the applicable sanctions under section 256J.46;

(2) a caregiver who is not a parent of a minor child in an assistance unit may choose to remove the child from the assistance unit unless the child is required to be in the assistance unit; and

(3) a parental caregiver who refuses to cooperate is ineligible for medical assistance.

[For text of subds 9 and 10, see M.S.2000]

Subd. 11. **Proof of good cause.** (a) An individual seeking a good cause exemption has 20 days from the date the good cause claim was provided to the public assistance agency to supply evidence supporting the claim. The public assistance agency may extend the time period in this section if it believes the individual is cooperating and needs additional time to submit the evidence required by this section. Failure to provide this evidence shall result in the child support agency resuming child support enforcement efforts.

(b) Evidence supporting a good cause claim includes, but is not limited to:

(1) a birth record or medical or law enforcement records indicating that the child was conceived as the result of incest or rape;

(2) court documents or other records indicating that legal proceedings for adoption are pending before a court of competent jurisdiction;

(3) court, medical, criminal, child protective services, social services, domestic violence advocate services, psychological, or law enforcement records indicating that the alleged father or obligor might inflict physical or emotional harm on the child. parent, or caregiver;

(4) medical records or written statements from a licensed medical professional indicating the emotional health history or status of the custodial parent, child, or caregiver, or indicating a diagnosis or prognosis concerning their emotional health;

(5) a written statement from a public or licensed private social services agency that the individual is deciding whether to keep the child or place the child for adoption; or

(6) sworn statements from individuals other than the applicant or recipient that provide evidence supporting the good cause claim.

(c) The child support agency and the public assistance agency shall assist an individual in obtaining the evidence in this section upon request of the individual.

[For text of subds 12 to 15, see M.S.2000]

History: *1Sp2001 c 9 art 12 s 2-4; art 15 s 32*

256.955 PRESCRIPTION DRUG PROGRAM.

[For text of subds 1 and 2, see M.S.2000]

Subd. 2a. **Eligibility.** An individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is at least 65 years of age or older; and

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3, 3a, or 3b, clause (1), or is eligible under section 256B.057, subdivision 3, 3a, or 3b, clause (1), and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5.

Subd. 2b. **Eligibility.** Effective July 1, 2002, an individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is under 65 years of age; and

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a or is eligible under section 256B.057, subdivision 3 or 3a and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5.

[For text of subds 3 to 9, see M.S.2000]

History: *1Sp2001 c 9 art 2 s 7,8*

NOTE: The amendment to subdivision 2b by Laws 2001, First Special Session chapter 9, article 2, section 8, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, section 8, the effective date.

256.956 PURCHASING ALLIANCE STOP-LOSS FUND.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Commissioner" means the commissioner of human services.

(b) "Health plan" means a policy, contract, or certificate issued by a health plan company to a qualifying purchasing alliance. Any health plan issued to the members of a qualifying purchasing alliance must meet the requirements of chapter 62L.

(c) "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) a community integrated service network operating under chapter 62N; or

(3) an accountable provider network operating under chapter 62T.

(d) "Qualifying employer" means an employer who:

(1) is a member of a qualifying purchasing alliance;

(2) has at least one employee but no more than ten employees or is a sole proprietor or farmer;

(3) did not offer employer-subsidized health care coverage to its employees for at least 12 months prior to joining the purchasing alliance; and

(4) is offering health coverage through the purchasing alliance to all employees who work at least 20 hours per week unless the employee is eligible for Medicare.

For purposes of this subdivision, "employer-subsidized health coverage" means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(e) "Qualifying enrollee" means an employee of a qualifying employer or the employee's dependent covered by a health plan.

(f) "Qualifying purchasing alliance" means a purchasing alliance as defined in section 62T.01, subdivision 2, that:

(1) meets the requirements of chapter 62T;

(2) services a geographic area located in outstate Minnesota, excluding the city of Duluth; and

(3) is organized and operating before May 1, 2001.

The criteria used by the qualifying purchasing alliance for membership must be approved by the commissioner of health. A qualifying purchasing alliance may begin enrolling qualifying employers after July 1, 2001, with enrollment ending by December 31, 2003.

Subd. 2. **Creation of account.** A purchasing alliance stop-loss fund account is established in the general fund. The commissioner shall use the money to establish a stop-loss fund from which a health plan company may receive reimbursement for claims paid for qualifying enrollees. The account consists of money appropriated by the legislature. Money from the account must be used for the stop-loss fund.

Subd. 3. **Reimbursement.** (a) A health plan company may receive reimbursement from the fund for 90 percent of the portion of the claim that exceeds $30,000 but not of the portion that exceeds $100,000 in a calendar year for a qualifying enrollee.

(b) Claims shall be reported and funds shall be distributed on a calendar-year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims were paid.

(c) Once claims paid on behalf of a qualifying enrollee reach $100,000 in a given calendar year, no further claims may be submitted for reimbursement on behalf of that enrollee in that calendar year.

Subd. 4. **Request process.** (a) Each health plan company must submit a request for reimbursement from the fund on a form prescribed by the commissioner. Requests for payment must be submitted no later than April 1 following the end of the calendar year for which the reimbursement request is being made, beginning April 1, 2002.

(b) The commissioner may require a health plan company to submit claims data as needed in connection with the reimbursement request.

Subd. 5. **Distribution.** (a) The commissioner shall calculate the total claims reimbursement amount for all qualifying health plan companies for the calendar year for which claims are being reported and shall distribute the stop-loss funds on an annual basis.

(b) In the event that the total amount requested for reimbursement by the health plan companies for a calendar year exceeds the funds available for distribution for claims paid by all health plan companies during the same calendar year, the commissioner shall provide for the pro rata distribution of the available funds. Each health plan company shall be eligible to receive only a proportionate amount of the available funds as the health plan company's total eligible claims paid compares to the total eligible claims paid by all health plan companies.

(c) In the event that funds available for distribution for claims paid by all health plan companies during a calendar year exceed the total amount requested for reimbursement by all health plan companies during the same calendar year, any excess funds shall be reallocated for distribution in the next calendar year.

Subd. 6. **Data.** Upon the request of the commissioner, each health plan company shall furnish such data as the commissioner deems necessary to administer the fund. The commissioner may require that such data be submitted on a per enrollee, aggregate, or categorical basis. Any data submitted under this section shall be classified as private data or nonpublic data as defined in section 13.02.

Subd. 7. **Delegation.** The commissioner may delegate any or all of the commissioner's administrative duties to another state agency or to a private contractor.

Subd. 8. **Report.** The commissioner of commerce, in consultation with the office of rural health and the qualifying purchasing alliances, shall evaluate the extent to which the purchasing alliance stop-loss fund increases the availability of employer-subsidized

health care coverage for residents residing in the geographic areas served by the qualifying purchasing alliances. A preliminary report must be submitted to the legislature by February 15, 2003, and a final report must be submitted by February 15, 2004.

Subd. 9. **Sunset.** This section shall expire January 1, 2005.

History: *1Sp2001 c 9 art 2 s 9*

256.958 RETIRED DENTIST PROGRAM.

Subdivision 1. **Program.** The commissioner of human services shall establish a program to reimburse a retired dentist for the dentist's license fee and for the reasonable cost of malpractice insurance compared to other dentists in the community in exchange for the dentist providing 100 hours of dental services on a volunteer basis within a 12-month period at a community dental clinic or a dental training clinic located at a Minnesota state college or university.

Subd. 2. **Documentation.** Upon completion of the required hours, the retired dentist shall submit to the commissioner the following:

(1) documentation of the service provided;

(2) the cost of malpractice insurance for the 12-month period; and

(3) the cost of the license.

Subd. 3. **Reimbursement.** Upon receipt of the information described in subdivision 2, the commissioner shall provide reimbursement to the retired dentist for the cost of malpractice insurance for the previous 12-month period and the cost of the license.

History: *1Sp2001 c 9 art 2 s 10*

256.959 DENTAL PRACTICE DONATION PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services shall establish a dental practice donation program that coordinates the donation of a qualifying dental practice to a qualified charitable organization and assists in locating a dentist licensed under chapter 150A who wishes to maintain the dental practice.

Subd. 2. **Qualifying dental practice.** To qualify for the dental practice donation program, a dental practice must meet the following requirements:

(1) the dental practice must be owned by the donating dentist;

(2) the dental practice must be located in a designated underserved area of the state as defined by the commissioner; and

(3) the practice must be equipped with the basic dental equipment necessary to maintain a dental practice as determined by the commissioner.

Subd. 3. **Coordination.** The commissioner shall establish a procedure for dentists to donate their dental practices to a qualified charitable organization. The commissioner shall authorize a practice for donation only if it meets the requirements of subdivision 2 and there is a licensed dentist who is interested in entering into an agreement as described in subdivision 4. Upon donation of the practice, the commissioner shall provide the donating dentist with a statement verifying that a donation of the practice was made to a qualifying charitable organization for purposes of state and federal income tax returns.

Subd. 4. **Donated dental practice agreement.** (a) A dentist accepting the donated practice must enter into an agreement with the qualified charitable organization to maintain the dental practice for a minimum of five years at the donated practice site and to provide services to underserved populations up to a preagreed percentage of patients served.

(b) The agreement must include the terms for the recovery of the donated dental practice if the dentist accepting the practice does not fulfill the service commitment required under this subdivision.

(c) Any costs associated with operating the dental practice during the service commitment time period are the financial responsibility of the dentist accepting the practice.

History: *1Sp2001 c 9 art 2 s 11*

256.9657 PROVIDER SURCHARGES.

[For text of subds 1 to 1c, see M.S.2000]

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

[For text of subds 3 to 8, see M.S.2000]

History: *1Sp2001 c 9 art 2 s 12*

256.969 PAYMENT RATES.

[For text of subds 1 to 2c, see M.S.2000]

Subd. 3a. **Payments.** Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services

rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

[For text of subds 4a to 25, see M.S.2000]

Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23. The commissioner may adjust this percentage each year so that the estimated payment increases under this paragraph are equal to the funding provided under section 256B.195 for this purpose.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;

(2) 371 cesarean section without complicating diagnosis;

(3) 372 vaginal delivery with complicating diagnosis;

(4) 373 vaginal delivery without complicating diagnosis;

(5) 386 extreme immaturity and respiratory distress syndrome, neonate;

(6) 388 full-term neonates with other problems;

(7) 390 prematurity without major problems;

(8) 391 normal newborn;

(9) 385 neonate, died or transferred to another acute care facility;

(10) 425 acute adjustment reaction and psychosocial dysfunction;

(11) 430 psychoses;

(12) 431 childhood mental disorders; and

(13) 164-167 appendectomy.

History: *1Sp2001 c 9 art 2 s 13; art 9 s 37*

NOTE: The amendment to subdivision 3a by Laws 2001, First Special Session chapter 9, article 9, section 37, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 9, section 37, the effective date.

256.9693 CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission

criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

History: *1Sp2001 c 9 art 9 s 38*

NOTE: This section, as added by Laws 2001, First Special Session chapter 9, article 9, section 38, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 9, section 38, the effective date.

256.975 MINNESOTA BOARD ON AGING.

[For text of subds 1 to 6, see M.S.2000]

Subd. 7. **Consumer information and assistance; senior linkage.** (a) The Minnesota board on aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; and

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health.

(c) The Minnesota board on aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Subd. 8. **Promotion of long-term care insurance.** Within the limits of appropriations specifically for this purpose, the Minnesota board on aging, either directly or through contract, shall promote the provision of employer-sponsored, long-term care insurance. The board shall encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide technical assistance to employers in designing long-term care insurance products and contacting companies offering long-term care insurance products.

History: *1Sp2001 c 9 art 4 s 2; art 8 s 13*

256.9754 COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Community" means a town, township, city, or targeted neighborhood within a city, or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

(b) "Older adult services" means any services available under the elderly waiver program or alternative care grant programs; nursing facility services; transportation services; respite services; and other community-based services identified as necessary either to maintain lifestyle choices for older Minnesotans, or to promote independence.

(c) "Older adult" refers to individuals 65 years of age and older.

Subd. 2. **Creation.** The community services development grants program is created under the administration of the commissioner of human services.

Subd. 3. **Provision of grants.** The commissioner shall make grants available to communities, providers of older adult services identified in subdivision 1, or to a consortium of providers of older adult services, to establish older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services, fund programs that would allow older adults or disabled individuals to stay in their own homes by sharing a home, fund programs that coordinate and manage formal and informal services to older adults in their homes to enable them to live as independently as possible in their own homes as an alternative to nursing home care, or expand state-funded programs in the area.

Subd. 4. **Eligibility.** Grants may be awarded only to communities and providers or to a consortium of providers that have a local match of 50 percent of the costs for the project in the form of donations, local tax dollars, in-kind donations, fundraising, or other local matches.

Subd. 5. **Grant preference.** The commissioner of human services shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring. The commissioner may award grants to the extent grant funds are available and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to $750,000.

History: *1Sp2001 c 9 art 4 s 3*

256.979 CHILD SUPPORT INCENTIVES.

Subd. 5. **Paternity establishment and child support order establishment and modification bonus incentives.** (a) A bonus incentive program is created to increase the number of paternity establishments and establishment and modifications of child support orders done by county child support enforcement agencies.

(b) A bonus must be awarded to a county child support agency for each child for which the agency completes a paternity or child support order establishment or modification through judicial or administrative processes.

(c) The rate of bonus incentive is $100 per child for each paternity or child support order establishment and modification set in a specific dollar amount.

(d) No bonus shall be paid for a modification that is a result of a termination of child care costs according to section 518.551, subdivision 5, paragraph (b), or due solely to a reduction of child care expenses.

Subd. 6. **Claims for bonus incentive.** (a) The commissioner of human services and the county agency shall develop procedures for the claims process and criteria using automated systems where possible.

(b) Only one county agency may receive a bonus per paternity establishment or child support order establishment or modification for each child. The county agency

completing the action or procedure needed to establish paternity or a child support order or modify an order is the county agency entitled to claim the bonus incentive.

(c) Disputed claims must be submitted to the commissioner of human services and the commissioner's decision is final.

[For text of subd 7, see M.S.2000]

Subd. 8. **Medical provider reimbursement.** (a) A fee to the providers of medical services is created for the purpose of increasing the numbers of signed and notarized recognition of parentage forms completed in the medical setting.

(b) A fee of $25 shall be paid to each medical provider for each properly completed recognition of parentage form sent to the department of vital statistics.

(c) The office of the state registrar shall notify the department of human services quarterly of the numbers of completed forms received and the amounts paid.

(d) The department of human services shall remit quarterly to each medical provider a payment for the number of signed recognition of parentage forms completed by that medical provider and sent to the office of the state registrar.

(e) The commissioners of the department of human services and the department of health shall develop procedures for the implementation of this provision.

(f) Payments will be made to the medical provider within the limit of available appropriations.

(g) Federal matching funds received as reimbursement for the costs of the medical provider reimbursement must be retained by the commissioner of human services for educational programs dedicated to the benefits of paternity establishment.

[For text of subds 10 and 11, see M.S.2000]

History: *1Sp2001 c 9 art 12 s 5,6; art 15 s 32*

256.98 WRONGFULLY OBTAINING ASSISTANCE; THEFT.

[For text of subds 1 to 7, see M.S.2000]

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program, the food stamp program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification

period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of three months, six months, and two years for the first, second, and third offenses respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

Subd. 9. **Welfare reform coverage.** All references to MFIP or Minnesota family investment program contained in sections 256.017, 256.019, 256.045, 256.046, and 256.98 to 256.9866 shall be construed to include all variations of the Minnesota family investment program including, but not limited to, chapter 256J, MFIP, MFIP-R, and chapter 256K.

History: *1Sp2001 c 9 art 10 s 2,66*