CHAPTER 256

HUMAN SERVICES

256.001 MS 2006 [Renumbered 15.001]

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subdivision 1. **Powers transferred.** All the powers and duties now vested in or imposed upon the State Board of Control by the laws of this state or by any law of the United States are hereby transferred to, vested in, and imposed upon the commissioner of human services, except the powers and duties otherwise specifically transferred by Laws 1939, chapter 431, to other agencies. The commissioner of human services is hereby constituted the "state agency" as defined by the Social Security Act of the United States and the laws of this state.

Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall carry out the specific duties in paragraphs (a) through (cc):

(a) 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:

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

(2) 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;

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

(4) 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;

(5) 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;

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

(7) 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.

(b) 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.

(c) Administer and supervise all child welfare activities; promote the enforcement of laws protecting disabled, 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.

(d) Administer and supervise all noninstitutional service to disabled persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise disabled. 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.

(e) 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.

(f) 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.

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

(h) 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 developmentally disabled. For children under the guardianship of the commissioner or a tribe in Minnesota recognized by the Secretary of the Interior 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 or tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, tribal governing body, 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.

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

(j) 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.

(k) 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.

(l) 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 experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(1) 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; and

(2) a comprehensive plan, including estimated project costs, shall be approved by the Legislative Advisory Commission and filed with the commissioner of administration.

(m) 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.

(n) 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:

(1) 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; and

(2) notwithstanding the provisions of clause (1), 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 clause (1), 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 clause (1).

(o) 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.

(p) 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.

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

(1) 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;

(2) 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;

(3) if the required reports are not received by the deadlines established in clause (2), 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;

(4) 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;

(5) 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;

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) 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 clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

(7) counties subject to withholding of funds under clause (3) or forfeiture or repayment of funds under clause (5) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under clause (3) or (5).

(r) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample in direct proportion to each county's claim for that period.

(s) 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.

(t) 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.

(u) 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 rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. 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.

(v) 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.

(w) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program. The commissioner may enter into supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13.

(x) 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.

(y) 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.

(z) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

(aa) 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.

(bb) Authorize the method of payment to or from the department as part of the human services programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the human services programs administered by the department.

(cc) Have the authority to administer a drug rebate program for drugs purchased for persons eligible for general assistance medical care under section 256D.03, subdivision 3. For manufacturers that agree to participate in the general assistance medical care rebate program, the commissioner shall enter into a rebate agreement for covered drugs as defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide payment within the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act. The rebate program shall utilize the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act.

Effective January 1, 2006, drug coverage under general assistance medical care shall be limited to those prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with such agreements. Prescription drug coverage under general assistance medical care shall conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

The rebate revenues collected under the drug rebate program are deposited in the general fund.

Subd. 2a. **Authorization for test sites for health care programs.** In coordination with the development and implementation of HealthMatch, an automated eligibility system for medical assistance, general assistance medical care, and MinnesotaCare, the commissioner, in cooperation with county agencies, is authorized to test and compare a variety of administrative models to demonstrate and evaluate outcomes of integrating health care program business processes and points of access. The models will be evaluated for ease of enrollment for health care program applicants and recipients and administrative efficiencies. Test sites will combine the administration of all three programs and will include both local county and centralized statewide

customer assistance. The duration of each approved test site shall be no more than one year. Based on the evaluation, the commissioner shall recommend the most efficient and effective administrative model for statewide implementation.

Subd. 2b. **Performance payments.** The commissioner shall develop and implement a pay-for-performance system to provide performance payments to eligible medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors, including consumer surveys, studies, and external quality reviews as required by the federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438-managed care, subpart E-external quality review. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

Subd. 3. **Executive council, powers transferred.** All the powers and duties now vested in or imposed upon the executive council, or any other agency which may have succeeded to its authority, relating to the administration and distribution of direct relief to the indigent or destitute, including war veterans and their families and dependents, are hereby transferred to, vested in, and imposed upon the commissioner of human services.

Subd. 4. **Duties as state agency.** (a) The state agency shall:

(1) supervise the administration of assistance to dependent children under Laws 1937, chapter 438, by the county agencies in an integrated program with other service for dependent children maintained under the direction of the state agency;

(2) establish adequate standards for personnel employed by the counties and the state agency in the administration of Laws 1937, chapter 438, and make the necessary rules to maintain such standards;

(3) prescribe the form of and print and supply to the county agencies blanks for applications, reports, affidavits, and such other forms as it may deem necessary and advisable;

(4) cooperate with the federal government and its public welfare agencies in any reasonable manner as may be necessary to qualify for federal aid for temporary assistance for needy families and in conformity with title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and successor amendments, including the making of such reports and such forms and containing such information as the Federal Social Security Board may from time to time require, and comply with such provisions as such board may from time to time find necessary to assure the correctness and verification of such reports;

(5) on or before October 1 in each even-numbered year make a biennial report to the governor concerning the activities of the agency;

(6) enter into agreements with other departments of the state as necessary to meet all requirements of the federal government; and

(7) cooperate with the commissioner of education to enforce the requirements for program integrity and fraud prevention for investigation for child care assistance under chapter 119B.

(b) The state agency may:

(1) subpoena witnesses and administer oaths, make rules, and take such action as may be necessary or desirable for carrying out the provisions of Laws 1937, chapter 438. All rules made by the state agency shall be binding on the counties and shall be complied with by the respective county agencies;

(2) cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving Minnesota family investment program assistance moves or contemplates moving into or out of the state, in order that the child may continue to receive supervised aid from the state moved from until the child has resided for one year in the state moved to; and

(3) administer oaths and affirmations, take depositions, certify to official acts, and issue subpoenas to compel the attendance of individuals and the production of documents and other personal property necessary in connection with the administration of programs administered by the Department of Human Services.

(c) The fees for service of a subpoena in paragraph (b), clause (3), must be paid in the same manner as prescribed by law for a service of process issued by a district court. Witnesses must receive the same fees and mileage as in civil actions.

(d) The subpoena in paragraph (b), clause (3), shall be enforceable through the district court in the district where the subpoena is issued.

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 or food support 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.

Subd. 5. **Gifts, contributions, pensions and benefits; acceptance.** The commissioner shall have the power and authority to accept in behalf of the state contributions and gifts for the use and benefit of children under the guardianship or custody of the commissioner; the commissioner may also receive and accept on behalf of such children, and on behalf of patients and residents at the several state hospitals for persons with mental illness or developmental disabilities during the period of their hospitalization and while on provisional discharge therefrom, money due and payable to them as old age and survivors insurance benefits, veterans benefits, pensions or other such monetary benefits. Such gifts, contributions, pensions and benefits shall be deposited in and disbursed from the social welfare fund provided for in sections 256.88 to 256.92.

Subd. 6. **Advisory task forces.** The commissioner may appoint advisory task forces to provide consultation on any of the programs under the commissioner's administration and supervision. A task force shall expire and the compensation, terms of office and removal of members shall be as provided in section 15.059. Notwithstanding section 15.059, the commissioner may pay a per diem of $35 to consumers and family members whose participation is needed in legislatively authorized state-level task forces, and whose participation on the task force is not as a paid representative of any agency, organization, or association.

Subd. 7. **Special consultant on aging.** The commissioner of human services may appoint a special consultant on aging in the classified service. Within the limits of appropriations available therefor, the commissioner may appoint such other employees in the classified service as the

commissioner deems necessary to carry out the purposes of Laws 1961, Chapter 466. Such special consultant and staff shall encourage cooperation among agencies, both public and private, including the departments of the state government, in providing services for the aging. They shall provide consultation to local social services agencies in developing local services for the aging, shall promote volunteer services programs and stimulate public interest in the problem of the aging.

Subd. 8. **County services coordinators.** Any county or group of counties acting through its or their local social services agency or agencies may designate a county services coordinator who shall coordinate services and activities, both public and private, that may further the well being of the aging and meet their social, psychological, physical and economic needs. The coordinator shall perform such other duties as the agency may direct to stimulate, demonstrate, initiate, and coordinate local public, private, and voluntary services within the county dedicated to providing the maximum opportunities for self help, independence, and productivity of individuals concerned. The agency may appoint a citizens advisory committee which shall advise the coordinator and the agency on the development of services and perform such other functions at the county level as are prescribed for the Minnesota Board on Aging at the state level. The members shall serve without compensation. Members of citizens advisory committees required by federal law for programs for the aging who receive federal money in payment for a portion of their actual expenses incurred in performance of their duties may receive the remaining portion from state money appropriated for programs for the aging.

Subd. 9. **Staff assistance to the Minnesota Board on Aging.** The board shall be provided staff assistance from the Department of Human Services through the special consultant on aging, who shall serve as the executive secretary to the board and its committees.

Subd. 10. **Authority to accept and disburse funds.** The Minnesota Board on Aging is authorized to accept through the Department of Human Services grants, gifts, and bequests from public or private sources for implementing programs and services on behalf of the aging, and to disburse funds to public and private agencies for the purpose of research, demonstration, planning, training, and service projects pertaining to the state's aging citizens.

Subd. 11. **Centralized disbursement system.** The state agency may establish a system for the centralized disbursement of food coupons, assistance payments, and related documents. Benefits shall be issued by the state or county subject to section 256.017.

Subd. 11a. **Contracting with financial institutions.** The state agency may contract with banks or other financial institutions to provide services associated with the processing of public assistance checks and may pay a service fee for these services, provided the fee charged does not exceed the fee charged to other customers of the institution for similar services.

Subd. 12. **Child mortality review panel.** (a) The commissioner shall establish a child mortality review panel to review deaths of children in Minnesota, including deaths attributed to maltreatment or in which maltreatment may be a contributing cause and to review near fatalities as defined in section 626.556, subdivision 11d. The commissioners of health, education, and public safety and the attorney general shall each designate a representative to the child mortality review panel. Other panel members shall be appointed by the commissioner, including a board-certified pathologist and a physician who is a coroner or a medical examiner. The purpose of the panel shall be to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure.

(b) The commissioner may require a county agency to establish a local child mortality review panel. The commissioner may establish procedures for conducting local reviews and may require that all professionals with knowledge of a child mortality case participate in the local review. In this section, "professional" means a person licensed to perform or a person performing a specific service in the child protective service system. "Professional" includes law enforcement personnel, social service agency attorneys, educators, and social service, health care, and mental health care providers.

(c) If the commissioner of human services has reason to believe that a child's death was caused by maltreatment or that maltreatment was a contributing cause, the commissioner has access to not public data under chapter 13 maintained by state agencies, statewide systems, or political subdivisions that are related to the child's death or circumstances surrounding the care of the child. The commissioner shall also have access to records of private hospitals as necessary to carry out the duties prescribed by this section. Access to data under this paragraph is limited to police investigative data; autopsy records and coroner or medical examiner investigative data; hospital, public health, or other medical records of the child; hospital and other medical records of the child's parent that relate to prenatal care; and records created by social service agencies that provided services to the child or family within three years preceding the child's death. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner. Not public data may be shared with members of the state or local child mortality review panel in connection with an individual case.

(d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state child mortality review panel in the exercise of its duties is protected nonpublic or confidential data as defined in section 13.02, but may be disclosed as necessary to carry out the purposes of the review panel. The data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under section 13.10, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in section 626.556, subdivision 11d, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.

(e) A person attending a child mortality review panel meeting shall not disclose what transpired at the meeting, except to carry out the purposes of the mortality review panel. The proceedings and records of the mortality review panel are protected nonpublic data as defined in section 13.02, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state or a county agency, arising out of the matters the panel is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the review panel. A person who presented information before the review panel or who is a member of the panel shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review panel or opinions formed by the person as a result of the review meetings.

Subd. 13. **Pilot project; protocols for persons lacking proficiency in English.** The commissioner of human services shall establish pilot projects in Hennepin and Ramsey Counties to provide language assistance to clients applying for or receiving aid through the county social service agency. The projects shall be designed to provide translation, in the five foreign languages

that are most common to applicants and recipients in the pilot counties, to individuals lacking proficiency in English, who are applying for or receiving assistance under any program supervised by the commissioner of human services. As part of the project, the commissioner shall ensure that the Combined Application Form (CAF) is available in these five languages. The projects shall also provide language assistance to individuals applying for or receiving aid under programs which the department of human services operates jointly with other executive branch agencies, including all work and training programs operated under this chapter and chapter 256D. The purpose of the pilot projects is to ensure that information regarding a program is presented in translation to applicants for and recipients of assistance who lack proficiency in English. In preparing the protocols to be used in the pilot programs, the commissioner shall seek input from the following groups: advocacy organizations that represent non-English-speaking clients, county social service agencies, legal advocacy groups, employment and training providers, and other affected groups. The commissioner shall develop the protocols by October 1, 1995, and shall implement them as soon as feasible in the pilot counties. The commissioner shall report to the legislature by February 1, 1996, on the protocols developed, on the status of their implementation in the pilot counties, and shall include recommendations for statewide implementation.

Subd. 14. **Child welfare reform pilots.** The commissioner of human services shall encourage local reforms in the delivery of child welfare services and is authorized to approve local pilot programs which focus on reforming the child protection and child welfare systems in Minnesota. Authority to approve pilots includes authority to waive existing state rules as needed to accomplish reform efforts. Notwithstanding section 626.556, subdivision 10, 10b, or 10d, the commissioner may authorize programs to use alternative methods of investigating and assessing reports of child maltreatment, provided that the programs comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. Pilot programs must be required to address responsibility for safety and protection of children, be time limited, and include evaluation of the pilot program.

Subd. 14a. **Single benefit demonstration.** The commissioner may conduct a demonstration program under a federal Title IV-E waiver to demonstrate the impact of a single benefit level on the rate of permanency for children in long-term foster care through transfer of permanent legal custody or adoption. The commissioner of human services is authorized to waive enforcement of related statutory program requirements, rules, and standards in one or more counties for the purpose of this demonstration. The demonstration must comply with the requirements of the secretary of health and human services under federal waiver and be cost neutral to the state.

The commissioner may measure cost neutrality to the state by the same mechanism approved by the secretary of health and human services to measure federal cost neutrality. The commissioner is authorized to accept and administer county funds and to transfer state and federal funds among the affected programs as necessary for the conduct of the demonstration.

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. Notwithstanding section 626.556, the commissioner may authorize projects to use alternative methods of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 626.556 dealing

with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4) have capacity to respond to reports of abuse and neglect under section 626.556;

(5) provide a wide range of services to families in need of child welfare services; and

(6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause (14), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

Subd. 15. **Citizen review panels.** (a) The commissioner shall establish a minimum of three citizen review panels to examine the policies and procedures of state and local welfare agencies to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities. Local social service agencies shall cooperate and work with the citizen review panels. Where appropriate, the panels may examine specific cases to evaluate the effectiveness of child protection activities. The panels must examine the extent to which the state and local agencies are meeting the requirements of the federal Child Abuse Prevention and Treatment Act and the Reporting of Maltreatment of Minors Act. The commissioner may authorize mortality review panels or child protection teams to carry out the duties of a citizen review panel if membership meets or is expanded to meet the requirements of this section.

(b) The panel membership must include volunteers who broadly represent the community in which the panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, child protection advocates, and representatives of the councils of color and ombudsperson for families.

(c) A citizen review panel has access to the following data for specific case review under this paragraph: police investigative data; autopsy records and coroner or medical examiner investigative data; hospital, public health, or other medical records of the child; hospital and other medical records of the child's parent that relate to prenatal care; records created by social

service agencies that provided services to the child or family; and personnel data related to an employee's performance in discharging child protection responsibilities. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner. Not public data may be shared with members of the state or local citizen review panel in connection with an individual case.

(d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state citizen review panel in the exercise of its duties are protected nonpublic or confidential data as defined in section 13.02, but may be disclosed as necessary to carry out the purposes of the review panel. The data are not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but may not disclose data on individuals that were classified as confidential or private data on individuals in the possession of the state agency, statewide system, or political subdivision from which the data were received, except that the commissioner may disclose local social service agency data as provided in section 626.556, subdivision 11d, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.

(e) A person attending a citizen review panel meeting may not disclose what transpired at the meeting, except to carry out the purposes of the review panel. The proceedings and records of the review panel are protected nonpublic data as defined in section 13.02, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or county agency arising out of the matters the panel is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the review panel. A person who presented information before the review panel or who is a member of the panel is not prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding, a person must not be questioned about the person's presentation of information to the review panel or opinions formed by the person as a result of the review panel meetings.

Subd. 16. **Information for persons with limited English-language proficiency.** By July 1, 1998, the commissioner shall implement a procedure for public assistance applicants and recipients to identify a language preference other than English in order to receive information pertaining to the public assistance programs in that preferred language.

Subd. 17. **Appropriation transfers to be reported.** When the commissioner transfers operational money between programs under section 16A.285, in addition to the requirements of that section the commissioner must provide the chairs of the legislative committees that have jurisdiction over the agency's budget with sufficient detail to identify the account to which the money was originally appropriated, and the account to which the money is being transferred.

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. 18a. **Public Assistance Reporting Information System.** (a) Effective October 1, 2009, the commissioner shall comply with the federal requirements in Public Law 110-379 in implementing the Public Assistance Reporting Information System (PARIS) to determine eligibility for all individuals applying for:

(1) health care benefits under chapters 256B, 256D, and 256L; and

(2) public benefits under chapters 119B, 256D, and 256I, and the supplemental nutrition assistance program.

(b) The commissioner shall determine eligibility under paragraph (a) by performing data matches, including matching with medical assistance, cash, child care, and supplemental assistance programs operated by other states.

Subd. 18b. [Repealed, 2012 c 216 art 13 s 20]

Subd. 18c. **Drug convictions.** (a) The state court administrator shall provide a report every six months by electronic means to the commissioner of human services, including the name, address, date of birth, and, if available, driver's license or state identification card number, date of the sentence, effective date of the sentence, and county in which the conviction occurred, of each person convicted of a felony under chapter 152 during the previous six months.

(b) The commissioner shall determine whether the individuals who are the subject of the data reported under paragraph (a) are receiving public assistance under chapter 256D or 256J, and if the individual is receiving assistance under chapter 256D or 256J, the commissioner shall instruct the county to proceed under section 256D.024 or 256J.26, whichever is applicable, for this individual.

(c) The commissioner shall not retain any data received under paragraph (a) or (d) that does not relate to an individual receiving publicly funded assistance under chapter 256D or 256J.

(d) In addition to the routine data transfer under paragraph (a), the state court administrator shall provide a onetime report of the data fields under paragraph (a) for individuals with a felony drug conviction under chapter 152 dated from July 1, 1997, until the date of the data transfer. The commissioner shall perform the tasks identified under paragraph (b) related to this data and shall retain the data according to paragraph (c).

[See Note.]

Subd. 18d. **Data sharing with the Department of Human Services; multiple identification cards.** (a) The commissioner of public safety shall, on a monthly basis, provide the commissioner of human services with the first, middle, and last name, and the address, date of birth, and driver's license or state identification card number of all applicants and holders whose drivers' licenses and state identification cards have been canceled under section 171.14, paragraph

(a), clause (2) or (3), by the commissioner of public safety. After the initial data report has been provided by the commissioner of public safety to the commissioner of human services under this paragraph, subsequent reports shall only include cancellations that occurred after the end date of the cancellations represented in the previous data report.

(b) The commissioner of human services shall compare the information provided under paragraph (a) with the commissioner's data regarding recipients of all public assistance programs managed by the Department of Human Services to determine whether any individual with multiple identification cards issued by the Department of Public Safety has illegally or improperly enrolled in any public assistance program managed by the Department of Human Services.

(c) If the commissioner of human services determines that an applicant or recipient has illegally or improperly enrolled in any public assistance program, the commissioner shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

[See Note.]

Subd. 18e. **Data sharing with the Department of Human Services; legal presence date.** (a) The commissioner of public safety shall, on a monthly basis, provide the commissioner of human services with the first, middle, and last name, and address, date of birth, and driver's license or state identification card number of all applicants and holders of drivers' licenses and state identification cards whose temporary legal presence date has expired and as a result the driver's license or identification card has been accordingly canceled under section 171.14 by the commissioner of public safety.

(b) The commissioner of human services shall use the information provided under paragraph (a) to determine whether the eligibility of any recipients of public assistance programs managed by the Department of Human Services has changed as a result of the status change in the Department of Public Safety data.

(c) If the commissioner of human services determines that a recipient has illegally or improperly received benefits from any public assistance program, the commissioner shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

[See Note.]

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.

Subd. 20. **Ryan White Comprehensive AIDS Resources Emergency Act.** (a) The commissioner shall act as the designated state agent for carrying out responsibilities required under Title II of the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. These responsibilities include:

(1) coordinating statewide HIV/AIDS needs assessment activities;

(2) developing the state's plan to meet identified health and support service needs of people living with HIV/AIDS;

(3) administering federal funds designed to provide comprehensive health and support services to persons living with HIV/AIDS;

(4) administering federal funds designated for the AIDS drug assistance program (ADAP);

(5) collecting rebates from pharmaceutical manufacturers on drugs purchased with federal ADAP funds; and

(6) utilizing ADAP rebate funds in accordance with guidelines of the federal Health Resources and Services Administration.

(b) Rebates collected under this subdivision shall be deposited into the ADAP account in the special revenue fund and are appropriated to the commissioner for purposes of this subdivision.

Subd. 21. **Interagency agreement with Department of Health.** The commissioner of human services shall amend the interagency agreement with the commissioner of health to certify nursing facilities for participation in the medical assistance program, to require the commissioner of health, as a condition of the agreement, to comply beginning July 1, 2005, with action plans included in the annual survey and certification quality improvement report required under section 144A.10, subdivision 17.

Subd. 22. **Homeless services.** The commissioner of human services may contract directly with nonprofit organizations providing homeless services in two or more counties.

Subd. 23. MS 2010 [Expired, 2007 c 147 art 2 s 16; 2008 c 277 art 1 s 32]

Subd. 23a. **Administration of publicly funded health care programs.** (a) The commissioner of human services, in cooperation with the representatives of county human services agencies and with input from organizations that advocate on behalf of families and children, shall develop a plan that, to the extent feasible, seeks to align standards, income and asset methodologies, and procedures for families and children under medical assistance and MinnesotaCare. The commissioner shall evaluate the impact of different approaches toward alignment on the number of potential medical assistance and MinnesotaCare enrollees who are families and children, and on administrative, health care, and other costs to the state. The commissioner shall present recommendations to the legislative committees with jurisdiction over health care by September 15, 2010.

(b) The commissioner shall report in detail to the chair of the Health Care and Human Services Finance Committee of the house of representatives and to the chair of the Health and Human Services Division of the Finance Committee of the senate, prior to entering into any contracts involving counties for streamlined electronic enrollment and eligibility determinations for publicly funded health care programs, if such contracts would require payment from either the general fund, or the health care access fund, as described in sections 295.58 and 297I.05.

Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability Linkage Line, to serve as Minnesota's neutral access point for statewide disability information and assistance. The Disability Linkage Line shall:

(1) deliver information and assistance based on national and state standards;

(2) provide information about state and federal eligibility requirements, benefits, and service options;

(3) provide benefits and options counseling;

(4) make referrals to appropriate support entities;

(5) educate people on their options so they can make well-informed choices;

(6) help support the timely resolution of service access and benefit issues;

(7) inform people of their long-term community services and supports;

(8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; and

(9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org.

Subd. 25. **Nonstate funding for program costs.** Notwithstanding sections 16A.013 to 16A.016, the commissioner may accept, on behalf of the state, additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

Subd. 26. **Systems continuity.** In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the Department of Human Services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

Subd. 27. **Application and renewal forms.** The commissioner shall make state health care program applications and renewals available on the department's Web site in the most common foreign languages.

Subd. 28. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

(2) the commissioner or the commissioner's designated representative must have the right to participate in the governance of the legal entity under the same terms and conditions and subject to the same requirements as any other member in the legal entity and in that role shall act to advance state interests and lessen the burdens of government.

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, and 256B.055, subdivision 12, the commissioner shall review all medical evidence submitted by county agencies with a referral and seek additional information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:

(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief appeals referee.

Subd. 30. **Donated funds from private postsecondary institutions.** The commissioner may accept, on behalf of the state, funds donated from private postsecondary institutions, as the state's share in claiming federal Title IV-E reimbursement, to support the Child Welfare State/University Partnership, consistent with Code of Federal Regulations, title 45, chapter 235, section 235.66, Sources of State Funds, if the funds:

(1) are transferred to the state and under the state's administrative control;

(2) are donated with no restriction that the funds be used for the training of a particular individual or at a particular facility or institution; and

(3) do not revert to the donor's facility or use.

Subd. 31. **Consumer satisfaction; human services.** (a) The commissioner of human services shall submit a memorandum each year to the governor and the chairs of the house of representatives and senate standing committees with jurisdiction over the department's programs that provides the following information:

(1) the number of calls made to each of the department's help lines by consumers and citizens regarding the services provided by the department;

(2) the program area related to the call;

(3) the number of calls resolved at the department;

(4) the number of calls that were referred to a county agency for resolution;

(5) the number of calls that were referred elsewhere for resolution;

(6) the number of calls that remain open; and

(7) the number of calls that were without merit.

(b) The initial memorandum shall be submitted no later than February 15, 2012, with subsequent memoranda submitted no later than February 15 each following year.

(c) The commissioner shall publish the annual memorandum on the department's Web site each year no later than March 1.

Subd. 32. **Review and evaluation of ongoing studies.** The commissioner shall review all ongoing studies, reports, and program evaluations completed by the Department of Human Services for state fiscal years 2006 through 2010. For each item, the commissioner shall report the legislature's appropriation for that work, if any, and the actual reported cost of the completed work by the Department of Human Services. The commissioner shall make recommendations to the legislature about which studies, reports, and program evaluations required by law on an ongoing basis are duplicative, unnecessary, or obsolete. The commissioner shall repeat this review every five fiscal years.

Subd. 33. **Contingency contract fees.** (a) When the commissioner enters into a contingency-based contract for the purpose of recovering medical assistance or MinnesotaCare funds, the commissioner may retain that portion of the recovered funds equal to the amount of the contingency fee.

(b) Amounts attributed to new recoveries under this subdivision are appropriated to the commissioner to the extent they fulfill the payment terms of the contract with the vendor and shall be deposited into an account in a fund other than the general fund for purposes of fulfilling the terms of the vendor contract.

Subd. 34. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

(1) reimbursement for the Minnesota senior health options project; and

(2) reimbursement related to prior authorization and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

History: *(3199-102, 8688-4) 1937 c 438 s 2; 1939 c 431 art 7 s 2(a)(c); 1943 c 7 s 1; 1943 c 177 s 1; 1943 c 570 s 1; 1943 c 612 s 1,2; 1949 c 40 s 1; 1949 c 512 s 5,6; 1949 c 618 s 1; 1949 c 704 s 1; 1951 c 330 s 1; 1951 c 403 s 1; 1951 c 713 s 27; 1953 c 30 s 1; 1953 c 593 s 2; 1955 c 534 s 1; 1955 c 627 s 1; 1955 c 847 s 21; 1957 c 287 s 3; 1957 c 641 s 1; 1957 c 762 s 1,2; 1957 c 791 s 1; 1959 c 43 s 1; 1959 c 609 s 1; 1961 c 466 s 3-6; 1963 c 794 s 1; 1967 c 122 s 1; 1967 c 148 s 2; 1969 c 365 s 1; 1969 c 493 s 2; 1969 c 703 s 1; 1969 c 1157 s 1; 1971 c 24 s 26; 1973 c 540 s 4; 1973 c 717 s 12; 1974 c 536 s 2; 1975 c 271 s 6; 1975 c 437 art 2 s 1; 1976 c 2 s 89; 1976 c 107 s 1; 1976 c 149 s 52; 1976 c 163 s 55; 1977 c 400 s 1; 1980 c 357 s 21; 1980 c 618 s 8; 1983 c 7 s 3; 1983 c 10 s 1; 1983 c 243 s 5 subd 3; 1983 c 312 art 5 s 3; 1984 c 654 art 5 s 21,58; 1985 c 21 s 48,49; 1985 c 248 s 70; 1Sp1985 c 14 art 9 s 15; 1986 c 444; 1987 c 270 s 1; 1987 c 343 s 1; 1987 c 403 art 2 s 60; art 3 s 2; 1988 c 689 art 2 s 121; 1988 c 719 art 8 s 1; 1989 c 89 s 5; 1989 c 209 art 1 s 22; 1989 c 282 art 2 s 111,112; 1990 c 568 art 4 s 84; 1991 c 292 art 3 s 6; art 5 s 6,7; 1994 c 631 s 31; 1995 c 178 art 2 s 1,2; 1Sp1995 c 3 art 16 s 13; 1997 c 7 art 2 s 40; 1997 c 85 art 4 s 8; art 5 s 2; 1997 c 203 art 5 s 4,5; 1997 c 225 art 4 s 1; 1998 c 406 art 1 s 8,9,37; 1998 c 407 art 4 s 5; art 6 s 7; art 9 s 8,9; 1999 c 159 s 33,34; 1999 c 205 art 1 s 48; 1999 c 216 art 6 s 7; 1999 c 245 art 1 s 16,17; art 5 s 19; 2000 c 488 art 9 s 6; art 10 s 2; 2001 c 178 art 1 s 2; 1Sp2001 c 9 art 2 s 6; art 3 s 8; art 10 s 1,66; 2002 c 220 art 15 s 4; 2002 c 277 s 5; 2002 c 375 art 2 s 10,11; 2002 c 379 art 1 s 113; 2003 c 130 s 12; 1Sp2003 c 14 art 1 s 106; art 12*

s 2; 2004 c 247 s 4; 2004 c 288 art 3 s 19,20; art 6 s 17; 2005 c 56 s 1; 1Sp2005 c 4 art 3 s 8; art 5 s 12; art 8 s 5,6; 2006 c 282 art 16 s 5; 2007 c 147 art 1 s 1; art 2 s 15,16; art 7 s 4; art 15 s 15; art 19 s 15,16; 2008 c 277 art 1 s 32; 2008 c 286 art 1 s 1; 2008 c 326 art 1 s 7; 2008 c 358 art 3 s 2; 2008 c 361 art 1 s 2; 2009 c 79 art 5 s 5-7,77; art 8 s 12; 2009 c 163 art 2 s 2; 2009 c 173 art 1 s 12; 2010 c 261 s 1; 2010 c 301 art 3 s 2; 2010 c 329 art 1 s 21; 1Sp2010 c 1 art 16 s 1; 1Sp2011 c 9 art 6 s 18; art 7 s 2,3; art 9 s 1; art 10 s 10; 2012 c 216 art 5 s 1; 2012 c 247 art 3 s 2-4

NOTE: Subdivisions 18c, 18d, and 18e, as added by Laws 2012, chapter 247, article 3, sections 2 to 4, are effective July 1, 2013. Laws 2012, chapter 247, article 3, sections 2 to 4, the effective dates.

256.011 ADMINISTRATION OF FEDERAL GRANTS-IN-AID.

Subdivision 1. **Administration of grants-in-aid.** If, when and during such time as grants-in-aid are provided by the federal government for relief of the poor and accepted by this state, such aid shall be administered pursuant to and in accordance with rules promulgated and adopted by the commissioner of human services; and during such time any provision of Minnesota Statutes 1945, chapter 261, as amended by Laws 1947, chapter 546, of Minnesota Statutes 1945, chapter 262, and of Minnesota Statutes 1945, chapter 263, in conflict with such rules shall be and remain, to the extent of such conflict, inoperative and suspended.

Subd. 2. **Treatment of grants-in-aid.** Grants-in-aid received from the federal government for any welfare, assistance or relief program or for administration under the jurisdiction of the commissioner of human services shall, in the first instance, be credited to a federal grant fund and shall be transferred therefrom to the credit of the commissioner of human services in the appropriate account upon certification of the commissioner of human services that the amounts so requested to be transferred have been earned or are required for the purposes and programs intended. Moneys received by the federal grant fund need not be budgeted as such, provided transfers from the fund are budgeted for allotment purposes in the appropriate appropriations.

Subd. 3. **Securing grants-in-aid.** The commissioner of human services shall negotiate with the federal government, or any agency, bureau, or department thereof, for the purpose of securing or obtaining any grants or aids. Any grants or aids thus secured or received are appropriated to the commissioner of human services and made available for the uses and purposes for which they were received but shall be used to reduce the direct appropriations provided by law unless federal law prohibits such action or unless the commissioner of human services obtains approval of the governor who shall seek the advice of the Legislative Advisory Commission.

History: *1949 c 618 s 2; 1953 c 593 s 2; 1976 c 163 s 56; 1984 c 654 art 5 s 58; 1985 c 248 s 70*

256.0112 GRANTS AND PURCHASE OF SERVICE CONTRACTS.

Subdivision 1. **Authority.** The local agency may purchase community social services by grant or purchase of service contract from agencies or individuals approved as vendors.

Subd. 2. **Duties of local agency.** The local agency must:

(1) use a written grant or purchase of service contract when purchasing community social services. Every grant and purchase of service contract must be completed, signed, and approved by all parties to the agreement, including the county board, unless the county board has designated the local agency to sign on its behalf. No service shall be provided before the effective date of the grant or purchase of service contract;

(2) determine a client's eligibility for purchased services, or delegate the responsibility for making the preliminary determination to the approved vendor under the terms of the grant or purchase of service contract;

(3) ensure the development of an individual social service plan based on the client's needs;

(4) monitor purchased services and evaluate grants and contracts on the basis of client outcomes; and

(5) purchase only from approved vendors.

Subd. 3. **Local agency criteria.** When the local agency chooses to purchase community social services from a vendor that is not subject to state licensing laws or department rules, the local agency must establish written criteria for vendor approval to ensure the health, safety, and well being of clients.

Subd. 4. **Case records and reporting requirements.** Case records and data reporting requirements for grants and purchased services are the same as case record and data reporting requirements for direct services.

Subd. 5. **Files.** The local agency must keep an administrative file for each grant and contract.

Subd. 6. **Contracting within and across county lines; lead county contracts.** Paragraphs (a) to (e) govern contracting within and across county lines and lead county contracts.

(a) Once a local agency and an approved vendor execute a contract that meets the requirements of this subdivision, the contract governs all other purchases of service from the vendor by all other local agencies for the term of the contract. The local agency that negotiated and entered into the contract becomes the lead county for the contract.

(b) When the local agency in the county where a vendor is located wants to purchase services from that vendor and the vendor has no contract with the local agency or any other county, the local agency must negotiate and execute a contract with the vendor.

(c) When a local agency in one county wants to purchase services from a vendor located in another county, it must notify the local agency in the county where the vendor is located. Within 30 days of being notified, the local agency in the vendor's county must:

(1) if it has a contract with the vendor, send a copy to the inquiring agency;

(2) if there is a contract with the vendor for which another local agency is the lead county, identify the lead county to the inquiring agency; or

(3) if no local agency has a contract with the vendor, inform the inquiring agency whether it will negotiate a contract and become the lead county. If the agency where the vendor is located will not negotiate a contract with the vendor because of concerns related to clients' health and safety, the agency must share those concerns with the inquiring agency.

(d) If the local agency in the county where the vendor is located declines to negotiate a contract with the vendor or fails to respond within 30 days of receiving the notification under paragraph (c), the inquiring agency is authorized to negotiate a contract and must notify the local agency that declined or failed to respond.

(e) When the inquiring county under paragraph (d) becomes the lead county for a contract and the contract expires and needs to be renegotiated, that county must again follow the requirements under paragraph (c) and notify the local agency where the vendor is located. The local agency where the vendor is located has the option of becoming the lead county for the new contract. If the local agency does not exercise the option, paragraph (d) applies.

(f) This subdivision does not affect the requirement to seek county concurrence under section 256B.092, subdivision 8a, when the services are to be purchased for a person with a developmental disability or under section 245.4711, subdivision 3, when the services to be purchased are for an adult with serious and persistent mental illness.

Subd. 7. **Contracts with community mental health boards.** A local agency within the geographic area served by a community mental health board authorized by sections 245.61 to 245.69, may contract directly with the community mental health board. However, if a local agency outside of the geographic area served by a community mental health board wishes to purchase services from the board, the local agency must follow the requirements under subdivision 6.

Subd. 8. **Placement agreements.** A placement agreement must be used for residential services. Placement agreements are valid when signed by authorized representatives of the facility and the county of financial responsibility. If the county of financial responsibility and the county where the approved vendor is located are not the same, the county of financial responsibility must, if requested, mail a copy of the placement agreement to the county where the approved vendor is providing the service and to the lead county within ten calendar days after the date on which the placement agreement is signed. The placement agreement must specify that the service will be provided in accordance with the individual service plan as required and must specify the unit cost, the date of placement, and the date for the review of the placement. A placement agreement may also be used for nonresidential services.

Subd. 9. **Contracting for performance.** In addition to the agreements in subdivision 8, a local agency may negotiate a supplemental agreement to a contract executed between a lead agency and an approved vendor under subdivision 6 for the purposes of contracting for specific performance. The supplemental agreement may augment the lead contract requirements and rates for services authorized by that local agency only. The additional provisions must be negotiated with the vendor and designed to encourage successful, timely, and cost-effective outcomes for clients, and may establish incentive payments, penalties, performance-related reporting requirements, and similar conditions. The per diem rate allowed under this subdivision must not be less than the rate established in the lead county contract. Nothing in the supplemental agreement between a local agency and an approved vendor binds the lead agency or other local agencies to the terms and conditions of the supplemental agreement.

History: *1Sp2003 c 14 art 11 s 10; 2005 c 56 s 1; 2012 c 253 art 2 s 1*

256.012 MINNESOTA MERIT SYSTEM.

Subdivision 1. **Minnesota Merit System.** The commissioner of human services shall promulgate by rule personnel standards on a merit basis in accordance with federal standards for a merit system of personnel administration for all employees of county boards engaged in the administration of community social services or income maintenance programs, all employees of human services boards that have adopted the rules of the Minnesota Merit System, and all employees of local social services agencies.

Excluded from the rules are employees of institutions and hospitals under the jurisdiction of the aforementioned boards and agencies; employees of county personnel systems otherwise provided for by law that meet federal merit system requirements; duly appointed or elected members of the aforementioned boards and agencies; and the director of community social services and employees in positions that, upon the request of the appointing authority, the commissioner chooses to exempt, provided the exemption accords with the federal standards for a merit system of personnel administration.

Subd. 2. **Payment for services provided.** (a) The cost of merit system operations shall be paid by counties and other entities that utilize merit system services. Total costs shall be determined by the commissioner annually and must be set at a level that neither significantly overrecovers nor underrecovers the costs of providing the service. The costs of merit system services shall be prorated among participating counties in accordance with an agreement between the commissioner and these counties. Participating counties will be billed quarterly in advance and shall pay their share of the costs upon receipt of the billing.

(b) This subdivision does not apply to counties with personnel systems otherwise provided by law that meet federal merit system requirements. A county that applies to withdraw from the merit system must notify the commissioner of the county's intent to develop its own personnel system. This notice must be provided in writing by December 31 of the year preceding the year of final participation in the merit system. The county may withdraw after the commissioner has certified that its personnel system meets federal merit system requirements.

(c) A county merit system operations account is established in the special revenue fund. Payments received by the commissioner for merit system costs must be deposited in the merit system operations account and must be used for the purpose of providing the services and administering the merit system.

(d) County payment of merit system costs is effective July 1, 2003, however payment for the period from July 1, 2003, through December 31, 2003, shall be made no later than January 31, 2004.

Subd. 3. **Participating county consultation.** The commissioner shall ensure that participating counties are consulted regularly and offered the opportunity to provide input on the management of the merit system to ensure effective use of resources and to monitor system performance.

History: *1980 c 614 s 129; 1984 c 654 art 5 s 58; 1986 c 444; 1994 c 631 s 31; 1Sp2003 c 14 art 6 s 48*

256.0121 SOUTHERN CITIES COMMUNITY HEALTH CLINIC.

Subdivision 1. **Service provision.** The commissioner of human services shall offer medically necessary psychiatric and dental services to developmentally disabled clients in the Faribault service area through the Southern Cities Community Health Clinic. For purposes of this requirement, the Faribault service area is expanded to also include geographic areas of the state within 100 miles of Faribault.

Subd. 2. **Consultation required.** The commissioner of human services shall consult with providers of psychiatric and dental services to developmentally disabled clients, family members of developmentally disabled clients, the chairs of the house of representatives and senate committees with jurisdiction over health and human services fiscal issues, and the exclusive representatives when considering policy changes related to:

(1) the future of the Southern Cities Community Health Clinic;

(2) the services currently provided by that clinic to developmentally disabled clients in the Faribault regional center catchment area; and

(3) changes in the model for providing those services.

Subd. 3. **Guarantee of service availability; legislative notice.** (a) The Department of Human Services shall guarantee the provision of medically necessary psychiatric and dental

services to developmentally disabled clients in the Faribault service area through the Southern Cities Community Health Clinic until or unless other appropriate arrangements have been made to provide those clients with those services and the requirements of paragraph (b) are met.

(b) The commissioner shall notify the chairs of the house of representatives and senate committees with jurisdiction over health and human services fiscal issues of plans to use other arrangements to provide medically necessary psychiatric and dental services to developmentally disabled clients in the Faribault service area. The commissioner must not implement these arrangements unless a regular legislative session has convened and adjourned since the date notice was given under this paragraph.

History: *2000 c 465 s 6*

256.013 [Repealed, 1965 c 45 s 73; 1965 c 116 s 1]

256.014 STATE AND COUNTY SYSTEMS.

Subdivision 1. **Establishment of systems.** (a) The commissioner of human services shall establish and enhance computer systems necessary for the efficient operation of the programs the commissioner supervises, including:

(1) management and administration of the food stamp, food support, and income maintenance programs, including the electronic distribution of benefits;

(2) management and administration of the child support enforcement program; and

(3) administration of medical assistance and general assistance medical care.

(b) The commissioner's development costs incurred by computer systems for statewide programs administered by that computer system and mandated by state or federal law must not be assessed against county agencies. The commissioner may charge a county for development and operating costs incurred by computer systems for functions requested by the county and not mandated by state or federal law for programs administered by the computer system incurring the cost.

(c) The commissioner shall distribute the nonfederal share of the costs of operating and maintaining the systems to the commissioner and to the counties participating in the system in a manner that reflects actual system usage, except that the nonfederal share of the costs of the MAXIS computer system and child support enforcement systems for statewide programs administered by those systems and mandated by state or federal law shall be borne entirely by the commissioner.

The commissioner may enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to participate in state-operated computer systems related to the management and administration of the food stamp, food support, income maintenance, child support enforcement, and medical assistance and general assistance medical care programs 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.

Subd. 2. **State systems account created.** A state systems account is created in the state treasury. Money collected by the commissioner of human services for the programs in subdivision 1 must be deposited in the account. Money in the state systems account and federal matching money is appropriated to the commissioner of human services for purposes of this section.

Subd. 3. [Repealed, 2005 c 98 art 2 s 18]

Subd. 4. **Issuance operations center.** Payments to the commissioner from other governmental units and private enterprises for: services performed by the issuance operations center; or reports generated by the payment and eligibility systems must be deposited in the account created under subdivision 2. These payments are appropriated to the commissioner for the operation of the issuance center or system, according to the provisions of this section.

History: *1Sp1986 c 1 art 8 s 4; 1989 c 282 art 5 s 5; 1990 c 568 art 4 s 84; 1993 c 4 s 24; 1995 c 207 art 2 s 21; 1998 c 407 art 6 s 8; 1999 c 245 art 1 s 18; 1Sp2003 c 14 art 1 s 106; 2009 c 175 art 2 s 1*

256.015 PUBLIC ASSISTANCE LIEN ON RECIPIENT'S CAUSE OF ACTION.

Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the agency shall have a lien for the cost of the care and payments on any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury which accrue to the person to whom the care or payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

Subd. 2. **Perfection; enforcement.** (a) The state agency may perfect and enforce its lien under sections 514.69, 514.70, and 514.71, and must file the verified lien statement with the appropriate court administrator in the county of financial responsibility. The verified lien statement must contain the following: the name and address of the person to whom medical care, subsistence, or other payment was furnished; the date of injury; the name and address of vendors furnishing medical care; the dates of the service or payment; the amount claimed to be due for the care or payment; and to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries.

(b) This section does not affect the priority of any attorney's lien. The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4, paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received, or (2) the date the person's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later.

(c) If the notice required in subdivision 4 is not provided by any of the parties to the claim at any stage of the claim, the state agency will have one year from the date the state agency learns of the lack of notice to commence an action. If amounts on the claim or cause of action are paid and the amount required to be paid to the state agency under subdivision 5 is not paid to the state agency, the state agency may commence an action to recover on the lien against any or all of the parties or entities which have either paid or received the payments.

Subd. 3. **Prosecutor.** The attorney general shall represent the commissioner to enforce the lien created under this section or, if no action has been brought, may initiate and prosecute an

independent action on behalf of the commissioner against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

Any prepaid health plan providing services under sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce their lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

Subd. 4. **Notice.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages to the injured person when the state agency has paid for or become liable for the cost of medical care or payments related to the injury. Notice must be given as follows:

(a) Applicants for public assistance shall notify the state or county agency of any possible claims they may have against a person, firm, or corporation when they submit the application for assistance. Recipients of public assistance shall notify the state or county agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of public assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice at that stage of the claim. If the required notice under this paragraph is not provided to the state agency, every party will be deemed to have failed to provide the required notice. A party to a claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual lien claim.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 5. **Costs deducted.** Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has filed its lien, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of public assistance paid to or on behalf of the person as a result of the injury must be deducted next, and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and other collection costs.

Subd. 6. **When effective.** The lien created under this section is effective with respect to any public assistance paid on or after August 1, 1987.

Subd. 7. **Cooperation with information requests required.** (a) Upon the request of the commissioner of human services:

(1) any state agency or third-party payer shall cooperate by furnishing information to help establish a third-party liability, as required by the federal Deficit Reduction Act of 2005, Public Law 109-171;

(2) any employer or third-party payer shall cooperate by furnishing a data file containing information about group health insurance plan or medical benefit plan coverage of its employees or insureds within 60 days of the request.

(b) For purposes of section 176.191, subdivision 4, the commissioner of labor and industry may allow the commissioner of human services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the commissioner of human services.

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138 (d)(4), the commissioner of public safety shall provide accident data as requested by the commissioner of human services. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

(d) The commissioner of human services and county agencies shall limit its use of information gained from agencies, third-party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third-party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

History: *1987 c 370 art 2 s 3; 1988 c 689 art 2 s 122; 1990 c 568 art 4 s 84; 1Sp1993 c 1 art 5 s 9; 1995 c 207 art 6 s 9-11; 1997 c 217 art 2 s 2-4; 1999 c 245 art 4 s 16,17; 2004 c 228 art 1 s 75; 2007 c 147 art 2 s 17; 2009 c 173 art 3 s 3*

256.016 PLAIN LANGUAGE IN WRITTEN MATERIALS.

(a) To the extent reasonable and consistent with the goals of providing easily understandable and readable materials and complying with federal and state laws governing the programs, all written materials relating to services and determinations of eligibility for or amounts of benefits that will be given to applicants for or recipients of assistance under a program administered or supervised by the commissioner of human services must be understandable to a person who reads at the seventh-grade level, using the Flesch scale analysis readability score as determined under section 72C.09.

(b) All written materials relating to determinations of eligibility for or amounts of benefits that will be given to applicants for or recipients of assistance under programs administered or supervised by the commissioner of human services must be developed to satisfy the plain language requirements of the Plain Language Contract Act under sections 325G.29 to 325G.36. Materials may be submitted to the attorney general for review and certification. Notwithstanding section 325G.35, subdivision 1, the attorney general shall review submitted materials to determine whether they comply with the requirements of section 325G.31. The remedies available pursuant to sections 8.31 and 325G.33 to 325G.36 do not apply to these materials. Failure to comply with

this section does not provide a basis for suspending the implementation or operation of other laws governing programs administered by the commissioner.

(c) The requirements of this section apply to all materials modified or developed by the commissioner on or after July 1, 1988. The requirements of this section do not apply to materials that must be submitted to a federal agency for approval, to the extent that application of the requirements prevents federal approval.

(d) Nothing in this section may be construed to prohibit a lawsuit brought to require the commissioner to comply with this section or to affect individual appeal rights granted pursuant to section 256.045.

History: *1988 c 689 art 2 s 123; 1997 c 7 art 2 s 41*

256.0161 FORECAST ON CHILDREN'S HEALTH CARE SERVICES.

Beginning November 2011, and as part of its annual November and February forecasts thereafter, the commissioner of human services shall provide an accounting of health care expenditures for persons aged birth to 22 years, separate from expenditures for enrolled parents, for all services provided in a Minnesota public health care program.

History: *2011 c 29 s 1*

256.017 COMPLIANCE SYSTEM.

Subdivision 1. **Authority and purpose.** The commissioner shall administer a compliance system for the Minnesota family investment program, the food stamp or food support program, emergency assistance, general assistance, medical assistance, general assistance medical care, emergency general assistance, Minnesota supplemental assistance, preadmission screening, alternative care grants, and the child care assistance program under the powers and authorities named in section 256.01, subdivision 2. The purpose of the compliance system is to permit the commissioner to supervise the administration of public assistance programs and to enforce timely and accurate distribution of benefits, completeness of service and efficient and effective program management and operations, to increase uniformity and consistency in the administration and delivery of public assistance programs throughout the state, and to reduce the possibility of sanctions and fiscal disallowances for noncompliance with federal regulations and state statutes.

The commissioner shall utilize training, technical assistance, and monitoring activities, as specified in section 256.01, subdivision 2, to encourage county agency compliance with written policies and procedures.

Subd. 2. **Definitions.** The following terms have the meanings given for purposes of this section.

(a) "Administrative penalty" means an adjustment against the county agency's state and federal benefit and federal administrative reimbursement when the commissioner determines that the county agency is not in compliance with the policies and procedures established by the commissioner.

(b) "Quality control case penalty" means an adjustment against the county agency's federal administrative reimbursement and state and federal benefit reimbursement when the commissioner determines through a quality control review that the county agency has made incorrect payments, terminations, or denials of benefits as determined by state quality control procedures for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program, food stamp, food support, or medical assistance programs,

or any other programs for which the commissioner has developed a quality control system. Quality control case penalties apply only to agency errors as defined by state quality control procedures.

(c) "Quality control/quality assurance" means a review system of a statewide random sample of cases, designed to provide data on program outcomes and the accuracy with which state and federal policies are being applied in issuing benefits and as a fiscal audit to ensure the accuracy of expenditures. The quality control/quality assurance system is administered by the department. For the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, food stamp, food support, and medical assistance programs, the quality control system is that required by federal regulation, or those developed by the commissioner.

Subd. 3. **Quality control case penalty.** The department shall disallow, withhold, or deny state and federal benefit reimbursement and federal administrative reimbursement payment to a county when the commissioner determines that the county has incorrectly issued benefits or incorrectly denied or terminated benefits. These cases shall be identified by state quality control reviews.

Subd. 4. **Determining the amount of the quality control case penalty.** (a) The amount of the quality control case penalty is limited to the amount of the dollar error for the quality control sample month in a reviewed case as determined by the state quality control review procedures for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, and food stamp or food support programs or for any other income transfer program for which the commissioner develops a quality control program.

(b) Payment errors in medical assistance or any other medical services program for which the department develops a quality control program are subject to set rate penalties based on the average cost of the specific quality control error element for a sample review month for that household size and status of institutionalization and as determined from state quality control data in the preceding fiscal year for the corresponding program.

(c) Errors identified in negative action cases, such as incorrect terminations or denials of assistance are subject to set rate penalties based on the average benefit cost of that household size as determined from state quality control data in the preceding fiscal year for the corresponding program.

Subd. 5. **Administrative penalties.** The department shall disallow or withhold state and federal benefit reimbursement and federal administrative reimbursement from county agencies when the actions performed by the county agency are not in compliance with the written policies and procedures established by the commissioner. The policies and procedures must be previously communicated to the county agency. A county agency shall not be penalized for complying with a written policy or procedure, even if the policy or procedure is found to be erroneous and is subsequently rescinded by the commissioner.

Subd. 6. **Determining the amount of the administrative penalty.** The amount of the penalty imposed on any county agency is based on the numbers of public assistance applicants and recipients that may be affected by the county agency's failure to comply with the policies and procedures established by the commissioner, the fiscal impact of the county agency's action, and the duration of the noncompliance as determined by the commissioner. Administrative penalties shall be imposed independent of any quality control case penalties.

Subd. 7. **Process and exception.** (a)(1) The department shall notify the county agency in writing of all proposed quality control case penalties.

(2) The county agency may submit a written exception of the quality control error claim and proposed penalty. The exception must be submitted to the commissioner within ten calendar days of the receipt of the penalty notice.

(3) Within 20 calendar days of receipt of the written exception, the commissioner shall sustain, dismiss, or amend the quality control findings and case penalty and notify the county agency, in writing, of the decision and the amount of any penalty. The commissioner's decision is not subject to judicial review.

(b)(1) The department shall notify the county agency in writing of any proposed administrative penalty, the date by which the county agency must correct the issues noted in the penalty, and the time period within which the county agency must submit a corrective action plan for compliance.

(2) If the county agency fails to submit a corrective action plan within the stated time period, or if the corrective action plan does not bring the agency into compliance as determined by the department, or if the county agency fails to meet the commitments in the corrective action plan, the department shall issue the administrative penalty and notify the county agency in writing.

(3) The county agency may file written exception to the administrative penalty with the commissioner within 30 days of the receipt of the department's notice of issuing the administrative penalty. The county agency must notify the commissioner of its intent to file a written exception within ten days of the delivery of the department's notice of the administrative penalty. If the county agency does not notify the commissioner of its intent to file and does not file a written exception within the prescribed time periods, the department's initial decision shall be final.

(4) The commissioner shall sustain, dismiss, or amend the administrative penalty findings, and shall issue a written order to the county agency within 30 calendar days after receiving the county agency's written exception.

Subd. 8. **Judicial review.** A county agency that is aggrieved by the order of the commissioner in an administrative penalty of over $75,000, or 1.5 percent of the total benefit expenditures for the income maintenance programs listed in subdivision 1, for that county, whichever is the lesser amount, may appeal the order to the Court of Appeals by serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the administrative penalty order, and by filing the original notice and proof of service with the court administrator of the court of appeals. Service may be made personally or by mail. Service by mail is complete upon mailing. The record of review shall consist of the advance notice of the administrative penalty to the county agency, the county agency corrective action plan if any, the final notice of the administrative penalty, the county agency's written exception to the administrative penalty order, and any other material submitted for the commissioner's consideration, and the commissioner's final written order. The court may affirm the commissioner's decision or remand the case for further proceedings, or it may reverse or modify the decision if the substantial rights of the county agency have been prejudiced because the decision is: (1) in excess of the statutory authority or jurisdiction of the agency; (2) unsupported by substantial evidence in view of the entire record as submitted; (3) arbitrary or capricious; or (4) in violation of constitutional provisions.

Subd. 9. **Timing and disposition of penalty and case disallowance funds.** Quality control case penalty and administrative penalty amounts shall be disallowed or withheld from the next regular reimbursement made to the county agency for state and federal benefit reimbursements and federal administrative reimbursements for all programs covered in this section, according to

procedures established in statute, but shall not be imposed sooner than 30 calendar days from the date of written notice of such penalties. Except for penalties withheld under the child care assistance program, all penalties must be deposited in the county incentive fund provided in section 256.018. Penalties withheld under the child care assistance program shall be reallocated to counties using the allocation formula under section 119B.03, subdivision 5. All penalties must be imposed according to this provision until a decision is made regarding the status of a written exception. Penalties must be returned to county agencies when a review of a written exception results in a decision in their favor.

Subd. 10. **County obligation to make benefit payments.** Counties subject to fiscal penalties shall not reduce or withhold benefits from eligible recipients of programs listed in subdivision 1 in order to cover the cost of penalties under this section. County funds shall be used to cover the cost of any penalties.

History: *1988 c 719 art 8 s 2; 1990 c 568 art 4 s 84; 1997 c 85 art 4 s 9,10; art 5 s 3; 1999 c 159 s 35-37; 1Sp2003 c 14 art 1 s 106; 2007 c 147 art 2 s 18,19*

256.018 COUNTY PUBLIC ASSISTANCE INCENTIVE FUND.

The commissioner shall grant incentive awards of money specifically appropriated for this purpose to counties: (1) that have not been assessed an administrative penalty under section 256.017 in the corresponding fiscal year; and (2) that perform satisfactorily according to indicators established by the commissioner.

After consultation with county agencies, the commissioner shall inform county agencies in writing of the performance indicators that govern the awarding of the incentive fund for each fiscal year by April of the preceding fiscal year.

The commissioner may set performance indicators to govern the awarding of the total fund, may allocate portions of the fund to be awarded by unique indicators, or may set a sole indicator to govern the awarding of funds.

The funds shall be awarded to qualifying county agencies according to their share of benefits for the programs related to the performance indicators governing the distribution of the fund or part of it as compared to the total benefits of all qualifying county agencies for the programs related to the performance indicators governing the distribution of the fund or part of it.

History: *1988 c 719 art 8 s 3; 1989 c 282 art 2 s 113; 1990 c 568 art 4 s 84*

256.019 RECOVERY OF MONEY; APPORTIONMENT.

Subdivision 1. **Retention rates.** When an assistance recovery amount is collected and posted by a county agency under the provisions governing public assistance programs including general assistance medical care, general assistance, and Minnesota supplemental aid, the county may keep one-half of the recovery made by the county agency using any method other than recoupment. For medical assistance, if the recovery is made by a county agency using any method other than recoupment, the county may keep one-half of the nonfederal share of the recovery. For MinnesotaCare, if the recovery is collected and posted by the county agency, the county may keep one-half of the nonfederal share of the recovery.

This does not apply to recoveries from medical providers or to recoveries begun by the Department of Human Services' Surveillance and Utilization Review Division, State Hospital Collections Unit, and the Benefit Recoveries Division or, by the attorney general's office, or child support collections. In the food stamp or food support program, the nonfederal share of recoveries

in the federal tax offset program only will be divided equally between the state agency and the involved county agency.

Subd. 2. **Retention rates for AFDC and MFIP.** (a) When an assistance recovery amount is collected and posted by a county agency under the provisions governing the aid to families with dependent children program formerly codified in 1996 in sections 256.72 to 256.87 or MFIP under chapter 256J, the commissioner shall reimburse the county agency from the proceeds of the recovery using the applicable rate specified in paragraph (b) or (c).

(b) For recoveries of overpayments made on or before September 30, 1996, from the aid to families with dependent children program including the emergency assistance program, the commissioner shall reimburse the county agency at a rate of one-quarter of the recovery made by any method other than recoupment.

(c) For recoveries of overpayments made after September 30, 1996, from the aid to families with dependent children including the emergency assistance program and programs funded in whole or in part by the temporary assistance to needy families program under section 256J.02, subdivision 2, and recoveries of nonfederally funded food assistance under section 256J.11, the commissioner shall reimburse the county agency at a rate of one-quarter of the recovery made by any method other than recoupment.

History: *1988 c 719 art 8 s 29; 1993 c 306 s 2; 1997 c 85 art 5 s 4; 1999 c 159 s 38; 2000 c 488 art 10 s 3; 1Sp2003 c 14 art 1 s 106; 1Sp2005 c 4 art 8 s 7*

256.02 INVESTIGATIONS; EXAMINATIONS; SUPERVISION.

Subdivision 1. **Duties.** The commissioner of human services shall investigate the whole system of public charities and charitable institutions in the state, especially infirmaries and public hospitals, and examine their condition and management. The commissioner may require the officers in charge of any such institution to furnish such information and statistics as the commissioner deems necessary, upon blanks furnished by the commissioner. The commissioner shall examine all plans for new infirmaries, or for repairs at an estimated cost of over $200, before the same are adopted by the county or other municipal board, and have an advisory supervision over all such institutions. Upon the request of the governor, the commissioner shall specially investigate any charitable institution and report its condition; and for this purpose the commissioner is hereby authorized to send for persons and papers, administer oaths, and take testimony to be transcribed and included in the report.

Subd. 2. [Temporary]

History: *(4448) RL s 1899; 1949 c 228 s 1; 1961 c 750 s 27 subd 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.021 VULNERABLE ADULT MALTREATMENT REVIEW PANEL.

Subdivision 1. **Creation.** (a) The commissioner of human services shall establish a review panel for purposes of reviewing lead investigative agency determinations regarding maltreatment of a vulnerable adult in response to requests received under section 626.557, subdivision 9d, paragraph (b). The panel shall hold quarterly meetings for purposes of conducting reviews under this section.

(b) The review panel consists of:

(1) the commissioners of health and human services or their designees;

(2) the ombudsman for long-term care and ombudsman for mental health and developmental disabilities, or their designees;

(3) a member of the board on aging, appointed by the board; and

(4) a representative from the county human services administrators appointed by the commissioner of human services or the administrator's designee.

Subd. 2. **Review procedure.** (a) If a vulnerable adult or an interested person acting on behalf of the vulnerable adult 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 investigation memorandum and may review any other data on the investigation maintained by the lead investigative agency that are pertinent and necessary to its review of the final disposition. If more than one person requests a review under this section with respect to the same final disposition, the review panel shall combine the requests into one review. The panel shall submit its written request for the case file and other documentation relevant to the review to the supervisor of the investigator conducting the investigation under review.

(b) Within 30 days of the review under this section, the panel shall notify the director or manager of the lead investigative agency and the vulnerable adult or interested person who requested the review as to whether the panel concurs with the final disposition or whether the lead investigative agency must reconsider the final disposition. If the panel determines that the lead investigative agency must reconsider the final disposition, the panel must make specific recommendations to the director or manager of the lead investigative agency. The recommendation must include an explanation of the factors that form the basis of the recommendation to reconsider the final disposition and must specifically identify the disputed facts, the disputed application of maltreatment definitions, the disputed application of responsibility for maltreatment, and the disputed weighing of evidence, whichever apply. Within 30 days the lead investigative agency shall conduct a review and report back to the panel with its determination and the specific rationale for its final disposition. At a minimum, the specific rationale must include a detailed response to each of the factors identified by the panel that formed the basis for the recommendations of the panel.

(c) Upon receiving the report of reconsideration from the lead investigative agency, the panel shall communicate the decision in writing to the vulnerable adult or interested person acting on behalf of the vulnerable adult who requested the review. The panel shall include the specific rationale provided by the lead investigative agency as part of the communication.

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 626.557 regarding the number of requests for review it receives under this section, the number of cases where the panel requires the lead investigative agency to reconsider its final disposition, and the number of cases where the final disposition is changed, and any recommendations to improve the review or investigative process.

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

History: *2000 c 465 s 2; 2005 c 56 s 1; 2011 c 28 s 3*

256.022 [Repealed, 2012 c 216 art 1 s 51; art 6 s 14]

256.023 ONE HUNDRED PERCENT COUNTY ASSISTANCE.

The commissioner of human services may maintain client records and issue public assistance benefits that are over state and federal standards or that are not required by state or federal law, providing the cost of benefits is paid by the counties to the Department of Human Services.

History: *1991 c 292 art 5 s 8; 2002 c 277 s 6*

256.025 [Repealed, 2002 c 277 s 34]

256.026 [Repealed, 1997 c 203 art 11 s 13]

256.027 USE OF VANS PERMITTED.

The commissioner, after consultation with the commissioner of public safety, shall prescribe procedures to permit the occasional use of lift-equipped vans that have been financed, in whole or in part, by public money to transport an individual whose own lift-equipped vehicle is unavailable because of equipment failure and who is thus unable to complete a trip home or to a medical facility. The commissioner shall encourage publicly financed lift-equipped vans to be made available to a county sheriff's department, and to other persons who are qualified to drive the vans and who are also qualified to assist the individual in need of transportation, for this purpose.

History: *1Sp1993 c 1 art 5 s 10; 1997 c 187 art 1 s 17*

256.028 TAX REBATES.

Any federal or state tax rebate received by a recipient of a public assistance program shall not be counted as income or as an asset for purposes of any of the public assistance programs under this chapter or any other chapter, including, but not limited to, chapter 256B, 256D, 256E, 256I, 256J, or 256L to the extent permitted under federal law.

History: *1999 c 245 art 4 s 18*

256.0281 INTERAGENCY DATA EXCHANGE.

The Department of Human Services, the Department of Health, and the Office of the Ombudsman for Mental Health and Developmental Disabilities may establish interagency agreements governing the electronic exchange of data on providers and individuals collected, maintained, or used by each agency when such exchange is outlined by each agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

(1) to improve provider enrollment processes for home and community-based services and state plan home care services;

(2) to improve quality management of providers between state agencies;

(3) to establish and maintain provider eligibility to participate as providers under Minnesota health care programs; or

(4) to meet the quality assurance reporting requirements under federal law under section 1915(c) of the Social Security Act related to home and community-based waiver programs.

Each interagency agreement must include provisions to ensure anonymity of individuals, including mandated reporters, and must outline the specific uses of and access to shared data within each agency. Electronic interfaces between source data systems developed under these

interagency agreements must incorporate these provisions as well as other HIPAA provisions related to individual data.

History: *2009 c 79 art 8 s 13; 2009 c 173 art 1 s 44*

256.029 DOMESTIC VIOLENCE INFORMATIONAL BROCHURE.

(a) The commissioner shall provide a domestic violence informational brochure that provides information about the existence of domestic violence waivers for eligible public assistance applicants to all applicants of general assistance, general assistance medical care, Minnesota family investment program, medical assistance, and MinnesotaCare. The brochure must explain that eligible applicants may be temporarily waived from certain program requirements due to domestic violence. The brochure must provide information about services and other programs to help victims of domestic violence.

(b) The brochure must be funded with TANF funds.

History: *2006 c 282 art 22 s 7*

256.03 [Repealed, 1961 c 561 s 17]

256.031 Subdivision 1. [Repealed, 1998 c 407 art 6 s 118]

Subd. 1a. [Repealed, 1999 c 159 s 154]

Subd. 2. [Repealed, 1998 c 407 art 6 s 118]

Subd. 3. [Repealed, 1998 c 407 art 6 s 118]

Subd. 4. [Repealed, 1998 c 407 art 6 s 118]

Subd. 5. [Repealed, 1998 c 407 art 6 s 118]

Subd. 6. [Repealed, 1998 c 407 art 6 s 118]

256.032 [Repealed, 1998 c 407 art 6 s 118]

256.033 [Repealed, 1998 c 407 art 6 s 118]

256.034 [Repealed, 1998 c 407 art 6 s 118]

256.035 [Repealed, 1998 c 407 art 6 s 118]

256.036 [Repealed, 1998 c 407 art 6 s 118]

256.0361 [Repealed, 1998 c 407 art 6 s 118]

256.04 [Temporary]

HEARINGS

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICES MATTERS.

Subdivision 1. **Powers of the state agency.** The commissioner of human services may appoint one or more state human services referees to conduct hearings and recommend orders in accordance with subdivisions 3, 3a, 3b, 4a, and 5. Human services referees designated pursuant to this section may administer oaths and shall be under the control and supervision of the

commissioner of human services and shall not be a part of the Office of Administrative Hearings established pursuant to sections 14.48 to 14.56.

Subd. 2. [Repealed, 1987 c 148 s 9]

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 245C, any individual or facility determined by a lead investigative 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) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) 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;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, 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 245C.15, subdivisions 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 (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, 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; or

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), 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 paragraph (a), 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 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), 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.

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

(d) The scope of hearings involving claims to foster care payments under paragraph (a), 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.

(e) 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 is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(f) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(g) 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.

Subd. 3a. **Prepaid health plan appeals.** (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health

plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Subd. 3b. **Standard of evidence for maltreatment and disqualification hearings.** (a) 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 245C.15, subdivisions 1 to 4; or

(3) failed to make required reports under section 626.556 or 626.557, for incidents in which the final disposition under section 626.556 or 626.557 was substantiated maltreatment that was serious or recurring.

(b) 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 245C.22, and whether the disqualification should be set aside or not set aside. In determining whether the disqualification should be set aside, the human services referee shall consider all of the characteristics that cause the individual to be disqualified, including those characteristics that were not subject to review under paragraph (a), in order to determine whether the individual poses a risk of harm. A decision to set aside a disqualification that is the subject of the hearing constitutes a determination that the individual does not pose a risk of harm and that the individual may provide direct contact services in the individual program specified in the set aside. If a determination that the information relied upon to disqualify an individual was correct and is conclusive under section 245C.29, and the individual is subsequently disqualified under section 245C.14, the individual has a right to again request reconsideration on the risk of harm under section 245C.21. Subsequent determinations regarding risk of harm are not subject to another hearing under this section.

(c) The state human services referee shall recommend an order to the commissioner of health, education, 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. In any licensing appeal under chapters 245A and 245C

and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive, as provided under section 245C.29.

Subd. 3c. [Repealed, 2005 c 98 art 2 s 18]

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 $1,000, 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.

(c) In hearings under subdivision 3, paragraph (a), clauses (4), (8), and (9), involving determinations of maltreatment or disqualification made by more than one county agency, by a county agency and a state agency, or by more than one state agency, the hearings may be consolidated into a single fair hearing upon the consent of all parties and the state human services referee.

(d) For hearings under subdivision 3, paragraph (a), clause (4) or (10), involving a vulnerable adult, the human services referee shall notify the vulnerable adult who is the subject of the maltreatment determination and, if known, a guardian of the vulnerable adult appointed under section 524.5-310, or a health care agent designated by the vulnerable adult in a health care directive that is currently effective under section 145C.06 and whose authority to make health care decisions is not suspended under section 524.5-310, of the hearing. The notice must be sent by certified mail and inform the vulnerable adult of the right to file a signed written statement in the proceedings. A guardian or health care agent who prepares or files a written statement for the vulnerable adult must indicate in the statement that the person is the vulnerable adult's guardian or health care agent and sign the statement in that capacity. The vulnerable adult, the guardian, or the health care agent may file a written statement with the human services referee hearing the case no later than five business days before commencement of the hearing. The human services referee shall include the written statement in the hearing record and consider the statement in deciding the appeal. This subdivision does not limit, prevent, or excuse the vulnerable adult from being called as a witness testifying at the hearing or grant the vulnerable adult, the guardian, or health care agent a right to participate in the proceedings or appeal the human services referee's decision in the case. The lead investigative agency must consider including the vulnerable adult victim of maltreatment as a witness in the hearing. If the lead investigative agency determines that participation in the hearing would endanger the well-being of the vulnerable adult or not be in the best interests of the vulnerable adult, the lead investigative agency shall inform the human services referee of the basis for this determination, which must be included in the final order. If the human services referee is not reasonably able to determine the address of the vulnerable adult, the guardian, or the health care agent, the human services referee is not required to send a hearing notice under this subdivision.

Subd. 4a. **Case management appeals.** Any recipient of case management services pursuant to section 256B.092, who contests the county agency's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a conciliation conference to the county agency. The county agency shall inform the commissioner of the receipt of a request when it is submitted and shall schedule a conciliation conference. The county agency shall notify the recipient, the commissioner, and all interested persons of the time, date, and location of the conciliation conference. The commissioner may assist the county by providing mediation services or by identifying other resources that may assist in the mediation between the parties. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management services have been provided in accordance with applicable laws and rules or whether the county agency has assured that the services identified in the recipient's individual service plan have been delivered in accordance with the laws and rules governing the provision of those services. The state human services referee shall recommend an order to the commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The

order may direct the county agency to take those actions necessary to comply with applicable laws or rules. The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

Subd. 5. **Orders of the commissioner of human services.** A state human services referee shall conduct a hearing on the appeal and shall recommend an order to the commissioner of human services. The recommended order must be based on all relevant evidence and must not be limited to a review of the propriety of the state or county agency's action. A referee may take official notice of adjudicative facts. The commissioner of human services may accept the recommended order of a state human services referee and issue the order to the county agency and the applicant, recipient, former recipient, or prepaid health plan. The commissioner on refusing to accept the recommended order of the state human services referee, shall notify the petitioner, the agency, or prepaid health plan of that fact and shall state reasons therefor and shall allow each party ten days' time to submit additional written argument on the matter. After the expiration of the ten-day period, the commissioner shall issue an order on the matter to the petitioner, the agency, or prepaid health plan.

A party aggrieved by an order of the commissioner may appeal under subdivision 7, or request reconsideration by the commissioner within 30 days after the date the commissioner issues the order. The commissioner may reconsider an order upon request of any party or on the commissioner's own motion. A request for reconsideration does not stay implementation of the commissioner's order. Upon reconsideration, the commissioner may issue an amended order or an order affirming the original order.

Any order of the commissioner issued under this subdivision shall be conclusive upon the parties unless appeal is taken in the manner provided by subdivision 7. Any order of the commissioner is binding on the parties and must be implemented by the state agency, a county agency, or a prepaid health plan according to subdivision 3a, until the order is reversed by the district court, or unless the commissioner or a district court orders monthly assistance or aid or services paid or provided under subdivision 10.

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 is not a party and may not request a hearing or seek judicial review of an order issued under this section, unless assisting a recipient as provided in subdivision 4. A prepaid health plan is a party to an appeal under subdivision 3a, but cannot seek judicial review of an order issued under this section.

Subd. 6. **Additional powers of commissioner; subpoenas.** (a) The commissioner of human services, or the commissioner of health for matters within the commissioner's jurisdiction under subdivision 3b, may initiate a review of any action or decision of a county agency and direct that the matter be presented to a state human services referee for a hearing held under subdivision 3, 3a, 3b, or 4a. In all matters dealing with human services committed by law to the discretion of the county agency, the commissioner's judgment may be substituted for that of the county agency. The commissioner may order an independent examination when appropriate.

(b) Any party to a hearing held pursuant to subdivision 3, 3a, 3b, or 4a may request that the commissioner issue a subpoena to compel the attendance of witnesses and the production of records at the hearing. A local agency may request that the commissioner issue a subpoena to compel the release of information from third parties prior to a request for a hearing under section 256.046 upon a showing of relevance to such a proceeding. The issuance, service, and enforcement of subpoenas under this subdivision is governed by section 357.22 and the Minnesota Rules of Civil Procedure.

(c) The commissioner may issue a temporary order staying a proposed demission by a residential facility licensed under chapter 245A while an appeal by a recipient under subdivision 3 is pending or for the period of time necessary for the county agency to implement the commissioner's order.

Subd. 7. **Judicial review.** Except for a prepaid health plan, any party who is aggrieved by an order of the commissioner of human services, or the commissioner of health in appeals within the commissioner's jurisdiction under subdivision 3b, may appeal the order to the district court of the county responsible for furnishing assistance, or, in appeals under subdivision 3b, the county where the maltreatment occurred, by serving a written copy of a notice of appeal upon the commissioner and any adverse party of record within 30 days after the date the commissioner issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with the court administrator of the district court. Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision, with the exception of appeals taken under subdivision 3b. The commissioner may elect to become a party to the proceedings in the district court. Except for appeals under subdivision 3b, any party may demand that the commissioner furnish all parties to the proceedings with a copy of the decision, and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the human services referee, by serving a written demand upon the commissioner within 30 days after service of the notice of appeal. Any party aggrieved by the failure of an adverse party to obey an order issued by the commissioner under subdivision 5 may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

Subd. 8. **Hearing.** Any party may obtain a hearing at a special term of the district court by serving a written notice of the time and place of the hearing at least ten days prior to the date of the hearing. The court may consider the matter in or out of chambers, and shall take no new or additional evidence unless it determines that such evidence is necessary for a more equitable disposition of the appeal.

Subd. 9. **Appeal.** Any party aggrieved by the order of the district court may appeal the order as in other civil cases. Except for appeals under subdivision 3b, no costs or disbursements shall be taxed against any party nor shall any filing fee or bond be required of any party.

Subd. 10. **Payments pending appeal.** If the commissioner of human services or district court orders monthly assistance or aid or services paid or provided in any proceeding under this section, it shall be paid or provided pending appeal to the commissioner of human services, district court, court of appeals, or supreme court. The human services referee may order the local human services agency to reduce or terminate medical assistance or general assistance medical care to a recipient before a final order is issued under this section if: (1) the human services referee determines at the hearing that the sole issue on appeal is one of a change in state or federal law; and (2) the commissioner or the local agency notifies the recipient before the action. The state or

county agency has a claim for food stamps, food support, cash payments, medical assistance, general assistance medical care, and MinnesotaCare program payments made to or on behalf of a recipient or former recipient while an appeal is pending if the recipient or former recipient is determined ineligible for the food stamps, food support, cash payments, medical assistance, general assistance medical care, or MinnesotaCare as a result of the appeal, except for medical assistance and general assistance medical care made on behalf of a recipient pursuant to a court order. In enforcing a claim on MinnesotaCare program payments, the state or county agency shall reduce the claim amount by the value of any premium payments made by a recipient or former recipient during the period for which the recipient or former recipient has been determined to be ineligible. Provision of a health care service by the state agency under medical assistance, general assistance medical care, or MinnesotaCare pending appeal shall not render moot the state agency's position in a court of law.

History: *1976 c 131 s 1; 1978 c 560 s 7; 1982 c 424 s 130; 1983 c 247 s 108,109; 1983 c 312 art 5 s 4; 1984 c 534 s 14-18; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 148 s 1-8; 1987 c 403 art 2 s 61; 1989 c 282 art 5 s 12-20; 1990 c 568 art 4 s 84; 1991 c 94 s 11; 1991 c 292 art 4 s 16; art 6 s 58 subd 2; 1993 c 247 art 4 s 1; 1993 c 339 s 9; 1994 c 625 art 8 s 72; 1995 c 207 art 2 s 27-29; art 11 s 5; 1995 c 229 art 3 s 6-14; 1996 c 408 art 10 s 6; 1996 c 416 s 1; 1996 c 451 art 5 s 9; 1997 c 85 art 5 s 5; 1997 c 203 art 4 s 11; art 5 s 6-10; art 9 s 5; 1997 c 225 art 2 s 55; 1999 c 205 art 1 s 49-51; 2001 c 178 art 2 s 6; 1Sp2001 c 9 art 14 s 26-28; 2002 c 375 art 1 s 19,20; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 2003 c 130 s 12; 1Sp2003 c 14 art 1 s 106; art 11 s 11; 2004 c 228 art 1 s 72; 2004 c 288 art 1 s 76,77; 2005 c 98 art 1 s 9,10; art 3 s 18; 1Sp2005 c 4 art 8 s 8,9; 2009 c 79 art 2 s 9; 2009 c 142 art 2 s 36,37; 2010 c 329 art 2 s 4; 2011 c 28 s 4,17*

256.0451 HEARING PROCEDURES.

Subdivision 1. **Scope.** The requirements in this section apply to all fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (1), (2), (3), (5), (6), and (7). Except as provided in subdivisions 3 and 19, the requirements under this section apply to fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9).

The term "person" is used in this section to mean an individual who, on behalf of themselves or their household, is appealing or disputing or challenging an action, a decision, or a failure to act, by an agency in the human services system. When a person involved in a proceeding under this section is represented by an attorney or by an authorized representative, the term "person" also refers to the person's attorney or authorized representative. Any notice sent to the person involved in the hearing must also be sent to the person's attorney or authorized representative.

The term "agency" includes the county human services agency, the state human services agency, and, where applicable, any entity involved under a contract, subcontract, grant, or subgrant with the state agency or with a county agency, that provides or operates programs or services in which appeals are governed by section 256.045.

Subd. 2. **Access to files.** A person involved in a fair hearing appeal has the right of access to the person's complete case files and to examine all private welfare data on the person which has been generated, collected, stored, or disseminated by the agency. A person involved in a fair hearing appeal has the right to a free copy of all documents in the case file involved in a fair hearing appeal. "Case file" means the information, documents, and data, in whatever form, which have been generated, collected, stored, or disseminated by the agency in connection with the person and the program or service involved.

Subd. 3. **Agency appeal summary.** (a) Except in fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9), the agency involved in an appeal must prepare a state agency appeal summary for each fair hearing appeal. The state agency appeal summary shall be mailed or otherwise delivered to the person who is involved in the appeal at least three working days before the date of the hearing. The state agency appeal summary must also be mailed or otherwise delivered to the department's Appeals Office at least three working days before the date of the fair hearing appeal.

(b) In addition, the appeals referee shall confirm that the state agency appeal summary is mailed or otherwise delivered to the person involved in the appeal as required under paragraph (a). The person involved in the fair hearing should be provided, through the state agency appeal summary or other reasonable methods, appropriate information about the procedures for the fair hearing and an adequate opportunity to prepare. These requirements apply equally to the state agency or an entity under contract when involved in the appeal.

(c) The contents of the state agency appeal summary must be adequate to inform the person involved in the appeal of the evidence on which the agency relies and the legal basis for the agency's action or determination.

Subd. 4. **Enforcing access to files.** A person involved in a fair hearing appeal may enforce the right of access to data and copies of the case file by making a request to the appeals referee. The appeals referee will make an appropriate order enforcing the person's rights under the Minnesota Government Data Practices Act, including but not limited to, ordering access to files, data, and documents; continuing a hearing to allow adequate time for access to data; or prohibiting use by the agency of files, data, or documents which have been generated, collected, stored, or disseminated without compliance with the Minnesota Government Data Practices Act and which have not been provided to the person involved in the appeal.

Subd. 5. **Prehearing conferences.** (a) The appeals referee prior to a fair hearing appeal may hold a prehearing conference to further the interests of justice or efficiency and must include the person involved in the appeal. A person involved in a fair hearing appeal or the agency may request a prehearing conference. The prehearing conference may be conducted by telephone, in person, or in writing. The prehearing conference may address the following:

(1) disputes regarding access to files, evidence, subpoenas, or testimony;

(2) the time required for the hearing or any need for expedited procedures or decision;

(3) identification or clarification of legal or other issues that may arise at the hearing;

(4) identification of and possible agreement to factual issues; and

(5) scheduling and any other matter which will aid in the proper and fair functioning of the hearing.

(b) The appeals referee shall make a record or otherwise contemporaneously summarize the prehearing conference in writing, which shall be sent to both the person involved in the hearing, the person's attorney or authorized representative, and the agency.

Subd. 6. **Appeal request for emergency assistance or urgent matter.** (a) When an appeal involves an application for emergency assistance, the agency involved shall mail or otherwise deliver the state agency appeal summary to the department's Appeals Office within two working days of receiving the request for an appeal. A person may also request that a fair hearing be held on an emergency basis when the issue requires an immediate resolution. The appeals referee shall

schedule the fair hearing on the earliest available date according to the urgency of the issue involved. Issuance of the recommended decision after an emergency hearing shall be expedited.

(b) The commissioner shall issue a written decision within five working days of receiving the recommended decision, shall immediately inform the parties of the outcome by telephone, and shall mail the decision no later than two working days following the date of the decision.

Subd. 7. **Continuance, rescheduling, or adjourning a hearing.** (a) A person involved in a fair hearing, or the agency, may request a continuance, a rescheduling, or an adjournment of a hearing for a reasonable period of time. The grounds for granting a request for a continuance, a rescheduling, or adjournment of a hearing include, but are not limited to, the following:

(1) to reasonably accommodate the appearance of a witness;

(2) to ensure that the person has adequate opportunity for preparation and for presentation of evidence and argument;

(3) to ensure that the person or the agency has adequate opportunity to review, evaluate, and respond to new evidence, or where appropriate, to require that the person or agency review, evaluate, and respond to new evidence;

(4) to permit the person involved and the agency to negotiate toward resolution of some or all of the issues where both agree that additional time is needed;

(5) to permit the agency to reconsider a previous action or determination;

(6) to permit or to require the performance of actions not previously taken; and

(7) to provide additional time or to permit or require additional activity by the person or agency as the interests of fairness may require.

(b) Requests for continuances or for rescheduling may be made orally or in writing. The person or agency requesting the continuance or rescheduling must first make reasonable efforts to contact the other participants in the hearing or their representatives and seek to obtain an agreement on the request. Requests for continuance or rescheduling should be made no later than three working days before the scheduled date of the hearing, unless there is a good cause as specified in subdivision 13. Granting a continuance or rescheduling may be conditioned upon a waiver by the requester of applicable time limits but should not cause unreasonable delay.

Subd. 8. **Subpoenas.** A person involved in a fair hearing or the agency may request a subpoena for a witness, for evidence, or for both. A reasonable number of subpoenas shall be issued to require the attendance and the testimony of witnesses, and the production of evidence relating to any issue of fact in the appeal hearing. The request for a subpoena must show a need for the subpoena and the general relevance to the issues involved. The subpoena shall be issued in the name of the department and shall be served and enforced as provided in section 357.22 and the Minnesota Rules of Civil Procedure.

An individual or entity served with a subpoena may petition the appeals referee in writing to vacate or modify a subpoena. The appeals referee shall resolve such a petition in a prehearing conference involving all parties and shall make a written decision. A subpoena may be vacated or modified if the appeals referee determines that the testimony or evidence sought does not relate with reasonable directness to the issues of the fair hearing appeal; that the subpoena is unreasonable, over broad, or oppressive; that the evidence sought is repetitious or cumulative; or that the subpoena has not been served reasonably in advance of the time when the appeal hearing will be held.

Subd. 9. **No ex parte contact.** The appeals referee shall not have ex parte contact on substantive issues with the agency or with any person or witness in a fair hearing appeal. No employee of the department or agency shall review, interfere with, change, or attempt to influence the recommended decision of the appeals referee in any fair hearing appeal, except through the procedure allowed in subdivision 18. The limitations in this subdivision do not affect the commissioner's authority to review or reconsider decisions or make final decisions.

Subd. 10. **Telephone or face-to-face hearing.** A fair hearing appeal may be conducted by telephone, by other electronic media, or by an in-person, face-to-face hearing. At the request of the person involved in a fair hearing appeal or their representative, a face-to-face hearing shall be conducted with all participants personally present before the appeals referee.

Subd. 11. **Hearing facilities and equipment.** The appeals referee shall conduct the hearing in the county where the person involved resides, unless an alternate location is mutually agreed upon before the hearing, or unless the person has agreed to a hearing by telephone. Hearings under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9), must be conducted in the county where the determination was made, unless an alternate location is mutually agreed upon before the hearing. The hearing room shall be of sufficient size and layout to adequately accommodate both the number of individuals participating in the hearing and any identified special needs of any individual participating in the hearing. The appeals referee shall ensure that all communication and recording equipment that is necessary to conduct the hearing and to create an adequate record is present and functioning properly. If any necessary communication or recording equipment fails or ceases to operate effectively, the appeals referee shall take any steps necessary, including stopping or adjourning the hearing, until the necessary equipment is present and functioning properly. All reasonable efforts shall be undertaken to prevent and avoid any delay in the hearing process caused by defective communication or recording equipment.

Subd. 12. **Interpreter and translation services.** The appeals referee has a duty to inquire and to determine whether any participant in the hearing needs the services of an interpreter or translator in order to participate in or to understand the hearing process. Necessary interpreter or translation services must be provided at no charge to the person involved in the hearing. If it appears that interpreter or translation services are needed but are not available for the scheduled hearing, the appeals referee shall continue or postpone the hearing until appropriate services can be provided.

Subd. 13. **Failure to appear; good cause.** If a person involved in a fair hearing appeal fails to appear at the hearing, the appeals referee may dismiss the appeal. The person may reopen the appeal if within ten working days the person submits information to the appeals referee to show good cause for not appearing. Good cause can be shown when there is:

(1) a death or serious illness in the person's family;

(2) a personal injury or illness which reasonably prevents the person from attending the hearing;

(3) an emergency, crisis, or unforeseen event which reasonably prevents the person from attending the hearing;

(4) an obligation or responsibility of the person which a reasonable person, in the conduct of one's affairs, could reasonably determine takes precedence over attending the hearing;

(5) lack of or failure to receive timely notice of the hearing in the preferred language of the person involved in the hearing; and

(6) excusable neglect, excusable inadvertence, excusable mistake, or other good cause as determined by the appeals referee.

Subd. 14. **Commencement of hearing.** The appeals referee shall begin each hearing by describing the process to be followed in the hearing, including the swearing in of witnesses, how testimony and evidence are presented, the order of examining and cross-examining witnesses, and the opportunity for an opening statement and a closing statement. The appeals referee shall identify for the participants the issues to be addressed at the hearing and shall explain to the participants the burden of proof which applies to the person involved and the agency. The appeals referee shall confirm, prior to proceeding with the hearing, that the state agency appeal summary, if required under subdivision 3, has been properly completed and provided to the person involved in the hearing, and that the person has been provided documents and an opportunity to review the case file, as provided in this section.

Subd. 15. **Conduct of the hearing.** The appeals referee shall act in a fair and impartial manner at all times. At the beginning of the hearing the agency must designate one person as their representative who shall be responsible for presenting the agency's evidence and questioning any witnesses. The appeals referee shall make sure that the person and the agency are provided sufficient time to present testimony and evidence, to confront and cross-examine all adverse witnesses, and to make any relevant statement at the hearing. The appeals referee shall make reasonable efforts to explain the hearing process to persons who are not represented and shall ensure that the hearing is conducted fairly and efficiently. Upon the reasonable request of the person or the agency involved, the appeals referee may direct witnesses to remain outside the hearing room, except during their individual testimony. The appeals referee shall not terminate the hearing before affording the person and the agency a complete opportunity to submit all admissible evidence and reasonable opportunity for oral or written statement. When a hearing extends beyond the time which was anticipated, the hearing shall be rescheduled or continued from day-to-day until completion. Hearings that have been continued shall be timely scheduled to minimize delay in the disposition of the appeal.

Subd. 16. **Scope of issues addressed at the hearing.** The hearing shall address the correctness and legality of the agency's action and shall not be limited simply to a review of the propriety of the agency's action. The person involved may raise and present evidence on all legal claims or defenses arising under state or federal law as a basis for appealing or disputing an agency action but not constitutional claims beyond the jurisdiction of the fair hearing. The appeals referee may take official notice of adjudicative facts.

Subd. 17. **Burden of persuasion.** The burden of persuasion is governed by specific state or federal law and regulations that apply to the subject of the hearing. If there is no specific law, then the participant in the hearing who asserts the truth of a claim is under the burden to persuade the appeals referee that the claim is true.

Subd. 18. **Inviting comment by department.** The appeals referee or the commissioner may determine that a written comment by the department about the policy implications of a specific legal issue could help resolve a pending appeal. Such a written policy comment from the department shall be obtained only by a written request that is also sent to the person involved and to the agency or its representative. When such a written comment is received, both the person involved in the hearing and the agency shall have adequate opportunity to review, evaluate, and respond to the written comment, including submission of additional testimony or evidence, and cross-examination concerning the written comment.

Subd. 19. **Developing the record.** The appeals referee shall accept all evidence, except evidence privileged by law, that is commonly accepted by reasonable people in the conduct of their affairs as having probative value on the issues to be addressed at the hearing. Except in fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9), in cases involving medical issues such as a diagnosis, a physician's report, or a review team's decision, the appeals referee shall consider whether it is necessary to have a medical assessment other than that of the individual making the original decision. When necessary, the appeals referee shall require an additional assessment be obtained at agency expense and made part of the hearing record. The appeals referee shall ensure for all cases that the record is sufficiently complete to make a fair and accurate decision.

Subd. 20. **Unrepresented persons.** In cases involving unrepresented persons, the appeals referee shall take appropriate steps to identify and develop in the hearing relevant facts necessary for making an informed and fair decision. These steps may include, but are not limited to, asking questions of witnesses and referring the person to a legal services office. An unrepresented person shall be provided an adequate opportunity to respond to testimony or other evidence presented by the agency at the hearing. The appeals referee shall ensure that an unrepresented person has a full and reasonable opportunity at the hearing to establish a record for appeal.

Subd. 21. **Closing of the record.** The agency must present its evidence prior to or at the hearing. The agency shall not be permitted to submit evidence after the hearing except by agreement at the hearing between the person involved, the agency, and the appeals referee. If evidence is submitted after the hearing, based on such an agreement, the person involved and the agency must be allowed sufficient opportunity to respond to the evidence. When necessary, the record shall remain open to permit a person to submit additional evidence on the issues presented at the hearing.

Subd. 22. **Decisions.** A timely, written decision must be issued in every appeal. Each decision must contain a clear ruling on the issues presented in the appeal hearing and should contain a ruling only on questions directly presented by the appeal and the arguments raised in the appeal.

(a) A written decision must be issued within 90 days of the date the person involved requested the appeal unless a shorter time is required by law. An additional 30 days is provided in those cases where the commissioner refuses to accept the recommended decision.

(b) The decision must contain both findings of fact and conclusions of law, clearly separated and identified. The findings of fact must be based on the entire record. Each finding of fact made by the appeals referee shall be supported by a preponderance of the evidence unless a different standard is required under the regulations of a particular program. The "preponderance of the evidence" means, in light of the record as a whole, the evidence leads the appeals referee to believe that the finding of fact is more likely to be true than not true. The legal claims or arguments of a participant do not constitute either a finding of fact or a conclusion of law, except to the extent the appeals referee adopts an argument as a finding of fact or conclusion of law.

The decision shall contain at least the following:

(1) a listing of the date and place of the hearing and the participants at the hearing;

(2) a clear and precise statement of the issues, including the dispute under consideration and the specific points which must be resolved in order to decide the case;

(3) a listing of the material, including exhibits, records, reports, placed into evidence at the hearing, and upon which the hearing decision is based;

(4) the findings of fact based upon the entire hearing record. The findings of fact must be adequate to inform the participants and any interested person in the public of the basis of the decision. If the evidence is in conflict on an issue which must be resolved, the findings of fact must state the reasoning used in resolving the conflict;

(5) conclusions of law that address the legal authority for the hearing and the ruling, and which give appropriate attention to the claims of the participants to the hearing;

(6) a clear and precise statement of the decision made resolving the dispute under consideration in the hearing; and

(7) written notice of the right to appeal to district court or to request reconsideration, and of the actions required and the time limits for taking appropriate action to appeal to district court or to request a reconsideration.

(c) The appeals referee shall not independently investigate facts or otherwise rely on information not presented at the hearing. The appeals referee may not contact other agency personnel, except as provided in subdivision 18. The appeals referee's recommended decision must be based exclusively on the testimony and evidence presented at the hearing, and legal arguments presented, and the appeals referee's research and knowledge of the law.

(d) The commissioner will review the recommended decision and accept or refuse to accept the decision according to section 256.045, subdivision 5.

Subd. 23. **Refusal to accept recommended orders.** (a) If the commissioner refuses to accept the recommended order from the appeals referee, the person involved, the person's attorney or authorized representative, and the agency shall be sent a copy of the recommended order, a detailed explanation of the basis for refusing to accept the recommended order, and the proposed modified order.

(b) The person involved and the agency shall have at least ten business days to respond to the proposed modification of the recommended order. The person involved and the agency may submit a legal argument concerning the proposed modification, and may propose to submit additional evidence that relates to the proposed modified order.

Subd. 24. **Reconsideration.** Reconsideration may be requested within 30 days of the date of the commissioner's final order. If reconsideration is requested, the other participants in the appeal shall be informed of the request. The person seeking reconsideration has the burden to demonstrate why the matter should be reconsidered. The request for reconsideration may include legal argument and may include proposed additional evidence supporting the request. The other participants shall be sent a copy of all material submitted in support of the request for reconsideration and must be given ten days to respond.

(a) When the requesting party raises a question as to the appropriateness of the findings of fact, the commissioner shall review the entire record.

(b) When the requesting party questions the appropriateness of a conclusion of law, the commissioner shall consider the recommended decision, the decision under reconsideration, and the material submitted in connection with the reconsideration. The commissioner shall review the remaining record as necessary to issue a reconsidered decision.

(c) The commissioner shall issue a written decision on reconsideration in a timely fashion. The decision must clearly inform the parties that this constitutes the final administrative decision, advise the participants of the right to seek judicial review, and the deadline for doing so.

Subd. 25. **Access to appeal decisions.** Appeal decisions must be maintained in a manner so that the public has ready access to previous decisions on particular topics, subject to appropriate procedures for safeguarding names, personal identifying information, and other private data on the individual persons involved in the appeal.

History: *1Sp2003 c 14 art 6 s 49*

256.046 ADMINISTRATIVE FRAUD DISQUALIFICATION HEARINGS.

Subdivision 1. **Hearing authority.** A local agency must initiate an administrative fraud disqualification hearing for individuals, including child care providers caring for children receiving child care assistance, accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, food stamp programs, general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare except for children through age 18. The Department of Human Services, in lieu of a local agency, may initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration or investigation of the program for which benefits were wrongfully obtained. The hearing is subject to the requirements of section 256.045 and the requirements in Code of Federal Regulations, title 7, section 273.16.

Subd. 2. **Combined hearing.** The referee may combine a fair hearing and administrative fraud disqualification hearing into a single hearing if the factual issues arise out of the same, or related, circumstances and the individual receives prior notice that the hearings will be combined. If the administrative fraud disqualification hearing and fair hearing are combined, the time frames for administrative fraud disqualification hearings specified in Code of Federal Regulations, title 7, section 273.16, apply. If the individual accused of wrongfully obtaining assistance is charged under section 256.98 for the same act or acts which are the subject of the hearing, the individual may request that the hearing be delayed until the criminal charge is decided by the court or withdrawn.

History: *1992 c 513 art 8 s 10; 1997 c 85 art 4 s 12; art 5 s 6; 1Sp1997 c 5 s 13; 1999 c 159 s 40; 1999 c 205 art 1 s 52; 1Sp2003 c 14 art 9 s 31; art 12 s 3; 2004 c 288 art 4 s 25; 1Sp2005 c 4 art 8 s 10; 2008 c 286 art 1 s 2; 2010 c 301 art 1 s 1*

256.047 [Repealed, 1998 c 407 art 6 s 118]

256.0471 OVERPAYMENTS BECOME JUDGMENTS BY OPERATION OF LAW.

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361, and the AFDC program formerly codified under sections 256.72 to 256.871; chapters 256B for state-funded medical assistance, 256D, 256I, 256J, 256K, and 256L for state-funded MinnesotaCare; and the food stamp or food support program, except agency error claims, become

a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

Subd. 2. **Overpayments included.** This section is limited to overpayments for which notification is issued within the time period specified under section 541.05.

Subd. 3. **Notification requirements.** A judgment is only obtained after:

(1) a notice of overpayment has been personally served on the recipient or former recipient in a manner sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or mailed to the recipient or former recipient certified mail return receipt requested; and

(2) the time period under section 256.045, subdivision 3, has elapsed without a request for a hearing, or a hearing decision has been rendered under section 256.045 or 256.046 which concludes the existence of an overpayment that meets the requirements of this section.

Subd. 4. **Notice of overpayment.** The notice of overpayment shall include the amount and cause of the overpayment, appeal rights, and an explanation of the consequences of the judgment that will be established if an appeal is not filed timely or if the administrative hearing decision establishes that there is an overpayment which qualifies for judgment.

Subd. 5. **Judgments entered and docketed.** A judgment shall be entered and docketed under section 548.09 only after at least three months have elapsed since:

(1) the notice of overpayment was served on the recipient pursuant to subdivision 3; and

(2) the last time a monthly recoupment was applied to the overpayment.

Subd. 6. **Docketing of overpayments.** On or after the date an unpaid overpayment becomes a judgment by operation of law under subdivision 1, the agency or public authority may file with the court administrator:

(1) a statement identifying, or a copy of, the overpayment notice which provides for an appeal process and requires payment of the overpayment;

(2) proof of service of the notice of overpayment;

(3) an affidavit of default, stating the full name, occupation, place of residence, and last known post office address of the debtor; the name and post office address of the agency or public authority; the date or dates the overpayment was incurred; the program that was overpaid; and the total amount of the judgment; and

(4) an affidavit of service of a notice of entry of judgment shall be made by first class mail at the address where the debtor was served with the notice of overpayment. Service is completed upon mailing in the manner designated.

Subd. 6a. **Administrative renewal of overpayment judgments.** Overpayment judgments may be renewed by service of notice upon the debtor. Service must be by first class mail at the last known address of the debtor, with service deemed complete upon mailing in that manner designated, or in the manner provided for the service of civil process. Upon filing of the notice and proof of service, the court administrator shall administratively renew the judgment for the overpayment without any additional filing fee in the same court file as the original overpayment judgment. The judgment must be renewed in an amount equal to the unpaid principal plus the accrued unpaid interest. Overpayment judgments may be renewed multiple times until satisfied.

Subd. 7. **Does not impede other methods.** Nothing in this section shall be construed to impede or restrict alternative recovery methods for these overpayments or overpayments which do not meet the requirements of this section.

History: *1997 c 85 art 5 s 7; 1999 c 159 s 41; 1Sp2003 c 14 art 1 s 106; art 9 s 32; 2009 c 175 art 2 s 2,3*

256.0475 [Repealed, 1998 c 407 art 6 s 118]

256.048 [Repealed, 1998 c 407 art 6 s 118]

256.049 [Repealed, 1998 c 407 art 6 s 118]

256.05 [Repealed, 1Sp2003 c 14 art 6 s 68]

256.06 [Repealed, 1Sp2003 c 14 art 6 s 68]

256.07 [Repealed, 1975 c 208 s 35]

256.08 [Repealed, 1Sp2003 c 14 art 6 s 68]

256.09 [Repealed, 1Sp2003 c 14 art 6 s 68]

256.10 [Repealed, 1Sp2003 c 14 art 6 s 68]

256.11 [Repealed, 1973 c 717 s 33]

256.12 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1973 c 717 s 33]

Subd. 3. [Repealed, 1973 c 717 s 33]

Subd. 4. [Repealed, 1973 c 717 s 33]

Subd. 5. [Repealed, 1973 c 717 s 33]

Subd. 6. [Repealed, 1973 c 717 s 33]

Subd. 7. [Repealed, 1973 c 717 s 33]

Subd. 8. [Repealed, 1973 c 717 s 33]

Subd. 9. [Repealed, 1997 c 85 art 1 s 74]

Subd. 10. [Repealed, 1997 c 85 art 1 s 74]

Subd. 11. [Repealed, 1973 c 717 s 33]

Subd. 12. [Repealed, 1973 c 717 s 33]

Subd. 13. [Repealed, 1973 c 717 s 33]

Subd. 14. [Repealed, 1997 c 85 art 1 s 74]

Subd. 15. [Repealed, 1997 c 85 art 1 s 74]

Subd. 16. [Repealed, 1973 c 717 s 33]

Subd. 17. [Repealed, 1973 c 717 s 33]

Subd. 18. [Repealed, 1969 c 329 s 1]

Subd. 19. [Repealed, 1997 c 85 art 1 s 74]

Subd. 20. [Repealed, 1997 c 85 art 1 s 74]

Subd. 21. [Repealed, 1997 c 85 art 1 s 74]

Subd. 22. [Repealed, 1997 c 85 art 1 s 74]

Subd. 23. [Repealed, 1997 c 85 art 1 s 74]

256.13 [Repealed, 1973 c 717 s 33]

256.14 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1959 c 622 s 7]

Subd. 3. [Repealed, 1959 c 622 s 7]

Subd. 4. [Repealed, 1959 c 622 s 7]

Subd. 5. [Repealed, 1959 c 622 s 7]

256.15 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1973 c 717 s 33]

Subd. 3. [Repealed, 1951 c 92 s 1]

Subd. 4. [Repealed, 1973 c 717 s 33]

256.151 [Repealed, 1951 c 92 s 2]

256.16 [Repealed, 1973 c 717 s 33]

256.17 [Repealed, 1973 c 717 s 33]

256.18 [Repealed, 1973 c 717 s 33]

256.183 [Expired]

256.184 [Expired]

256.185 [Expired]

256.19 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1973 c 717 s 33]

Subd. 3. [Repealed, 1973 c 717 s 33]

Subd. 4. [Repealed, 1971 c 681 s 5]

256.20 [Repealed, 1973 c 717 s 33]

256.21 [Repealed, 1973 c 717 s 33]

256.22 [Repealed, 1973 c 717 s 33]

256.23 [Repealed, 1973 c 717 s 33]

256.24 [Repealed, Ex1971 c 16 s 6]

256.25 OLD AGE ASSISTANCE TO BE ALLOWED AS CLAIM IN DISTRICT COURT.

On the death of any person who received any old age assistance under this or any previous old age assistance law of this state, or on the death of the survivor of a married couple, either or both of whom received old age assistance, the total amount paid as old age assistance to either or both, without interest, shall be allowed as a claim against the estate of such person or persons by the court having jurisdiction to probate the estate. If the value of the estate of any such person has been enhanced as a result of the failure on the part of a recipient to make a full disclosure of the amount or value of the recipient's property, or the amount or value of the combined property of a married couple, in any old age assistance proceeding, the claim shall be allowed by the court as a preferred claim and have preference to the extent of such enhancement over all other claims, excepting only claims for expenses of administration, funeral expenses, and expenses of last sickness. If the value of any such estate, exclusive of household goods, wearing apparel, and a burial lot, is more than the value of the property of such person, as disclosed by the applicant in any old age assistance proceeding, it shall be prima facie evidence that the value of such estate was enhanced by the payment of old age assistance to the extent of the excess, but not exceeding the total amount of old age assistance paid to such person or persons. The statute of limitations which limits the county agency or the state agency, or both, to recover only for assistance granted within six years shall not apply to any claim made under Minnesota Statutes 1971, sections 256.11 to 256.43 for reimbursement for any assistance granted hereunder.

History: *(3199-25) Ex1935 c 95 s 15; 1939 c 242 s 1; 1Sp1981 c 4 art 1 s 123; 1986 c 444; 1995 c 189 s 8; 1996 c 277 s 1*

256.26 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1973 c 717 s 33]

Subd. 3. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 4. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 5. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 6. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 7. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 8. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 9. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 10. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

Subd. 11. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

256.263 LAND ACQUIRED BY STATE UNDER OLD AGE ASSISTANCE LIENS.

Subdivision 1. **Duty of county board.** When land shall have been acquired by the state under the provisions of Minnesota Statutes 1971, section 256.26, either by conveyance in settlement of the lien held by the state, or by foreclosure of such lien, it shall be the duty of the county board to manage and lease the real estate while the state continues to own it.

Subd. 2. **Management.** While the state owns such real estate, if the county board by resolution stating the price to be paid in cash shall recommend the sale and conveyance thereof, and transmit a copy of such resolution to the state agency, the state agency shall make an order approving the sale for the price recommended and transmit a copy thereof to the county auditor, in

the county where the land is situated. Thereupon, when the purchase price is paid by the purchaser to the treasurer of such county, the chair of the county board shall execute a deed in the name of the state, which shall be attested by the county auditor, conveying such land to the purchaser.

History: *1945 c 172 s 1,2; 1Sp1981 c 4 art 1 s 124; 1986 c 444*

256.27 [Repealed, 1973 c 717 s 33]

256.28 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1967 c 89 s 2; 1967 c 885 s 6]

256.29 [Repealed, 1973 c 717 s 33]

256.30 [Repealed, 1973 c 717 s 33]

256.31 [Repealed, 1971 c 550 s 2]

256.32 [Repealed, 1973 c 717 s 33]

256.33 [Repealed, 1973 c 717 s 33]

256.34 [Repealed, 1973 c 717 s 33]

256.35 [Repealed, 1973 c 717 s 33]

256.36 [Repealed, 1973 c 717 s 33]

256.362 REPORTS AND IMPLEMENTATION.

Subdivision 1. **Wellness component.** The commissioners of human services and health shall recommend to the legislature, by January 1, 1993, methods to incorporate discounts for wellness factors of up to 25 percent into the MinnesotaCare program premium sliding scale. Beginning October 1, 1992, the commissioner of human services shall inform MinnesotaCare program enrollees of the future availability of the wellness discount, and shall encourage enrollees to incorporate wellness factors into their lifestyles.

Subd. 2. **Federal health insurance credit.** By October 1, 1992, the commissioners of human services and revenue shall apply for any federal waivers or approvals necessary to allow enrollees in state health care programs to assign the federal health insurance credit component of the earned income tax credit to the state.

Subd. 3. **Coordination of medical assistance and the MinnesotaCare program.** (a) The commissioner shall develop and implement a plan to combine medical assistance and MinnesotaCare program application and eligibility procedures. The plan may include the following changes:

(1) use of a single mail-in application;

(2) elimination of the requirement for personal interviews;

(3) postponing notification of paternity disclosure requirements;

(4) modifying verification requirements for pregnant women and children;

(5) using shorter forms for recertifying eligibility;

(6) expedited and more efficient eligibility determinations for applicants;

(7) expanded outreach efforts, including combined marketing of the two plans; and

(8) other changes that improve access to services provided by the two programs.

(b) The plan may include seeking the following changes in federal law:

(1) extension and expansion of exemptions for different eligibility groups from Medicaid quality control sanctions;

(2) changing requirements for the redetermination of eligibility;

(3) eliminating asset tests for all children; and

(4) other changes that improve access to services provided by the two programs.

(c) The commissioner shall seek any necessary federal approvals, and any necessary changes in federal law. The commissioner shall implement each element of the plan as federal approval is received, and shall report to the legislature by January 1, 1993, on progress in implementing this plan.

Subd. 4. **Plan for managed care.** By January 1, 1993, the commissioner of human services shall present a plan to the legislature for providing all medical assistance and MinnesotaCare program services through managed care arrangements. The commissioner shall apply to the secretary of health and human services for any necessary federal waivers or approvals, and shall begin to implement the plan for managed care upon receipt of the federal waivers or approvals.

Subd. 5. [Repealed, 1994 c 625 art 8 s 74]

History: *1992 c 549 art 4 s 1; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

256.37 [Repealed, Ex1971 c 16 s 6]

256.38 [Repealed, 1973 c 717 s 33]

256.39 [Repealed, 1973 c 717 s 33]

256.40 [Repealed, 1973 c 717 s 33]

256.41 [Repealed, 1973 c 717 s 33]

256.42 [Repealed, 1973 c 717 s 33]

256.43 [Repealed, 1973 c 717 s 33]

256.431-256.434 [Expired]

256.44 [Repealed, 1947 c 535 s 16]

256.45 [Repealed, 1947 c 535 s 16]

256.451 [Repealed, 1973 c 717 s 33]

256.452 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1973 c 717 s 33]

Subd. 3. [Repealed, 1973 c 717 s 33]

Subd. 4. [Repealed, 1973 c 717 s 33]

Subd. 5. [Repealed, 1973 c 717 s 33]

Subd. 6. [Repealed, 1973 c 717 s 33]

Subd. 7. [Repealed, 1973 c 717 s 33]

Subd. 8. [Repealed, 1967 c 885 s 6]

Subd. 9. [Repealed, 1967 c 885 s 6]

Subd. 10. [Repealed, 1967 c 885 s 6]

Subd. 11. [Repealed, 1973 c 717 s 33]

Subd. 12. [Repealed, 1973 c 717 s 33]

256.453 [Repealed, 1973 c 717 s 33]

256.454 [Repealed, 1973 c 717 s 33]

256.455 [Repealed, 1973 c 717 s 33]

256.456 [Repealed, 1973 c 717 s 33]

256.457 [Repealed, 1973 c 717 s 33]

256.458 [Repealed, 1973 c 717 s 33]

256.459 [Repealed, 1973 c 717 s 33]

256.46 [Repealed, 1947 c 535 s 16]

256.461 [Repealed, 1973 c 717 s 33]

256.462 APPLICABILITY OF OTHER LAW; RECOVERY OF ASSISTANCE FURNISHED.

Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. **Applicability.** The provisions of Minnesota Statutes 1971, section 256.25, as to the allowance as claims in the probate court of amounts paid as old age assistance are made applicable to amounts paid as assistance under the provisions of Minnesota Statutes 1971, sections 256.451 to 256.475.

Subd. 3. **Recovery of assistance furnished; apportionment.** When any amount shall be recovered from any source for assistance furnished under the provisions of any public assistance program, there shall be paid to the United States the amount which shall be due under the terms of the Social Security Act, and the balance thereof shall be paid into the treasuries of the state and county, substantially in the proportion in which they respectively contributed toward the total assistance paid. The amount due the respective participating units of government shall be determined by rule adopted by the commissioner of human services pursuant to a formula of reimbursement prescribed or authorized by the federal Social Security Administration.

Subd. 4. [Repealed, 1973 c 717 s 33]

Subd. 5. [Repealed, 1973 c 717 s 33]

Subd. 6. [Repealed, 1973 c 717 s 33]

Subd. 7. [Repealed, 1973 c 717 s 33]

History: *1953 c 617 s 11; 1959 c 25 s 1; 1973 c 717 s 14; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1987 c 384 art 2 s 62*

256.463 [Repealed, 1973 c 717 s 33]

256.464 [Repealed, 1973 c 717 s 33]

256.465 Subdivision 1. [Repealed, 1971 c 550 s 2]

Subd. 2. [Repealed, 1973 c 717 s 33]

256.466 [Repealed, 1973 c 717 s 33]

256.467 [Repealed, 1973 c 717 s 33]

256.468 [Repealed, 1973 c 717 s 33]

256.469 [Repealed, 1973 c 717 s 33]

256.47 [Repealed, 1947 c 535 s 16]

256.471 [Repealed, 1973 c 717 s 33]

256.472 [Repealed, 1973 c 717 s 33]

256.473 [Repealed, 1973 c 717 s 33]

256.474 [Repealed, 1973 c 717 s 33]

256.475 [Repealed, 1973 c 717 s 33]

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 program shall:

(1) make support grants available to individuals or families as an effective alternative to the 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, the person's legal representative, or other authorized 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, the person's legal representative, or other authorized representative. 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 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 personal care attendant and home health aide services, or private duty nursing under section 256B.0625; a 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) Individuals receiving home and community-based waivers under United States Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except for individuals receiving consumer support grants before July 1, 2003, as long as other eligibility criteria are met.

(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, a person's legal representative, or other authorized representative 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, a person's legal representative, or other authorized representative to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service agreement, 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, a person's legal representative, or other authorized representative. 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, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any. The application shall be made to the local agency and shall specify the needs of the person or the person's legal representative or other authorized representative, 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 the person's legal representative or other authorized representative, the local agency shall make grants to the person or the person's legal representative or other authorized representative. 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 legal representative or other authorized representative.

(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 268.035.

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from the family support program and personal care assistance services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the 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 monthly grant levels 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 monthly grant levels 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 person or the person's legal representative or other authorized representative 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.

Subd. 6. **Right to appeal.** Notice, appeal, and hearing procedures shall be conducted in accordance with section 256.045. The denial, suspension, or termination of services under this program may be appealed by a recipient or applicant under section 256.045, subdivision 3. It is an absolute defense to an appeal under this section, if the county board proves that it followed the established written procedures and criteria and determined that the grant could not be provided within the county board's allocation of money for consumer support grants.

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.

Subd. 9. **County board responsibilities.** County boards receiving funds under this section shall:

(1) determine the needs of persons and families for services and supports;

(2) determine the eligibility for persons proposed for program participation;

(3) approve items and services to be reimbursed and inform families of their determination;

(4) issue support grants directly to or on behalf of persons;

(5) submit quarterly financial reports and an annual program report to the commissioner;

(6) coordinate services and supports with other programs offered or made available to persons or their families; and

(7) provide assistance to persons or their families in securing or maintaining supports, as needed.

Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section shall:

(1) spend the grant money in a manner consistent with their agreement with the local agency;

(2) notify the local agency of any necessary changes in the grant or the items on which it is spent;

(3) notify the local agency of any decision made by the person, a person's legal representative, or other authorized representative that would change their eligibility for consumer support grants;

(4) arrange and pay for supports; and

(5) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

Subd. 11. **Consumer support grant program after July 1, 2001.** 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 sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly grant levels are calculated by:

(i) determining the service authorization for each individual based on the individual's home care assessment;

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

(iii) applying the overall ratio to 50 percent of the service authorization level of each home care rating; and

(iv) adjusting the result for any authorized rate changes provided by the legislature.

(2) The commissioner shall ensure the methodology is consistent with the home care programs.

History: *1995 c 207 art 3 s 15; 1997 c 203 art 4 s 12-15; 1999 c 10 s 1-3; 1999 c 249 s 2; 1Sp2001 c 9 art 3 s 9-15; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 11-15; 2007 c 147 art 6 s 3-8; 2008 c 277 art 1 s 33; 2008 c 286 art 1 s 3,4; 2009 c 79 art 8 s 14,15; 2012 c 216 art 9 s 9*

256.48 [Repealed, 1947 c 535 s 16]

COUNCIL ON DISABILITY

256.481 DISABLED PERSON; DEFINITION.

For the purposes of sections 256.481 to 256.482 "disabled person" means any person who:

(a) has a physical, mental, or emotional impairment which substantially limits one or more major life activities;

(b) has a record of such an impairment; or

(c) is regarded as having such an impairment.

History: *1973 c 757 s 1; 1983 c 260 s 55; 1983 c 277 s 1; 2005 c 56 s 1*

256.482 COUNCIL ON DISABILITY.

Subdivision 1. **Establishment; members.** There is hereby established the Council on Disability which shall consist of 21 members appointed by the governor. Members shall be appointed from the general public and from organizations which provide services for persons who have a disability. A majority of council members shall be persons with a disability or parents or guardians of persons with a disability. There shall be at least one member of the council appointed from each of the state development regions. The commissioners of the Departments of Education, Human Services, Health, and Human Rights and the directors of the Rehabilitation Services and State Services for the Blind in the Department of Employment and Economic Development or their designees shall serve as ex officio members of the council without vote. In addition, the council may appoint ex officio members from other bureaus, divisions, or sections of state departments which are directly concerned with the provision of services to persons with a disability.

Notwithstanding the provisions of section 15.059, each member of the council appointed by the governor shall serve a three-year term and until a successor is appointed and qualified. The compensation and removal of all members shall be as provided in section 15.059. The council performs functions that are not purely advisory, therefore the expiration dates provided in section 15.059 do not apply. The governor shall appoint a chair of the council from among the members appointed from the general public or who are persons with a disability or their parents or guardians. Vacancies shall be filled by the authority for the remainder of the unexpired term.

Subd. 2. **Executive director; staff.** The council may select an executive director of the council by a vote of a majority of all council members. The executive director shall be in the unclassified service of the state and shall provide administrative support for the council and provide administrative leadership to implement council mandates, policies, and objectives. The executive director shall employ and direct staff authorized according to state law and necessary to carry out council mandates, policies, activities, and objectives. The salary of the executive director and staff shall be established pursuant to chapter 43A. The executive director and staff shall be reimbursed for the actual and necessary expenses incurred as a result of their council responsibilities.

Subd. 3. **Receipt of funds.** Whenever any person, firm, corporation, or the federal government offers to the council funds by the way of gift, grant, or loan, for purposes of assisting the council to carry out its powers and duties, the council may accept the offer by majority vote and upon acceptance the chair shall receive the funds subject to the terms of the offer. However, no money shall be accepted or received as a loan nor shall any indebtedness be incurred except in the manner and under the limitations otherwise provided by law.

Subd. 4. **Organization; committees.** The council shall organize itself in conformity with its responsibilities under sections 256.481 to 256.482 and shall establish committees which shall give detailed attention to the special needs of each category of persons who have a disability. The members of the committees shall be designated by the chair with the approval of a majority of the council. The council shall serve as liaison in Minnesota for the president's committee on

employment of the disabled and for any other organization for which it is so designated by the governor or state legislature.

Subd. 5. **Duties and powers.** The council shall have the following duties and powers:

(1) to advise and otherwise aid the governor; appropriate state agencies, including but not limited to the Departments of Education, Human Services, Employment and Economic Development, and Human Rights and the Divisions of Rehabilitation Services and Services for the Blind; the state legislature; and the public on matters pertaining to public policy and the administration of programs, services, and facilities for persons who have a disability in Minnesota;

(2) to encourage and assist in the development of coordinated, interdepartmental goals and objectives and the coordination of programs, services and facilities among all state departments and private providers of service as they relate to persons with a disability;

(3) to serve as a source of information to the public regarding all services, programs and legislation pertaining to persons with a disability;

(4) to review and make comment to the governor, state agencies, the legislature, and the public concerning adequacy of state programs, plans and budgets for services to persons with a disability and for funding under the various federal grant programs;

(5) to research, formulate and advocate plans, programs and policies which will serve the needs of persons who are disabled;

(6) to advise the Departments of Labor and Industry and Employment and Economic Development on the administration and improvement of the workers' compensation law as it relates to programs, facilities and personnel providing assistance to workers who are injured and disabled;

(7) to advise the Workers' Compensation Division of the Department of Labor and Industry and the Workers' Compensation Court of Appeals as to the necessity and extent of any alteration or remodeling of an existing residence or the building or purchase of a new or different residence which is proposed by a licensed architect under section 176.137;

(8) to initiate or seek to intervene as a party in any administrative proceeding and judicial review thereof to protect and advance the right of all persons who are disabled to an accessible physical environment as provided in section 326B.139; and

(9) to initiate or seek to intervene as a party in any administrative or judicial proceeding which concerns programs or services provided by public or private agencies or organizations and which directly affects the legal rights of persons with a disability.

Subd. 5a. [Renumbered 16B.055, subd 2]

Subd. 5b. **Meetings.** (a) Notwithstanding section 13D.01, the Minnesota State Council on Disability may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the council participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the council can hear all discussion and all votes of members of the council and participate in testimony;

(3) at least one member of the council is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so each member's vote on each issue can be identified and recorded.

(b) Each member of the council participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

(c) If telephone or another electronic means is used to conduct a meeting, the council, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The council may require the person making such a connection to pay for documented marginal costs that the council incurs as a result of the additional connection.

(d) If telephone or another electronic means is used to conduct a regular, special, or emergency meeting, the council shall provide notice of the regular meeting location, of the fact that some members may participate by electronic means, and of the provisions of paragraph (c). The timing and method of providing notice is governed by section 13D.04.

Subd. 6. [Repealed, 1975 c 315 s 26]

Subd. 7. **Collection of fees.** The council is empowered to establish and collect fees for documents or technical services provided to the public. The fees shall be set at a level to reimburse the council for the actual cost incurred in providing the document or service. All fees collected shall be deposited into the state treasury and credited to the general fund.

Subd. 8. [Repealed by amendment, 2007 c 33 s 2]

History: *1973 c 254 s 3; 1973 c 757 s 2; 1975 c 61 s 1; 1975 c 271 s 6; 1975 c 315 s 18; 1975 c 359 s 23; 1977 c 177 s 2; 1977 c 305 s 45; 1977 c 430 s 14; 1983 c 216 art 2 s 5; 1983 c 260 s 56; 1983 c 277 s 2; 1983 c 299 s 25; 1984 c 654 art 5 s 58; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 354 s 6; 1988 c 629 s 50; 1989 c 335 art 1 s 185,186; art 4 s 67; 1991 c 292 art 3 s 7; 1994 c 483 s 1; 1Sp1995 c 3 art 16 s 13; 1996 c 451 art 6 s 7; 1999 c 250 art 1 s 114; 2001 c 161 s 45; 1Sp2001 c 9 art 13 s 21; 2003 c 130 s 12; 1Sp2003 c 14 art 3 s 16; 2004 c 195 s 1; 2004 c 206 s 35,52; 2005 c 56 s 1; 2007 c 33 s 1,2; 2007 c 140 art 4 s 61; art 13 s 4*

256.4825 REPORT REGARDING PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES.

The Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of each year, beginning in 2012, to the chairs and ranking minority members of the legislative committees with jurisdiction over programs serving people with disabilities as provided in this section. The report must describe the existing state policies and goals for programs serving people with disabilities including, but not limited to, programs for employment, transportation, housing, education, quality assurance, consumer direction, physical and programmatic access, and health. The report must provide data and measurements to assess the extent to which the policies and goals are being met. The commissioner of human services and the commissioners of other state agencies administering programs for people with disabilities shall cooperate with the Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota and provide those organizations with existing published information and reports that will assist in the preparation of the report.

History: *1Sp2010 c 1 art 17 s 7*

256.483 [Repealed, 1983 c 260 s 68; 1983 c 277 s 3]

SOCIAL ADJUSTMENT SERVICES TO REFUGEES

256.484 SOCIAL ADJUSTMENT SERVICES TO REFUGEES.

Subdivision 1. **Special projects.** The commissioner of human services shall establish a grant program to provide social adjustment services to refugees residing in Minnesota who experience depression, emotional stress, and personal crises resulting from past trauma and refugee camp experiences.

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

(a) "Refugee" means a refugee or asylee status granted by the United States Citizenship and Immigration Services.

(b) "Social adjustment services" means treatment or services, including psychiatric assessment, chemical therapy, individual or family counseling, support group participation, after care or follow-up, information and referral, and crisis intervention.

Subd. 3. **Project selection.** The commissioner shall select projects for funding under this section. Projects selected must be administered by service providers who have experience in providing bilingual social adjustment services to refugees. Project administrators must present evidence that the service provider's social adjustment services for targeted refugees has historically resolved major problems identified at the time of intake.

Subd. 4. **Project design.** Project proposals selected under this section must:

(1) use existing resources when possible;

(2) clearly specify program goals and timetables for project operation;

(3) identify available support services, social services, and referral procedures to be used in serving the targeted refugees;

(4) provide bilingual services; and

(5) identify the training and experience that enable project staff to provide services to targeted refugees, and identify the number of staff with bilingual service expertise.

Subd. 5. **Annual report.** Selected service providers must report to the commissioner by June 30 of each year on the number of refugees served, the average cost per refugee served, the number and percentage of refugees who are successfully assisted through social adjustment services, and recommendations for modifications in service delivery for the upcoming year.

History: *1989 c 282 art 5 s 22; 2007 c 13 art 1 s 25*

256.485 [Expired]

256.486 [Renumbered 299A.2994]

256.49 Subdivision 1. [Repealed, 1973 c 717 s 33]

Subd. 2. [Repealed, 1955 c 711 s 3]

256.50 [Repealed, 1973 c 717 s 33]

256.51 [Repealed, 1973 c 717 s 33]

256.515 [Repealed, 1973 c 717 s 33]

256.52 [Repealed, 1973 c 717 s 33]

256.53 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, Ex1971 c 16 s 6]

256.54 [Repealed, 1973 c 717 s 33]

256.55 [Repealed, 1973 c 717 s 33]

256.56 [Repealed, 1973 c 717 s 33]

256.57 [Repealed, 1973 c 717 s 33]

256.58 [Repealed, 1973 c 717 s 33]

256.59 [Repealed, 1973 c 717 s 33]

256.60 [Repealed, 1973 c 717 s 33]

256.61 [Repealed, 1973 c 717 s 33]

256.62 [Repealed, 1973 c 717 s 33]

256.63 [Repealed, 1973 c 717 s 33]

256.64 [Repealed, 1973 c 717 s 33]

256.65 [Repealed, 1973 c 574 s 2]

256.66 [Repealed, 1973 c 717 s 33]

256.67 [Repealed, 1973 c 717 s 33]

256.68 [Repealed, 1971 c 550 s 2]

256.69 [Repealed, 1973 c 717 s 33]

256.70 [Repealed, 1973 c 717 s 33]

256.71 [Repealed, 1973 c 717 s 33]

256.72 [Repealed, 1997 c 85 art 1 s 74]

256.73 Subdivision 1. [Repealed, 1997 c 85 art 1 s 74; 1Sp1997 c 5 s 12]
Subd. 1a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 1b. [Repealed, 1997 c 85 art 1 s 74; 1Sp1997 c 5 s 12]
Subd. 2. [Repealed, 1997 c 85 art 1 s 74]
Subd. 3. [Repealed, 1973 c 717 s 33]
Subd. 3a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 3b. [Repealed, 1997 c 85 art 1 s 74]
Subd. 4. [Repealed, 1987 c 363 s 14]
Subd. 5. [Repealed, 1997 c 85 art 1 s 74]

Subd. 5a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 6. [Repealed, 1997 c 85 art 1 s 74]
Subd. 7. [Repealed, 1989 c 343 s 7]
Subd. 8. [Repealed, 1997 c 85 art 1 s 74]
Subd. 8a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 9. [Repealed, 1997 c 85 art 1 s 74]
Subd. 10. [Repealed, 1997 c 85 art 1 s 74]
Subd. 11. [Repealed, 1997 c 85 art 1 s 74]

256.734 [Repealed, 1995 c 178 art 2 s 49]

256.7341 [Repealed, 1997 c 85 art 1 s 74]

256.735 [Repealed, 1969 c 334 s 2]

256.7351 [Repealed, 1997 c 85 art 2 s 11]

256.7352 [Repealed, 1997 c 85 art 2 s 11]

256.7353 [Repealed, 1997 c 85 art 2 s 11]

256.7354 [Repealed, 1997 c 85 art 2 s 11]

256.7355 [Repealed, 1997 c 85 art 2 s 11]

256.7356 [Repealed, 1997 c 85 art 2 s 11]

256.7357 [Repealed, 1997 c 85 art 2 s 11]

256.7358 [Repealed, 1997 c 85 art 2 s 11]

256.7359 [Repealed, 1997 c 85 art 2 s 11]

256.736 [Repealed, 1999 c 159 s 154]

256.7365 Subdivision 1. [Repealed, 1997 c 85 art 1 s 74]
Subd. 2. [Repealed, 1997 c 85 art 1 s 74]
Subd. 3. [Repealed, 1997 c 85 art 1 s 74]
Subd. 4. [Repealed, 1997 c 85 art 1 s 74]
Subd. 5. [Repealed, 1997 c 85 art 1 s 74]
Subd. 6. [Repealed, 1997 c 85 art 1 s 74]
Subd. 7. [Repealed, 1997 c 85 art 1 s 74]
Subd. 8. [Repealed, 1990 c 568 art 4 s 85]
Subd. 9. [Repealed, 1997 c 85 art 1 s 74]

256.7366 [Repealed, 1997 c 85 art 1 s 74]

256.737 [Repealed, 1997 c 85 art 1 s 74]

256.738 [Repealed, 1997 c 85 art 1 s 74]

256.7381 [Repealed, 1997 c 85 art 1 s 74]

256.7382 [Repealed, 1997 c 85 art 1 s 74]

256.7383 [Repealed, 1997 c 85 art 1 s 74]

256.7384 [Repealed, 1997 c 85 art 1 s 74]

256.7385 [Repealed, 1997 c 85 art 1 s 74]

256.7386 [Repealed, 1997 c 85 art 1 s 74]

256.7387 [Repealed, 1997 c 85 art 1 s 74]

256.7388 [Repealed, 1997 c 85 art 1 s 74]

256.739 [Repealed, 1997 c 85 art 1 s 74]

256.74 Subdivision 1. [Repealed, 1997 c 85 art 1 s 74]

Subd. 1a. [Repealed, 1997 c 85 art 1 s 74]

Subd. 1b. [Repealed, 1997 c 85 art 1 s 74]

Subd. 1c. [Repealed, 1999 c 159 s 154]

Subd. 2. [Repealed, 1997 c 85 art 1 s 74]

Subd. 3. [Repealed, Ex1971 c 16 s 6]

Subd. 4. [Repealed, Ex1971 c 16 s 6]

Subd. 5. [Repealed, 1997 c 203 art 6 s 93]

Subd. 6. [Repealed, 1997 c 85 art 1 s 74]

Subd. 7. [Repealed, 1997 c 203 art 6 s 93]

CHILD SUPPORT AND MAINTENANCE

256.741 CHILD SUPPORT AND MAINTENANCE.

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

(b) The term "public assistance" as used in this chapter and chapters 257, 518, 518A, 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 formerly codified 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.

(e) The terms "child support" and "arrears" as used in this section have the meanings provided in section 518A.26.

(f) The term "maintenance" as used in this section has the meaning provided in section 518.003.

Subd. 2. **Assignment of support and maintenance rights.** (a) An individual receiving public assistance in the form of assistance under any of the following programs: the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program formerly codified under chapter 256K is considered to have assigned to the state at the time of application all rights to child support and maintenance from any other person the applicant or recipient may have in the individual's own behalf or in the behalf of any other family member for whom application for public assistance is made. An assistance unit is ineligible for the Minnesota family investment program unless the caregiver assigns all rights to child support and maintenance benefits according to this section.

(1) The assignment is effective as to any current child support and current maintenance.

(2) Any child support or maintenance arrears that accrue while an individual is receiving public assistance in the form of assistance under any of the programs listed in this paragraph are permanently assigned to the state.

(3) The assignment of current child support and current maintenance ends on the date the individual ceases to receive or is no longer eligible to receive public assistance under any of the programs listed in this paragraph.

(b) An individual receiving public assistance in the form of medical assistance, including MinnesotaCare, is considered to have assigned to the state at the time of application all rights to medical support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom medical assistance is provided.

(1) An assignment made after September 30, 1997, is effective as to any medical support accruing after the date of medical assistance or MinnesotaCare eligibility.

(2) Any medical support arrears that accrue while an individual is receiving public assistance in the form of medical assistance, including MinnesotaCare, are permanently assigned to the state.

(3) The assignment of current medical support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of medical assistance or MinnesotaCare.

(c) An individual receiving public assistance in the form of child care assistance under the child care fund pursuant to chapter 119B is considered to have assigned to the state at the time of application all rights to child care support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom child care assistance is provided.

(1) The assignment is effective as to any current child care support.

(2) Any child care support arrears that accrue while an individual is receiving public assistance in the form of child care assistance under the child care fund in chapter 119B are permanently assigned to the state.

(3) The assignment of current child care support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of child care assistance under the child care fund under chapter 119B.

Subd. 2a. **Distribution of child support.** (a) The state shall distribute current child support and maintenance received by the state to an individual who assigns the right to that support under subdivision 2, paragraph (a).

(b) When the public authority collects child support arrearages on behalf of an individual who is receiving public assistance, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

(c) When the public authority collects child support arrearages on behalf of an individual who is not receiving public assistance, the public authority shall first apply the collection to satisfy those arrears that are not permanently assigned to the state.

(d) When the public authority collects child support arrearages certified under the federal tax offset, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

Subd. 3. **Existing assignments.** Assignments based on the receipt of public assistance in existence prior to July 1, 1997, are permanently assigned to the state. Arrears that accrued prior to the receipt of assistance that were assigned to the state between July 1, 1997, and October 1, 2009, must no longer be assigned as of October 1, 2009.

Subd. 4. **Effect of assignment.** Assignments in this section take effect upon a determination that the applicant is eligible for public assistance. The amount of support assigned under this subdivision may not exceed the total amount of public assistance issued or the total support obligation, whichever is less. Child care support collections made according to an assignment under subdivision 2, paragraph (c), must be deposited, subject to any limitations of federal law, in the general fund.

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.

Subd. 6. **Determination.** If the individual cannot provide the information required in subdivision 5, before making a determination that the individual is cooperating, the child support agency shall make a finding that the individual could not reasonably be expected to provide the information. In making this finding, the child support agency shall consider:

(1) the age of the child for whom support is being sought;

(2) the circumstances surrounding the conception of the child;

(3) the age and mental capacity of the parent or caregiver of the child for whom support is being sought;

(4) the time period that has expired since the parent or caregiver of the child for whom support is sought last had contact with the alleged father or obligor, or the person's relatives; and

(5) statements from the applicant or recipient or other individuals that show evidence of an inability to provide correct information about the alleged father or obligor because of deception by the alleged father or obligor.

Subd. 7. **Noncooperation.** Unless good cause is found to exist under subdivision 10, upon a determination of noncooperation by the child support agency, the agency shall promptly notify the individual and each public assistance agency providing public assistance to the individual that the individual is not cooperating with the child support agency. Upon notice of noncooperation, the individual shall be sanctioned in the amount determined according to the public assistance agency responsible for enforcing the sanction.

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.

Subd. 9. **Good cause exemption from cooperating with support requirements.** The IV-A or IV-D agency must notify the caregiver that the caregiver may claim a good cause exemption from cooperating with the requirements in subdivision 5. Good cause may be claimed and exemptions determined according to subdivisions 10 to 13.

Subd. 10. **Good cause exemption.** (a) Cooperation with the child support agency under subdivision 5 is not necessary if the individual asserts, and both the child support agency and the

public assistance agency find, good cause exists under this subdivision for failing to cooperate. An individual may request a good cause exemption by filing a written claim with the public assistance agency on a form provided by the commissioner of human services. Upon notification of a claim for good cause exemption, the child support agency shall cease all child support enforcement efforts until the claim for good cause exemption is reviewed and the validity of the claim is determined. Designated representatives from public assistance agencies and at least one representative from the child support enforcement agency shall review each claim for a good cause exemption and determine its validity.

(b) Good cause exists when an individual documents that pursuit of child support enforcement services could reasonably result in:

(1) physical or emotional harm to the child for whom support is sought;

(2) physical harm to the parent or caregiver with whom the child is living that would reduce the ability to adequately care for the child; or

(3) emotional harm to the parent or caregiver with whom the child is living, of such nature or degree that it would reduce the person's ability to adequately care for the child.

Physical and emotional harm under this paragraph must be of a serious nature in order to justify a finding of good cause exemption. A finding of good cause exemption based on emotional harm may only be based upon a demonstration of emotional impairment that substantially affects the individual's ability to function.

(c) Good cause also exists when the designated representatives in this subdivision believe that pursuing child support enforcement would be detrimental to the child for whom support is sought and the individual applicant or recipient documents any of the following:

(1) the child for whom child support enforcement is sought was conceived as a result of incest or rape;

(2) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) the parent or caregiver of the child is currently being assisted by a public or licensed private social service agency to resolve the issues of whether to keep the child or place the child for adoption.

The parent or caregiver's right to claim a good cause exemption based solely on this paragraph expires if the assistance lasts more than 90 days.

(d) The public authority shall consider the best interests of the child in determining good cause.

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.

Subd. 12. **Decision.** A good cause exemption must be granted if the individual's claim and the investigation of the supporting evidence satisfy the investigating agencies that the individual has good cause for refusing to cooperate.

Subd. 13. **Duration.** (a) A good cause exemption may not continue for more than one year without redetermination of cooperation and good cause pursuant to this section. The child support agency may redetermine cooperation and the designated representatives in subdivision 10 may redetermine the granting of a good cause exemption before the one year expiration in this subdivision.

(b) A good cause exemption must be allowed under subsequent applications and redeterminations without additional evidence when the factors that led to the exemption continue to exist. A good cause exemption must end when the factors that led to the exemption have changed.

Subd. 14. **Training.** The commissioner shall establish domestic violence and sexual abuse training programs for child support agency employees. The training programs must be developed in consultation with experts on domestic violence and sexual assault. To the extent possible, representatives of the child support agency involved in making a determination of cooperation under subdivision 6 or reviewing a claim for good cause exemption under subdivision 9 shall receive training in accordance with this subdivision.

Subd. 15. [Repealed, 2008 c 363 art 16 s 8]

History: *1997 c 203 art 6 s 5; 1997 c 245 art 3 s 5; 1998 c 382 art 1 s 1; 1998 c 407 art 6 s 10; 1999 c 159 s 42,43; 1999 c 205 art 1 s 53; 2000 c 488 art 10 s 4; 1Sp2001 c 9 art 10 s 66; art 12 s 2-4; art 15 s 32; 2002 c 379 art 1 s 113; 2003 c 130 s 12; 1Sp2005 c 4 art 5 s 13; 2007 c 13 art 3 s 14; 2008 c 363 art 16 s 1-4*

256.742 [Repealed, 2010 c 200 art 1 s 21]

256.745 [Repealed, 1997 c 85 art 1 s 74]

256.75 [Repealed, 1997 c 85 art 1 s 74]

256.76 Subdivision 1. [Repealed, 1997 c 85 art 1 s 74]

Subd. 2. [Repealed, 1987 c 363 s 14]

256.77 [Repealed, 1976 c 131 s 2]

256.78 [Repealed, 1997 c 85 art 1 s 74]

256.79 [Repealed, 1987 c 363 s 14]

256.80 [Repealed, 1997 c 85 art 1 s 74]

256.81 [Repealed, 1997 c 85 art 1 s 74]

256.82 PAYMENTS BY STATE.

Subdivision 1. [Repealed, 1997 c 203 art 11 s 13]

Subd. 2. **Foster care maintenance payments.** Beginning January 1, 1986, for the purpose of foster care maintenance payments under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the county paying the maintenance costs must be reimbursed for the costs from the federal money available for the purpose. Beginning July 1, 1997, for the purposes of determining a child's eligibility under title IV-E of the Social Security Act, the placing agency shall use AFDC requirements in effect on July 16, 1996.

Subd. 3. **Setting foster care standard rates.** The commissioner shall annually establish minimum standard maintenance rates for foster care maintenance and difficulty of care payments for all children in foster care. Any increase in rates shall in no case exceed three percent per annum.

Subd. 4. **Rules.** The commissioner shall adopt rules to implement subdivision 3. In developing rules, the commissioner shall take into consideration any existing difficulty of care payment rates so that, to the extent possible, no child for whom a difficulty of care rate is currently established will be adversely affected.

Subd. 5. [Repealed, 2010 c 301 art 3 s 11]

History: *(8688-16) 1937 c 438 s 14; 1943 c 619 s 1; 1951 c 229 s 6; 1977 c 423 art 3 s 3; 1979 c 303 art 2 s 1; 1980 c 607 art 2 s 2; 1982 c 553 s 1; 1983 c 312 art 5 s 5; 1Sp1985 c 9 art 2 s 31; 1987 c 235 s 1,2; 1988 c 719 art 8 s 6; 1989 c 277 art 2 s 5; 1Sp1989 c 1 art 16 s 3; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 23; 1997 c 7 art 5 s 29; 1997 c 85 art 3 s 8; 1997 c 203 art 5 s 11; art 11 s 3; 1998 c 406 art 1 s 10,37; 1998 c 407 art 9 s 10; 1999 c 159 s 44; 2000 c 260 s 97; 2010 c 301 art 3 s 3*

256.83 [Repealed, 1971 c 550 s 2]

256.84 [Repealed, 1997 c 85 art 1 s 74]

256.85 [Repealed, 1997 c 85 art 1 s 74]

256.851 [Repealed, 1995 c 207 art 5 s 40]

256.86 [Repealed, 1997 c 85 art 1 s 74]

256.863 [Repealed, 1997 c 85 art 1 s 74]

256.87 CONTRIBUTION BY PARENTS.

Subdivision 1. **Actions against parents for assistance furnished.** A parent of a child is liable for the amount of public assistance, as defined in section 256.741, furnished to and for the

benefit of the child, including any assistance furnished for the benefit of the caretaker of the child, which the parent has had the ability to pay. Ability to pay must be determined according to chapter 518A. The parent's liability is limited to the two years immediately preceding the commencement of the action, except that where child support has been previously ordered, the state or county agency providing the assistance, as assignee of the obligee, shall be entitled to judgments for child support payments accruing within ten years preceding the date of the commencement of the action up to the full amount of assistance furnished. The action may be ordered by the state agency or county agency and shall be brought in the name of the county or in the name of the state agency against the parent for the recovery of the amount of assistance granted, together with the costs and disbursements of the action.

Subd. 1a. **Continuing support contributions.** In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing support contributions by a parent found able to reimburse the county or state agency. The order shall be effective for the period of time during which the recipient receives public assistance from any county or state agency and thereafter. The order shall require support according to chapter 518A and include the names and Social Security numbers of the father, mother, and the child or children. An order for continuing contributions is reinstated without further hearing upon notice to the parent by any county or state agency that public assistance, as defined in section 256.741, is again being provided for the child of the parent. The notice shall be in writing and shall indicate that the parent may request a hearing for modification of the amount of support or maintenance.

Subd. 2. [Repealed, 1983 c 308 s 32]

Subd. 3. MS 1980 [Repealed, 1981 c 360 art 2 s 52]

Subd. 3. **Continuing contributions to former recipient.** The order for continuing support contributions shall remain in effect following the period after public assistance, as defined in section 256.741, granted is terminated unless the former recipient files an affidavit with the court requesting termination of the order.

Subd. 4. [Repealed, 1989 c 282 art 2 s 219]

Subd. 5. **Child not receiving assistance.** A person or entity having physical custody of a dependent child not receiving public assistance as defined in section 256.741 has a cause of action for child support against the child's noncustodial parents. Upon a motion served on the noncustodial parent, the court shall order child support payments, including medical support and child care support, from the noncustodial parent under chapter 518A. A noncustodial parent's liability may include up to the two years immediately preceding the commencement of the action. This subdivision applies only if the person or entity has physical custody with the consent of a custodial parent or approval of the court.

Subd. 6. **Entry of judgment.** Any order for support issued under this section shall provide for a conspicuous notice that, if the obligor fails to make a support payment, the payment owed becomes a judgment by operation of law on and after the date the payment is due, and the obligee or public agency responsible for support enforcement may obtain entry and docketing of the judgment for the unpaid amounts under the provisions of section 548.091.

Subd. 7. **Notice of docketing of maintenance judgment.** Every order for maintenance issued under this section shall provide for a conspicuous notice that, if the obligor fails to make the maintenance payments, the obligee or public agency responsible for maintenance enforcement may obtain docketing of a judgment for the unpaid amount under the provisions of section

548.091. The notice shall enumerate the conditions that must be met before the judgment can be docketed.

Subd. 8. **Disclosure prohibited.** Notwithstanding statutory or other authorization for the public authority to release private data on the location of a party to the action, information on the location of one party may not be released to the other party by the public authority if:

(1) the public authority has knowledge that a protective order with respect to the other party has been entered; or

(2) the public authority has reason to believe that the release of the information may result in physical or emotional harm to the other party.

Subd. 9. **Arrears for parent who reunites with family.** (a) A parent liable for assistance under this section may seek a suspension of collection efforts under Title IV-D of the Social Security Act or a payment agreement based on ability to pay if the parent has reunited with that parent's family and lives in the same household as the child on whose behalf the assistance was furnished.

(b) The Title IV-D agency shall consider the individual financial circumstances of each obligor in evaluating the obligor's ability to pay a proposed payment agreement and shall propose a reasonable payment agreement tailored to those individual financial circumstances.

(c) The Title IV-D agency may suspend collection of arrears owed to the state under this section for as long as the obligor continues to live in the same household as the child on whose behalf the assistance was furnished if the total gross household income of the obligor is less than 185 percent of the federal poverty level.

(d) An obligor must annually reapply for suspension of collection of arrearages under paragraph (c).

(e) The obligor must notify the Title IV-D agency if the obligor no longer resides in the same household as the child.

History: *(8688-21, 8688-22, 8688-23) 1937 c 438 s 19-21; 1953 c 639 s 3; 1977 c 282 s 1; 1980 c 408 s 1; 1981 c 360 art 2 s 21; 1983 c 308 s 2; 1984 c 547 s 2; 1985 c 131 s 3,4; 1Sp1985 c 9 art 2 s 32; 1988 c 593 s 1-4; 1989 c 282 art 2 s 114; 1993 c 340 s 3-6; 1994 c 630 art 11 s 4; 1995 c 257 art 4 s 2; 1997 c 203 art 6 s 6-10; 1997 c 245 art 1 s 3; 1999 c 245 art 7 s 2; 2005 c 164 s 29; 1Sp2005 c 7 s 28*

256.871 [Repealed, 1997 c 85 art 1 s 74]

256.8711 [Repealed, 1997 c 85 art 3 s 56]

256.872 [Repealed, 1983 c 308 s 32]

256.873 [Repealed, 1983 c 308 s 32]

256.874 [Repealed, 1982 c 488 s 8]

256.875 [Repealed, 1982 c 488 s 8]

256.876 [Repealed, 1983 c 308 s 32]

256.877 [Repealed, 1982 c 488 s 8]

256.878 [Repealed, 1982 c 488 s 8]

256.879 [Repealed, 1997 c 85 art 1 s 74]

256.8799 FOOD STAMP OR FOOD SUPPORT OUTREACH PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services shall establish, in consultation with the representatives from community action agencies, a statewide outreach program to better inform potential recipients of the existence and availability of food stamps or food support under the food stamp or food support program. As part of the outreach program, the commissioner and community action agencies shall encourage recipients in the use of food stamps at food cooperatives. The commissioner shall explore and pursue federal funding sources, and specifically, apply for funding from the United States Department of Agriculture for the food stamp or food support outreach program.

Subd. 2. **Administration of the program.** A community association representing community action agencies under section 256E.31, in consultation with the commissioner shall administer the outreach program, issue the request for proposals, and review and approve the potential grantee's plan. Grantees shall comply with the monitoring and reporting requirements as developed by the commissioner in accordance with subdivision 4, and must also participate in the evaluation process as directed by the commissioner. Grantees must successfully complete one year of outreach and demonstrate compliance with all monitoring and reporting requirements in order to be eligible for additional funding.

Subd. 3. **Plan content.** In approving the plan, the association shall evaluate the plan and give highest priority to a plan that:

(1) targets communities in which 50 percent or fewer of the residents with incomes below 125 percent of the poverty level receive food stamps or food support;

(2) demonstrates that the grantee has the experience necessary to administer the program;

(3) demonstrates a cooperative relationship with the local county social service agencies;

(4) provides ways to improve the dissemination of information on the food stamp or food support program as well as other assistance programs through a statewide hotline or other community agencies;

(5) provides direct advocacy consisting of face-to-face assistance with the potential applicants;

(6) improves access to the food stamp or food support program by documenting barriers to participation and advocating for changes in the administrative structure of the program; and

(7) develops strategies for combatting community stereotypes about food stamp or food support recipients and the food stamp or food support program, misinformation about the program, and the stigma associated with using food stamps or food support.

Subd. 4. **Coordinated development.** The commissioner shall consult with representatives from the United States Department of Agriculture, Minnesota Community Action Association, Food First Coalition, Minnesota Department of Human Services, Urban Coalition/University of Minnesota extension services, county social service agencies, local social service agencies, and organizations that have previously administered state-funded food stamp or food support outreach programs to:

(1) develop the reporting requirements for the program;

(2) develop and implement the monitoring of the program;

(3) develop, coordinate, and assist in the evaluation process; and

(4) provide an interim report to the legislature by January 1997, and a final report to the legislature by January 1998, which includes the results of the evaluation and recommendations.

History: *1995 c 178 art 2 s 21; 1Sp1995 c 3 art 16 s 13; 1Sp2003 c 14 art 1 s 106; 2005 c 98 art 1 s 24*

SOCIAL WELFARE FUND

256.88 SOCIAL WELFARE FUND ESTABLISHED.

Except as otherwise expressly provided, all moneys and funds held by the commissioner of human services and the local social services agencies of the several counties in trust or for the benefit of disabled, dependent, neglected, and delinquent children, 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, persons determined to be developmentally disabled, mentally ill or chemically dependent, or other wards or beneficiaries, under any law, shall be kept in a single fund to be known as the "social welfare fund" which shall be deposited at interest, held, or disbursed as provided in sections 256.89 to 256.92.

History: *(4462) 1923 c 106 s 1; 1939 c 8 s 1; 1983 c 7 s 4; 1983 c 243 s 5 subd 4; 1984 c 654 art 5 s 58; 1994 c 631 s 31; 2005 c 56 s 1*

256.89 FUND DEPOSITED IN STATE TREASURY.

The social welfare fund and all accretions thereto shall be deposited in the state treasury, as a separate and distinct fund, to the credit of the commissioner of human services as trustee for the beneficiaries thereof in proportion to their several interests. The commissioner of management and budget shall be responsible only to the commissioner of human services for the sum total of the fund, and shall have no duties nor direct obligations toward the beneficiaries thereof individually. Subject to the rules of the commissioner of human services money so received by a local social services agency may be deposited by the executive secretary of the local social services agency in a local bank carrying federal deposit insurance, designated by the local social services agency for this purpose. The amount of such deposit in each such bank at any one time shall not exceed the amount protected by federal deposit insurance.

History: *(4463) 1923 c 106 s 2; 1939 c 8 s 2; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1994 c 631 s 31; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

256.90 SOCIAL WELFARE FUND; USE; DISPOSITION; DEPOSITORIES.

The commissioner of human services at least 30 days before the first day of January and the first day of July in each year shall file with the commissioner of management and budget an estimate of the amount of the social welfare fund to be held in the treasury during the succeeding six-month period, subject to current disbursement. Such portion of the remainder thereof as may be at any time designated by the request of the commissioner of human services may be invested by the commissioner of management and budget in bonds in which the permanent trust funds of the state of Minnesota may be invested, upon approval by the State Board of Investment. The portion of such remainder not so invested shall be placed by the commissioner of management and budget at interest for the period of six months, or when directed by the commissioner of human services, for the period of 12 months thereafter at the highest rate of interest obtainable in a bank, or banks, designated by the board of deposit as a suitable depository therefor. All the

provisions of law relative to the designation and qualification of depositories of other state funds shall be applicable to sections 256.88 to 256.92, except as herein otherwise provided. Any bond given, or collateral assigned or both, to secure a deposit hereunder may be continuous in character to provide for the repayment of any moneys belonging to the fund theretofore or thereafter at any time deposited in such bank until its designation as such depository is revoked and the security thereof shall be not impaired by any subsequent agreement or understanding as to the rate of interest to be paid upon such deposit, or as to time for its repayment. The amount of money belonging to the fund deposited in any bank, including other state deposits, shall not at any time exceed the amount of the capital stock thereof. In the event of the closing of the bank any sum deposited therein shall immediately become due and payable.

History: *(4464) 1923 c 106 s 3; 1925 c 253; 1943 c 236 s 1; 1984 c 654 art 5 s 58; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

256.91 PURPOSES.

From that part of the social welfare fund held in the state treasury subject to disbursement as provided in section 256.90 the commissioner of human services at any time may pay out such amounts as the commissioner deems proper for the support, maintenance, or other legal benefit of any of the disabled, dependent, neglected, and delinquent children, 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, persons with developmental disabilities, chemical dependency, or mental illness, or other wards or persons entitled thereto, not exceeding in the aggregate to or for any person the principal amount previously received for the benefit of the person, together with the increase in it from an equitable apportionment of interest realized from the social welfare fund.

When any such person dies or is finally discharged from the guardianship, care, custody, and control of the commissioner of human services, the amount then remaining subject to use for the benefit of the person shall be paid as soon as may be from the social welfare fund to the persons thereto entitled by law.

History: *(4465) 1923 c 106 s 4; 1983 c 7 s 5; 1983 c 243 s 5 subd 5; 1984 c 654 art 5 s 58; 1985 c 21 s 50; 1986 c 444; 2005 c 56 s 1*

256.92 COMMISSIONER OF HUMAN SERVICES, ACCOUNTS.

It shall be the duty of the commissioner of human services and of the local social services agencies of the several counties of this state to cause to be deposited with the commissioner of management and budget all moneys and funds in their possession or under their control and designated by section 256.91 as and for the social welfare fund; and all such moneys and funds shall be so deposited in the state treasury as soon as received. The commissioner of human services shall keep books of account or other records showing separately the principal amount received and deposited in the social welfare fund for the benefit of any person, together with the name of such person, and the name and address, if known to the commissioner of human services, of the person from whom such money was received; and, at least once every two years, the amount of interest, if any, which the money has earned in the social welfare fund shall be apportioned thereto and posted in the books of account or records to the credit of such beneficiary.

The provisions of sections 256.88 to 256.92 shall not apply to any fund or money now or hereafter deposited or otherwise disposed of pursuant to the lawful orders, decrees, judgments, or other directions of any district court having jurisdiction thereof.

History: *(4466, 4467) 1923 c 106 s 5,6; 1984 c 654 art 5 s 58; 1994 c 631 s 31; 1995 c 189 s 8; 1996 c 277 s 1; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

256.925 OPTIONAL VOTER REGISTRATION FOR PUBLIC ASSISTANCE APPLICANTS AND RECIPIENTS.

A county agency shall provide voter registration cards to every individual eligible to vote who applies for a public assistance program at the time application is made. The agency shall also make voter registration cards available to a public assistance recipient upon the recipient's request or at the time of the recipient's eligibility redetermination. The county agency shall assist applicants and recipients in completing the voter registration cards, as needed. Applicants must be informed that completion of the cards is optional. Completed forms shall be collected by agency employees and submitted to proper election officials.

History: *1988 c 689 art 2 s 136*

256.93 COMMISSIONER OF HUMAN SERVICES, POSSESSION OF ESTATES.

Subdivision 1. **Limitations.** In any case where the guardianship of any developmentally disabled, disabled, dependent, neglected or delinquent child, or a child born to a mother who was not married to the child's father when the child was conceived nor when the child was born, has been committed to the commissioner of human services, and in any case where the guardianship of any person with a developmental disability has been committed to the commissioner of human services, the court having jurisdiction of the estate may on such notice as the court may direct, authorize the commissioner to take possession of the personal property in the estate, liquidate it, and hold the proceeds in trust for the ward, to be invested, expended and accounted for as provided by sections 256.88 to 256.92.

Subd. 2. **Annual report.** The commissioner of human services shall annually or at such other times as the court may direct file with the court an account of moneys received and disbursed by the commissioner for wards and conservatees, pursuant to subdivision 1. Upon petition of the ward or conservatee or of any person interested in such estate and upon notice to the commissioner the court may terminate such trust and require final accounting thereof.

History: *(4467-1, 4467-2) 1929 c 55 s 1,2; 1939 c 9; 1943 c 612 s 4,5; 1949 c 32 s 1; 1975 c 208 s 31,32; 1983 c 7 s 6; 1983 c 10 s 1; 1983 c 243 s 5 subd 6; 1984 c 654 art 5 s 58; 1985 c 21 s 51; 1986 c 444; 1995 c 189 s 8; 1996 c 277 s 1; 2005 c 10 art 4 s 13; 2005 c 56 s 1*

256.935 FUNERAL EXPENSES, PAYMENT BY COUNTY AGENCY.

Subdivision 1. **Cremation, burial, and funeral expenses.** On the death of any person receiving public assistance through MFIP, the county agency shall attempt to contact the decedent's spouse or next of kin. If the agency is not able to contact a spouse or next of kin and the personal preferences of the decedent or the practices of the decedent's faith tradition are not known, the agency shall pay for cremation of the person's remains and the burial or interment if the spouse or next of kin does not want to take possession of the ashes. If the county agency contacts the decedent's spouse or next of kin and it is determined that cremation is not in accordance with the decedent's personal preferences or the practices of the decedent's faith tradition or the personal preferences of the decedent's spouse or the decedent's next of kin, the

county agency shall pay an amount for funeral expenses including the transportation of the body into or out of the community in which the deceased resided not exceeding the amount paid for comparable services under section 261.035 plus actual cemetery charges. No cremation, burial, or funeral expenses shall be paid if the estate of the deceased is sufficient to pay such expenses or if the spouse, who was legally responsible for the support of the deceased while living, is able to pay such expenses. Freedom of choice in the selection of a funeral director shall be granted to persons lawfully authorized to make arrangements for the cremation or burial of any such deceased recipient. In determining the sufficiency of such estate, due regard shall be had for the nature and marketability of the assets of the estate. The county agency may grant cremation, burial, or funeral expenses where the sale would cause undue loss to the estate. Any amount paid for cremation, burial, or funeral expenses shall be a prior claim against the estate, as provided in section 524.3-805, and any amount recovered shall be reimbursed to the agency which paid the expenses. The commissioner shall specify requirements for reports, including fiscal reports, according to section 256.01, subdivision 2, paragraph (q). The state share shall pay the entire amount of county agency expenditures. Benefits shall be issued to recipients by the state or county subject to provisions of section 256.017.

Subd. 2. [Repealed, 3Sp1981 c 3 s 20]

History: *Ex1971 c 16 s 4,5; 1973 c 717 s 15; 1976 c 239 s 81; 1986 c 444; 1988 c 719 art 8 s 9; 1989 c 89 s 9; 1Sp1989 c 1 art 16 s 5; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 25; 1992 c 513 art 8 s 13; 1997 c 85 art 4 s 13; 1997 c 203 art 11 s 5; 1999 c 159 s 45; 2009 c 174 art 1 s 4*

256.9351 [Renumbered 256L.01]

256.9352 Subdivision 1. [Renumbered 256L.02, subdivision 1]

Subd. 2. [Renumbered 256L.02, subd 2]

Subd. 3. [Renumbered 256L.02, subd 3]

Subd. 4. [Deleted, 1995 c 233 art 2 s 56]

256.9353 Subdivision 1. [Renumbered 256L.03, subdivision 1]

Subd. 2. [Renumbered 256L.03, subd 2]

Subd. 3. [Renumbered 256L.03, subd 3]

Subd. 4. [Repealed, 1995 c 234 art 6 s 46]

Subd. 5. [Repealed, 1995 c 234 art 6 s 46]

Subd. 6. [Renumbered 256L.03, subd 4]

Subd. 7. [Renumbered 256L.03, subd 5]

Subd. 8. [Renumbered 256L.03, subd 6]

256.9354 Subdivision 1. [Renumbered 256L.04, subdivision 1]

Subd. 1a. [Renumbered 256L.04, subd 2]

Subd. 2. [Renumbered 256L.04, subd 3]

Subd. 3. [Renumbered 256L.04, subd 4]

Subd. 4. [Renumbered 256L.04, subd 5]

Subd. 4a. [Renumbered 256L.04, subd 6]

Subd. 5. [Renumbered 256L.04, subd 7]

Subd. 6. [Renumbered 256L.04, subd 8]

Subd. 7. [Renumbered 256L.04, subd 9]

256.9355 [Renumbered 256L.05]

256.9356 [Renumbered 256L.06]

256.9357 [Renumbered 256L.07]

256.9358 [Renumbered 256L.08]

256.9359 [Renumbered 256L.09]

256.936 Subdivision 1. MS 1991 Supp [Renumbered 256.9351]

Subd. 2. MS 1990 [Renumbered 256.9352]

Subd. 2a. MS 1990 [Renumbered 256.9353]

Subd. 2b. MS 1990 [Renumbered 256.9354]

Subd. 3. MS 1990 [Renumbered 256.9355]

Subd. 4. MS 1990 [Renumbered 256.9356]

Subd. 4a. MS 1990 [Renumbered 256.9357]

Subd. 4b. MS 1990 [Renumbered 256.9358]

Subd. 4c. MS 1990 [Renumbered 256.9359]

Subd. 5. MS 1991 Supp [Renumbered 256.9361]

256.9361 [Renumbered 256L.10]

256.9362 [Renumbered 256L.11]

256.9363 [Renumbered 256L.12]

256.9364 [Expired]

256.9365 PURCHASE OF CONTINUATION COVERAGE FOR AIDS PATIENTS.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must satisfy the following requirements:

(1) the applicant must provide a physician's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;

(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;

(3) the applicant must not own assets with a combined value of more than $25,000; and

(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan.

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under subdivision 2, clause (5), must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance or general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

History: *1990 c 568 art 3 s 15; 1991 c 292 art 4 s 18,19; 1995 c 207 art 6 s 13*

256.9366 [Renumbered 256L.13]

256.9367 [Renumbered 256L.14]

256.9368 [Renumbered 256L.15]

256.9369 [Renumbered 256L.16]

256.94 CONFERENCES OF VARIOUS OFFICIALS.

For the purpose of promoting economy and efficiency in the enforcement of laws relating to children, and particularly of laws relating to defective, delinquent, dependent, and neglected children, the commissioner of human services may, at such times and places as the commissioner deems advisable, call an annual conference with officials responsible for the enforcement of such laws. When practicable such conference shall be held at the same time and place as the state conference of social work.

History: *(4468) 1917 c 224 s 1; 1921 c 403 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.95 EXPENSE OF ATTENDANCE AT CONFERENCE.

The necessary expenses of all judges and of one member of the county child welfare board in each county invited to attend such conference shall be paid out of the funds of their respective counties.

History: *(4469) 1917 c 224 s 2; 1921 c 403 s 2; 1995 c 189 s 8; 1996 c 277 s 1*

256.954 MS 2003 Supp [Expired, 1Sp2003 c 14 art 12 s 4]

256.955 [Repealed, 1Sp2005 c 4 art 8 s 88]

256.956 [Repealed, 2007 c 147 art 5 s 41]

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; 2002 c 379 art 1 s 113*

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; 2002 c 379 art 1 s 113*

256.96 COOPERATION WITH OTHER BOARDS.

The commissioner of human services and the several county child welfare boards within their respective jurisdictions, upon request of county boards, city councils, town boards, or other public boards or authorities charged by law with the administration of the laws relating to the relief of the poor, may cooperate with such boards and authorities in the administration of such laws.

History: *(4461) 1923 c 152 s 1; 1973 c 123 art 5 s 7; 1984 c 654 art 5 s 58*

256.962 MINNESOTA HEALTH CARE PROGRAMS OUTREACH.

Subdivision 1. **Public awareness and education.** The commissioner, in consultation with community organizations, health plans, and other public entities experienced in outreach to the uninsured, shall design and implement a statewide campaign to raise public awareness on the availability of health coverage through medical assistance, general assistance medical care, and MinnesotaCare and to educate the public on the importance of obtaining and maintaining health care coverage. The campaign shall include multimedia messages directed to the general population.

Subd. 2. **Outreach grants.** (a) The commissioner shall award grants to public and private organizations, regional collaboratives, and regional health care outreach centers for outreach activities, including, but not limited to:

(1) providing information, applications, and assistance in obtaining coverage through Minnesota public health care programs;

(2) collaborating with public and private entities such as hospitals, providers, health plans, legal aid offices, pharmacies, insurance agencies, and faith-based organizations to develop outreach activities and partnerships to ensure the distribution of information and applications and provide assistance in obtaining coverage through Minnesota health care programs;

(3) providing or collaborating with public and private entities to provide multilingual and culturally specific information and assistance to applicants in areas of high uninsurance in the state or populations with high rates of uninsurance; and

(4) targeting geographic areas with high rates of (i) eligible but unenrolled children, including children who reside in rural areas, or (ii) racial and ethnic minorities and health disparity populations.

(b) The commissioner shall ensure that all outreach materials are available in languages other than English.

(c) The commissioner shall establish an outreach trainer program to provide training to designated individuals from the community and public and private entities on application assistance in order for these individuals to provide training to others in the community on an as-needed basis.

Subd. 3. **Application and assistance.** (a) The Minnesota health care programs application must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries. The commissioner shall ensure that applications are available in languages other than English.

(b) Local human service agencies, hospitals, and health care community clinics receiving state funds must provide direct assistance in completing the application form, including the free use of a copy machine and a drop box for applications. These locations must ensure that the drop box is checked at least weekly and any applications are submitted to the commissioner. The commissioner shall provide these entities with an identification number to stamp on each application to identify the entity that provided assistance. Other locations where applications are required to be available shall either provide direct assistance in completing the application form or provide information on where an applicant can receive application assistance.

(c) Counties must offer applications and application assistance when providing child support collection services.

(d) Local public health agencies and counties that provide immunization clinics must offer applications and application assistance during these clinics.

(e) The commissioner shall coordinate with the commissioner of health to ensure that maternal and child health outreach efforts include information on Minnesota health care programs and application assistance, when needed.

Subd. 4. **Statewide toll-free telephone number.** The commissioner shall provide funds for a statewide toll-free telephone number to provide information on public and private health coverage options and sources of free and low-cost health care. The statewide telephone number must provide the option of obtaining this information in languages other than English.

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare, medical assistance, or general assistance medical care, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a $25 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

Subd. 6. **School districts and charter schools.** (a) At the beginning of each school year, a school district or charter school shall provide information to each student on the availability of health care coverage through the Minnesota health care programs and how to obtain an application for the Minnesota health care programs.

(b) A school district or charter school shall also ensure that applications and information on application assistance are available at early childhood education sites and public schools located within the district's jurisdiction.

(c) If a school district or charter school maintains a district Web site, the school district or charter school shall provide on its Web site a link to information on how to obtain an application and application assistance.

Subd. 7. [Repealed, 2009 c 79 art 5 s 80]

Subd. 8. **Eligibility end dates.** The commissioner shall develop and implement a process by January 1, 2013, to provide eligibility end dates upon request from the managed care and county-based purchasing plans for medical assistance and MinnesotaCare enrollees.

History: *2007 c 147 art 5 s 2; 2008 c 358 art 3 s 3,4; 2009 c 79 art 5 s 8,9; 2009 c 174 art 2 s 9; 2012 c 253 art 1 s 3*

256.963 PRIMARY CARE ACCESS INITIATIVE.

Subdivision 1. **Establishment.** (a) The commissioner shall award a grant to implement in Hennepin and Ramsey Counties a Web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee must establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings. The program must refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program must provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for a Minnesota health care program, the program must connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program must also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

(b) The program must not require a provider to pay a fee for accepting charity care patients or patients enrolled in a Minnesota public health care program.

Subd. 2. **Evaluation.** (a) The grantee must report to the commissioner on a quarterly basis the following information:

(1) the total number of appointments available for scheduling by specialty;

(2) the average length of time between scheduling and actual appointment;

(3) the total number of patients referred and whether the patient was insured or uninsured; and

(4) the total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

(b) The commissioner, in consultation with the Minnesota Hospital Association, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the legislature by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.

History: *2007 c 147 art 5 s 3*

256.964 DENTAL CARE PILOT PROJECTS.

The commissioner shall authorize pilot projects to reduce the total cost to the state for dental services provided to enrollees of the state public health care programs by reducing hospital emergency room costs for preventable or nonemergency dental services. As part of the project, a community dental clinic or dental provider, in collaboration with a hospital emergency room, shall provide urgent care dental services as an alternative to the hospital emergency room for nonemergency dental care. The project participants shall establish a process to divert a patient presenting at the emergency room for nonemergency dental care to the dental community clinic or to an appropriate dental provider. The commissioner may establish special payment rates for urgent care services provided and may change or waive existing payment policies in order to adequately reimburse providers for providing cost-effective alternative services in an outpatient

or urgent care setting. The commissioner may establish a project in conjunction with the initiative authorized under section 256.963.

History: *2009 c 79 art 5 s 10*

256.965 [Repealed, 1988 c 719 art 8 s 33]

256.9655 PAYMENTS TO MEDICAL PROVIDERS.

Subdivision 1. **Duties of commissioner.** The commissioner shall establish procedures to analyze and correct problems associated with medical care claims preparation and processing under the medical assistance, general assistance medical care, and MinnesotaCare programs. At a minimum, the commissioner shall:

(1) designate a full-time position as a liaison between the Department of Human Services and providers;

(2) analyze impediments to timely processing of claims, provide information and consultation to providers, and develop methods to resolve or reduce problems;

(3) provide to each acute care hospital a quarterly listing of claims received and identify claims that have been suspended and the reason the claims were suspended;

(4) provide education and information on reasons for rejecting and suspending claims and identify methods that would avoid multiple submissions of claims; and

(5) for each acute care hospital, identify and prioritize claims that are in jeopardy of exceeding time factors that eliminate payment.

Subd. 2. **Electronic claim submission.** Medical providers designated by the commissioner of human services are permitted to purchase authorized materials through commodity contracts administered by the commissioner of administration for the purpose of submitting electronic claims to the medical programs designated in subdivision 1. Providers so designated must be actively enrolled and participating in the medical programs and must sign a hardware purchase and electronic biller agreement with the commissioner of human services prior to purchase from the contract.

History: *1988 c 689 art 2 s 138; 1992 c 513 art 7 s 14; 1995 c 234 art 8 s 56*

256.9656 DEPOSITS INTO THE GENERAL FUND.

All money collected under section 256.9657 shall be deposited in the general fund. Deposits do not cancel and are available until expended.

History: *1991 c 292 art 4 s 20; 1992 c 513 art 7 s 15*

256.9657 PROVIDER SURCHARGES.

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the

15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

Subd. 1a. **Waiver request.** The commissioner shall request a waiver from the secretary of health and human services to: (1) exclude from the surcharge under subdivision 1 a nursing home that provides all services free of charge; (2) make a pro rata reduction in the surcharge paid by a nursing home that provides a portion of its services free of charge; and (3) limit the hospital surcharge to acute care hospitals only. If a waiver is approved under this subdivision, the commissioner shall adjust the nursing home surcharge accordingly. Any waivers granted by the federal government shall be effective on or after October 1, 1992.

Subd. 1b. [Repealed, 1998 c 254 art 1 s 68]

Subd. 1c. **Waiver implementation.** If a waiver is approved under subdivision 1b, the commissioner shall implement subdivision 1b as follows:

(a) The commissioner, in cooperation with the Board of Medical Practice, shall notify each physician whose license is scheduled to be issued or renewed between April 1 and September 30 that an application to be excused from the surcharge must be received by the commissioner prior to September 1 of that year for the period of 12 consecutive calendar months beginning December 15. For each physician whose license is scheduled to be issued or renewed between October 1 and March 31, the application must be received from the physician by March 1 for the period of 12 consecutive calendar months beginning June 15. For each physician whose license is scheduled to be issued or renewed between April 1 and September 30, the commissioner shall make the notification required in this paragraph by July 1. For each physician whose license is scheduled to be issued or renewed between October 1 and March 31, the commissioner shall make the notification required in this paragraph by January 1.

(b) The commissioner shall establish an application form for waiver applications. Each physician who applies to be excused from the surcharge under subdivision 1b, paragraph (a), clause (1), must include with the application:

(1) a statement from the operator of the facility at which the physician provides services, that the physician provides services without charge; and

(2) a statement by the physician that the physician will not charge for any physician services during the period for which the exemption from the surcharge is granted.

Each physician who applies to be excused from the surcharge under subdivision 1b, paragraph (a), clauses (2) to (5), must include with the application:

(i) the physician's own statement certifying that the physician does not intend to practice medicine and will not charge for any physician services during the period for which the exemption from the surcharge is granted;

(ii) the physician's own statement describing in general the reason for the leave of absence from the practice of medicine and the anticipated date when the physician will resume the practice of medicine, if applicable;

(iii) an attending physician's statement certifying that the applicant has a terminal illness or permanent disability, if applicable; and

(iv) the physician's own statement indicating on what date the physician retired or became unemployed, if applicable.

(c) The commissioner shall notify in writing the physicians who are excused from the surcharge under subdivision 1b.

(d) A physician who decides to charge for physician services prior to the end of the period for which the exemption from the surcharge has been granted under subdivision 1b, paragraph (a), clause (1), or to return to the practice of medicine prior to the end of the period for which the exemption from the surcharge has been granted under subdivision 1b, paragraph (a), clause (2), (4), or (5), may do so by notifying the commissioner and shall be responsible for payment of the full surcharge for that period.

(e) Whenever the commissioner determines that the number of physicians likely to be excused from the surcharge under subdivision 1b may cause the physician surcharge to violate the requirements of Public Law 102-234 or regulations adopted under that law, the commissioner shall immediately notify the chairs of the senate Health Care Committee and Health Care and Family Services Funding Division and the house of representatives Human Services Committee and Human Services Funding Division.

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.

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of

the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wraparound subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains

liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Subd. 3a. **ICF/MR license surcharge.** Effective July 1, 2003, each non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

Subd. 4. **Payments into the account.** (a) Payments to the commissioner under subdivisions 1 to 3 must be paid in monthly installments due on the 15th of the month beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. Payments to the commissioner under subdivisions 2 and 3 for fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues earned in the second previous calendar year.

(b) Effective October 1, 1995, and each October 1 thereafter, the payments in subdivisions 2 and 3 must be based on revenues earned in the previous calendar year.

(c) If the commissioner of health does not provide by August 15 of any year data needed to update the base year for the hospital and health maintenance organization surcharges, the commissioner of human services may estimate base year revenue and use that estimate for the purposes of this section until actual data is provided by the commissioner of health.

(d) Payments to the commissioner under subdivision 3a must be paid in monthly installments due on the 15th of the month beginning July 15, 2003. The monthly payment must be equal to the annual surcharge divided by 12.

Subd. 5. [Repealed, 1992 c 513 art 7 s 135]

Subd. 6. **Notice; appeals.** At least 30 days prior to the date the payment is due, the commissioner shall give each provider a written notice of each payment due. A provider may request a contested case hearing under chapter 14 within 30 days of receipt of the notice. The decision of the commissioner regarding the amount due stands until the appeal is decided. The provider shall pay the contested payment at the time of appeal with settle up at the time of appeal resolution.

Subd. 7. **Collection; civil penalties.** The provisions of sections 270C.31, except subdivisions 5 and 7; 270C.32, except subdivisions 6 and 10; 270C.33; 270C.61, subdivision 2; and 289A.35 to 289A.50 relating to the authority to audit, assess, collect, and pay refunds of other state taxes may be implemented by the commissioner of human services with respect to the tax, penalty, and interest imposed by this section. The commissioner of human services shall impose

civil penalties for violation of this section as provided in section 289A.60, and the tax and penalties are subject to interest at the rate provided in section 270C.40. The commissioner of human services shall have the power to abate penalties and interest when discrepancies occur resulting from, but not limited to, circumstances of error and mail delivery. The commissioner of human services shall bring appropriate civil actions to collect provider payments due under this section.

Subd. 7a. **Withholding.** If any provider obligated to pay an annual surcharge under this section is more than two months delinquent in the timely payment of a monthly surcharge installment payment, the provisions in paragraphs (a) to (f) apply.

(a) The department may withhold some or all of the amount of the delinquent surcharge, together with any interest and penalties due and owing on those amounts, from any money the department owes to the provider. The department may, at its discretion, also withhold future surcharge installment payments from any money the department owes the provider as those installments become due and owing. The department may continue this withholding until the department determines there is no longer any need to do so.

(b) The department shall give prior notice of the department's intention to withhold by mailing a written notice to the provider at the address to which remittance advices are mailed or faxing a copy of the notice to the provider at least ten business days before the date of the first payment period for which the withholding begins. The notice may be sent by ordinary or certified mail, or facsimile, and shall be deemed received as of the date of mailing or receipt of the facsimile. The notice shall:

(1) state the amount of the delinquent surcharge;

(2) state the amount of the withholding per payment period;

(3) state the date on which the withholding is to begin;

(4) state whether the department intends to withhold future installments of the provider's surcharge payments;

(5) inform the provider of their rights to informally object to the proposed withholding and to appeal the withholding as provided for in this subdivision;

(6) state that the provider may prevent the withholding during the pendency of their appeal by posting a bond; and

(7) state other contents as the department deems appropriate.

(c) The provider may informally object to the withholding in writing anytime before the withholding begins. An informal objection shall not stay or delay the commencement of the withholding. The department may postpone the commencement of the withholding as deemed appropriate and shall not be required to give another notice at the end of the postponement and before commencing the withholding. The provider shall have the right to appeal any withholding from remittances by filing an appeal with Ramsey County District Court and serving notice of the appeal on the department within 30 days of the date of the written notice of the withholding. Notice shall be given and the appeal shall be heard no later than 45 days after the appeal is filed. In a hearing of the appeal, the department's action shall be sustained if the department proves the amount of the delinquent surcharges or overpayment the provider owes, plus any accrued interest and penalties, has not been repaid. The department may continue withholding for delinquent and current surcharge installment payments during the pendency of an appeal unless the provider posts a bond from a surety company licensed to do business in Minnesota in favor of

the department in an amount equal to two times the provider's total annual surcharge payment for the fiscal year in which the appeal is filed with the department.

(d) The department shall refund any amounts due to the provider under any final administrative or judicial order or decree which fully and finally resolves the appeal together with interest on those amounts at the rate of three percent per annum simple interest computed from the date of each withholding, as soon as practical after entry of the order or decree.

(e) The commissioner, or the commissioner's designee, may enter into written settlement agreements with a provider to resolve disputes and other matters involving unpaid surcharge installment payments or future surcharge installment payments.

(f) Notwithstanding any law to the contrary, all unpaid surcharges, plus any accrued interest and penalties, shall be overpayments for purposes of section 256B.0641.

Subd. 8. **Commissioner's duties.** The commissioner of human services shall report to the legislature quarterly on the first day of January, April, July, and October regarding the provider surcharge program. The report shall include information on total billings, total collections, and administrative expenditures. The report on January 1, 1993, shall include information on all surcharge billings, collections, federal matching payments received, efforts to collect unpaid amounts, and administrative costs pertaining to the surcharge program in effect from July 1, 1991, to September 30, 1992. The surcharge shall be adjusted by inflationary and caseload changes in future bienniums to maintain reimbursement of health care providers in accordance with the requirements of the state and federal laws governing the medical assistance program, including the requirements of the Medicaid moratorium amendments of 1991 found in Public Law No. 102-234. The commissioner shall request the Minnesota congressional delegation to support a change in federal law that would prohibit federal disallowances for any state that makes a good faith effort to comply with Public Law 102-234 by enacting conforming legislation prior to the issuance of federal implementing regulations.

History: *1991 c 292 art 4 s 21; 1992 c 513 art 7 s 16-21,133; 1993 c 345 art 1 s 21; 1Sp1993 c 1 art 5 s 11-16; 1994 c 625 art 8 s 61; 1995 c 207 art 6 s 14,15; 1997 c 225 art 2 s 57; 1998 c 254 art 1 s 67,69; 1998 c 407 art 4 s 7; 1Sp2001 c 9 art 2 s 12; 2002 c 220 art 14 s 5; 2002 c 277 s 32; 2002 c 374 art 10 s 4; 2002 c 375 art 2 s 12; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 13-15; 2005 c 17 art 3 s 3; 2005 c 151 art 2 s 4; 1Sp2005 c 4 art 8 s 11; 2012 c 216 art 9 s 10*

256.9658 TOBACCO HEALTH IMPACT FEE.

Subdivision 1. **Purpose.** A tobacco use health impact fee is imposed on and collected from cigarette distributors and tobacco products distributors to recover for the state health costs related to or caused by tobacco use and to reduce tobacco use, particularly by youths.

Subd. 2. **Definitions.** The definitions under section 297F.01 apply to this section.

Subd. 3. **Fee imposed.** (a) A fee is imposed upon the sale of cigarettes in this state, upon having cigarettes in possession in this state with intent to sell, upon any person engaged in business as a distributor, and upon the use or storage by consumers of cigarettes. The fee is imposed at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, 37.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, 75 mills on each cigarette.

(b) A fee is imposed upon all tobacco products in this state and upon any person engaged in business as a distributor in an amount equal to the liability for tax under section 297F.05, subdivision 3, or on a consumer of tobacco products equal to the tax under section 297F.05, subdivision 4. Liability for the fee is in addition to the tax under section 297F.05, subdivision 3 or 4.

Subd. 4. **Payment.** A distributor must pay the fee at the same time and in the same manner as provided for payment of tax under chapter 297F.

Subd. 5. **Fee on use of unstamped cigarettes.** Any person, other than a distributor, that purchases or possesses cigarettes that have not been stamped and on which the fee imposed under this section has not been paid is liable for the fee under this section on the possession or use of those cigarettes.

Subd. 6. **Administration.** The audit, assessment, interest, appeal, refund, penalty, enforcement, administrative, and collection provisions of chapters 270C and 297F apply to the fee imposed under this section.

Subd. 7. **Cigarette stamp.** (a) The stamp in section 297F.08 must be affixed to each package and is prima facie evidence that the fee imposed by this section has been paid.

(b) Notwithstanding any other provisions of this section, the fee due on the return is based upon actual stamps purchased during the reporting period.

Subd. 8. **License revocation.** The commissioner of revenue may revoke or suspend the license of a distributor for failure to pay the fee or otherwise comply with the requirements under this section. The provisions and procedures under section 297F.04 apply to a suspension or revocation under this subdivision.

Subd. 9. **Deposit of revenues.** The commissioner of revenue shall deposit the revenues from the fee under this section in the state treasury and credit them to the health impact fund.

History: *1Sp2005 c 4 art 4 s 2*

256.966 MEDICAL CARE PAYMENTS; COST PER SERVICE UNIT.

Subdivision 1. **In general.** For the biennium ending June 30, 1985, the annual increase in the cost per service unit paid to any vendor under medical assistance and general assistance medical care shall not exceed five percent, except that the five percent annual increase limitation applied to vendors under this subdivision does not apply to nursing homes licensed under chapter 144A or boarding care homes licensed under sections 144.50 to 144.56. The estimated acquisition cost of prescription drug ingredients is not subject to the five percent increase limit, any general state payment reduction, or cost limitation described in this section, except as required under federal law or regulation. For vendors enrolled in the general assistance medical care program, the annual increase in cost per service unit allowable during state fiscal year 1984 shall not exceed five percent. The basis for measuring growth shall be the cost per service unit that would have been reimbursable in state fiscal year 1983 if payments had not been ratably reduced and if payments had been based on the 50th percentile of usual and customary billings for medical assistance in 1978. The increase in cost per service unit allowable for vendors in the general assistance medical care program during state fiscal year 1985 shall not exceed five percent. The basis for measuring growth shall be state fiscal year 1984.

Subd. 2. [Repealed, 1987 c 403 art 2 s 164]

History: *1981 c 360 art 2 s 1; 1982 c 640 s 9; 1983 c 312 art 5 s 6; 1984 c 580 s 2; 1984 c 654 art 5 s 58*

256.967 [Repealed, 1Sp1985 c 9 art 2 s 104]

256.968 [Repealed, 1987 c 299 s 25]

INPATIENT HOSPITAL PAYMENT SYSTEM

256.9685 ESTABLISHMENT OF INPATIENT HOSPITAL PAYMENT SYSTEM.

Subdivision 1. **Authority.** (a) The commissioner shall establish procedures for determining medical assistance and general assistance medical care payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), to be eligible for payment.

(b) The commissioner may reduce the types of inpatient hospital admissions that are required to be certified as medically necessary after notice in the State Register and a 30-day comment period.

Subd. 1a. **Administrative reconsideration.** Notwithstanding sections 256B.04, subdivision 15, and 256D.03, subdivision 7, the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 days after receiving notice of the decision. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by physicians that are independent of the case under reconsideration. A majority decision by the physicians is necessary to make a determination that the services were not medically necessary.

Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the commissioner may recover inpatient hospital payments for services that have been determined to be medically unnecessary after the reconsideration and determinations. A physician or hospital may appeal the result of the reconsideration process by submitting a written request for review to the commissioner within 30 days after receiving notice of the action. The commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner shall issue an order upholding or reversing the decision of the reconsideration process based on the review.

Subd. 1c. **Judicial review.** A hospital or physician aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician or hospital is located by:

(1) serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order; and

(2) filing the original notice of appeal and proof of service with the court administrator of the district court. The appeal shall be treated as a dispositive motion under the Minnesota General Rules of Practice, rule 115. The district court scope of review shall be as set forth in section 14.69.

Subd. 1d. **Transmittal of record.** Within 30 days after being served with the notice of appeal, the commissioner shall transmit to the district court the original or certified copy of the entire record considered by the commissioner in making the final agency decision. The district court shall not consider evidence that was not included in the record before the commissioner.

Subd. 2. **Federal requirements.** If it is determined that a provision of this section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare limitations.

History: *1989 c 282 art 3 s 36; 1991 c 292 art 4 s 22; 1992 c 513 art 7 s 22; 1Sp1993 c 1 art 5 s 17; 1995 c 207 art 6 s 16-18; 1997 c 187 art 1 s 19; 1998 c 407 art 4 s 8; 1999 c 245 art 4 s 24; 2002 c 277 s 7*

256.9686 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this section and sections 256.969 and 256.9695, the following terms and phrases have the meanings given.

Subd. 2. **Base year.** "Base year" means a hospital's fiscal year that is recognized by the Medicare program or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information by the Medicare program from which cost and statistical data are used to establish medical assistance and general assistance medical care payment rates.

Subd. 3. **Case mix index.** "Case mix index" means a hospital's distribution of relative values among the diagnostic categories.

Subd. 4. **Charges.** "Charges" means the usual and customary payment requested of the general public.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Hospital.** "Hospital" means a facility defined in section 144.696, subdivision 3, and licensed under sections 144.50 to 144.58, an out-of-state facility licensed to provide acute care under the requirements of that state in which it is located, or an Indian health service facility designated to provide acute care by the federal government.

Subd. 7. **Medical assistance.** "Medical assistance" means the program established under chapter 256B and Title XIX of the Social Security Act. Medical assistance includes general assistance medical care established under chapter 256D, unless otherwise specifically stated.

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.

Subd. 9. **Relative value.** "Relative value" means the average allowable cost of inpatient services provided within a diagnostic category divided by the average allowable cost of inpatient services provided in all diagnostic categories.

History: *1989 c 282 art 3 s 37; 1991 c 292 art 4 s 23,24; 1993 c 339 s 10*

256.969 PAYMENT RATES.

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the

calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care, except that the inflation adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply through calendar year 2001. The index for calendar year 2000 shall be reduced 2.5 percentage points to recover overprojections of the index from 1994 to 1996. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance and general assistance medical care, based upon the hospital cost index.

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, including the system used by the Medicare program to determine the relative values of inpatient services and case mix indices. The commissioner may combine diagnostic classifications into diagnostic categories and may establish separate categories and numbers of categories based on program eligibility or hospital peer group. Relative values shall be recalculated when the base year is changed. Relative value determinations shall include paid claims for admissions during each hospital's base year. The commissioner may extend the time period forward to obtain sufficiently valid information to establish relative values. Relative value determinations shall not include property cost data, Medicare crossover data, and data on admissions that are paid a per day transfer rate under subdivision 14. The computation of the base year cost per admission must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs recognized in outlier payments beyond that point. The commissioner may recategorize the diagnostic classifications and recalculate relative values and case mix indices 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. The commissioner shall recategorize the diagnostic classifications and recalculate relative values and case mix indices based on the two-year schedule in effect prior to January 1, 2013, reflected in subdivision 2b. The first recategorization shall occur January 1, 2013, and shall occur every two years after. When rates are not rebased under subdivision 2b, the commissioner may establish relative values and case mix indices based on charge data and may update the base year to the most recent data available.

Subd. 2a. [Repealed, 1989 c 282 art 3 s 98]

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009. For the rebased period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent rate setting periods

in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. Effective January 1, 2013, and after, rates shall not be rebased. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Subd. 2c. **Property payment rates.** For each hospital's first two consecutive fiscal years beginning on or after July 1, 1988, the commissioner shall limit the annual increase in property payment rates for depreciation, rents and leases, and interest expense to the annual growth in the hospital cost index derived from the methodology in effect on the day before July 1, 1989. When computing budgeted and settlement property payment rates, the commissioner shall use the annual increase in the hospital cost index forecasted by Data Resources, Inc., consistent with the quarter of the hospital's fiscal year end. For admissions occurring on or after the rate year beginning January 1, 1991, the commissioner shall obtain property data from an updated base year and establish property payment rates per admission for each hospital. Property payment rates shall be derived from data from the same base year that is used to establish operating payment rates. The property information shall include cost categories not subject to the hospital cost index and shall reflect the cost-finding methods and allowable costs of the Medicare program. The base year property payment rates shall be adjusted for increases in the property cost by increasing the base year property payment rate 85 percent of the percentage change from the base year through the year for which a Medicare cost report has been submitted to the Medicare program and filed with the department by the October 1 before the rate year. The property rates shall only reflect inpatient services covered by medical assistance. The commissioner shall adjust rates for the rate year beginning January 1, 1991, to ensure that all hospitals are subject to the hospital cost index limitation for two complete years.

Subd. 3. [Repealed, 1989 c 282 art 3 s 98]

Subd. 3a. **Payments.** (a) 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.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities

defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

Subd. 3b. **Nonpayment for hospital-acquired conditions and for certain treatments.** (a) The commissioner must not make medical assistance payments to a hospital for any costs of care that result from a condition listed in paragraph (c), if the condition was hospital acquired.

(b) For purposes of this subdivision, a condition is hospital acquired if it is not identified by the hospital as present on admission. For purposes of this subdivision, medical assistance includes general assistance medical care and MinnesotaCare.

(c) The prohibition in paragraph (a) applies to payment for each hospital-acquired condition listed in this paragraph that is represented by an ICD-9-CM diagnosis code and is designated as a complicating condition or a major complicating condition:

(1) foreign object retained after surgery (ICD-9-CM codes 998.4 or 998.7);

(2) air embolism (ICD-9-CM code 999.1);

(3) blood incompatibility (ICD-9-CM code 999.6);

(4) pressure ulcers stage III or IV (ICD-9-CM codes 707.23 or 707.24);

(5) falls and trauma, including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock (ICD-9-CM codes with these ranges on the complicating condition and major complicating condition list: 800-829; 830-839; 850-854; 925-929; 940-949; and 991-994);

(6) catheter-associated urinary tract infection (ICD-9-CM code 996.64);

(7) vascular catheter-associated infection (ICD-9-CM code 999.31);

(8) manifestations of poor glycemic control (ICD-9-CM codes 249.10; 249.11; 249.20; 249.21; 250.10; 250.11; 250.12; 250.13; 250.20; 250.21; 250.22; 250.23; and 251.0);

(9) surgical site infection (ICD-9-CM codes 996.67 or 998.59) following certain orthopedic procedures (procedure codes 81.01; 81.02; 81.03; 81.04; 81.05; 81.06; 81.07; 81.08; 81.23; 81.24; 81.31; 81.32; 81.33; 81.34; 81.35; 81.36; 81.37; 81.38; 81.83; and 81.85);

(10) surgical site infection (ICD-9-CM code 998.59) following bariatric surgery (procedure codes 44.38; 44.39; or 44.95) for a principal diagnosis of morbid obesity (ICD-9-CM code 278.01);

(11) surgical site infection, mediastinitis (ICD-9-CM code 519.2) following coronary artery bypass graft (procedure codes 36.10 to 36.19); and

(12) deep vein thrombosis (ICD-9-CM codes 453.40 to 453.42) or pulmonary embolism (ICD-9-CM codes 415.11 or 415.19) following total knee replacement (procedure code 81.54) or hip replacement (procedure codes 00.85 to 00.87 or 81.51 to 81.52).

(d) The prohibition in paragraph (a) applies to any additional payments that result from a hospital-acquired condition listed in paragraph (c), including, but not limited to, additional treatment or procedures, readmission to the facility after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital. In the event of a transfer to another hospital, the hospital where the condition listed under paragraph (c) was acquired is responsible for any costs incurred at the hospital to which the patient is transferred.

(e) A hospital shall not bill a recipient of services for any payment disallowed under this subdivision.

Subd. 3c. **Rateable reduction and readmissions reduction.** (a) The total payment for fee for service admissions occurring on or after September 1, 2011, through June 30, 2015, made to hospitals for inpatient services before third-party liability and spenddown, is reduced ten percent from the current statutory rates. Facilities defined under subdivision 16, long-term hospitals as determined under the Medicare program, children's hospitals whose inpatients are predominantly under 18 years of age, and payments under managed care are excluded from this paragraph.

(b) Effective for admissions occurring during calendar year 2010 and each year after, the commissioner shall calculate a regional readmission rate for admissions to all hospitals occurring within 30 days of a previous discharge. The commissioner may adjust the readmission rate taking into account factors such as the medical relationship, complicating conditions, and sequencing of treatment between the initial admission and subsequent readmissions.

(c) Effective for payments to all hospitals on or after July 1, 2013, through June 30, 2015, the reduction in paragraph (a) is reduced one percentage point for every percentage point reduction in the overall readmissions rate between the two previous calendar years to a maximum of five percent.

Subd. 4. [Repealed, 1989 c 282 art 3 s 98]

Subd. 4a. **Reports.** If, under this section or section 256.9685, 256.9686, or 256.9695, a hospital is required to report information to the commissioner by a specified date, the hospital must report the information on time. If the hospital does not report the information on time, the commissioner may determine the information that will be used and may disregard the information that is reported late. If the Medicare program does not require or does not audit information that is needed to establish medical assistance rates, the commissioner may, after consulting the affected hospitals, require reports to be provided, in a format specified by the commissioner, that are based on allowable costs and cost-finding methods of the Medicare program in effect during the base year. The commissioner may require any information that is necessary to implement this section and sections 256.9685, 256.9686, and 256.9695 to be provided by a hospital within a reasonable time period.

Subd. 5. [Repealed, 1989 c 282 art 3 s 98]

Subd. 5a. **Audits and adjustments.** Inpatient hospital rates and payments must be established under this section and sections 256.9685, 256.9686, and 256.9695. The commissioner may adjust rates and payments based on the findings of audits of payments to hospitals, hospital billings, costs, statistical information, charges, or patient records performed by the commissioner or the Medicare program that identify billings, costs, statistical information, or charges for

services that were not delivered, never ordered, in excess of limits, not covered by the medical assistance program, paid separately from rates established under this section and sections 256.9685, 256.9686, and 256.9695, or for charges that are not consistent with other payor billings. Charges to the medical assistance program must be less than or equal to charges to the general public. Charges to the medical assistance program must not exceed the lowest charge to any other payor. The audit findings may be based on a statistically valid sample of hospital information that is needed to complete the audit. If the information the commissioner uses to establish rates or payments is not audited by the Medicare program, the commissioner may require an audit using Medicare principles and may adjust rates and payments to reflect any subsequent audit.

Subd. 6. [Repealed, 1989 c 282 art 3 s 98]

Subd. 6a. **Special considerations.** In determining the payment rates, the commissioner shall consider whether the circumstances in subdivisions 7 to 14 exist.

Subd. 7. [Repealed, 1992 c 513 art 7 s 135]

Subd. 8. **Unusual length of stay experience.** The commissioner shall establish day outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2, 2b, and 2c. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn diagnostic categories shall be established at one standard deviation beyond the mean length of stay, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of 60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission.

Subd. 8a. **Short length of stay.** Except as provided in subdivision 13, for admissions occurring on or after July 1, 1995, payment shall be determined as follows and shall be included in the base year for rate setting purposes:

(1) for an admission that is categorized to a neonatal diagnostic related group in which the length of stay is less than 50 percent of the average length of stay for the category in the base year and the patient at admission is equal to or greater than the age of one, payments shall be established according to the methods of subdivision 14;

(2) for an admission that is categorized to a diagnostic category that includes neonatal respiratory distress syndrome, the hospital must have a level II or level III nursery and the patient must receive treatment in that unit or payment will be made without regard to the syndrome condition.

Subd. 8b. **Admissions for persons who apply during hospitalization.** For admissions for individuals under section 256D.03, subdivision 3, paragraph (a), clause (2), that occur before the date of eligibility, payment for the days that the patient is eligible shall be established according to the methods of subdivision 14.

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance

disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service;

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class;

(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment

volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and

(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).

(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.

(f) For hospital services occurring on or after July 1, 2005, to June 30, 2007:

(1) general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be considered Medicaid disproportionate share hospital payments, except as limited below:

(i) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used for general assistance medical care expenditures;

(ii) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;

(iii) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(iv) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures; and

(2) certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(g) Upon federal approval of the related state plan amendment, paragraph (f) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Subd. 9a. **Disproportionate population adjustments until July 1, 1993.** For admissions occurring between January 1, 1993 and June 30, 1993, the adjustment under this subdivision shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of one standard deviation above the arithmetic mean. The adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, and the result must be multiplied by 1.1.

The provisions of this paragraph are effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 9b. **Implementation of ratable reductions.** Notwithstanding the provisions in subdivision 9, any ratable reductions required under that subdivision or subdivision 9a for fiscal year 1993 shall be implemented as follows:

(1) no ratable reductions shall be applied to admissions occurring between October 1, 1992, and December 31, 1992; and

(2) sufficient ratable reductions shall be taken from hospitals receiving a payment under subdivision 9a for admissions occurring between January 1, 1993, and June 30, 1993, to ensure that all state payments under subdivisions 9 and 9a during federal fiscal year 1993 qualify for federal match.

Subd. 10. **Separate billing by certified registered nurse anesthetists.** Hospitals may exclude certified registered nurse anesthetist costs from the operating payment rate as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of even-numbered years to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services.

For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.

Subd. 11. **Special rates.** The commissioner may establish special rate-setting methodologies, including a per day operating and property payment system, for hospice, ventilator dependent, and other services on a hospital and recipient specific basis taking into consideration such variables as federal designation, program size, and admission from a medical assistance waiver or home care program. The data and rate calculation method shall conform to the requirements of subdivision 13, except that rates shall not be standardized by the case mix index or adjusted by relative values and hospice rates shall not exceed the amount allowed under

federal law. Rates and payments established under this subdivision must meet the requirements of section 256.9685, subdivisions 1 and 2. The cost and charges used to establish rates shall only reflect inpatient medical assistance covered services. Hospital and claims data that are used to establish rates under this subdivision shall not be used to establish payments or relative values under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 12. **Rehabilitation distinct parts.** Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating and property payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services. The commissioner may establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

Subd. 13. **Neonatal transfers.** For admissions occurring on or after July 1, 1989, neonatal diagnostic category transfers shall have operating and property payment rates established at receiving hospitals which have neonatal intensive care units on a per day payment system that is based on the cost finding methods and allowable costs of the Medicare program during the base year. Other neonatal diagnostic category transfers shall have rates established according to subdivision 14. The rate per day for the neonatal service setting within the hospital shall be determined by dividing base year neonatal allowable costs by neonatal patient days. The operating payment rate portion of the rate shall be adjusted by the hospital cost index and the disproportionate population adjustment. For admissions occurring after the transition period specified in section 256.9695, subdivision 3, the operating payment rate portion of the rate shall be standardized by the case mix index and adjusted by relative values. The cost and charges used to establish rates shall only reflect inpatient services covered by medical assistance. Hospital and claims data used to establish rates under this subdivision shall not be used to establish rates under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 14. **Transfers.** Except as provided in subdivisions 11 and 13, operating and property payment rates for admissions that result in transfers and transfers shall be established on a per day payment system. The per day payment rate shall be the sum of the adjusted operating and property payment rates determined under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 12, divided by the arithmetic mean length of stay for the diagnostic category. Each admission that results in a transfer and each transfer is considered a separate admission to each hospital, and the total of the admission and transfer payments to each hospital must not exceed the total per admission payment that would otherwise be made to each hospital under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 13.

Subd. 15. **Routine service cost limitation; applicability.** The computation of each hospital's payment rate and the relative values of the diagnostic categories are not subject to the routine service cost limitation imposed under the Medicare program.

Subd. 16. **Indian health service facilities.** Facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are exempt from the rate

establishment methods required by this section and shall be paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are located within a Minnesota local trade area and that have more than 20 admissions in the base year shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by rule. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Subd. 18. **Out-of-state hospitals outside local trade areas.** Hospitals that are not located within Minnesota or a Minnesota local trade area shall have operating and property rates established at the average of statewide and local trade area rates or, at the commissioner's discretion, at an amount negotiated by the commissioner. Relative values shall not include data from hospitals that have rates established under this subdivision. Payments, including third-party and recipient liability, established under this subdivision may not exceed the charges on a claim specific basis for inpatient services that are covered by medical assistance.

Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical assistance inpatient payment rates must include the cost incurred by hospitals to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients, if the cost is not recognized by another payment source.

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if:

(1) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if:

(1) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if:

(1) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if:

(1) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

Subd. 21. **Mental health or chemical dependency admissions; rates.** Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total

of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

Subd. 22. **Hospital payment adjustment.** For admissions occurring from January 1, 1993 until June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1. Any payment under this clause must be reduced by the amount of any payment received under subdivision 9a. For purposes of this subdivision, medical assistance does not include general assistance medical care.

This subdivision is effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 23. **Hospital payment adjustment after June 30, 1993.** (a) For admissions occurring after June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1.

(b) Any payment under this subdivision must be reduced by the amount of any payment received under subdivision 9, paragraph (b), clause (1) or (2). For purposes of this subdivision, medical assistance does not include general assistance medical care.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in this section. The adjustment must be made on a nondiscounted hospital-specific basis.

Subd. 24. [Repealed, 1995 c 207 art 6 s 124]

Subd. 25. **Long-term hospital rates.** For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

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.

(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.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient

days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199, paragraphs (a) to (d). The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, paragraphs (a) to (d), except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments. Effective for federal disproportionate share hospital funds earned on payments reported under section 256B.199, paragraphs (a) to (d), for services rendered on or after April 1, 2010, payments shall not be made under this subdivision or subdivision 28.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, paragraphs (a) to (d), whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate

entities identified in section 256B.199, paragraphs (a) to (d), adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199, paragraphs (a) to (d), when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199, paragraphs (a) to (d), and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Subd. 28. **Temporary rate increase for qualifying hospitals.** For the period from April 1, 2009, to September 30, 2010, for each hospital with a medical assistance utilization rate equal to or greater than 25 percent during the base year, the commissioner shall provide an equal percentage rate increase for each medical assistance admission. The commissioner shall estimate the percentage rate increase using as the state share of the increase the amount available under section 256B.199, paragraph (d). The commissioner shall settle up payments to qualifying hospitals based on actual payments under that section and actual hospital admissions.

Subd. 29. **Reimbursement for the fee increase for the early hearing detection and intervention program.** For admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under section 144.125, subdivision 1, that is paid by the hospital for public program recipients. This payment increase shall be in effect until the increase is fully recognized in the base year cost under subdivision 2b. This payment shall be included in payments to contracted managed care organizations.

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

History: *1983 c 312 art 5 s 9; 1984 c 534 s 20,21; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1Sp1985 c 9 art 2 s 34-36; 1986 c 420 s 6; 1Sp1986 c 3 art 2 s 51; 1987 c 403 art 2 s 64,65; 1988 c 435 s 1; 1988 c 689 art 2 s 139,140; 1989 c 282 art 3 s 38; 1990 c 568 art 3 s 16,17; 1991 c 292 art 4 s 25-29; 1992 c 464 art 1 s 27,28; 1992 c 513 art 7 s 23-27; 1992 c 603 s 34,35; 1993 c 20 s 1-5; 1Sp1993 c 1 art 5 s 18-25; 1Sp1993 c 6 s 7,8; 1995 c 207 art 6 s 19-25; 1996 c 395 s 11; 1996 c 451 art 2 s 5; art 5 s 11-13; 1997 c 187 art 1 s 20; 1997 c 203 art 4 s 16; 1998 c 407 art 4 s 9,10; 1999 c 245 art 4 s 25; 1Sp2001 c 9 art 2 s 13; art 9 s 37; 2002 c 220 art 15 s 5; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 8-10; 1Sp2005 c 4 art 8 s 12-15; 2007 c 147 art 5 s 4,5; 2008 c 363 art 17 s 5,6; 2009 c 79 art 5 s 11-15; 2009 c 101 art 2 s 109; 2009 c 173 art 1 s 13-15; art 3 s 4; 2010 c 200 art 1 s 2,3; 2010 c 382 s 48; 1Sp2010 c 1 art 16 s 2,3; 1Sp2011 c 9 art 6 s 19-21*

256.9691 TECHNOLOGY ASSISTANCE REVIEW PANEL.

Subdivision 1. **Establishment.** The commissioner of health shall establish a technology assistance review panel to resolve disputes over the provision of health care benefits for technology-assisted persons who receive benefits under a policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under chapter 62A, a subscriber contract of a nonprofit health service plan corporation regulated under chapter 62C, or a certificate of coverage of a health maintenance organization regulated under chapter 62D.

Subd. 2. **Definition.** For purposes of this section, "technology-assisted person" means a person who:

(1) has a chronic health condition;

(2) requires the routine use of a medical device to compensate for the loss of a life-sustaining body function; and

(3) requires ongoing care or monitoring by trained personnel on a daily basis.

Subd. 3. **Steering committee.** The commissioner shall appoint a seven-member steering committee to appoint the review panel members, develop policies and procedures for the review process, including the replacement of review panel members, serve as a liaison between the regulatory agencies and the review panel, and provide the review panel with technical assistance. The steering committee shall consist of representatives of the Departments of Health, Human Services, and Commerce; a health maintenance organization regulated under chapter 62D; an insurer regulated under chapter 62A or a health service plan corporation regulated under chapter 62C; an advocacy organization representing persons who are technology assisted; and a tertiary care center that serves technology-assisted persons. The steering committee shall not be reimbursed for any expenses as defined under section 15.0575, subdivision 3. The steering committee shall dissolve no later than June 30, 1992.

Subd. 4. **Composition of review panel.** (a) The review panel shall be appointed by the members of the steering committee that do not represent state agencies and must include:

(1) a medical director from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(2) a contract benefits analyst from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(3) a consumer board member of an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(4) a physician with expertise in providing care for technology-assisted persons in a nonhospital setting;

(5) a registered nurse with expertise in providing care for technology-assisted persons in a nonhospital setting; and

(6) a consumer of health care benefits regulated under chapter 62A, 62C, or 62D who is a technology-assisted person or the parent or guardian of a technology-assisted person.

(b) The term of service for review panel members is three years except that, for the initial appointment, the steering committee shall establish procedures to assure that the terms of the members are staggered. Members are eligible to serve two consecutive terms.

Subd. 5. **Authority.** The review panel may review cases involving disputes over the provision of contract benefits regarding discharge planning, home health care benefits eligibility and coverage, or changes in the level of home health care services for technology-assisted persons. The review may be requested by a third-party payor, a health or social service professional, or a parent or guardian of a technology-assisted child or a technology-assisted adult. For the case to be eligible for review by the panel, the parent or guardian of a technology-assisted child or technology-assisted adult must consent to the review. The review panel may not review cases involving discharge to a long-term care facility or cases involving coverage by title 18 or 19 of the Social Security Act or other public funding sources. The review panel may seek advice from experts outside the membership of the panel as necessary. The internal grievance process within an insurer, health service plan corporation, or health maintenance organization, except binding arbitration, must be exhausted before requesting a review by the review panel. The recommendations of the review panel are not binding. If, following a review by the review panel, a complaint is filed with the appropriate state agency regarding the same subject matter, the findings of the review panel must be made available to the agency upon request and with the consent of the parent or guardian of a technology-assisted child or technology-assisted adult. The information must be maintained by the agency as nonpublic information under chapter 13. The steering committee may establish policies for reimbursement of expenses for review panel members consistent with the provisions of section 15.0575, subdivision 3.

Subd. 6. **Confidentiality.** All proceedings of the review organization are nonpublic under chapter 13. All data, information, and findings acquired and developed by the review panel in the exercise of its duties or functions must be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review panel or as described in subdivision 5, and are not subject to subpoena or discovery. Members of the review panel may not disclose what transpired at a meeting of the review panel except to the extent necessary to carry out one or more of the purposes of the review panel. The proceedings and record of the review panel are not subject to discovery or introduction into evidence in any civil action against a health care professional or insurer, health service plan corporation, or health maintenance organization, arising out of the matter or matters that are the subject of consideration by the review panel.

Subd. 7. **Limitation on liability for members of steering committee and review panel.** A person who is a member of, or who acts in an advisory capacity to or who gives counsel or services to, the steering committee or review panel is not liable for damages or other relief in any action brought by a person or persons whose case has been reviewed by the panel, by reason of the performance of any duty, function, or activity of the review panel, unless the performance of the duty, function, or activity was motivated by malice toward the person affected. A member is not liable for damages or other relief in any action by reason of the performance of the member of any duty, function, or activity as a member of the steering committee or review panel or by reason of any recommendation or action of the review committee when the member acts in the reasonable belief that the action or recommendation is warranted by the facts known to the member or review panel after reasonable efforts to ascertain the facts.

History: *1990 c 534 s 1*

256.9692 EFFECT OF INTEGRATION AGREEMENT ON DIVISION OF COST.

Beginning in the first calendar month after there is a definitive integration agreement affecting the University of Minnesota hospital and clinics and Fairview hospital and health care services, Fairview hospital and health care services shall pay the University of Minnesota $505,000 on the 15th of each month, after receiving the state payment, provided that the University of Minnesota has fulfilled the requirements of section 256B.19, subdivision 1c.

History: *1996 c 395 s 12; 1996 c 451 art 2 s 6*

256.9693 INPATIENT TREATMENT FOR 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. The commissioner may authorize additional days beyond 45 based on an individual review of medical necessity. 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; 2002 c 379 art 1 s 113; 2005 c 165 art 1 s 2*

256.9695 APPEALS OF RATES; PROHIBITED PRACTICES FOR HOSPITALS; TRANSITION RATES.

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values shall not be recalculated. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

(a) To appeal a payment rate or payment determination or a determination made from base year information, the hospital shall file a written appeal request to the commissioner within 60 days of the date the payment rate determination was mailed. The appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or rule upon which the hospital relies for each disputed item; and (iii) the name and address of the person to contact regarding

the appeal. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information. In the case of Medicare settled appeals, the 60-day appeal period shall begin on the mailing date of the notice by the Medicare program or the date the medical assistance payment rate determination notice is mailed, whichever is later.

(b) To appeal a payment rate or payment change that results from a difference in case mix between the base year and a rate year, the procedures and requirements of paragraph (a) apply. However, the appeal must be filed with the commissioner within 120 days after the end of a rate year. A case mix appeal must apply to the cost of services to all medical assistance patients that received inpatient services from the hospital during the rate year appealed. For case mix appeals filed after January 1, 1997, the difference in case mix and the corresponding payment adjustment must exceed a threshold of five percent.

Subd. 2. **Prohibited practices.** (a) Hospitals that have a provider agreement with the department may not limit medical assistance admissions to percentages of certified capacity or to quotas unless patients from all payors are limited in the same manner. This requirement does not apply to certified capacity that is unavailable due to contracts with payors for specific occupancy levels.

(b) Hospitals may not transfer medical assistance patients to or cause medical assistance patients to be admitted to other hospitals without the explicit consent of the receiving hospital when service needs of the patient are available and within the scope of the transferring hospital. The transferring hospital is liable to the receiving hospital for patient charges and ambulance services without regard to medical assistance payments plus the receiving hospital's reasonable attorney fees if found in violation of this prohibition.

Subd. 3. **Transition.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Subd. 4. **Study.** The commissioner shall contract for an evaluation of the inpatient and outpatient hospital payment systems. The study shall include recommendations concerning:

(1) more effective methods of assigning operating and property payment rates to specific services or diagnoses;

(2) effective methods of cost control and containment;

(3) fiscal impacts of alternative payment systems;

(4) the relationships of the use of and payment for inpatient and outpatient hospital services;

(5) methods to relate reimbursement levels to the efficient provision of services; and

(6) methods to adjust reimbursement levels to reflect cost differences between geographic areas.

The commissioner shall report the findings to the legislature by January 15, 1991, along with recommendations for implementation.

Subd. 5. **Rules.** The commissioner of human services shall adopt permanent rules to implement this section and sections 256.9685, 256.9686, and 256.969 under chapter 14, the Administrative Procedure Act.

History: *1989 c 282 art 3 s 39; 1990 c 568 art 3 s 18,19; 1991 c 292 art 4 s 30,78; 1992 c 513 art 7 s 28; 1993 c 339 s 11,12; 1Sp1993 c 1 art 5 s 26; 1994 c 465 art 3 s 571; 1997 c 203 art 4 s 17*

256.97 [Repealed, 1957 c 737 s 2]

256.971 SERVICES FOR DEAF.

The commissioner of human services shall provide such services for the deaf and hard of hearing in the state as will best promote their personal, economic and social well being. The commissioner shall maintain a register of all such persons, with such information as the commissioner deems necessary to improve services for them. The commissioner shall gather and disseminate information relating to the causes of deafness, collect statistics on the deaf and ascertain what trades or occupations are most suitable for them, and use best efforts to aid them in securing vocational rehabilitation and employment, through cooperation with other agencies, both public and private.

History: *1957 c 737 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.973 [Repealed, 1Sp2003 c 14 art 2 s 57]

256.9731 [Repealed, 2002 c 220 art 16 s 3]

256.974 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE; LOCAL PROGRAMS.

The ombudsman for long-term care serves in the classified service under section 256.01, subdivision 7, in an office within the Minnesota Board on Aging that incorporates the long-term care ombudsman program required by the Older Americans Act, as amended, United States Code, title 42, section 3027(a)(9) and 3058g(a), and established within the Minnesota Board on Aging. The Minnesota Board on Aging may make grants to and designate local programs for the provision of ombudsman services to clients in county or multicounty areas. The local program may not be an agency engaged in the provision of nursing home care, hospital care, or home care services either directly or by contract, or have the responsibility for planning, coordinating, funding, or administering nursing home care, hospital care, or home care services.

History: *1987 c 403 art 2 s 66; 1989 c 282 art 2 s 115; 2007 c 147 art 6 s 9*

256.9741 DEFINITIONS.

Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10; a boarding care home licensed under sections 144.50 to 144.56; or a licensed or registered residential setting that provides or arranges for the provision of home care services.

Subd. 2. **Acute care facility.** "Acute care facility" means a facility licensed as a hospital under sections 144.50 to 144.56.

Subd. 3. **Client.** "Client" means an individual who requests, or on whose behalf a request is made for, ombudsman services and is (a) a resident of a long-term care facility or (b) a Medicare beneficiary who requests assistance relating to access, discharge, or denial of inpatient or outpatient services, or (c) an individual reserving, receiving, or requesting a home care service.

Subd. 4. **Area agency on aging.** "Area agency on aging" means an agency responsible for coordinating a comprehensive aging services system within a planning and service area that has been designated an area agency on aging by the Minnesota Board on Aging.

Subd. 5. **Office.** "Office" means the office of ombudsman established within the Minnesota Board on Aging or local ombudsman programs that the Board on Aging designates.

Subd. 6. **Home care service.** "Home care service" means health, social, or supportive services provided to an individual for a fee in the individual's residence and in the community to

promote, maintain, or restore health, or maximize the individual's level of independence, while minimizing the effects of disability and illness.

History: *1987 c 403 art 2 s 67; 1989 c 282 art 2 s 116-118; 2007 c 147 art 6 s 10,11*

256.9742 DUTIES AND POWERS OF THE OFFICE.

Subdivision 1. **Duties.** The ombudsman's program shall:

(1) gather information and evaluate any act, practice, policy, procedure, or administrative action of a long-term care facility, acute care facility, home care service provider, or government agency that may adversely affect the health, safety, welfare, or rights of any client;

(2) mediate or advocate on behalf of clients;

(3) monitor the development and implementation of federal, state, or local laws, rules, regulations, and policies affecting the rights and benefits of clients;

(4) comment on and recommend to public and private agencies regarding laws, rules, regulations, and policies affecting clients;

(5) inform public agencies about the problems of clients;

(6) provide for training of volunteers and promote the development of citizen participation in the work of the office;

(7) conduct public forums to obtain information about and publicize issues affecting clients;

(8) provide public education regarding the health, safety, welfare, and rights of clients; and

(9) collect and analyze data relating to complaints, conditions, and services.

Subd. 1a. **Designation; local ombudsman staff and volunteers.** (a) In designating an individual to perform duties under this section, the ombudsman must determine that the individual is qualified to perform the duties required by this section.

(b) An individual designated as ombudsman staff under this section must successfully complete an orientation training conducted under the direction of the ombudsman or approved by the ombudsman. Orientation training shall be at least 20 hours and will consist of training in: investigation, dispute resolution, health care regulation, confidentiality, resident and patients' rights, and health care reimbursement.

(c) The ombudsman shall develop and implement a continuing education program for individuals designated as ombudsman staff under this section. The continuing education program shall be at least 60 hours annually.

(d) An individual designated as an ombudsman volunteer under this section must successfully complete an approved orientation training course with a minimum curriculum including federal and state bills of rights for long-term care residents, acute hospital patients and home care clients, the Vulnerable Adults Act, confidentiality, and the role of the ombudsman.

(e) The ombudsman shall develop and implement a continuing education program for ombudsman volunteers which will provide a minimum of 12 hours of continuing education per year.

(f) The ombudsman may withdraw an individual's designation if the individual fails to perform duties of this section or meet continuing education requirements. The individual may request a reconsideration of such action by the Board on Aging whose decision shall be final.

Subd. 2. **Immunity from liability.** The ombudsman or designee including staff and volunteers under this section is immune from civil liability that otherwise might result from the person's actions or omissions if the person's actions are in good faith, are within the scope of the person's responsibilities as an ombudsman or designee, and do not constitute willful or reckless misconduct.

Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a conspicuous place the address and telephone number of the office. A home care service provider shall provide all recipients, including those in housing with services under chapter 144D, with the address and telephone number of the office. Counties shall provide clients receiving long-term care consultation services under section 256B.0911 or home and community-based services through a state or federally funded program with the name, address, and telephone number of the office. The posting or notice is subject to approval by the ombudsman.

Subd. 4. **Access to long-term care and acute care facilities and clients.** The ombudsman or designee may:

(1) enter any long-term care facility without notice at any time;

(2) enter any acute care facility without notice during normal business hours;

(3) enter any acute care facility without notice at any time to interview a patient or observe services being provided to the patient as part of an investigation of a matter that is within the scope of the ombudsman's authority, but only if the ombudsman's or designee's presence does not intrude upon the privacy of another patient or interfere with routine hospital services provided to any patient in the facility;

(4) communicate privately and without restriction with any client, as long as the ombudsman has the client's consent for such communication;

(5) inspect records of a long-term care facility, home care service provider, or acute care facility that pertain to the care of the client according to sections 144.291 to 144.298; and

(6) with the consent of a client or client's legal guardian, the ombudsman or designated staff shall have access to review records pertaining to the care of the client according to sections 144.291 to 144.298. If a client cannot consent and has no legal guardian, access to the records is authorized by this section.

A person who denies access to the ombudsman or designee in violation of this subdivision or aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

Subd. 5. **Access to state records.** The ombudsman or designee, excluding volunteers, has access to data of a state agency necessary for the discharge of the ombudsman's duties, including records classified confidential or private under chapter 13, or any other law. The data requested must be related to a specific case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the ombudsman or designee shall first obtain the individual's consent. If the individual cannot consent and has no legal guardian, then access to the data is authorized by this section.

Each state agency responsible for licensing, regulating, and enforcing state and federal laws and regulations concerning long-term care, home care service providers, and acute care facilities shall forward to the ombudsman on a quarterly basis, copies of all correction orders, penalty assessments, and complaint investigation reports, for all long-term care facilities, acute care facilities, and home care service providers.

Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a patient, resident, or guardian or family member of a patient, resident, or guardian for filing in good faith a complaint with or providing information to the ombudsman or designee including volunteers. A person who violates this subdivision or who aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

(b) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose of this clause, the term "adverse action" refers to action taken by the entity involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from a facility;

(2) termination of service;

(3) restriction or prohibition of access to the facility or its residents;

(4) discharge from or termination of employment;

(5) demotion or reduction in remuneration for services; and

(6) any restriction of rights set forth in section 144.651, 144A.44, or 144A.751.

History: *1987 c 403 art 2 s 68; 1989 c 282 art 2 s 119; 1997 c 7 art 2 s 44; 1997 c 203 art 9 s 6; 2007 c 147 art 6 s 12-14; art 10 s 15*

256.9743 [Repealed, 2007 c 147 art 7 s 76]

256.9744 OFFICE DATA.

Subdivision 1. **Classification.** Except as provided in this section, data maintained by the office under sections 256.974 to 256.9744 are private data on individuals or nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained in accordance with the requirements of the Older Americans Act, as amended, United States Code, title 42, section 3058g(d).

Subd. 2. **Release.** Data maintained by the office that does not relate to the identity of a complainant, a client receiving home-care services, or a resident of a long-term facility may be released at the discretion of the ombudsman responsible for maintaining the data. Data relating to the identity of a complainant, a client receiving home-care services, or a resident of a long-term facility may be released only with the consent of the complainant, the client or resident or by court order.

History: *1987 c 403 art 2 s 70; 1989 c 282 art 2 s 120; 1997 c 203 art 9 s 7; 2007 c 147 art 6 s 15*

256.9745 [Repealed, 1993 c 337 s 20]

256.975 MINNESOTA BOARD ON AGING.

Subdivision 1. **Creation.** There is created a Minnesota Board on Aging consisting of 25 members to be appointed by the governor. At least one member shall be appointed from each congressional district and the remaining members shall be appointed at large. No member shall be appointed for more than two consecutive terms of four years each. In making appointments, the governor shall give consideration to individuals having a special interest in aging, and so far

as practicable, shall include persons affiliated with agriculture, labor, industry, education, social work, health, housing, religion, recreation, and voluntary citizen groups, including senior citizens.

The governor shall designate the chair. Other officers, including vice-chair and secretary, shall be elected by the board members.

Subd. 1a. **Removal; vacancies.** The membership terms, compensation, removal of members, and filling of vacancies on the board shall be as provided in section 15.0575.

Subd. 2. **Duties.** The board shall carry out the following duties:

(1) to advise the governor and heads of state departments and agencies regarding policy, programs, and services affecting the aging;

(2) to provide a mechanism for coordinating plans and activities of state departments and citizens' groups as they pertain to aging;

(3) to create public awareness of the special needs and potentialities of older persons;

(4) to gather and disseminate information about research and action programs, and to encourage state departments and other agencies to conduct needed research in the field of aging;

(5) to stimulate, guide, and provide technical assistance in the organization of local councils on aging;

(6) to provide continuous review of ongoing services, programs and proposed legislation affecting the elderly in Minnesota;

(7) to administer and to make policy relating to all aspects of the Older Americans Act of 1965, as amended, including implementation thereof; and

(8) to award grants, enter into contracts, and adopt rules the Minnesota Board on Aging deems necessary to carry out the purposes of this section.

Subd. 2a. **Electronic meetings.** (a) Notwithstanding section 13D.01, the Minnesota Board on Aging may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the board participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the board can hear all discussion and testimony and all votes of members of the board;

(3) at least one member of the board is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so that each member's vote on each issue can be identified and recorded.

(b) Each member of the board participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

(c) If telephone or other electronic means is used to conduct a meeting, the board, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The board may require the person making a connection to pay for documented marginal costs that the board incurs as a result of the additional connection.

(d) If telephone or other electronic means is used to conduct a regular, special, or emergency meeting, the board shall provide notice of the regular meeting location, of the fact that some members may participate by telephone or other electronic means, and of the provisions of paragraph (c). The timing and method of providing notice is governed by section 13D.04.

Subd. 3. **Policy.** The board shall recommend to the state legislature no later than January 1, 1977, a proposed state policy for citizens dependent on long-term care and services. The proposed state policy shall address, but need not be limited to, the following:

(1) developing alternatives to institutionalization in long-term care facilities and other programs which will assist each citizen dependent on long-term care and services to maintain the highest level of self-sufficiency and independence which the citizen's mental and physical condition allows;

(2) developing methods for ensuring citizens dependent on long-term care and services an effective voice in determining which programs and services are made available to them;

(3) protecting citizens dependent on long-term care and services from unnecessary governmental interference in private and personal affairs; and

(4) informing citizens dependent on long-term care and services of the programs and services for which they are eligible.

Subd. 4. **Home-delivered meals.** The Board on Aging shall take appropriate action to secure reimbursement from public and private medical care programs, health plans, and health insurers for home-delivered meals that are a necessary part of medical treatment for the elderly.

Subd. 5. **Programs for senior citizens and disabled persons.** Any sums collected under section 325F.71 must be deposited into the state treasury and credited to the account of the state Board on Aging. The money credited to the account of the state Board on Aging is annually appropriated to the state board on aging and shall be expended for the following purposes:

(1) to prepare and distribute educational materials to inform senior citizens, disabled persons, and the public regarding consumer protection laws and consumer rights that are of particular interest to senior citizens and disabled persons; or

(2) to underwrite educational seminars and other forms of educational projects for the benefit of senior citizens and disabled persons.

Subd. 6. **Indian elders position.** The Minnesota Board on Aging shall create an Indian elders coordinator position, and shall hire staff as appropriations permit for the purposes of coordinating efforts with the National Indian Council on Aging and developing a comprehensive statewide service system for Indian elders. An Indian elder is defined for purposes of this subdivision as an Indian enrolled in a band or tribe who is 55 years or older. The statewide service system must include the following components:

(1) an assessment of the program eligibility, examining the need to change the age-based eligibility criteria to need-based eligibility criteria;

(2) a planning system that would grant or make recommendations for granting federal and state funding for services;

(3) a plan for service focal points, senior centers, or community centers for socialization and service accessibility for Indian elders;

(4) a plan to develop and implement education and public awareness campaigns including awareness programs, sensitivity cultural training, and public education on Indian elder needs;

(5) a plan for information and referral services including trained advocates and an Indian elder newsletter;

(6) a plan for a coordinated health care system including health promotion/prevention, in-home service, long-term care service, and health care services;

(7) a plan for ongoing research involving Indian elders including needs assessment and needs analysis;

(8) information and referral services for legal advice or legal counsel; and

(9) a plan to coordinate services with existing organizations including the Council of Indian Affairs, the Minnesota Indian Council of Elders, the Minnesota Board on Aging, and tribal governments.

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide 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 provide long-term care options counseling by assisting older adults, caregivers, and providers in accessing information and options counseling 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;

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

(9) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the

data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(10) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

(ii) provide Web-based educational information and collateral written materials to familiarize consumers, family members, or other helpers with the long-term care basics, issues to be considered, and the range of options available in the community;

(iii) provide long-term care futures planning, which means providing assistance to individuals who anticipate having long-term care needs to develop a plan for the more distant future; and

(iv) provide expertise in benefits and financing options for long-term care, including Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages, private pay options, and ways to access low or no-cost services or benefits through volunteer-based or charitable programs;

(11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner. In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:

(i) long-term care consultation services under section 256B.0911;

(ii) designated care coordinators of contracted entities under section 256B.035 for persons who are enrolled in a managed care plan; or

(iii) the long-term care consultation team for those who are appropriate for relocation service coordination due to high-risk factors or psychological or physical disability; and

(12) develop referral protocols and processes that will assist certified health care homes and hospitals to identify at-risk older adults and determine when to refer these individuals to the Senior LinkAge Line for long-term care options counseling under this section. The commissioner is directed to work with the commissioner of health to develop protocols that would comply with the health care home designation criteria and protocols available at the time of hospital discharge. The commissioner shall keep a record of the number of people who choose long-term care options counseling as a result of this section.

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.

Subd. 9. **Prescription drug assistance.** The Minnesota Board on Aging shall establish and administer a prescription drug assistance program to assist individuals in accessing programs offered by pharmaceutical manufacturers that provide free or discounted prescription drugs or provide coverage for prescription drugs. The board shall use computer software programs to:

(1) list eligibility requirements for pharmaceutical assistance programs offered by manufacturers;

(2) list drugs that are included in a supplemental rebate contract between the commissioner and a pharmaceutical manufacturer under section 256.01, subdivision 2, clause (23); and

(3) link individuals with the pharmaceutical assistance programs most appropriate for the individual. The board shall make information on the prescription drug assistance program available to interested individuals and health care providers and shall coordinate the program with the statewide information and assistance service provided through the Senior LinkAge Line under subdivision 7.

Subd. 10. **Communities for a lifetime.** (a) For purposes of this subdivision, "communities for a lifetime" means partnerships of small cities, counties, municipalities, statutory or home rule charter cities, or towns, whose citizens seek to affirmatively extend to persons ages 65 and older the opportunities, supports, and services that will enable them to continue to be contributing, civically engaged residents.

(b) The opportunities extended within a reasonable distance to senior residents by communities for a lifetime must include, but not be limited to:

(1) the opportunity to contribute time and talents through volunteer community service;

(2) the opportunity to participate in the paid workforce, with flexibility of hours and scheduling;

(3) the opportunity for socializing, recreation, and wellness activities, including both physical exercise and mental stimulation;

(4) the opportunity to "age in place" and choose among a variety of affordable, accessible housing options, including single-family housing, independent congregate senior housing, and senior housing with services;

(5) the opportunity to access quality long-term care in the setting of the senior's own choice; and

(6) the opportunity for community-wide mobility and to access public transportation, including door-to-door assistance and weekend and evening access.

(c) Communities for a lifetime must demonstrate the availability of supports and services for senior residents that include, but are not limited to:

(1) an array of home and community-based services to support seniors' options to remain in an independent living setting as they age and become more frail;

(2) access to contemporary remote medical technology for cost-effective home-based monitoring of medical conditions;

(3) access to nutrition programs, including congregate meal and home-delivered meal opportunities;

(4) access to a comprehensive caregiver support system for family members and volunteer caregivers, including:

(i) technological support for caregivers remaining in the paid workforce to manage caregiver responsibilities effectively; and

(ii) respite care that offers temporary substitute care and supervision for frail seniors;

(5) personal assistance in accessing services and supports, and in seeking financing for these services and supports;

(6) high-quality assisted living facilities within a senior's geographic setting of choice;

(7) high-quality nursing care facilities within a senior's geographic setting of choice; and

(8) the protection offered to vulnerable seniors by a publicly operated adult protective service.

(d) Communities for a lifetime must also:

(1) establish an ongoing local commission to advise the community for a lifetime on its provision of the opportunities, services, and supports identified in paragraphs (b) and (c);

(2) offer training and learning opportunities for businesses, civic groups, fire and police personnel, and others frequently interacting with seniors on appropriate methods of interacting with seniors; and

(3) incorporate into its local plan, developed in accordance with sections 366.10, 394.232, and 462.353, elements that address the impact of the forecast change in population age structure on land use, housing, public facilities, transportation, capital improvement, and other areas addressed by local plans; provisions addressing the availability of the opportunities, supports, and services identified in paragraphs (b) and (c); and strategies to develop physical infrastructure responsive to the needs of the projected population.

(e) In implementing this subdivision, the Minnesota Board on Aging shall:

(1) consult with, and when appropriate work through, the area agencies on aging;

(2) consult with the commissioners of human services, health, and employment and economic development, and the League of Minnesota Cities and other organizations representing local units of government; and

(3) review models of senior-friendly community initiatives from other states and organizations.

(f) The Board on Aging shall report to the legislature by February 28, 2010, with recommendations on (1) a process for communities to request and receive the designation of community for a lifetime, and (2) funding sources to implement these communities.

History: *1961 c 466 s 1,2; 1974 c 536 s 1; 1975 c 271 s 6; 1976 c 134 s 59,60; 1976 c 275 s 1; 1986 c 404 s 10; 1986 c 444; 1989 c 282 art 2 s 121; 1989 c 294 s 1; 1995 c 207 art 3 s 17; 1Sp2001 c 9 art 4 s 2; art 8 s 13; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 11; 2005 c 56 s 1; 1Sp2005 c 4 art 8 s 16; 2007 c 147 art 6 s 16; art 7 s 5; 2009 c 60 s 1; 2009 c 79 art 8 s 16; 2009 c 173 art 1 s 16; 1Sp2010 c 1 art 17 s 8; 2012 c 247 art 4 s 14*

256.9751 [Renumbered 256.9731]

256.9752 SENIOR NUTRITION PROGRAMS.

Subdivision 1. **Program goals.** It is the goal of all agencies on aging and senior nutrition programs to support the physical and mental health of seniors living in the community by:

(1) promoting nutrition programs that serve senior citizens in their homes and communities; and

(2) providing, within the limit of funds available, the support services that will enable the senior citizen to access nutrition programs in the most cost-effective and efficient manner.

Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate to area agencies on aging the federal funds which are received for the senior nutrition programs of congregate dining and home-delivered meals in a manner consistent with federal requirements.

Subd. 3. **Nutrition support services.** (a) Funds allocated to an area agency on aging for nutrition support services may be used for the following:

(1) transportation of home-delivered meals and purchased food and medications to the residence of a senior citizen;

(2) expansion of home-delivered meals into unserved and underserved areas;

(3) transportation to supermarkets or delivery of groceries from supermarkets to homes;

(4) vouchers for food purchases at selected restaurants in isolated rural areas;

(5) food stamp or food support outreach;

(6) transportation of seniors to congregate dining sites;

(7) nutrition screening assessments and counseling as needed by individuals with special dietary needs, performed by a licensed dietitian or nutritionist; and

(8) other appropriate services which support senior nutrition programs, including new service delivery models.

(b) An area agency on aging may transfer unused funding for nutrition support services to fund congregate dining services and home-delivered meals.

History: *1996 c 451 art 6 s 10; 1Sp2003 c 14 art 1 s 106*

256.9753 VOLUNTEER PROGRAMS FOR RETIRED SENIOR CITIZENS.

Subdivision 1. **Policy.** The legislature finds that the services of volunteers are crucial to the effectiveness of public and private human services programs in the state. The legislature further finds that retired senior citizens are an excellent source of volunteer services, and that by recognizing and supporting retired senior volunteer programs the state will be serving the interests of human services as well as the interests of those senior citizens who participate in the volunteer programs.

Subd. 2. **State support.** The Board on Aging, with the cooperation of heads of other affected state agencies, shall provide staff and material support and shall make financial grants consistent with the purposes of subdivisions 1 to 4, to retired senior volunteer programs in the state. This support may include reimbursement of expenses incurred by program participants in the performance of their volunteer activities.

Subd. 3. **Expenditures.** The board shall consult with the commissioner of human services, prior to expending money available for the retired senior volunteer programs. Expenditures shall be made (1) to strengthen and expand existing retired senior volunteer programs, and (2) to

encourage the development of new programs in areas in the state where these programs do not exist. Grants shall be made consistent with applicable federal guidelines.

Subd. 4. **Report.** The board shall report to the governor and the legislature by July 1, 1981, on (1) the number, type and location of human services activities assisted by retired senior volunteer programs supported pursuant to subdivisions 1 to 4; (2) the number of retired seniors participating in these activities; (3) the sources and recipients of direct support for the volunteer programs; and (4) any other information which the board believes will assist the governor and the legislature in evaluating the programs.

History: *1980 c 455 s 1-4; 1996 c 305 art 1 s 57; 2002 c 220 art 10 s 33*

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, fund-raising, 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; 2002 c 379 art 1 s 113*

256.976 FOSTER GRANDPARENTS PROGRAM.

Subdivision 1. **Program established.** There is established a foster grandparents program which will engage the services of low-income persons aged 60 or over to provide supportive person to person assistance in health, education, welfare, and related fields to persons receiving care in resident group homes for dependent and neglected persons, day care centers or other public or private nonprofit institutions or agencies providing care for neglected and disadvantaged persons who lack close personal relationships.

Subd. 2. **Compensation.** Persons employed as foster grandparents shall be compensated for no more than 20 hours per week and at an hourly rate not to exceed the federal minimum wage by more than 20 percent. In addition to such compensation foster grandparents shall be eligible for protective clothing, including replacement of glasses; transportation assistance, not to exceed mileage payments for 20 miles per day or chartered transportation service, for travel between residence and place of employment; workers' compensation; annual physical examinations; food services during employment, generally provided by the employing agency or institution; and such other assistance as the Minnesota Board on Aging may prescribe. No person employed as a foster grandparent shall be terminated because of redefinition of income standards, or a change of income, marital status, or number of dependents.

Subd. 3. **Grants-in-aid.** The Minnesota Board on Aging, hereinafter called the board, may make grants-in-aid for the employment of foster grandparents to qualified resident group homes for dependent and neglected persons, day care centers and other public or nonprofit private institutions and agencies providing care for neglected and disadvantaged persons who lack close personal relationships. Agencies and institutions seeking aid shall apply on a form prescribed by the board. Priority shall be given to agencies and institutions providing care for retarded children. Grants shall not be made to local public or nonprofit agencies until 40 percent of the recognized need for foster grandparents within state institutions has been met. Grants shall be for a period of 12 months or less, and grants to local public and nonprofit agencies or institutions shall be based on 90 percent state, and ten percent local sharing of program expenditures authorized by the board. Grants shall not be used to match other state funds nor shall any person paid from grant funds be used to replace any staff member of the grantee. Grants may be used to match federal funds. Each grantee shall file a semiannual report with the board at the time and containing such information as the board shall prescribe.

Subd. 4. **Rulemaking authority.** The board is authorized, subject to the provisions of chapter 14, to make rules necessary to the operation of the foster grandparent program and to employ assistance in performing its administrative duties. In adopting rules the board shall give consideration to applicable federal guidelines.

History: *1971 c 938 s 1; 1973 c 302 s 1,2; 1975 c 271 s 6; 1975 c 359 s 23; 1983 c 216 art 1 s 39*

256.977 SENIOR COMPANION PROGRAM.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Senior Companion Act."

Subd. 2. **Establishment of program.** There is established a senior companion program to engage the services of low-income persons aged 60 or over to provide supportive person to person assistance in health, education, welfare and related fields primarily to disabled adults and elderly people living in their own homes. Senior companions may also be used to provide such

services to disabled adults and elderly persons living or receiving care in resident group homes for dependent and neglected persons, nursing homes, private homes, or other public or private nonprofit institutions or agencies providing care for disabled adults or elderly persons. Foster grandparents currently serving individuals over 21 years of age pursuant to section 256.976 shall, after July 1, 1976, be called senior companions.

Subd. 3. **Compensation.** Persons serving as senior companions shall be compensated for no more than 20 hours per week at an hourly rate not to exceed the rate established under the Older Americans Act. In addition, senior companions shall receive such other assistance as the Minnesota Board on Aging may prescribe. No person serving as a senior companion shall be terminated as a result of a change in the eligibility requirements set by the Minnesota Board on Aging, nor as a result of a change in income, marital status, or number of dependents.

Subd. 4. **Grants.** The Minnesota Board on Aging may make grants-in-aid for the purchase of senior companion services by nonprofit agencies and institutions and individuals who have access to or responsibility for disabled adults and the elderly. Applications to provide senior companion services to individuals in their homes shall have priority over applications to provide services to individuals living in group homes, nursing homes, or other institutions. Applications for grants shall be made on forms prescribed by the Minnesota Board on Aging.

Grants shall be paid as follows: 90 percent of the program expenditures authorized by the Minnesota Board on Aging shall be paid by the state and ten percent shall be paid by local matching funds. Grants shall be for a period of 12 months or less. Grants shall not be used to match other state funds nor shall any person paid from grant funds be used to replace any staff members of the grantee. Each grantee shall file a semiannual report with the Minnesota Board on Aging at the time and containing the information as the board shall prescribe.

Subd. 5. **Rules.** The Minnesota Board on Aging shall promulgate rules necessary to implement the provisions of this section and may employ necessary assistance in performing its administrative duties. Rules adopted shall be consistent with applicable federal guidelines.

History: *1976 c 323 s 1-2; 1986 c 444; 2005 c 56 s 1*

256.9772 [Repealed, 1Sp2003 c 14 art 2 s 57]

256.978 LOCATION OF PARENTS, ACCESS TO RECORDS.

Subdivision 1. **Request for information.** (a) The public authority responsible for child support in this state or any other state, in order to locate a person or to obtain information necessary to establish paternity and child support or to modify or enforce child support or distribute collections, may request information reasonably necessary to the inquiry from the records of (1) state agencies or political subdivisions of this state, as defined in section 13.02, which shall, notwithstanding the provisions of section 268.19 or any other law to the contrary, provide the information necessary for this purpose; and (2) employers, utility companies, insurance companies, financial institutions, credit grantors, and labor associations doing business in this state. They shall provide a response upon written or electronic request within 30 days of service of the request made by the public authority. Information requested and used or transmitted by the commissioner according to the authority conferred by this section may be made available to other agencies, statewide systems, and political subdivisions of this state, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program.

(b) For purposes of this section, "state" includes the District of Columbia, Puerto Rico, the United States Virgin Islands, and any territory or insular possession subject to the jurisdiction of the United States.

Subd. 2. **Access to information.** (a) A request for information by the public authority responsible for child support of this state or any other state may be made to:

(1) employers when there is reasonable cause to believe that the subject of the inquiry is or was an employee or independent contractor of the employer. Information to be released by employers of employees is limited to place of residence or address, home telephone, work telephone, mobile telephone, e-mail address, employment status, wage or payment information, benefit information, and Social Security number. Information to be released by employers of independent contractors is limited to place of residence or address, home telephone, work telephone, mobile telephone, e-mail address, contract status, payment information, benefit information, and Social Security number or identification number;

(2) utility companies when there is reasonable cause to believe that the subject of the inquiry is or was a retail customer of the utility company. Customer information to be released by utility companies is limited to place of residence or address, home telephone, work telephone, mobile telephone, e-mail address, source of income, employer and place of employment, and Social Security number;

(3) insurance companies when there is reasonable cause to believe that the subject of the inquiry is or was receiving funds either in the form of a lump sum or periodic payments. Information to be released by insurance companies is limited to place of residence or address, home telephone, work telephone, mobile telephone, e-mail address, employer, Social Security number, and amounts and type of payments made to the subject of the inquiry;

(4) labor organizations when there is reasonable cause to believe that the subject of the inquiry is or was a member of the labor association. Information to be released by labor associations is limited to place of residence or address, home telephone, work telephone, mobile telephone, e-mail address, Social Security number, and current and past employment information; and

(5) financial institutions when there is reasonable cause to believe that the subject of the inquiry has or has had accounts, stocks, loans, certificates of deposits, treasury bills, life insurance policies, or other forms of financial dealings with the institution. Information to be released by the financial institution is limited to place of residence or address, home telephone, work telephone, mobile telephone, e-mail address, identifying information on the type of financial relationships, Social Security number, current value of financial relationships, and current indebtedness of the subject with the financial institution.

(b) For purposes of this section, utility companies include telephone companies, as defined in section 325F.675, subdivision 3, clause (3), radio common carriers, and telecommunications carriers as defined in section 237.01, and companies that provide electrical, telephone, natural gas, propane gas, oil, coal, or cable or satellite television services to retail customers, and Internet service providers. The term financial institution includes banks, savings and loans, credit unions, brokerage firms, mortgage companies, insurance companies, benefit associations, safe deposit companies, money market mutual funds, or similar entities authorized to do business in the state.

(c) For purposes of this section, the public authority may request or obtain information from any person or entity enumerated in this section, or from any third party who contracts with any such person or entity to obtain or retain information that may be requested by the public authority.

Subd. 3. **Immunity.** A person who releases information to the public authority as authorized under this section is immune from liability for release of the information.

History: *1963 c 401 s 1; 1982 c 488 s 1; 1984 c 654 art 5 s 58; 1988 c 668 s 3; 1989 c 184 art 2 s 10; 1993 c 340 s 7; 1995 c 257 art 3 s 1; 1997 c 66 s 79; 1997 c 203 art 6 s 11,12; 1997 c 245 art 3 s 6; 1999 c 245 art 7 s 3; 2000 c 458 s 2; 2000 c 468 s 24; 2005 c 159 art 4 s 1; 2010 c 238 s 1*

256.979 CHILD SUPPORT INCENTIVES.

Subdivision 1. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 2. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 3. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 4. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 5. [Repealed, 1Sp2011 c 9 art 1 s 35]

Subd. 6. [Repealed, 1Sp2011 c 9 art 1 s 35]

Subd. 7. [Repealed, 1Sp2011 c 9 art 1 s 35]

Subd. 8. [Repealed, 2010 c 200 art 1 s 21]

Subd. 9. [Repealed, 1997 c 203 art 6 s 93]

Subd. 10. [Repealed, 1Sp2011 c 9 art 1 s 35]

Subd. 11. **Federal child support incentives.** (a) The commissioner of human services shall distribute to the counties the earned federal child support incentive payments using the methodology specified in Title IV-D of the Social Security Act and applicable federal regulations for earning federal incentives by the states except for the paternity portion of the incentive. The commissioner shall distribute the federal paternity incentive earned using the IV-D paternity establishment percentage. The commissioner shall follow the federal transition plans in distributing the incentives to the counties. The commissioner shall distribute to the county child support agency estimated federal incentive payments within 60 days after the end of each calendar quarter. The commissioner shall issue actual federal incentive payments to the county agency within 60 days of receiving the final federal incentive grant award from the federal agency.

(b) The county child support agency shall reinvest incentive funds disbursed under this section in the county child support enforcement program. These funds may not be used by a county to reduce funding of the child support enforcement program by the amount of the incentive earned below the base amount allowed under the applicable federal regulations. The county agency shall maintain a record of incentives earned and expended according to a procedure approved by the commissioner. The county agency shall repay any incentive erroneously issued.

History: *1987 c 403 art 3 s 25; 1993 c 340 s 8-11; 1994 c 529 s 8; 1995 c 178 art 2 s 22; 1997 c 245 art 1 s 4-8; 2000 c 458 s 3; 1Sp2001 c 9 art 12 s 5,6; art 15 s 32; 2002 c 344 s 6,7; 2002 c 379 art 1 s 113; 2005 c 164 s 29; 1Sp2005 c 7 s 28*

256.9791 [Repealed, 1Sp2011 c 9 art 1 s 35]

256.9792 ARREARAGE COLLECTION PROJECTS.

Subdivision 1. **Arrearage collections.** Arrearage collection projects are created to increase the revenue to the state and counties, reduce public assistance expenditures for former public assistance cases, and increase payments of arrearages to persons who are not receiving public

assistance by submitting cases for arrearage collection to collection entities, including but not limited to, the Department of Revenue and private collection agencies.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section:

(b) "Public assistance arrearage case" means a case where current support may be due, no payment, with the exception of tax offset, has been made within the last 90 days, and the arrearages are assigned to the public agency according to section 256.741.

(c) "Public authority" means the public authority responsible for child support enforcement.

(d) "Nonpublic assistance arrearage case" means a support case where arrearages have accrued that have not been assigned according to section 256.741.

Subd. 3. **Agency participation.** (a) The collection remedy under this section is in addition to and not in substitution for any other remedy available by law to the public authority. The public authority remains responsible for the case even after collection efforts are referred to the Department of Revenue, a private agency, or other collection entity.

(b) The Department of Revenue, a private agency, or other collection entity may not claim collections made on a case submitted by the public authority for a state tax offset under chapter 270A as a collection for the purposes of this project.

Subd. 4. **Eligible cases.** (a) For a case to be eligible for a collection project, the criteria in paragraphs (b) and (c) must be met. Any case from a county participating in the collections project meeting the criteria under this subdivision must be subcommitted for collection.

(b) Notice must be sent to the debtor, as defined in section 270A.03, subdivision 4, at the debtor's last known address at least 30 days before the date the collections effort is transferred. The notice must inform the debtor that the Department of Revenue or a private collections agency will use enforcement and collections remedies and may charge a fee of up to 30 percent of the arrearages. The notice must advise the debtor of the right to contest the debt on grounds limited to mistakes of fact. The debtor may contest the debt by submitting a written request for review to the public authority within 21 days of the date of the notice.

(c) The arrearages owed must be based on a court or administrative order. The arrearages to be collected must be at least $100 and must be at least 90 days past due. For nonpublic assistance cases referred to private agencies, the arrearages must be a docketed judgment under sections 548.09 and 548.091.

Subd. 5. **County participation.** (a) The commissioner of human services shall designate the counties to participate in the projects, after requesting counties to volunteer for the projects.

(b) The commissioner of human services shall designate which counties shall submit cases to the Department of Revenue, a private collection agency, or other collection entity.

Subd. 6. **Fees.** A collection fee set by the commissioner of human services shall be charged to the person obligated to pay the arrearages. The collection fee is in addition to the amount owed, and must be deposited by the commissioner of revenue in the state treasury and credited to the general fund to cover the costs of administering the program or retained by the private agency or other collection entity to cover the costs of administering the collection services.

Subd. 7. **Contracts.** (a) The commissioner of human services may contract with the commissioner of revenue, private agencies, or other collection entities to implement the projects, charge fees, and exchange necessary information.

(b) The commissioner of human services may provide an advance payment to the commissioner of revenue for collection services to be repaid to the Department of Human Services out of subsequent collection fees.

(c) Summary reports of collections, fees, and other costs charged shall be submitted monthly to the state office of child support enforcement.

Subd. 8. **Remedies.** (a) The commissioner of revenue is authorized to use the tax collection remedies in sections 270C.32, subdivision 1, 270C.63, 270C.67, 270C.68, 270C.69, 270C.70 to 270C.72, and 270C.728, and tax return information to collect arrearages.

(b) Liens arising under paragraph (a) shall be perfected under the provisions of section 270C.63. The lien may be filed as long as the time period allowed by law for collecting the arrearages has not expired. The lien shall attach to all property of the debtor within the state, both real and personal under the provisions of section 270C.63. The lien shall be enforced under the provisions in section 270C.63 relating to state tax liens.

History: *1993 c 340 s 14; 1997 c 203 art 6 s 13,14; 2005 c 151 art 2 s 5*

256.98 WRONGFULLY OBTAINING ASSISTANCE; THEFT.

Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapters 256B, 256D, 256J, 256K, or 256L, and child care assistance programs, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or vouchers produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Subd. 2. **Joint trials.** When two or more defendants are jointly charged with the same offense under subdivision 1, or are jointly charged with different offenses under subdivision 1 arising from the same course of conduct, they shall be tried jointly; however, if it appears to the court that a defendant or the state is substantially prejudiced by the joinder for trial, the court may order an election or separate trial of counts, grant a severance of defendants, or provide other relief.

Subd. 3. **Amount of assistance incorrectly paid.** The amount of the assistance incorrectly paid under this section is:

(1) the difference between the amount of assistance actually received on the basis of misrepresented or concealed facts and the amount to which the recipient would have been entitled had the specific concealment or misrepresentation not occurred. Unless required by law, rule, or regulation, earned income disregards shall not be applied to earnings not reported by the recipient; or

(2) equal to all payments for health care services, including capitation payments made to a health plan, made on behalf of a person enrolled in MinnesotaCare, medical assistance, or general assistance medical care, for which the person was not entitled due to the concealment or misrepresentation of facts.

Subd. 4. **Recovery of assistance.** The amount of assistance determined to have been incorrectly paid is recoverable from:

(1) the recipient or the recipient's estate by the county or the state as a debt due the county or the state or both; and

(2) any person found to have taken independent action to establish eligibility for, conspired with, or aided and abetted, any recipient of public assistance found to have been incorrectly paid.

The obligations established under this subdivision shall be joint and several and shall extend to all cases involving client error as well as cases involving wrongfully obtained assistance.

MinnesotaCare participants who have been found to have wrongfully obtained assistance as described in subdivision 1, but who otherwise remain eligible for the program, may agree to have their MinnesotaCare premiums increased by an amount equal to ten percent of their premiums or $10 per month, whichever is greater, until the debt is satisfied.

Subd. 5. **Criminal or civil action.** To prosecute or to recover assistance wrongfully obtained under this section, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general, may institute a criminal or civil action or both.

Subd. 6. **Rule superseded.** Rule 17.03, subdivision 2, of the Minnesota Rules of Criminal Procedure that relates to joint trials is superseded by this section to the extent that it conflicts with this section.

Subd. 7. **Division of recovered amounts.** Except for recoveries under chapter 119B, if the state is responsible for the recovery, the amounts recovered shall be paid to the appropriate units of government. If the recovery is directly attributable to a county, the county may retain one-half of the nonfederal share of any recovery from a recipient or the recipient's estate.

This subdivision does not apply to recoveries from medical providers or to recoveries involving the department of human services, surveillance and utilization review division, state hospital collections unit, and the benefit recoveries division.

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 and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support 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 or food support 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.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, 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. The disqualification must be for a period of one year for the first offense and two years for the second offense. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, 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, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and 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.

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: *1971 c 550 s 1; 1973 c 348 s 1; 1973 c 717 s 16; 1975 c 437 art 2 s 2; 1977 c 225 s 1; 1986 c 444; 1987 c 254 s 6; 1987 c 403 art 2 s 72; 1988 c 712 s 2; 1990 c 566 s 6; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 26; 1992 c 513 art 8 s 14; 1995 c 207 art 2 s 30,31; 1997 c 85 art 5 s 8-10; 1Sp1997 c 5 s 14,15; 1999 c 159 s 46,47; 1999 c 205 art 1 s 54-56; 1Sp2001 c 9 art 10 s 2,66; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 1 s 106; art 9 s 33; art 12 s 12-14; 2004 c 288 art 4 s 26; 2008 c 277 art 1 s 34; 2010 c 301 art 1 s 2*

256.981 TRAINING OF WELFARE FRAUD PROSECUTORS.

The commissioner of human services shall, to the extent an appropriation is provided for this purpose, contract with the county attorney's council or other public or private entity experienced in providing training for prosecutors to conduct quarterly workshops and seminars focusing on current Minnesota family investment program issues, other income maintenance program changes, recovery issues, alternative sentencing methods, use of technical aids for interviews and interrogations, and other matters affecting prosecution of welfare fraud cases.

History: *1987 c 403 art 2 s 154; 1997 c 85 art 4 s 14; 1999 c 159 s 48*

256.982 TRAINING OF WELFARE FRAUD INVESTIGATORS.

The commissioner of human services shall, to the extent an appropriation is provided for this purpose, establish a pilot project for further education and training of welfare fraud investigators. The commissioner may enter into contractual agreements with other state, federal, or county agencies as part of cooperative projects employing experienced investigators to provide on-the-job training to county investigators.

History: *1987 c 403 art 2 s 155*

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioner of human services shall require the maintenance of budget neutral fraud prevention investigation programs in the counties participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties provided the expansion is budget neutral to the state. Under any expansion, the commissioner has the final authority in decisions regarding the creation and realignment of individual county or regional operations.

Subd. 2. **County proposals.** Each participating county agency shall develop and submit an annual staffing and funding proposal to the commissioner no later than April 30 of each year. Each proposal shall include, but not be limited to, the staffing and funding of the fraud prevention investigation program, a job description for investigators involved in the fraud prevention

investigation program, and the organizational structure of the county agency unit, training programs for case workers, and the operational requirements which may be directed by the commissioner. The proposal shall be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

Subd. 3. **Department responsibilities.** The commissioner shall establish training programs which shall be attended by all investigative and supervisory staff of the involved county agencies. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms, which shall be used by the involved county agencies. An individual's application or redetermination form for public assistance benefits, including child care assistance programs and medical care programs, must include an authorization for release by the individual to obtain documentation for any information on that form which is involved in a fraud prevention investigation. The authorization for release is effective for six months after public assistance benefits have ceased.

Subd. 4. **Funding.** (a) County agency reimbursement shall be made through the settlement provisions applicable to the food stamp or food support program, MFIP, child care assistance programs, the medical assistance program, and other federal and state-funded programs.

(b) The commissioner will maintain program compliance if for any three consecutive month period, a county agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioner. This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county agency for fraud prevention investigation (FPI) service provided by the commissioner, or reallocation of program grant funds, or investigative resources, or both, to other counties. The denial of funding shall apply to the general settlement received by the county agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

History: *1989 c 282 art 5 s 41; 1991 c 292 art 5 s 27; 1Sp1993 c 1 art 6 s 24; 1995 c 178 art 2 s 23; 1995 c 207 art 2 s 32; 1997 c 85 art 5 s 11,12; 1999 c 159 s 49; 1999 c 205 art 1 s 57,58; 2000 c 260 s 97; 1Sp2003 c 14 art 1 s 106; 2009 c 79 art 2 s 10*

256.9831 BENEFITS; GAMBLING ESTABLISHMENTS.

Subdivision 1. **Definition.** For purposes of this section, "gambling establishment" means a racetrack licensed under section 240.06 or 240.09, a casino operated under a tribal-state compact under section 3.9221, or any other establishment that receives at least 50 percent of its gross revenue from the conduct of gambling.

Subd. 2. **Financial transaction cards.** The commissioner shall take all actions necessary to ensure that no person may obtain benefits under chapter 256, 256D, or 256J through the use of a financial transaction card, as defined in section 609.821, subdivision 1, paragraph (a), at a terminal located in or attached to a gambling establishment, liquor store, tobacco store, or tattoo parlor.

Subd. 3. **Warrants.** The commissioner shall take all actions necessary to ensure that warrants issued to pay benefits under chapter 256 or 256D bear a restrictive endorsement that prevents their being cashed in a gambling establishment.

History: *1996 c 465 art 3 s 27; 2006 c 212 art 3 s 18; 2012 c 247 art 3 s 5*

256.984 DECLARATION AND PENALTY.

Subdivision 1. **Declaration.** Every application for public assistance under this chapter or chapters 256B, 256D, 256J, and 256L; child care programs under chapter 119B; and food stamps or food support under chapter 393 shall be in writing or reduced to writing as prescribed by the state agency and shall contain the following declaration which shall be signed by the applicant:

"I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or to payment of a fine of not more than $10,000, or both."

Subd. 2. **Penalty.** Any person who willfully and falsely makes the declaration in subdivision 1 is guilty of perjury and shall be subject to the penalties prescribed in section 609.48.

History: *1991 c 292 art 5 s 28; 1997 c 85 art 5 s 13; 1Sp2001 c 9 art 10 s 66; 1Sp2003 c 14 art 1 s 2; 2007 c 147 art 2 s 20*

256.985 [Repealed, 1Sp1993 c 1 art 6 s 56]

256.9850 [Repealed, 1999 c 159 s 154]

256.986 COUNTY COORDINATION OF FRAUD CONTROL ACTIVITIES.

(a) The county agency shall prepare and submit to the commissioner of human services by April 30 of each state fiscal year a plan to coordinate county duties related to the prevention, investigation, and prosecution of fraud in public assistance programs. Each county must submit its first annual plan prior to April 30, 1998.

(b) Within the limits of appropriations specifically made available for this purpose, the commissioner may make grants to counties submitting plans under paragraph (a) to implement coordination activities.

History: *1995 c 178 art 2 s 25; 1997 c 85 art 5 s 14*

256.9861 FRAUD CONTROL; PROGRAM INTEGRITY REINVESTMENT PROJECT.

Subdivision 1. **Program established.** Within the limits of available state and federal appropriations, the commissioner of human services shall make funding available to county agencies for fraud control efforts and require the maintenance of county efforts and financial contributions that were in place during fiscal year 1996.

Subd. 2. **County proposals.** Each included county shall develop and submit annual funding, staffing, and operating grant proposals to the commissioner no later than April 30 of each year for the purpose of allocating federal and state funding and appropriations. Each proposal shall provide information on:

(1) the staffing and funding of the fraud investigation and prosecution operations;

(2) job descriptions for agency fraud control staff;

(3) contracts covering outside investigative agencies;

(4) operational methods to integrate the use of fraud prevention investigation techniques; and

(5) implementation and utilization of administrative disqualification hearings and diversions by the existing county fraud control and prosecution procedures.

Subd. 3. **Department responsibilities.** The commissioner shall provide written instructions outlining the contents of the proposals to be submitted under this section. Instructions shall be made available 30 days prior to the date by which proposals under subdivision 2 must be submitted. The commissioner shall establish training programs which shall be attended by fraud control staff of all involved counties. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms which shall be used by the involved counties.

Subd. 4. **Standards.** The commissioner shall, after consultation with the involved counties, establish standards governing the performance levels of county investigative units based on grant agreements with the county agencies. The standards shall take into consideration and may include investigative caseloads, grant savings levels, the comparison of fraud prevention and prosecution directed investigations, utilization levels of administrative disqualification hearings, the timely reporting and implementation of disqualifications, and the timeliness of the submission of statistical reports.

Subd. 5. **Funding.** (a) State funding shall be made available contingent on counties submitting a plan that is approved by the Department of Human Services. Failure or delay in obtaining that approval shall not, however, eliminate the obligation to maintain fraud control efforts at the June 30, 1996, level. County agency reimbursement shall be made through the settlement provisions applicable to the MFIP, food stamp or food support, and medical assistance programs.

(b) Should a county agency fail to comply with the standards set, or fail to meet cost-effectiveness standards developed by the commissioner for any three-month period, the commissioner shall deny reimbursement or administrative costs, after allowing an opportunity to establish compliance.

(c) Any denial of reimbursement under paragraph (b) is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent months of noncompliance. The county agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or continued deviation from standards of more than ten percent after submission of corrective action plan, will result in denial of funding for each such month during the grant year, or billing of the county agency for program integrity reinvestment project services provided by the commissioner or reallocation of grant funds to other counties. The denial of funding shall apply to the general settlement received by the county agency on a quarterly basis and shall not reduce the grant amount applicable to the program integrity reinvestment project.

History: *1995 c 207 art 2 s 33; 1997 c 85 art 5 s 15-18; 1999 c 159 s 50; 1Sp2003 c 14 art 1 s 106*

256.9862 ELECTRONIC BENEFIT TRANSACTION CARD FEE.

Subdivision 1. **Replacement card.** The commissioner of human services may charge a cardholder, defined as a person in whose name the transaction card was issued, a $2 fee to replace

an electronic benefit transaction card. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

Subd. 2. **Transaction fee.** The commissioner may charge transaction fees in accordance with this subdivision up to a maximum of $10 in transaction fees per cardholder per month. In a given month, the first four cash withdrawals made by an individual cardholder are free. For subsequent cash withdrawals, $1 may be charged. No transaction fee can be charged if the card is used to purchase goods or services on a point of sale basis. A transaction fee subsequently set by the federal government may supersede a fee established under this subdivision. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

History: *1995 c 207 art 2 s 34; 2012 c 247 art 3 s 30*

256.9863 ELECTRONIC BENEFIT TRANSACTION CARD; RECEIPT OF BENEFITS.

Any person in whose name an electronic benefit transaction card has been issued shall be presumed to have received the benefit of all transactions involving that card. This presumption applies in all situations unless the card in question has been reported lost or stolen by the cardholder. This presumption may be overcome by a preponderance of evidence indicating that the card was neither used by nor with the consent of the cardholder. Overcoming this presumption does not create any new or additional payment obligation not otherwise established in law, rule, or regulation.

History: *1997 c 85 art 5 s 19; 2012 c 247 art 3 s 30*

256.9864 REPORTS BY RECIPIENT.

(a) An assistance unit with a recent work history or with earned income shall report monthly to the county agency on income received and other circumstances affecting eligibility or assistance amounts. All other assistance units shall report on income and other circumstances affecting eligibility and assistance amounts, as specified by the state agency.

(b) An assistance unit required to submit a report on the form designated by the commissioner and within ten days of the due date or the date of the significant change, whichever is later, or otherwise report significant changes which would affect eligibility or assistance amounts, is considered to have continued its application for assistance effective the date the required report is received by the county agency, if a complete report is received within a calendar month in which assistance was received.

History: *1997 c 85 art 5 s 20; 1998 c 407 art 6 s 11*

256.9865 RECOVERY OF OVERPAYMENTS AND ATM ERRORS.

Subdivision 1. **Obligation to recover.** If an amount of MFIP assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. This recovery authority also extends to preexisting claims or newly discovered claims established under the AFDC program in effect on January 1, 1997. The agency shall give written notice to the recipient of its intention to recover the overpayment. County agency efforts and financial contributions shall be maintained at the level in place during fiscal year 1996.

Subd. 2. **Recoupment.** When an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member for one or more monthly assistance payments until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent

where fraud has occurred. For recipients receiving benefits via electronic benefits transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error. In cases where there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

Subd. 3. **Voluntary repayments.** Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions in subdivision 2, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

Subd. 4. **Closed case recoveries.** The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance according to standards adopted by rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance unless the individual has been convicted of fraud under section 256.98.

History: *1997 c 85 art 5 s 21; 1Sp2001 c 9 art 10 s 66*

256.9866 COMMUNITY SERVICE AS A COUNTY OBLIGATION.

Community service shall be an acceptable sentencing option but shall not reduce the state or federal share of any amount to be repaid or any subsequent recovery. Any reduction or offset of any such amount ordered by a court shall be treated as follows:

(1) any reduction in an overpayment amount, to include the amount ordered as restitution, shall not reduce the underlying amount established as an overpayment by the state or county agency;

(2) total overpayments shall continue as a debt owed and may be recovered by any civil or administrative means otherwise available to the state or county agency; and

(3) any amount ordered to be offset against any overpayment shall be deducted from the county share only of any recovery and shall be based on the prevailing state minimum wage.

History: *1997 c 85 art 5 s 22; 2002 c 277 s 8*

256.987 ELECTRONIC BENEFIT TRANSFER CARD.

Subdivision 1. **Electronic benefit transfer (EBT) card.** Cash benefits for the general assistance and Minnesota supplemental aid programs under chapter 256D and programs under chapter 256J must be issued on an EBT card with the name of the head of household printed on the card. The card must include the following statement: "It is unlawful to use this card to purchase tobacco products or alcoholic beverages." This card must be issued within 30 calendar days of an eligibility determination. During the initial 30 calendar days of eligibility, a recipient may have cash benefits issued on an EBT card without a name printed on the card. This card may be the same card on which food support benefits are issued and does not need to meet the requirements of this section.

Subd. 2. **Prohibited purchases.** An individual with an EBT card issued for one of the programs listed under subdivision 1 is prohibited from using the EBT debit card to purchase tobacco products and alcoholic beverages, as defined in section 340A.101, subdivision 2. Any prohibited purchases made under this subdivision shall constitute unlawful use and result in disqualification of the cardholder from the program as provided in subdivision 4.

Subd. 3. **EBT use restricted to certain states.** EBT debit cardholders in programs listed under subdivision 1 are prohibited from using the cash portion of the EBT card at vendors and automatic teller machines located outside of Minnesota, Iowa, North Dakota, South Dakota, or Wisconsin. This subdivision does not apply to the food portion.

[See Note.]

Subd. 4. **Disqualification.** (a) Any person found to be guilty of purchasing tobacco products or alcoholic beverages with their EBT debit card 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: (1) Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program under chapter 256J; (2) general assistance program under chapter 256D; or (3) Minnesota supplemental aid program under chapter 256D, shall be disqualified from all of the listed programs.

(b) The needs of the disqualified 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.

(c) The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility for 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.

History: *1Sp2011 c 9 art 1 s 10; 2012 c 247 art 3 s 6-9*

NOTE: Subdivision 3, as added by Laws 2012, chapter 247, article 3, section 8, is effective March 1, 2013. Laws 2012, chapter 247, article 3, section 8, the effective date.

256.9871 REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES, GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.

Liquor stores, tobacco stores, gambling establishments, and tattoo parlors must negotiate with their third-party processors to block EBT card cash transactions at their places of business and withdrawals of cash at automatic teller machines located in their places of business.

History: *1Sp2011 c 9 art 1 s 33*

256.99 REVERSE MORTGAGE PROCEEDS DISREGARDED.

All reverse mortgage loan proceeds received, including interest or earnings thereon, shall be disregarded and shall not be considered available to the borrower for purposes of determining initial or continuing eligibility for, or amount of, medical assistance, Minnesota supplemental assistance, general assistance, general assistance medical care, or a federal or state low interest loan or grant. This section applies regardless of the time elapsed since the loan was made or the disposition of the proceeds.

For purposes of medical assistance eligibility provided under sections 256B.055, 256B.056, and 256B.06, proceeds from a reverse mortgage must be disregarded as income in the month of receipt but are a resource if retained after the month of receipt.

History: *1979 c 265 s 2; 3Sp1981 c 3 s 16; 1985 c 252 s 18; 1988 c 689 art 2 s 268; 1996 c 414 art 1 s 35*

256.991 RULES.

The commissioner of human services may promulgate rules as necessary to implement sections 256.01, subdivision 2; 256.82, subdivision 3; 256.966, subdivision 1; 256D.03, subdivisions 3, 4, 6, and 7; and 261.23. The commissioner shall promulgate rules to establish standards and criteria for deciding which medical assistance services require prior authorization and for deciding whether a second medical opinion is required for an elective surgery. The commissioner shall promulgate rules as necessary to establish the methods and standards for determining inappropriate utilization of medical assistance services.

History: *1983 c 312 art 5 s 38; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1987 c 384 art 2 s 1; 1988 c 719 art 8 s 10; 1989 c 209 art 2 s 28; 1996 c 305 art 2 s 47*

256.995 SCHOOL-LINKED SERVICES FOR AT-RISK CHILDREN AND YOUTH.

Subdivision 1. **Program established.** In order to enhance the delivery of needed services to at-risk children and youth and maximize federal funds available for that purpose, the commissioners of human services and education shall design a statewide program of collaboration between providers of health and social services for children and local school districts, to be financed, to the greatest extent possible, from federal sources. The commissioners of health and public safety shall assist the commissioners of human services and education in designing the program.

Subd. 2. **At-risk children and youth.** The program shall target at-risk children and youth, defined as individuals, whether or not enrolled in school, who are under 21 years of age and who:

(1) are school dropouts;

(2) have failed in school;

(3) have become pregnant;

(4) are economically disadvantaged;

(5) are children of drug or alcohol abusers;

(6) are victims of physical, sexual, or psychological abuse;

(7) have committed a violent or delinquent act;

(8) have experienced mental health problems;

(9) have attempted suicide;

(10) have experienced long-term physical pain due to injury;

(11) are at risk of becoming or have become drug or alcohol abusers or chemically dependent;

(12) have experienced homelessness;

(13) have been excluded or expelled from school under sections 121A.40 to 121A.56; or

(14) have been adjudicated children in need of protection or services.

Subd. 3. **Services.** The program must be designed not to duplicate existing programs, but to enable schools to collaborate with county social service agencies and county health boards and with local public and private providers to assure that at-risk children and youth receive health care, mental health services, family drug and alcohol counseling, and needed social services. Screenings and referrals under this program shall not duplicate screenings under section 121A.17.

Subd. 4. **Funding.** The program must be designed to take advantage of available federal funding, including the following:

(1) child welfare funds under United States Code, title 42, sections 620-628 (1988) and United States Code, title 42, sections 651-669 (1988);

(2) funds available for health care and health care screening under medical assistance, United States Code, title 42, section 1396 (1988);

(3) social services funds available under United States Code, title 42, section 1397 (1988);

(4) children's day care funds available under federal transition year child care, the Family Support Act, Public Law 100-485; federal at-risk child care program, Public Law 101-5081; and federal child care and development block grant, Public Law 101-5082; and

(5) funds available for fighting drug abuse and chemical dependency in children and youth, including the following:

(i) funds received by the Office of Drug Policy under the federal Anti-Drug Abuse Act and other federal programs;

(ii) funds received by the commissioner of human services under the federal alcohol, drug abuse, and mental health block grant; and

(iii) funds received by the commissioner of human services under the Drug-Free Schools and Communities Act.

Subd. 5. **Waivers.** The commissioner of human services shall collaborate with the commissioners of education, health, and public safety to seek the federal waivers necessary to secure federal funds for implementing the statewide school-based program mandated by this section. Each commissioner shall amend the state plans for programs specified in subdivision 3, to the extent necessary to ensure the availability of federal funds for the school-based program.

Subd. 6. **Pilot projects.** Within 90 days of receiving the necessary federal waivers, the commissioners of human services and education shall implement at least two pilot programs that link health and social services in the schools. One program shall be located in a school district in the seven-county metropolitan area. The other program shall be located in a greater Minnesota school district. The commissioner of human services, in collaboration with the commissioner of education, shall select the pilot programs on a request for proposal basis. The commissioners shall give priority to school districts with some expertise in collocating services for at-risk children and youth. Programs funded under this subdivision must:

(1) involve a plan for collaboration between a school district and at least two local social service or health care agencies to provide services for which federal funds are available to at-risk children or youth;

(2) include parents or guardians in program planning and implementation;

(3) contain a community outreach component; and

(4) include protocol for evaluating the program.

Subd. 7. [Repealed, 1999 c 86 art 1 s 83]

History: *1992 c 571 art 10 s 18; 1Sp1995 c 3 art 16 s 13; 1998 c 397 art 11 s 3; 2003 c 130 s 12*

256.996 [Repealed, 1997 c 245 art 2 s 12]

256.997 CHILD SUPPORT OBLIGOR COMMUNITY SERVICE WORK EXPERIENCE PROGRAM.

Subdivision 1. **Authorization.** The commissioner of human services may contract with a county that operates a community work experience program or a judicial district Department of Corrections that operates a community work experience program to include child support obligors who are physically able to work and fail to pay child support as participants in the community work experience program.

Subd. 2. **Limitations.** (a) Except as provided in paragraph (f), a person ordered to participate in a work program under section 518A.72 shall do so if services are available.

(b) A person may not be required to participate for more than 32 hours per week in the program under this section.

(c) A person may not be required to participate for more than six weeks for each finding of contempt.

(d) If a person is required by a governmental entity to participate in another work or training program, the person may not be required to participate in a program under this section in a week for more than 32 hours minus the number of hours the person is required to participate in the other work or training program in that week.

(e) If a person is employed, the person may not be required to participate in a program under this section in a week for more than 80 percent of the difference between 40 hours and the number of hours actually worked in the unsubsidized job during that week, to a maximum of 32 hours.

(f) A person who works an average of 32 hours or more per week in an unsubsidized job is not required to participate in a program under this section.

Subd. 3. **Notice to court.** If a person does not complete six weeks of participation in a program under this section, the county operating the program shall inform the court administrator, by affidavit, of that noncompletion.

Subd. 4. **Injury protection for work experience participants.** (a) This subdivision applies to payment of any claims resulting from an alleged injury or death of a child support obligor participating in a community work experience program established and operated by a county or a judicial district department of corrections under this section.

(b) Claims that are subject to this section must be investigated by the county agency responsible for supervising the work to determine whether the claimed injury occurred, whether the claimed medical expenses are reasonable, and whether the loss is covered by the claimant's insurance. If insurance coverage is established, the county agency shall submit the claim to the appropriate insurance entity for payment. The investigating county agency shall submit all valid claims, in the amount net of any insurance payments, to the commissioner of human services.

(c) The commissioner of human services shall submit all claims for impairment compensation to the commissioner of labor and industry. The commissioner of labor and industry shall review all submitted claims and recommend to the commissioner of human services an amount of compensation comparable to what would be provided under the impairment compensation schedule of section 176.101, subdivision 3b.

(d) The commissioner of human services shall approve a claim of $1,000 or less for payment if appropriated funds are available, if the county agency responsible for supervising the work has made the determinations required by this section, and if the work program was operated

in compliance with the safety provisions of this section. The commissioner shall pay the portion of an approved claim of $1,000 or less that is not covered by the claimant's insurance within three months of the date of submission. On or before February 1 of each year, the commissioner shall submit to the appropriate committees of the senate and the house of representatives a list of claims of $1,000 or less paid during the preceding calendar year and shall be reimbursed by legislative appropriation for any claims that exceed the original appropriation provided to the commissioner to operate this program. Unspent money from this appropriation carries over to the second year of the biennium, and any unspent money remaining at the end of the second year must be returned to the general fund. On or before February 1 of each year, the commissioner shall submit to the appropriate committees of the senate and the house of representatives a list of claims in excess of $1,000 and a list of claims of $1,000 or less that were submitted to but not paid by the commissioner of human services, together with any recommendations of appropriate compensation. These claims shall be heard and determined by the appropriate committees of the senate and house of representatives and, if approved, paid under the legislative claims procedure.

(e) Compensation paid under this section is limited to reimbursement for reasonable medical expenses and impairment compensation for disability in like amounts as allowed in section 176.101, subdivision 3b. Compensation for injuries resulting in death shall include reasonable medical expenses and burial expenses in addition to payment to the participant's estate in an amount not to exceed the limits set forth in section 466.04. Compensation may not be paid under this section for pain and suffering, lost wages, or other benefits provided in chapter 176. Payments made under this section must be reduced by any proceeds received by the claimant from any insurance policy covering the loss. For the purposes of this section, "insurance policy" does not include the medical assistance program authorized under chapter 256B or the general assistance medical care program authorized under chapter 256D.

(f) The procedure established by this section is exclusive of all other legal, equitable, and statutory remedies against the state, its political subdivisions, or employees of the state or its political subdivisions. The claimant may not seek damages from any state or county insurance policy or self-insurance program.

(g) A claim is not valid for purposes of this subdivision if the local agency responsible for supervising the work cannot verify to the commissioner of human services:

(1) that appropriate safety training and information is provided to all persons being supervised by the agency under this subdivision; and

(2) that all programs involving work by those persons comply with federal Occupational Safety and Health Administration and state Department of Labor and Industry safety standards.

A claim that is not valid because of failure to verify safety training or compliance with safety standards may not be paid by the commissioner of human services or through the legislative claims process and must be heard, decided, and paid, if appropriate, by the local government unit responsible for supervising the work of the claimant.

Subd. 5. **Transportation expenses.** A county shall reimburse a person for reasonable transportation costs incurred because of participation in a program under this section, up to a maximum of $25 per month.

Subd. 6. **Payment to county.** The commissioner shall pay a county $200 for each person who participates in the program under this section in that county. The county is responsible for any additional costs of the program.

History: *1995 c 257 art 1 s 15; 2005 c 164 s 29; 1Sp2005 c 7 s 28*

256.998 WORK REPORTING SYSTEM.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Date of hiring" means the earlier of: (1) the first day for which an employee is owed compensation by an employer; or (2) the first day that an employee reports to work or performs labor or services for an employer.

(c) "Earnings" means payment owed by an employer for labor or services rendered by an employee.

(d) "Employee" means a person who resides or works in Minnesota, performs services for compensation, in whatever form, for an employer and satisfies the criteria of an employee under chapter 24 of the Internal Revenue Code. Employee does not include:

(1) persons hired for domestic service in the private home of the employer, as defined in the Federal Tax Code; or

(2) an employee of the federal or state agency performing intelligence or counterintelligence functions, if the head of such agency has determined that reporting according to this law would endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(e) "Employer" means a person or entity located or doing business in this state that employs one or more employees for payment, and satisfies the criteria of an employer under chapter 24 of the Internal Revenue Code. Employer includes a labor organization as defined in paragraph (g). Employer also includes the state, political or other governmental subdivisions of the state, and the federal government.

(f) "Hiring" means engaging a person to perform services for compensation and includes the reemploying or return to work of any previous employee who was laid off, furloughed, separated, granted a leave without pay, or terminated from employment when a period of 60 days elapses from the date of layoff, furlough, separation, leave, or termination to the date of the person's return to work.

(g) "Labor organization" means entities located or doing business in this state that meet the criteria of labor organization under section 2(5) of the National Labor Relations Act. This includes any entity, that may also be known as a hiring hall, used to carry out requirements described in chapter 7 of the National Labor Relations Act.

(h) "Payor" means a person or entity located or doing business in Minnesota who pays money to an independent contractor according to an agreement for the performance of services.

Subd. 2. **Work reporting system established.** The commissioner of human services shall establish a centralized work reporting system for the purpose of receiving and maintaining information from employers on newly hired or rehired employees. The commissioner of human services shall take reasonable steps to inform the state's employers of the requirements of this section and the acceptable processes by which employers can comply with the requirements of this section.

Subd. 3. **Duty to report.** Employers doing business in this state shall report to the commissioner of human services the hiring of any employee who resides or works in this state to whom the employer anticipates paying earnings. Employers shall submit reports required under this subdivision within 20 calendar days of the date of hiring of the employee.

Employers are not required to report the hiring of any person who will be employed for less than two months' duration; and will have gross earnings less than $250 per month.

Subd. 4. **Means to report.** Employers may report by delivering, mailing, or telefaxing a copy of the employee's federal W-4 form or W-9 form or any other document that contains the required information, submitting electronic media in a compatible format, toll-free telecommunication, or other means authorized by the commissioner of human services that will result in timely reporting.

Subd. 5. **Report contents.** Reports required under this section must contain all the information required by federal law.

Subd. 6. **Sanctions.** If an employer fails to report under this section, the commissioner of human services, by certified mail, shall send the employer a written notice of noncompliance requesting that the employer comply with the reporting requirements of this section. The notice of noncompliance must explain the reporting procedure under this section and advise the employer of the penalty for noncompliance. An employer who has received a notice of noncompliance and later incurs a second violation is subject to a civil penalty of $25 for each intentionally unreported employee. An employer who has received a notice of noncompliance is subject to a civil penalty of $500 for each intentionally unreported employee, if noncompliance is the result of a conspiracy between an employer and an employee not to supply the required report or to supply a false or incomplete report. These penalties may be imposed and collected by the commissioner of human services. An employer who has been served with a notice of noncompliance and incurs a second or subsequent violation resulting in a civil penalty, has the right to a contested case hearing under chapter 14. An employer has 20 days from the date of service of the notice, to file a request for a contested case hearing with the commissioner. The order of the administrative law judge constitutes the final decision in the case.

Subd. 7. **Access to data.** The commissioner of human services shall retain the information reported to the work reporting system for a period of six months. Data in the work reporting system may be disclosed to the public authority responsible for child support enforcement, federal agencies, state and local agencies of other states for the purposes of enforcing state and federal laws governing child support, and agencies responsible for the administration of programs under title IV-A of the Social Security Act, the Department of Employment and Economic Development, and the Department of Labor and Industry.

Subd. 8. **Authority to contract.** The commissioner may contract for services to carry out this section.

Subd. 9. **Independent contractors.** The state and all political subdivisions of the state, when acting in the capacity of an employer, shall report the hiring of any person as an independent contractor to the centralized work reporting system in the same manner as the hiring of an employee is reported.

Other payors may report independent contractors to whom they make payments that require the filing of a 1099-MISC report. Payors reporting independent contractors shall report by use of the same means and provide the same information required under subdivisions 4 and 5. The commissioner of human services shall establish procedures for payors reporting under this section.

Subd. 10. **Use of work reporting system information in determining eligibility for public assistance programs.** The commissioner of human services is authorized to use information from the work reporting system to determine eligibility for applicants and recipients of public assistance programs administered by the Department of Human Services. Data including names, dates of birth, and Social Security numbers of people applying for or receiving public assistance benefits will be compared to the work reporting system information to determine if applicants or recipients of public assistance are employed. County agencies will be notified of discrepancies in information obtained from the work reporting system.

Subd. 11. **Action on information.** Upon receipt of the discrepant information, county agencies will notify clients of the information and request verification of employment status and earnings. County agencies must attempt to resolve the discrepancy within 45 days of receipt of the information.

Subd. 12. **Client notification.** Persons applying for public assistance programs administered by the Department of Human Services will be notified at the time of application that data including their name, date of birth, and Social Security number will be shared with the work reporting system to determine possible employment. All current public assistance recipients will be notified of this provision prior to its implementation.

History: *1995 c 257 art 1 s 16; 1997 c 203 art 6 s 15-20; 1997 c 245 art 1 s 10; art 3 s 7; 2004 c 206 s 52; 2012 c 216 art 1 s 3,4*