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, except for the purposes of Title IV of the Social Security Act.

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 (bb):

(a) Administer and supervise the forms of public assistance provided for by state law and other welfare activities or services that 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.

The commissioner shall work in conjunction with the commissioner of children, youth, and families to carry out the duties of this paragraph when necessary and feasible.

(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 noninstitutional service to persons with disabilities, including persons who have vision impairments, and persons who are deaf, deafblind, and hard-of-hearing or with other disabilities. 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.

(d) 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.

(e) 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.

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

(g) 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.

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

(i) 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.

(j) 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.

(k) 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 United States Secretary of Health and Human Services 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.

(l) According to federal requirements and in coordination with the commissioner of children, youth, and families, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(m) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for medical assistance 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. 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 medical assistance. 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).

(n) 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.

(o) 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).

(p) 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.

(q) 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.

(r) 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.

(s) 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.

(t) 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.

(u) 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. 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.

(v) 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.

(w) 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.

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

(y) 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.

(z) Designate the agencies that operate the Senior LinkAge Line under section 256.975, subdivision 7, and the Disability Hub under subdivision 24 as the state of Minnesota Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006, and incorporate cost reimbursement claims from the designated centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement must be appropriated to the commissioner and treated consistent with section 256.011. All Aging and Disability Resource Center designated agencies shall receive payments of grant funding that supports the activity and generates the federal financial participation according to Board on Aging administrative granting mechanisms.

Subd. 2a. [Repealed, 2013 c 107 art 4 s 22]

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 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. 2c. **Grant consultation.** The commissioner must consult with the commissioner of management and budget to create, review, and revise grant program performance measures and to evaluate grant programs administered by the commissioner in accordance with section 16A.055, subdivisions 1a and 1b.

Subd. 3. [Repealed, 2014 c 262 art 1 s 12]

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

(1) in coordination with the commissioner of children, youth, and families, 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;

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

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

(4) require that the county or Tribal case manager for any person who is notified that their services will be terminated under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), develop an initial action plan within five business days of being notified of the termination; request technical assistance from the state agency; and proceed to promptly work to resolve the issues that led to the termination or arrange for alternative services as expeditiously as possible within the 60-day notice period.

(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; and

(2) 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, or for the purpose of any investigation, hearing, proceeding, or inquiry related to the duties and responsibilities of, the Department of Human Services.

(c) The fees for service of a subpoena in paragraph (b), clause (2), 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 (2), shall be enforceable through the district court in the district where the subpoena is issued.

(e) A subpoena issued under this subdivision must state that the person to whom the subpoena is directed may not disclose the fact that the subpoena was issued or the fact that the requested records have been given to law enforcement personnel or agents of the commissioner except:

(1) insofar as the disclosure is necessary and agreed upon by the commissioner, to find and disclose the records; or

(2) pursuant to court order.

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 SNAP benefits 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 may receive and accept 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. [Renumbered 142A.03, subd 7]

Subd. 12a. [Renumbered 142A.03, subd 8]

Subd. 12b. **Department of Human Services systemic critical incident review team.** (a) The commissioner may establish a Department of Human Services systemic critical incident review team to review critical incidents reported as required under section 626.557 for which the Department of Human Services is responsible under section 626.5572, subdivision 13; chapter 245D; or Minnesota Rules, chapter 9544; or child fatalities and near fatalities that occur in licensed facilities and are not due to natural causes. When reviewing a critical incident, the systemic critical incident review team shall identify systemic influences to the incident rather than determine the culpability of any actors involved in the incident. The systemic

critical incident review may assess the entire critical incident process from the point of an entity reporting the critical incident through the ongoing case management process. Department staff shall lead and conduct the reviews and may utilize county staff as reviewers. The systemic critical incident review process may include but is not limited to:

(1) data collection about the incident and actors involved. Data may include the relevant critical services; the service provider's policies and procedures applicable to the incident; the community support plan as defined in section 245D.02, subdivision 4b, for the person receiving services; or an interview of an actor involved in the critical incident or the review of the critical incident. Actors may include:

(i) staff of the provider agency;

(ii) lead agency staff administering home and community-based services delivered by the provider;

(iii) Department of Human Services staff with oversight of home and community-based services;

(iv) Department of Health staff with oversight of home and community-based services;

(v) members of the community including advocates, legal representatives, health care providers, pharmacy staff, or others with knowledge of the incident or the actors in the incident; and

(vi) staff from the Office of the Ombudsman for Mental Health and Developmental Disabilities and the Office of Ombudsman for Long-Term Care;

(2) systemic mapping of the critical incident. The team conducting the systemic mapping of the incident may include any actors identified in clause (1), designated representatives of other provider agencies, regional teams, and representatives of the local regional quality council identified in section 256B.097; and

(3) analysis of the case for systemic influences.

Data collected by the critical incident review team shall be aggregated and provided to regional teams, participating regional quality councils, and the commissioner. The regional teams and quality councils shall analyze the data and make recommendations to the commissioner regarding systemic changes that would decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system.

(b) Cases selected for the systemic critical incident review process shall be selected by a selection committee among the following critical incident categories:

(1) cases of caregiver neglect identified in section 626.5572, subdivision 17;

(2) cases involving financial exploitation identified in section 626.5572, subdivision 9;

(3) incidents identified in section 245D.02, subdivision 11;

(4) behavior interventions identified in Minnesota Rules, part 9544.0110;

(5) service terminations reported to the department in accordance with section 245D.10, subdivision 3a; and

(6) other incidents determined by the commissioner.

(c) The systemic critical incident review under this section shall not replace the process for screening or investigating cases of alleged maltreatment of an adult under section 626.557 or of a child under chapter

260E. The department may select cases for systemic critical incident review, under the jurisdiction of the commissioner, reported for suspected maltreatment and closed following initial or final disposition.

(d) The proceedings and records of the review team are confidential data on individuals or protected nonpublic data as defined in section 13.02, subdivisions 3 and 13. Data that document a person's opinions formed as a result of the review 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 that the team 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 the information, documents, and records were assessed or presented during proceedings of the review team. A person who presented information before the systemic critical incident review team or who is a member of the team shall not be prevented from testifying about matters within the person's knowledge. In a civil or criminal proceeding, a person shall not be questioned about opinions formed by the person as a result of the review.

(e) By October 1 of each year, the commissioner shall prepare an annual public report containing the following information:

(1) the number of cases reviewed under each critical incident category identified in paragraph (b) and a geographical description of where cases under each category originated;

(2) an aggregate summary of the systemic themes from the critical incidents examined by the critical incident review team during the previous year;

(3) a synopsis of the conclusions, incident analyses, or exploratory activities taken in regard to the critical incidents examined by the critical incident review team; and

(4) recommendations made to the commissioner regarding systemic changes that could decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system.

[See Note.]

Subd. 13. [Repealed, 2013 c 107 art 4 s 22]

Subd. 14. [Repealed, 2014 c 262 art 1 s 12]

Subd. 14a. [Repealed, 2014 c 262 art 1 s 12]

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to initiate 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. The commissioner may authorize projects to use alternative methods of (1) screening, investigating, and assessing reports of child maltreatment, and (2) administrative reconsideration, administrative appeal, and judicial appeal of maltreatment determinations, provided the alternative methods used by the projects comply with the provisions of section 256.045 and chapter 260E that deal with the rights of individuals who are the subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner shall only authorize alternative methods that comply with the public policy under section 260E.01. The commissioner may seek any federal approval 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)(i) have capacity to respond to reports of abuse and neglect under chapter 260E; or (ii) have codified the tribe's screening, investigation, and assessment of reports of child maltreatment procedures, if authorized to use an alternative method by the commissioner under paragraph (a);

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

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

(7) enter into host Tribal contracts pursuant to section 256.0112, subdivision 6.

(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 chapter 260E 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 (12), 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 section 142A.03, subdivision 7. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under section 142A.03, subdivision 7, 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. [Renumbered 142A.03, subd 10]

Subd. 16. **Information for persons with limited English-language proficiency.** 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, 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; and

(2) for all applicants for general assistance, Minnesota supplemental aid, MinnesotaCare, or housing support under chapter 256I, 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) 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 and 256L; and

(2) public benefits under chapters 256D and 256I.

(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, except for convictions under section 152.0263 or 152.0264, 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 142G or 256D, and if an individual is receiving assistance under chapter 142G or 256D, the commissioner shall instruct the county to proceed under section 142G.18 or 256D.024, whichever is applicable, for this individual.

(c) The commissioner shall not retain any data received under paragraph (a) that does not relate to an individual receiving publicly funded assistance under chapter 142G or 256D.

Subd. 18d. **Data sharing with 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, the address, date of birth, driver's license or state identification card number, and all photographs or electronically produced images 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.

Subd. 18e. **Data sharing with 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.

Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to verify assets for an individual applying for or renewing health care benefits under section 256B.055, subdivision 7.

Subd. 19. **Grants for supportive services to persons with HIV or AIDS.** The commissioner may award grants to eligible vendors for the development, implementation, and evaluation of supportive services for individuals infected with the human immunodeficiency virus. HIV/AIDS supportive 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. [Repealed, 2013 c 107 art 4 s 22]

Subd. 24. **Disability Hub.** The commissioner shall establish the Disability Hub, which shall serve people with disabilities as the designated Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006, in partnership with the Senior LinkAge Line and shall serve as Minnesota's neutral access point for statewide disability information and assistance and must be available during business hours through a statewide toll-free number and the Internet. The Disability Hub 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 and link them to quality profiles;

(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 website 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 or to develop and operate an encounter alerting service 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, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek 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) 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 human services judge.

Subd. 30. MS 2022 [Repealed, 2024 c 80 art 1 s 97]

Subd. 31. MS 2020 [Repealed, 2022 c 98 art 14 s 33]

Subd. 32. [Repealed, 2014 c 291 art 10 s 14]

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, review of medical necessity, 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.

Subd. 35. [Repealed, 2015 c 71 art 11 s 65]

Subd. 36. [Renumbered 142A.03, subd 22]

Subd. 37. **DHS receipt center accounting.** The commissioner may transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

Subd. 38. **Contract to match recipient third-party liability information.** The commissioner may enter into a contract with a national organization to match recipient third-party liability information and provide coverage and insurance primacy information to the department at no charge to providers and the clearinghouses.

Subd. 39. MS 2022 [Repealed, 2024 c 108 art 6 s 6]

Subd. 40. **Nonfederal share transfers.** The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

Subd. 41. **Reports on interagency agreements and intra-agency transfers.** (a) Beginning October 31, 2024, and annually thereafter, the commissioner of human services shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Department of Information Technology Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000; and

(2) transfers of appropriations of more than $100,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, the duration of the agreement, and a copy of the agreement.

(b) This subdivision expires December 31, 2034.

Subd. 42. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of human services to the legislature is mandated by statute and the enabling legislation does not include a date for the submission of a final report or an expiration date, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual or more frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021, shall expire three years after the date of enactment if the mandate requires the submission of an annual or more frequent report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report unless the enacting legislation provides for a different expiration date.

(d) By January 15 of each year, the commissioner shall submit a list of all reports set to expire during the following calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. Notwithstanding paragraph (c), this paragraph does not expire.

Subd. 43. **Education on contraceptive options.** The commissioner shall require hospitals and primary care providers serving medical assistance and MinnesotaCare enrollees to develop and implement protocols to provide enrollees, when appropriate, with comprehensive and scientifically accurate information on the full range of contraceptive options, in a medically ethical, culturally competent, and noncoercive manner. The information provided must be designed to assist enrollees in identifying the contraceptive method that best meets their needs and the needs of their families. The protocol must specify the enrollee categories to which this requirement will be applied, the process to be used, and the information and resources to be provided. Hospitals and providers must make this protocol available to the commissioner upon request.

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; 2013 c 62 s 19; 2013 c 81 s 2; 2013 c 107 art 1 s 9; art 4 s 4; 2013 c 108 art 1 s 3,67; art 2 s 4,5,44; art 14 s 9-11; art 15 s 3,4; 2014 c 228 art 3 s 2; 2014 c 262 art 3 s 11; 2014 c 312 art 24 s 2; art 30 s 12; 2015 c 21 art 1 s 53; 2015 c 71 art 1 s 8; art 14 s 11; 2015 c 78 art 1 s 7; art 4 s 49; art 6 s 6; 2016 c 158 art 1 s 105,106; art 2 s 53-55; 2016 c 163 art 3 s 6; 2016 c 189 art 19 s 3; 2017 c 40 art 1 s 121; 1Sp2017 c 6 art 2 s 39; art 4 s 4; 1Sp2019 c 9 art 1 s 19,42; 2020 c 115 art 3 s 12; 1Sp2020 c 2 art 5 s 97; art 8 s 84-86; 2021 c 30 art 1 s 1; art 10 s 11; 2021 c 31 art 2 s 16; 1Sp2021 c 7 art 1 s 1; 2022 c 98 art 10 s 2; art 14 s 13; 2023 c 50 art 1 s 23; 2023 c 61 art 1 s 9; 2023 c 63 art 6 s 44; 2023 c 70 art 1 s 1; 2024 c 79 art 8 s 16; 2024 c 80 art 1 s 46-54,96; art 7 s 12; 2024 c 115 art 12 s 1; art 16 s 34; 2024 c 127 art 66 s 14,15*

NOTE: The amendment to subdivision 12b by Laws 2024, chapter 115, article 12, section 1, is effective July 1, 2025. Laws 2024, chapter 115, article 12, section 1, the effective date.

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; lead Tribal contracts.** Paragraphs (a) to (e) govern contracting within and across county lines and lead county contracts. Paragraphs (a) to (e) govern contracting within and across reservation boundaries and lead Tribal contracts for initiative tribes under section 256.01, subdivision 14b. For purposes of this subdivision, "local agency" includes a tribe or a county agency.

(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 tribe or county for the contract.

(b) When the local agency in the county or reservation 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 tribe or county, the local agency must negotiate and execute a contract with the vendor.

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

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

(2) if there is a contract with the vendor for which another local agency is the lead tribe or county, identify the lead tribe or 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 tribe or 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 local 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 local agency under paragraph (d) becomes the lead tribe or county for a contract and the contract expires and needs to be renegotiated, that tribe or 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 tribe or 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 245.66, 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.

Subd. 10. [Renumbered 142A.07, subd 8]

History: *1Sp2003 c 14 art 11 s 10; 2005 c 56 s 1; 2012 c 253 art 2 s 1; 2013 c 108 art 17 s 1; 1Sp2020 c 2 art 5 s 35; 2021 c 30 art 10 s 12; 2023 c 25 s 134*

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.

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.

Subd. 4. **Consultation with commissioner of children, youth, and families required.** The commissioner must consult with the commissioner of children, youth, and families on the administration of the merit system, including on the requirements in this section.

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; 2024 c 80 art 1 s 55,56*

256.0121 [Renumbered 246.595]

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 medical assistance and other programs the commissioner supervises.

(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 for statewide programs administered by that system 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 medical assistance program to the extent necessary for the Tribe to operate the medical assistance program or any other program under the supervision of the commissioner.

Subd. 2. **State systems account created.** A state systems account for the Department of Human Services 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; 2016 c 158 art 2 s 56; 1Sp2019 c 9 art 1 s 42; 2023 c 70 art 12 s 19,20*

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, 256L.01, subdivision 7, 256L.03, subdivision 6, and 256L.12, and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); 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 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); 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. The information in the data file must include at least the following: full name, date of birth, Social Security number if collected and stored in a system routinely used for producing data files by the employer or third-party payer, employer name, policy identification number, group identification number, and plan or coverage type.

(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; 2013 c 108 art 1 s 4; 2015 c 71 art 11 s 10; 2016 c 158 art 2 s 57,58*

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 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; 2024 c 80 art 1 s 57*

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.** (a) The commissioner of human services shall directly administer the compliance system for general assistance, medical assistance, emergency general assistance, Minnesota supplemental assistance, housing support, preadmission screening, alternative care grants, and all other programs administered by the commissioner or on behalf of the commissioner under the powers and authorities named in section 256.01, subdivision 2.

(b) The commissioner of children, youth, and families shall administer the compliance system for the Minnesota family investment program, the Supplemental Nutrition Assistance Program (SNAP), the child care assistance program, and all other programs administered by the commissioner or on behalf of the commissioner under the powers and authorities named in section 142A.03, subdivision 2.

(c) The commissioners of human services and children, youth, and families shall cooperate as necessary to administer compliance systems related to the Minnesota family investment program, the Supplemental Nutrition Assistance Program (SNAP), general assistance, medical assistance, emergency general assistance, Minnesota supplemental assistance, housing support, preadmission screening, alternative care grants, the child care assistance program, and all other programs administered by the commissioner of human services or on behalf of the commissioner of human services under the powers and authorities named in section 256.01, subdivision 2.

(d) The purpose of the compliance system is to permit the commissioners 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 commissioners, or the commissioners' representatives, may issue administrative subpoenas as needed in administering the compliance system.

(e) The commissioners shall utilize training, technical assistance, and monitoring activities, as specified in sections 142A.03, subdivision 2, and 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) "Commissioner" means the commissioner of human services for programs listed in subdivision 1, paragraph (b), and the commissioner of children, youth, and families for programs listed in subdivision 1, paragraph (c).

(c) "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, SNAP, 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.

(d) "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, SNAP, and medical assistance, the quality control system is that required by federal regulation, or those developed by the commissioner.

Subd. 3. **Quality control case penalty.** The commissioner 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 SNAP 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 commissioner 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 commissioner 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 commissioner 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 commissioner, or if the county agency fails to meet the commitments in the corrective action plan, the commissioner 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 commissioner'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 commissioner'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 142E.04, subdivision 6. 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; 2013 c 107 art 3 s 1; 2015 c 71 art 1 s 9; 1Sp2017 c 6 art 2 s 39; 1Sp2019 c 9 art 1 s 42; 2024 c 80 art 1 s 58-62; art 5 s 7*

256.018 COUNTY PUBLIC ASSISTANCE INCENTIVE FUND.

The commissioner of human services, in coordination with the commissioner of children, youth, and families, 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; 2024 c 80 art 1 s 63*

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 formerly codified in chapter 256D, 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.

Subd. 2. **Retention rates for MFIP.** (a) When an assistance recovery amount is collected and posted by a county agency under the provisions governing MFIP under chapter 142G, the commissioner shall reimburse the county agency from the proceeds of the recovery using the applicable rate specified in paragraph (b).

(b) For recoveries of overpayments from programs funded in whole or in part by the temporary assistance to needy families program under section 142G.03, subdivision 2, and recoveries of nonfederally funded food assistance under section 142G.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; 2016 c 158 art 2 s 59; 1Sp2019 c 9 art 1 s 42; 2024 c 80 art 1 s 64,65; art 7 s 12*

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. MS 2022 [Repealed, 2024 c 85 s 115]

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; 2022 c 98 art 14 s 14*

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 142G, 256B, 256D, 256E, 256I, or 256L to the extent permitted under federal law.

History: *1999 c 245 art 4 s 18; 2024 c 80 art 7 s 12*

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, 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.

(c) The commissioner must work with the commissioner of children, youth, and families to create a brochure that meets the requirements of this section and section 142G.05.

History: *2006 c 282 art 22 s 7; 2016 c 158 art 2 s 60; 2024 c 80 art 1 s 66; 2024 c 115 art 16 s 14*

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]

256.041 CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL.

Subdivision 1. **Establishment; purpose.** There is hereby established the Cultural and Ethnic Communities Leadership Council for the Department of Human Services. The purpose of the council is to advise the commissioner of human services on implementing strategies to reduce inequities and disparities that particularly affect racial and ethnic groups in Minnesota.

Subd. 2. **Members.** (a) The council must consist of:

(1) the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services; and

(2) no fewer than 15 and no more than 25 members appointed by and serving at the pleasure of the commissioner of human services, in consultation with county, tribal, cultural, and ethnic communities; diverse program participants; parent representatives from these communities; and cultural and ethnic communities leadership council members.

(b) In making appointments under this section, the commissioner shall give priority consideration to public members of the legislative councils of color established under section 15.0145.

(c) Members must be appointed to allow for representation of the following groups:

(1) racial and ethnic minority groups;

(2) the American Indian community, which must be represented by two members;

(3) culturally and linguistically specific advocacy groups and service providers;

(4) human services program participants;

(5) public and private institutions;

(6) parents of human services program participants;

(7) members of the faith community;

(8) Department of Human Services employees; and

(9) any other group the commissioner deems appropriate to facilitate the goals and duties of the council.

Subd. 3. **Guidelines.** The commissioner shall direct the development of guidelines defining the membership of the council; setting out definitions; and developing duties of the commissioner, the council, and council members regarding racial and ethnic disparities reduction. The guidelines must be developed in consultation with:

(1) the chairs of relevant committees; and

(2) county, tribal, and cultural communities and program participants from these communities.

Subd. 4. **Chair.** The commissioner shall accept recommendations from the council to appoint a chair or chairs.

Subd. 5. MS 2020 [Repealed by amendment, 1Sp2021 c 7 art 14 s 7]

Subd. 6. **Terms.** A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall make appointments to replace members vacating their positions in a timely manner, no more than three months after the council reviews panel recommendations.

Subd. 7. **Duties of commissioner.** (a) The commissioner of human services or the commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

(2) supervise and coordinate policies for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(3) identify human services rules or statutes affecting persons from racial, ethnic, cultural, linguistic, and tribal communities that may need to be revised;

(4) investigate and implement cost-effective, equitable, and culturally responsive models of service delivery including careful adoption of proven services to increase the number of culturally relevant services available to currently underserved populations;

(5) based on recommendations of the council, review identified department policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities; make adjustments to ensure those disparities are not perpetuated; and advise the department on progress and accountability measures for addressing inequities;

(6) in partnership with the council, renew and implement equity policy with action plans and resources necessary to implement the action plans;

(7) support interagency collaboration to advance equity;

(8) address the council at least twice annually on the state of equity within the department; and

(9) support member participation in the council, including participation in educational and community engagement events across Minnesota that address equity in human services.

(b) The commissioner of human services or the commissioner's designee shall consult with the council and receive recommendations from the council when meeting the requirements in this subdivision.

Subd. 8. **Duties of council.** The council shall:

(1) recommend to the commissioner for review Department of Human Services policy, budgetary, and operational decisions and practices that impact racial, ethnic, cultural, linguistic, and tribal disparities;

(2) with community input, advance legislative proposals to improve racial and health equity outcomes;

(3) identify issues regarding inequities and disparities by engaging diverse populations in human services programs;

(4) engage in mutual learning essential for achieving human services parity and optimal wellness for service recipients;

(5) raise awareness about human services disparities to the legislature and media;

(6) provide technical assistance and consultation support to counties, private nonprofit agencies, and other service providers to build their capacity to provide equitable human services for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(7) provide technical assistance to promote statewide development of culturally and linguistically appropriate, accessible, and cost-effective human services and related policies;

(8) recommend and monitor training and outreach to facilitate access to culturally and linguistically appropriate, accessible, and cost-effective human services to prevent disparities;

(9) form work groups to help carry out the duties of the council that include, but are not limited to, persons who provide and receive services and representatives of advocacy groups, and provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish;

(10) promote information sharing in the human services community and statewide; and

(11) by February 15 in the second year of the biennium, prepare and submit to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services a report that summarizes the activities of the council, identifies the major problems and issues confronting racial and ethnic groups in accessing human services, makes recommendations to address issues, and lists the specific objectives that the council seeks to attain during the next biennium, and recommendations to strengthen equity, diversity, and inclusion within the department. The report must identify racial and ethnic groups' difficulty in accessing human services and make recommendations to address the issues. The report must include any updated Department of Human Services equity policy, implementation plans, equity initiatives, and the council's progress.

Subd. 9. **Duties of council members.** The members of the council shall:

(1) attend scheduled meetings with no more than three absences per year, participate in scheduled meetings, and be prepared by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that could impact the timely completion of tasks;

(4) collaborate on inequity and disparity reduction efforts;

(5) communicate updates of the council's work progress and status on the Department of Human Services website;

(6) participate in any activities the council or chair deems appropriate and necessary to facilitate the goals and duties of the council; and

(7) participate in work groups to carry out council duties.

Subd. 10. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

Subd. 11. **Compensation.** Compensation for members of the council is governed by section 15.059, subdivision 3.

History: *2015 c 78 art 4 s 50; 1Sp2020 c 2 art 1 s 14; 1Sp2021 c 7 art 14 s 7*

256.042 OPIATE EPIDEMIC RESPONSE ADVISORY COUNCIL.

Subdivision 1. **Establishment of the advisory council.** (a) The Opiate Epidemic Response Advisory Council is established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council shall focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, the role of adult protective services in prevention and response, and providing financial support to local law enforcement agencies for opiate antagonist programs;

(2) training on the treatment of opioid addiction, including the use of all Food and Drug Administration approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices;

(3) the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, recovery, and aftercare services; and

(4) the development of measures to assess and protect the ability of cancer patients and survivors, persons battling life-threatening illnesses, persons suffering from severe chronic pain, and persons at the end stages of life, who legitimately need prescription pain medications, to maintain their quality of life by accessing these pain medications without facing unnecessary barriers. The measures must also address the needs of individuals described in this clause who are elderly or who reside in underserved or rural areas of the state.

(b) The council shall:

(1) review local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families experiencing and affected by opioid use disorder;

(2) establish priorities to address the state's opioid epidemic, for the purpose of recommending initiatives to fund;

(3) recommend to the commissioner of human services specific projects and initiatives to be funded;

(4) ensure that available funding is allocated to align with other state and federal funding, to achieve the greatest impact and ensure a coordinated state effort;

(5) consult with the commissioners of human services, health, and management and budget to develop measurable outcomes to determine the effectiveness of funds allocated;

(6) develop recommendations for an administrative and organizational framework for the allocation, on a sustainable and ongoing basis, of any money deposited into the separate account under section 16A.151, subdivision 2, paragraph (f), in order to address the opioid abuse and overdose epidemic in Minnesota and the areas of focus specified in paragraph (a);

(7) review reports, data, and performance measures submitted by municipalities under subdivision 5;

(8) consult with relevant stakeholders, including lead agencies and municipalities, to review and provide recommendations for necessary revisions to the reporting requirements under subdivision 5 to ensure that the required reporting accurately measures progress in addressing the harms of the opioid epidemic; and

(9) meet with each of the 11 federally recognized Minnesota Tribal Nations individually on an annual basis in order to collaborate and communicate on shared issues and priorities.

(c) The council, in consultation with the commissioner of management and budget, and within available appropriations, shall select from projects awarded grants under section 256.043, subdivisions 3 and 3a, and municipality projects funded by direct payments received as part of a statewide opioid settlement agreement, that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. Grant proposals and municipality projects that include promising practices or theory-based activities and are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation. Grantees and municipalities shall collect and report information that is needed to complete the evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies.

(d) The council, in consultation with the commissioners of human services, health, public safety, and management and budget, shall establish goals related to addressing the opioid epidemic and determine a baseline against which progress shall be monitored and set measurable outcomes, including benchmarks.

The goals established must include goals for prevention and public health, access to treatment, and multigenerational impacts. The council shall use existing measures and data collection systems to determine baseline data against which progress shall be measured. The council shall include the proposed goals, the measurable outcomes, and proposed benchmarks to meet these goals in its initial report to the legislature under subdivision 5, paragraph (a), due January 31, 2021.

Subd. 2. **Membership.** (a) The council shall consist of the following 20 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) two members representing Indian tribes, one representing the Ojibwe tribes and one representing the Dakota tribes;

(13) one member representing an urban American Indian community;

(14) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

(15) one mental health advocate representing persons with mental illness;

(16) one member appointed by the Minnesota Hospital Association;

(17) one member representing a local health department; and

(18) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least one-third of council members appointed by the commissioner reside outside of the seven-county metropolitan area. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Subd. 3. **Conflict of interest.** Advisory council members must disclose to the council, refrain from participating in discussions, and recuse themselves from voting on any matter before the council if the member has a conflict of interest. A conflict of interest means a financial association that has the potential to bias or have the appearance of biasing a council member's decision related to the opiate epidemic response grant decision process or other council activities under this section.

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning December 1, 2022. This paragraph expires upon the expiration of the advisory council.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (n), and subdivision 3a, paragraph (d). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration.

Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 31 of each year. The report shall include information about the individual projects that receive grants, the municipality projects funded by direct payments received as part of a statewide opioid settlement agreement, and the overall role of the project in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and municipalities and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluations implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding.

(b) The commissioner of management and budget, in consultation with the Opiate Epidemic Response Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (c), is complete on the promising practices or theory-based projects that are selected for evaluation activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

(c) The advisory council, in its annual report to the legislature under paragraph (a) due by January 31, 2024, shall include recommendations on whether the appropriations to the specified entities under Laws 2019, chapter 63, should be continued, adjusted, or discontinued; whether funding should be appropriated for other purposes related to opioid abuse prevention, education, and treatment; and on the appropriate level of funding for existing and new uses.

(d) Municipalities receiving direct payments from a statewide opioid settlement agreement must report annually to the commissioner of human services on how the payments were used on opioid remediation. The report must be submitted in a format prescribed by the commissioner. The report must include data and measurable outcomes on expenditures funded with direct payments from a statewide opioid settlement agreement, including details on services listed in the categories of approved uses, as identified in agreements between the state of Minnesota, the Association of Minnesota Counties, and the League of Minnesota Cities. Reporting requirements must include, at a minimum:

(1) contact information;

(2) information on funded services and programs; and

(3) target populations for each funded service and program.

(e) In reporting data and outcomes under paragraph (d), municipalities must include, to the extent feasible, information on the use of evidence-based and culturally relevant services.

(f) For municipal projects using $25,000 or more of statewide opioid settlement agreement payments in a calendar year, municipalities must also include in the report required under paragraph (d):

(1) a brief qualitative description of successes or challenges; and

(2) results using process and quality measures.

(g) This subdivision expires upon the expiration of the advisory council.

Subd. 6. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Municipality" has the meaning provided in section 466.01, subdivision 1.

(c) "Statewide opioid settlement agreement" means an agreement as defined in section 3.757, subdivision 1, paragraph (f), involving a settling defendant as defined in section 3.757, subdivision 1, paragraph (e).

History: *2019 c 63 art 1 s 7; 2020 c 115 art 3 s 13,14; 1Sp2021 c 7 art 11 s 14; 2022 c 53 s 4-7; 2022 c 98 art 14 s 15,16; 2023 c 61 art 5 s 8,9; 2024 c 85 s 60*

256.043 OPIATE EPIDEMIC RESPONSE FUND.

Subdivision 1. **Establishment.** (a) The opiate epidemic response fund is established in the state treasury. The commissioner of management and budget shall establish within the opiate epidemic response fund two accounts: (1) a registration and license fee account; and (2) a settlement account. Beginning in fiscal year 2021, for each fiscal year, the fund shall be administered according to this section.

(b) The commissioner of management and budget shall deposit into the registration and license fee account the registration fee assessed by the Board of Pharmacy under section 151.066 and the license fees identified in section 151.065, subdivision 7, paragraphs (b) and (c).

(c) The commissioner of management and budget shall deposit into the settlement account any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, pursuant to section 16A.151, subdivision 2, paragraph (f).

Subd. 2. [Repealed by amendment, 2020 c 115 art 3 s 15]

Subd. 3. **Appropriations from registration and license fee account.** (a) The appropriations in paragraphs (b) to (n) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

(b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $100,000 is appropriated to the commissioner of human services for grants for opiate antagonist distribution. Grantees may utilize funds for opioid overdose prevention, community asset mapping, education, and opiate antagonist distribution.

(d) $2,000,000 is appropriated to the commissioner of human services for grants to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

(e) $400,000 is appropriated to the commissioner of human services for competitive grants for opioid-focused Project ECHO programs.

(f) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to the commissioner of human services to administer the funding distribution and reporting requirements in paragraph (o).

(g) $3,000,000 in fiscal year 2025 and $3,000,000 each year thereafter is appropriated to the commissioner of human services for safe recovery sites start-up and capacity building grants under section 254B.18.

(h) $395,000 in fiscal year 2024 and $415,000 each year thereafter is appropriated to the commissioner of human services for the opioid overdose surge alert system under section 245.891.

(i) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

(j) $261,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (n).

(k) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(l) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(m) After the appropriations in paragraphs (b) to (l) are made, 50 percent of the remaining amount is appropriated to the commissioner of children, youth, and families for distribution to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide prevention and child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects through a formula based on intake data from the previous three calendar years related to substance use and out-of-home placement episodes where parental drug abuse is a reason for the out-of-home placement. County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide prevention and child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

(n) After the appropriations in paragraphs (b) to (m) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

(o) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph (m) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (n) may be distributed on a calendar year basis.

(p) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (c), (d), (e), (g), (m), and (n) are available for three years after the funds are appropriated.

Subd. 3a. **Appropriations from settlement account.** (a) The appropriations in paragraphs (b) to (e) shall be made from the settlement account on a fiscal year basis in the order specified.

(b) If the balance in the registration and license fee account is not sufficient to fully fund the appropriations specified in subdivision 3, paragraphs (b) to (l), an amount necessary to meet any insufficiency shall be transferred from the settlement account to the registration and license fee account to fully fund the required appropriations.

(c) $209,000 in fiscal year 2023 and $239,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services for the administration of grants awarded under paragraph (e). $276,000 in fiscal year 2023 and $151,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services to collect, collate, and report data submitted and to monitor compliance with reporting and settlement expenditure requirements by grantees awarded grants under this section and municipalities receiving direct payments from a statewide opioid settlement agreement as defined in section 256.042, subdivision 6.

(d) After any appropriations necessary under paragraphs (b) and (c) are made, an amount equal to the calendar year allocation to Tribal social service agency initiative projects under subdivision 3, paragraph (m), is appropriated from the settlement account to the commissioner of children, youth, and families for distribution to Tribal social service agency initiative projects to provide child protection services to children and families who are affected by addiction. The requirements related to proportional distribution, annual reporting, and maintenance of effort specified in subdivision 3, paragraph (m), also apply to the appropriations made under this paragraph.

(e) After making the appropriations in paragraphs (b), (c), and (d), the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042.

(f) Funds for Tribal social service agency initiative projects under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) may be distributed on a calendar year basis.

(g) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (d) and (e) are available for three years after the funds are appropriated.

Subd. 4. MS 2022 [Repealed, 2024 c 125 art 3 s 20; 2024 c 127 art 48 s 20]

History: *2019 c 63 art 1 s 8; 1Sp2019 c 9 art 7 s 7; 2020 c 115 art 3 s 15; 1Sp2021 c 7 art 5 s 4; art 11 s 15; 2022 c 53 s 8-11; 2023 c 61 art 5 s 10,11; 2023 c 70 art 15 s 12; 2024 c 115 art 16 s 15,16; 2024 c 125 art 3 s 11; 2024 c 127 art 48 s 11*

256.044 HUMAN SERVICES RESPONSE CONTINGENCY ACCOUNT.

Subdivision 1. **Human services response contingency account.** A human services response contingency account is created in the special revenue fund in the state treasury. Money in the human services response contingency account does not cancel and is appropriated to the commissioner of human services for the purposes specified in this section.

Subd. 2. **Definition.** For purposes of this section, "human services response" means activities deemed necessary by the commissioner of human services to respond to emerging or immediate needs related to supporting the health, welfare, or safety of people.

Subd. 3. **Use of money.** (a) The commissioner may make expenditures from the human services response contingency account to respond to needs as defined in subdivision 2 and for which no other funding or insufficient funding is available.

(b) When the commissioner determines that a human services response is needed, the commissioner may make expenditures from the human services response contingency account for the following uses to implement the human services response:

(1) services, supplies, and equipment to support the health, welfare, or safety of people;

(2) training and coordination with service providers, Tribal Nations, and local government entities;

(3) communication with and outreach to impacted people;

(4) informational technology; and

(5) staffing.

(c) The commissioner may transfer money within the Department of Human Services and to the Department of Children, Youth, and Families for eligible uses under paragraph (b) as necessary to implement a human services response.

(d) Notwithstanding any other law or rule to the contrary, when implementing a human services response, the commissioner may allocate funds from the human services response contingency account to programs, providers, and organizations for eligible uses under paragraph (b) through one or more fiscal agents chosen by the commissioner. In contracting with a fiscal agent, the commissioner may use a sole-source contract and is not subject to the solicitation requirements of chapter 16B or 16C.

(e) Programs, providers, and organizations receiving funds from the human services response contingency account under paragraph (d) must describe how the money will be used. If a program, provider, or organization receiving money from the human services response contingency account receives money from a nonstate source other than a local unit of government or Tribe for the same human services response, the entity must notify the commissioner of the amount received from the nonstate source. If the commissioner determines that the total amount received under this section and from the nonstate source exceeds the entity's total costs for the human services response, the entity must pay the commissioner the amount that exceeds the costs up to the amount of funding provided to the entity under this section. All money paid to the commissioner under this paragraph must be deposited in the human services response contingency account.

Subd. 4. **Assistance from other sources.** (a) As a condition of making expenditures from the human services response contingency account, the commissioner must seek any appropriate assistance from other available sources, including the federal government, to assist with costs attributable to the human services response.

(b) If the commissioner recovers eligible costs for the human services response from a nonstate source after making expenditures from the human services response contingency account, the commissioner shall reimburse the human services response contingency account for those costs up to the amount recovered for eligible costs from the nonstate source.

Subd. 5. **Reporting.** The commissioner must develop required reporting for entities receiving human services response contingency account money. Entities receiving money from the commissioner of human services from the human services response contingency account must submit reports to the commissioner of human services with detailed information in a manner determined by the commissioner, including but not limited to:

(1) amounts expended by category of expenditure;

(2) outcomes achieved, including estimated individuals served;

(3) documentation necessary to verify that funds were spent in compliance with this section;

(4) expenditure reports for the purpose of requesting reimbursement from other available sources; and

(5) data necessary to comply with an audit of human services response contingency account expenditures.

Subd. 6. **Report.** By March 1 of each year, the commissioner shall submit a report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over human services finance and health and human services finance detailing expenditures made in the previous calendar year from the human services response contingency account. This report is exempt from section 256.01, subdivision 42.

History: *2024 c 125 art 7 s 1; 2024 c 127 art 52 s 1*

HEARINGS

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICES MATTERS.

Subdivision 1. **Human services judges; appointment.** The commissioner of human services, in consultation with the Direct Care and Treatment executive board, may appoint one or more state human services judges to conduct hearings and recommend orders in accordance with subdivisions 3, 3a, 3b, 4a, 5, and 5a. Human services judges 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. The commissioner shall only appoint as a full-time human services judge an individual who is licensed to practice law in Minnesota and who is:

(1) in active status;

(2) an inactive resident;

(3) retired;

(4) on disabled status; or

(5) on retired senior status.

Subd. 1a. **Direct Care and Treatment executive board or executive board.** For purposes of this section, "Direct Care and Treatment executive board" or "executive board" means the Direct Care and Treatment executive board established under section 246C.06.

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:

(i) applying for, receiving or having received public assistance, medical care, or a program of social services administered by the commissioner or a county agency on behalf of the commissioner; and

(ii) 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 to whom a right of appeal according to this section is given by other provision of law;

(6) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(7) 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;

(8) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under chapter 260E, after the individual or facility has exercised the right to administrative reconsideration under chapter 260E;

(9) 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 260E.06, subdivision 1, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (8), and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge 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;

(10) any person with an outstanding debt resulting from receipt of public assistance administered by the commissioner or medical care 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;

(11) a person issued a notice of service termination under section 245D.10, subdivision 3a, by a licensed provider of any residential supports or services listed in section 245D.03, subdivision 1, paragraphs (b) and (c), that is not otherwise subject to appeal under subdivision 4a;

(12) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914;

(13) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a; or

(14) a recovery community organization seeking medical assistance vendor eligibility under section 254B.01, subdivision 8, that is aggrieved by a membership or accreditation determination and that believes the organization meets the requirements under section 254B.05, subdivision 1, paragraph (d), clauses (1) to (10). The scope of the review by the human services judge shall be limited to whether the organization meets each of the requirements under section 254B.05, subdivision 1, paragraph (d), clauses (1) to (10).

(b) The hearing for an individual or facility under paragraph (a), clause (4), (8), or (9), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under 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 (8), 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 (4), (8), or (9), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or 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 section 142A.20, subdivision 2, clause (2), 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) The scope of hearings under paragraph (a), clauses (11) and (13), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) and (e), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) 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.

(g) 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.

(h) 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, except in matters covered by paragraph (i).

(i) When the subject of an administrative review is a matter within the jurisdiction of the Direct Care and Treatment executive board as a part of the board's powers and duties under chapter 246C, the executive board 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.

(j) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization 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, as defined in section 256.0451,

subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Subd. 3a. **Prepaid health plan appeals.** (a) All prepaid health plans under contract to the commissioner under chapter 256B 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 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 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 judge 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 judge may order a second medical opinion from a nonprepaid health plan provider at the expense of the Department of Human Services. 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 judge 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.

(d) Beginning January 1, 2018, the requirements of Code of Federal Regulations, part 42, sections 438.400 to 438.424, take precedence over any conflicting provisions in this subdivision. All other provisions of this section remain in effect.

Subd. 3b. **Standard of evidence for maltreatment and disqualification hearings.** (a) The state human services judge shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under section 626.557 and chapter 260E. For purposes of hearings regarding disqualification, the state human services judge 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 626.557 or chapter 260E that 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 626.557 or chapter 260E, for incidents in which the final disposition under section 626.557 or chapter 260E was substantiated maltreatment that was serious or recurring.

(b) If the disqualification is affirmed, the state human services judge 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 judge 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.

(c) If a disqualification is based solely on a conviction or is conclusive for any reason under section 245C.29, the disqualified individual does not have a right to a hearing under this section.

(d) The state human services judge shall recommend an order to the commissioner of health; education; children, youth, and families; 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.482, 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 judge 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. A human services judge may grant a request for a hearing in person by holding the hearing by interactive video technology or in person. The human services judge must hear the case in person if the person asserts that either the person or a witness has a physical or mental disability that would impair the person's or witness's ability to fully participate in a hearing held by interactive video technology. 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 judge 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 626.557 or chapter 260E 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), (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), clause (4), (8), or (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 judge.

(d) For hearings under subdivision 3, paragraph (a), clause (4) or (9), involving a vulnerable adult, the human services judge 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 judge hearing the case no later than five business days before commencement of the hearing. The human services judge 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 judge'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 judge of the basis for this determination, which must be included in the final order. If the human services judge is not reasonably able to determine the address of the vulnerable adult, the guardian, or the health care agent, the human services judge 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 judge 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 judge 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) Except as provided for under subdivision 5a for matters under the jurisdiction of the Direct Care and Treatment executive board and for hearings held under section 142A.20, subdivision 2, a state human services judge 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 human services judge may take official notice of adjudicative facts. The commissioner of human services may accept the recommended order of a state human services judge 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 judge, 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.

(b) 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. The person seeking reconsideration has the burden to demonstrate why the matter should be reconsidered. The request for reconsideration may include legal argument and proposed additional evidence supporting the request. If proposed additional evidence is submitted, the person must explain why the proposed additional evidence was not provided at the time of the hearing. If reconsideration is granted, the other participants must be sent a copy of all material submitted in support of the request for reconsideration and must be given ten days to respond. Upon reconsideration, the commissioner may issue an amended order or an order affirming the original order.

(c) 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.

(d) 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. 5a. **Orders of the Direct Care and Treatment executive board.** (a) When the subject of an administrative review is a matter within the jurisdiction of the Direct Care and Treatment executive board as a part of the board's powers and duties under chapter 246C, a state human services judge shall conduct a hearing on the appeal and shall recommend an order to the executive board. 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 human services judge may take official notice of adjudicative facts. The Direct Care and Treatment executive board may accept the recommended order of a state human services judge and issue the order to the parties. The executive board, on refusing to accept the recommended order of the state human services judge, shall notify the parties of the refusal and the reasoning and shall allow each party ten days to submit additional written argument on the matter. After the expiration of the ten-day period, the executive board shall issue an order on the matter to the parties.

(b) A party aggrieved by an order of the executive board may appeal under subdivision 7, or request reconsideration by the executive board within 30 days after the date the executive board issues the order. The executive board may reconsider an order upon request of any party or on the executive board's own motion. A request for reconsideration does not stay implementation of the executive board's order. The person seeking reconsideration has the burden to demonstrate why the matter should be reconsidered. The request for reconsideration may include legal argument and proposed additional evidence supporting the request. If proposed additional evidence is submitted, the person must explain why the proposed additional evidence was not provided at the time of the hearing. If reconsideration is granted, the other participants must be sent a copy of all material submitted in support of the request for reconsideration and must be given ten days to respond. Upon reconsideration, the executive board may issue an amended order or an order affirming the original order.

(c) Any order of the executive board 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 executive board is binding on the parties and must be implemented by the state agency or a county agency, until the order is reversed by the district court, or unless the executive board or a district court orders monthly services paid or provided under subdivision 10.

(d) 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. Direct Care and Treatment is not a vendor for the purposes of this paragraph.

Subd. 6. **Additional powers of commissioner; subpoenas.** (a) The commissioner of human services, the commissioner of health for matters within the commissioner's jurisdiction under subdivision 3b, or the Direct Care and Treatment executive board for matters within the jurisdiction of the executive board under subdivision 5a, 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 judge 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 judgment of the applicable commissioner or executive board may be substituted for that of the county agency. The applicable commissioner or executive board 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 applicable commissioner or executive board issue a subpoena to compel the attendance of witnesses and the production of records at the hearing. A local agency may request that the applicable commissioner or executive board 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 of human services may issue a temporary order staying a proposed demission by a residential facility licensed under chapter 245A:

(1) while an appeal by a recipient under subdivision 3 is pending;

(2) for the period of time necessary for the case management provider to implement the commissioner's order; or

(3) for appeals under subdivision 3, paragraph (a), clause (11), when the individual is seeking a temporary stay of demission on the basis that the county has not yet finalized an alternative arrangement for a residential facility, a program, or services that will meet the assessed needs of the individual by the effective date of the service termination, a temporary stay of demission may be issued for no more than 30 calendar days to allow for such arrangements to be finalized.

Subd. 7. **Judicial review.** Except for a prepaid health plan, any party who is aggrieved by an order of the commissioner of human services; the commissioner of health; or the commissioner of children, youth, and families in appeals within the commissioner's jurisdiction under subdivision 3b; or the Direct Care and Treatment executive board in appeals within the jurisdiction of the executive board under subdivision 5a 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 applicable commissioner or executive board and any adverse party of record within 30 days after the date the commissioner or executive board 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 applicable commissioner or executive board 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 or executive board 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 judge, by serving a written demand upon the applicable commissioner or executive board 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 or executive board under subdivision 5 or 5a 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 judge may order the local human services agency to reduce or terminate medical assistance to a recipient before a final order is issued under this section if: (1) the human services judge 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 cash payments, medical assistance, 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 cash payments, medical assistance, or MinnesotaCare as a result of the appeal, except for medical assistance 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 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; 2013 c 107 art 1 s 1-4,9; 2014 c 228 art 5 s 11; 2015 c 78 art 6 s 7,8; 2016 c 158 art 1 s 107; art 2 s 61,62; 2017 c 40 art 1 s 54,55; 1Sp2017 c 6 art 2 s 9; art 15 s 1; 1Sp2019 c 9 art 1 s 42; 1Sp2020 c 2 art 8 s 87-89; 2022 c 98 art 5 s 2; 2023 c 50 art 3 s 7; 2024 c 79 art 3 s 1-7; 2024 c 80 art 1 s 67-71; 2024 c 115 art 16 s 17-20; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43*

256.0451 HEARING PROCEDURES.

Subdivision 1. **Scope.** (a) The requirements in this section apply to all fair hearings and appeals under sections 142A.20, subdivision 2, and 256.045, subdivision 3, paragraph (a), clauses (1), (2), (3), (5), (6), (7), (10), and (12). 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), (9), and (11).

(b) For purposes of this section, "person" means 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 means 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.

(c) For purposes of this section, "agency" means 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. For purposes of this section, "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), (9), and (10), 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 human services judge 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 human services judge. The human services judge 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 human services judge 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 human services judge 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. A human services judge may make and issue rulings and orders while the appeal is pending. During the pendency of the appeal, these rulings and orders are not subject to a request for reconsideration or appeal. These rulings and orders are subject to review under subdivision 24 and section 256.045, subdivision 7.

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 human services judge 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 human services judge in writing to vacate or modify a subpoena. The human services judge 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 human services judge 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 human services judge 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 human services judge 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 human services judge.

Subd. 11. **Hearing facilities and equipment.** The human services judge 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), (9), and (10), 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 human services judge 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 human services judge 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 human services judge 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 human services judge 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 human services judge may dismiss the appeal. The human services judge may reopen the

appeal if within ten working days after the date of the dismissal the person files information in writing with the human services judge 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 human services judge.

Subd. 14. **Commencement of hearing.** The human services judge 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 human services judge 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 human services judge 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 human services judge 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 human services judge 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 human services judge 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 human services judge may direct witnesses to remain outside the hearing room, except during their individual testimony. The human services judge 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 human services judge 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 human services judge that the claim is true.

Subd. 18. **Inviting comment by department.** The human services judge 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 human services judge 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), (9), (10), and (12), in cases involving medical issues such as a diagnosis, a physician's report, or a review team's decision, the human services judge shall consider whether it is necessary to have a medical assessment other than that of the individual making the original decision. When necessary, the human services judge shall require an additional assessment be obtained at agency expense and made part of the hearing record. The human services judge 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 human services judge 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 human services judge 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 human services judge. 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. In appeals of maltreatment determinations or disqualifications filed pursuant to section 256.045, subdivision 3, paragraph (a), clause (4), (8), or (9), that also give rise to possible licensing actions, the 90-day period for issuing final decisions does not begin until the later of the date that the licensing authority provides notice to the appeals division that the authority has made the final determination in the matter or the date the appellant files the last appeal in the consolidated matters.

(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 human services judge 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 human services judge 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 human services judge 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 human services judge shall not independently investigate facts or otherwise rely on information not presented at the hearing. The human services judge may not contact other agency personnel, except as provided in subdivision 18. The human services judge's recommended decision must be based exclusively on the testimony and evidence presented at the hearing, and legal arguments presented, and the human services judge'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 142A.20, subdivision 3, or 256.045, subdivision 5.

Subd. 23. **Refusal to accept recommended orders.** (a) If the commissioner refuses to accept the recommended order from the human services judge, 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.** (a) Reconsideration may be requested within 30 days of the date of the commissioner's final order. If reconsideration is requested under section 142A.20, subdivision 3, or 256.045, subdivision 5, 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.

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

(c) 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.

(d) 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; 2013 c 107 art 1 s 5-8,9; 2017 c 40 art 1 s 56-59; 2024 c 80 art 1 s 72,73; 2024 c 115 art 16 s 21-23*

256.046 ADMINISTRATIVE FRAUD DISQUALIFICATION HEARINGS.

Subdivision 1. **Hearing authority.** A local agency must initiate an administrative fraud disqualification hearing for individuals accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, 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 sections 256.045 and 256.0451 and the requirements in Code of Federal Regulations, title 7, section 273.16.

[See Note.]

Subd. 2. **Combined hearing.** The human services judge may combine a fair hearing under section 142A.20 or 256.045 and administrative fraud disqualification hearing under this section or section 142A.27 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.

Subd. 3. [Renumbered 142E.51, subd 5]

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; 2013 c 107 art 1 s 9; 2016 c 158 art 2 s 63; 1Sp2019 c 9 art 1 s 42; art 2 s 106,107; 2023 c 70 art 10 s 15; art 13 s 23; 2024 c 80 art 1 s 74,75; 2024 c 115 art 16 s 24; art 18 s 12*

NOTE: The amendment to subdivision 1 by Laws 2023, chapter 70, article 10, section 15, is effective March 1, 2026, and applies to acts of wrongfully obtaining assistance and intentional program violations that occur on or after that date. Laws 2023, chapter 70, article 10, section 15, the effective date.

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 state-funded medical assistance under chapter 256B and state-funded MinnesotaCare under chapter 256L granted pursuant to section 256.045, subdivision 10; and for assistance granted under chapters 256D, 256I, and 256K, 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; 1Sp2019 c 9 art 1 s 42; 2023 c 70 art 1 s 2; 2024 c 80 art 1 s 76; 2024 c 127 art 55 s 2*

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]

OLD AGE ASSISTANCE

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]

REPORTS AND PLANS

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 MS 1949 [Expired]

256.432 MS 1949 [Expired]

256.433 MS 1949 [Expired]

256.434 MS 1949 [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]

GRANT PROGRAMS

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 home care 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 home care 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 home care 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, 256B.0653, and 256B.0654, 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 monthly consumer support grant level for individuals who are eligible for ten or more hours of personal care assistance services or community first services and supports per day shall be increased by 7.5 percent of the monthly grant amount calculated under clause (1) when the individual uses direct support services provided by a worker who has completed training as identified in section 256B.0659, subdivision 11, paragraph (d), or section 256B.85, subdivision 16, paragraph (e).

(3) 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; 2014 c 262 art 4 s 9; art 5 s 6; 2014 c 291 art 9 s 5; 1Sp2021 c 7 art 13 s 6*

256.4764 LONG-TERM SERVICES AND SUPPORTS WORKFORCE INCENTIVE GRANTS.

Subdivision 1. **Grant program established.** The commissioner of human services shall establish grants for long-term services and supports providers and facilities to assist with recruiting and retaining direct support professionals.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

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

(c) "Eligible employer" means an organization enrolled in a Minnesota health care program that is:

(1) a provider of home and community-based services under chapter 245D;

(2) a facility certified as an intermediate care facility for persons with developmental disabilities;

(3) a nursing facility under section 256R.02, subdivision 33;

(4) a provider of personal care assistance services under section 256B.0659;

(5) a provider of community first services and supports under section 256B.85;

(6) a provider of early intensive developmental and behavioral intervention services under section 256B.0949;

(7) a provider of home care services as defined under section 256B.0651, subdivision 1, paragraph (d);

(8) an eligible financial management services provider serving people through consumer-directed community supports under chapter 256S and sections 256B.092 and 256B.49, or consumer support grants under section 256.476; or

(9) a provider of customized living services as defined in section 256S.02.

(d) "Eligible worker" means a worker who earns $30 per hour or less and is currently employed or recruited to be employed by an eligible employer.

Subd. 3. **Allowable uses of grant money.** (a) Grantees must use grant money to provide payments to eligible workers for the following purposes:

(1) retention, recruitment, and incentive payments;

(2) postsecondary loan and tuition payments;

(3) child care costs;

(4) transportation-related costs;

(5) personal care assistant background study costs; and

(6) other costs associated with retaining and recruiting workers, as approved by the commissioner.

(b) Eligible workers may receive cumulative payments up to $1,000 per calendar year from the workforce incentive grant account and all other state money intended for the same purpose. Workers are not eligible for payments under this section if they received payments under section 256.4766.

(c) The commissioner must develop a grant cycle distribution plan that allows for equitable distribution of money among eligible employers. The commissioner's determination of the grant awards and amounts is final and is not subject to appeal.

Subd. 4. **Attestation.** As a condition of obtaining grant payments under this section, an eligible employer must attest and agree to the following:

(1) the employer is an eligible employer;

(2) the total number of eligible employees;

(3) the employer will distribute the entire value of the grant to eligible workers allowed under this section;

(4) the employer will create and maintain records under subdivision 6;

(5) the employer will not use the money appropriated under this section for any purpose other than the purposes permitted under this section; and

(6) the entire value of any grant amounts will be distributed to eligible workers identified by the employer.

Subd. 5. **Distribution plan; report.** (a) Each grantee shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the grantee expects to receive and how that money will be distributed for recruitment and retention purposes for eligible employees. Within 60 days of receiving the grant, the grantee must post the distribution plan and leave it posted for a period of at least six months in an area of the grantee's operation to which all direct support professionals have access.

(b) Within 12 months of receiving a grant under this section, each grantee that receives a grant shall submit a report to the commissioner that includes the following information:

(1) a description of how grant money was distributed to eligible employees; and

(2) the total dollar amount distributed.

(c) Failure to submit the report under paragraph (b) may result in recoupment of grant money.

Subd. 6. **Audits and recoupment.** (a) The commissioner may perform an audit under this section up to six years after a grant is awarded to ensure:

(1) the grantee used the money solely for allowable purposes under subdivision 3;

(2) the grantee was truthful when making attestations under subdivision 4; and

(3) the grantee complied with the conditions of receiving a grant under this section.

(b) If the commissioner determines that a grantee used grant money for purposes not authorized under this section, the commissioner must treat any amount used for a purpose not authorized under this section as an overpayment. The commissioner must recover any overpayment.

Subd. 7. **Grants not to be considered income.** (a) Notwithstanding any law to the contrary, grant awards under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under chapter 142E;

(2) general assistance, Minnesota supplemental aid, and food support under chapter 256D;

(3) housing support under chapter 256I;

(4) the Minnesota family investment program and diversionary work program under chapter 142G; and

(5) economic assistance programs under chapter 256P.

(b) The commissioner must not consider grant awards under this section as income or assets under section 256B.056, subdivision 1a, paragraph (a), 3, or 3c, or for persons with eligibility determined under section 256B.057, subdivision 3, 3a, 3b, 4, or 9.

Subd. 8. **Income tax subtractions.** (a) For the purposes of this section, "subtraction" has the meaning given in section 290.0132, subdivision 1, and the rules in that subdivision apply for this section. The definitions in section 290.01 apply to this section.

(b) The amount of a payment received under this section is a subtraction.

(c) Payments under this section and Laws 2021, First Special Session chapter 7, article 17, section 20, as amended, are excluded from income as defined in sections 290.0674, subdivision 2a, and 290A.03, subdivision 3.

Subd. 9. **Account created.** A workforce incentive grant account is created in the special revenue fund. Appropriations made for grants and payments administered under this section may be transferred to this account. Amounts in the account are appropriated to the commissioner of human services. Appropriations transferred to this account cancel and are returned to the fund of origin on the date the original appropriations would have lapsed.

Subd. 10. **Nursing facilities; applicable credit.** The commissioner must treat grant payments awarded under this section as an applicable credit as defined under section 256R.10, subdivision 6.

Subd. 11. **Self-directed services workforce.** Payments administered under this section, including reimbursements for paid family medical leave premiums, do not constitute a change in a term or condition for individual providers as defined in section 256B.0711 in covered programs and are not subject to the state's obligation to meet and negotiate under chapter 179A.

History: *2023 c 61 art 1 s 10; 2024 c 80 art 4 s 26; art 5 s 7; art 7 s 12; 2024 c 115 art 16 s 42; 2024 c 125 art 1 s 10; 2024 c 127 art 46 s 10*

256.4766 NURSING FACILITY WORKFORCE INCENTIVE GRANT PROGRAM.

Subdivision 1. **Grant program established.** The commissioner of human services shall establish grants for nursing facilities to assist with recruiting and retaining eligible workers.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

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

(c) "Eligible employer" means a nursing facility as defined in section 256R.02, subdivision 33.

(d) "Eligible worker" means a worker who earns $30 per hour or less and is currently employed or recruited to be employed by an eligible employer.

Subd. 3. **Allowable uses of grant money.** (a) Grantees must use grant money to provide payments to eligible workers for the following purposes:

(1) retention, recruitment, and incentive payments;

(2) employee-owned benefits, such as health savings accounts, HRSA, and flexible spending accounts;

(3) employee contributions to a 401k account;

(4) education, professional development, and financial counseling;

(5) child care, meals, transportation, and housing;

(6) health and wellness; and

(7) other flexible needs related to workforce challenges as determined by the commissioner.

(b) An eligible worker may receive payments of up to $3,000 per year from the workforce incentive grant account and all other state money intended for the same purpose.

(c) The commissioner must develop a grant cycle distribution plan that allows for equitable distribution of money among eligible employers. The commissioner's determination of the grant awards and amounts is final and is not subject to appeal.

Subd. 4. **Attestation.** As a condition of obtaining grant payments under this section, an eligible employer must attest and agree to the following:

(1) the employer is an eligible employer;

(2) the total number of eligible employees;

(3) the employer will distribute the entire value of the grant to eligible workers allowed under this section;

(4) the employer will create and maintain records under subdivision 6;

(5) the employer will not use the money appropriated under this section for any purpose other than the purposes permitted under this section; and

(6) the entire value of any grant amounts will be distributed to eligible workers identified by the employer.

Subd. 5. **Distribution plan; report.** (a) Each grantee shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the grantee expects to receive and how that money will be distributed for workforce incentives for eligible employees. Within 60 days of receiving the grant, the grantee must post the distribution plan and leave the plan posted for a period of at least six months in an area of the grantee's operation to which all direct support professionals have access.

(b) Within 12 months of receiving a grant under this section, each grantee that receives a grant shall submit a report to the commissioner that includes the following information:

(1) a description of how grant money was distributed to eligible employees; and

(2) the total dollar amount distributed.

(c) Failure to submit the report under paragraph (b) will result in recoupment of grant money.

Subd. 6. **Audits and recoupment.** (a) The commissioner may perform an audit under this section up to six years after a grant is awarded to ensure that:

(1) the grantee used the money solely for allowable purposes under subdivision 3;

(2) the grantee was truthful when making attestations under subdivision 4; and

(3) the grantee complied with the conditions of receiving a grant under this section.

(b) If the commissioner determines that a grantee used grant money for purposes not authorized under this section, the commissioner must treat any amount used for a purpose not authorized under this section as an overpayment. The commissioner must recover any overpayment.

Subd. 7. **Grants not to be considered income.** (a) Notwithstanding any law to the contrary, grant awards under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under chapter 142E;

(2) general assistance, Minnesota supplemental aid, and food support under chapter 256D;

(3) housing support under chapter 256I;

(4) the Minnesota family investment program and diversionary work program under chapter 142G; and

(5) economic assistance programs under chapter 256P.

(b) The commissioner must not consider grant awards under this section as income or assets under section 256B.056, subdivision 1a, paragraph (a), 3, or 3c, or for persons with eligibility determined under section 256B.057, subdivision 3, 3a, 3b, 4, or 9.

Subd. 8. **Income tax subtractions.** (a) For the purposes of this section, "subtraction" has the meaning given in section 290.0132, subdivision 1, and the rules in that subdivision apply for this section. The definitions in section 290.01 apply to this section.

(b) The amount of a payment received under this section is a subtraction.

(c) Payments under this section are excluded from income as defined in sections 290.0674, subdivision 2a, and 290A.03, subdivision 3.

Subd. 9. **Account created.** A nursing facility workforce incentive grant account is created in the special revenue fund. Appropriations made for grants and payments administered under this section may be transferred to this account. Amounts in the account are appropriated to the commissioner of human services. Appropriations transferred to this account cancel and are returned to the fund of origin on the date the original appropriations would have lapsed.

Subd. 10. **Nursing facilities; applicable credit.** The commissioner must treat grant payments awarded under this section as an applicable credit as defined under section 256R.10, subdivision 6.

History: *2023 c 74 s 1; 2024 c 80 art 4 s 26; art 5 s 7; art 7 s 12; 2024 c 115 art 16 s 42*

256.477 SELF-ADVOCACY GRANTS.

Subdivision 1. **The Rick Cardenas Statewide Self-Advocacy Network.** (a) The commissioner shall make available a grant for the purposes of establishing and maintaining the Rick Cardenas Statewide Self-Advocacy Network for persons with intellectual and developmental disabilities. The Rick Cardenas Statewide Self-Advocacy Network shall:

(1) ensure that persons with intellectual and developmental disabilities are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the intellectual and developmental disability community;

(2) provide public education and awareness of the civil and human rights issues persons with intellectual and developmental disabilities face;

(3) provide funds, technical assistance, and other resources for self-advocacy groups across the state;

(4) organize systems of communications to facilitate an exchange of information between self-advocacy groups;

(5) train and support the activities of a statewide network of peer-to-peer mentors for persons with developmental disabilities focused on building awareness among people with developmental disabilities of service options; assisting people with developmental disabilities choose service options; and developing the advocacy skills of people with developmental disabilities necessary for them to move toward full inclusion in community life, including by developing and delivering a curriculum to support the peer-to-peer network;

(6) provide outreach activities, including statewide conferences and disability networking opportunities, focused on self-advocacy, informed choice, and community engagement skills; and

(7) provide an annual leadership program for persons with intellectual and developmental disabilities.

(b) An organization receiving a grant under paragraph (a) must be an organization governed by people with intellectual and developmental disabilities that administers a statewide network of disability groups in order to maintain and promote self-advocacy services and supports for persons with intellectual and developmental disabilities throughout the state.

(c) An organization receiving a grant under this subdivision may use a portion of grant revenue determined by the commissioner for administration and general operating costs.

Subd. 2. **Subgrants for outreach to persons in institutional settings.** The commissioner shall make available to an organization described under subdivision 1 a grant for subgrants to organizations in Minnesota to conduct outreach to persons working and living in institutional settings to provide education and information about community options. Subgrant funds must be used to deliver peer-led skill training sessions in six regions of the state to help persons with intellectual and developmental disabilities understand community service options related to:

(1) housing;

(2) employment;

(3) education;

(4) transportation;

(5) emerging service reform initiatives contained in the state's Olmstead plan; the Workforce Innovation and Opportunity Act, Public Law 113-128; and federal home and community-based services regulations; and

(6) connecting with individuals who can help persons with intellectual and developmental disabilities make an informed choice and plan for a transition in services.

History: *1Sp2017 c 6 art 1 s 4; 1Sp2021 c 7 art 13 s 7*

256.4772 MINNESOTA INCLUSION INITIATIVE GRANT.

Subdivision 1. **Grant program established.** The commissioner of human services shall establish the Minnesota inclusion initiative grant program to encourage self-advocacy groups of persons with intellectual and developmental disabilities to develop and organize projects that increase the inclusion of persons with intellectual and developmental disabilities in the community, improve community integration outcomes, educate decision-makers and the public about persons with intellectual and developmental disabilities, including the systemic barriers that prevent them from being included in the community, and to advocate for changes that increase access to formal and informal supports and services necessary for greater inclusion of persons with intellectual and developmental disabilities in the community.

Subd. 2. **Administration.** The commissioner of human services, as authorized by section 256.01, subdivision 2, paragraph (a), clause (6), shall issue a request for proposals to contract with a public or private entity to (1) serve as a fiscal host for the money appropriated for the purposes described in this section, and (2) develop guidelines, criteria, and procedures for awarding grants. The fiscal host shall establish an advisory committee consisting of self-advocates, nonprofit advocacy organizations, and Department of Human Services staff to review applications and award grants under this section.

Subd. 3. **Applications.** (a) Entities seeking grants under this section shall apply to the advisory committee of the fiscal host under contract with the commissioner. The grant applicant must include a description of the project that the applicant is proposing, the amount of money that the applicant is seeking, and a proposed budget describing how the applicant will spend the grant money.

(b) The advisory committee may award grants to applicants only for projects that meet the requirements of subdivision 4.

Subd. 4. **Use of grant money.** Projects funded by grant money must have person-centered goals, call attention to issues that limit inclusion of persons with intellectual and developmental disabilities, address barriers to inclusion that persons with intellectual and developmental disabilities face in their communities, or increase the inclusion of persons with intellectual and developmental disabilities in their communities. Applicants may propose strategies to increase inclusion of persons with intellectual and developmental disabilities in their communities by:

(1) decreasing barriers to workforce participation experienced by persons with intellectual and developmental disabilities;

(2) overcoming barriers to accessible and reliable transportation options for persons with intellectual and developmental disabilities;

(3) identifying and addressing barriers to voting experienced by persons with intellectual and developmental disabilities;

(4) advocating for increased accessible housing for persons with intellectual and developmental disabilities;

(5) working with governmental agencies or businesses on accessibility issues under the Americans with Disabilities Act;

(6) increasing collaboration between self-advocacy groups and other organizations to effectively address systemic issues that impact persons with intellectual and developmental disabilities;

(7) increasing capacity for inclusion in a community; or

(8) providing public education and awareness of the civil and human rights of persons with intellectual and developmental disabilities.

Subd. 5. **Reports.** (a) Grant recipients shall provide the advisory committee with a report about the activities funded by the grant program in a format and at a time specified by the advisory committee. The advisory committee shall require grant recipients to include in the grant recipient's report at least the information necessary for the advisory committee to meet the advisory committee's obligation under paragraph (b).

(b) The advisory committee shall provide the commissioner with a report that describes all of the activities and outcomes of projects funded by the grant program in a format and at a time determined by the commissioner.

History: *1Sp2021 c 7 art 13 s 8*

256.4773 TECHNOLOGY FOR HOME GRANT.

Subdivision 1. **Establishment.** The commissioner must establish a technology for home grant program that provides assistive technology consultations and resources for people with disabilities who want to stay in their own home, move to their own home, or remain in a less restrictive residential setting. The grant program may be administered using a team approach that allows multiple professionals to assess and meet a person's assistive technology needs. The team may include but is not limited to occupational therapists, physical therapists, speech therapists, nurses, and engineers.

Subd. 2. **Eligible applicants.** An eligible applicant is a person who uses or is eligible for home care services under section 256B.0651, home and community-based services under section 256B.092 or 256B.49, personal care assistance under section 256B.0659, or community first services and supports under section 256B.85, and who meets one of the following conditions:

(1) lives in the applicant's own home and may benefit from assistive technology for safety, communication, community engagement, or independence;

(2) is currently seeking to live in the applicant's own home and needs assistive technology to meet that goal; or

(3) resides in a residential setting under section 256B.4914, subdivision 3, and is seeking to reduce reliance on paid staff to live more independently in the setting.

Subd. 3. **Allowable grant activities.** The technology for home grant program must provide at-home, in-person assistive technology consultation and technical assistance to help people with disabilities live more independently. Allowable activities include but are not limited to:

(1) consultations in people's homes, workplaces, or community locations;

(2) connecting people to resources to help them live in their own homes, transition to their own homes, or live more independently in residential settings;

(3) conducting training for and set up and installation of assistive technology; and

(4) participating on a person's care team to develop a plan to ensure assistive technology goals are met.

Subd. 4. **Data collection and outcomes.** Grantees must provide data summaries to the commissioner for the purpose of evaluating the effectiveness of the grant program. The commissioner must identify outcome

measures to evaluate program activities to assess whether the grant programs help people transition to or remain in the least restrictive setting.

History: *2023 c 61 art 1 s 11*

256.4776 PARENT-TO-PARENT PEER SUPPORT.

(a) The commissioner shall make a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for families of children with any type of disability or special health care needs. An eligible alliance member must have an established parent-to-parent peer support program that is statewide and represents diverse cultures and geographic locations, that conducts outreach and provides individualized support to any parent or guardian of a child with a disability or special health care need, including newly identified parents of such a child or parents experiencing transitions or changes in their child's care, and that implements best practices for peer-to-peer support, including providing support from trained parent staff and volunteer support parents who have received Parent to Parent USA's specialized parent-to-parent peer support training.

(b) Grant recipients must use grant money for the purposes specified in paragraph (a).

(c) For purposes of this section, "special health care needs" means disabilities, chronic illnesses or conditions, health-related educational or behavioral problems, or the risk of developing disabilities, conditions, illnesses, or problems.

(d) Grant recipients must report to the commissioner of human services annually by January 15 about the services and programs funded by this grant. The report must include measurable outcomes from the previous year, including the number of families served by the organization's parent-to-parent programs and the number of volunteer support parents trained by the organization's parent-to-parent programs.

History: *1Sp2021 c 7 art 13 s 9*

256.478 TRANSITION TO COMMUNITY INITIATIVE.

Subdivision 1. **Purpose and establishment.** (a) The commissioner shall establish the transition to community initiative to award grants to serve individuals who are not eligible for medical assistance or for whom goods, supports, and services not covered by medical assistance would allow them to:

(1) live in the least restrictive setting and as independently as possible;

(2) access services that support short- and long-term needs for developmental growth or individualized treatment needs;

(3) build or maintain relationships with family and friends; and

(4) participate in community life.

(b) Grantees must ensure that individuals are engaged in a process that involves person-centered planning and informed choice decision-making. The informed choice decision-making process must provide accessible written information and be experiential whenever possible, and must engage family members, legal guardians, or natural supports, as appropriate and whenever possible.

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual can demonstrate that current services are not capable of meeting individual treatment and service needs that can be met in the community with support, and the individual meets at least one of the following criteria:

(1) the person meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care, residential-level care, or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota Forensic Mental Health Program, the Child and Adolescent Behavioral Health Hospital program, a psychiatric residential treatment facility under section 256B.0941, intensive residential treatment services under section 256B.0622, children's residential services under section 245.4882, juvenile detention facility, county supervised building, or a hospital would be substantially delayed without additional resources available through the transitions to community initiative;

(3) the person (i) is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) expresses a desire to move; and (iii) has received approval from the commissioner; or

(4) the person can demonstrate that the person's needs are beyond the scope of current service designs and grant funding can support the inclusion of additional supports for the person to access appropriate treatment and services in the least restrictive environment.

Subd. 3. **Authorized uses of grant funds.** Grant funds may be used for but are not limited to the following:

(1) increasing access to home and community-based services for an individual;

(2) improving caregiver-child relationships and aiding progress toward treatment goals, including support for the individual to return to live in their home; and

(3) reducing emergency department visits.

Subd. 4. **Outcomes.** Program evaluation is based on but not limited to the following criteria:

(1) expediting discharges for individuals who no longer need hospital level of care;

(2) individuals obtaining and retaining housing, including successfully returning to live with support in their home;

(3) individuals maintaining community living by diverting admission to Anoka Metro Regional Treatment Center and Forensic Mental Health Program;

(4) reducing recidivism rates of individuals returning to state institutions; and

(5) individuals' ability to live in the least restrictive community setting.

History: *2013 c 108 art 4 s 14; 2015 c 71 art 7 s 25; 1Sp2021 c 7 art 17 s 1; 2022 c 98 art 6 s 22; 2023 c 70 art 9 s 26,27; art 17 s 35,36*

256.479 CUSTOMIZED LIVING QUALITY IMPROVEMENT GRANTS.

(a) The commissioner of human services shall develop incentive-based grants to providers of customized living services under the brain injury, community access for disability inclusion, and elderly waivers for achieving outcomes specified in a contract. The commissioner may solicit proposals from providers and implement those that, on a competitive basis, best meet the state's policy objectives.

(b) To be eligible for a grant under this section, at least 75 percent of the clients served by the provider must be waiver participants. For providers of customized living services under the brain injury or community access for disability inclusion, the waiver participants must reside at multiple locations each with six or more residents. The commissioner shall give greater preference to those providers serving a higher percentage of waiver participants.

(c) The commissioner shall limit expenditures under this subdivision to the amount appropriated for this purpose.

(d) In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) provide more efficient, higher quality services;

(2) encourage home and community-based services providers to innovate;

(3) equip home and community-based services providers with organizational tools and expertise to improve their quality;

(4) incentivize home and community-based services providers to invest in better services; and

(5) disseminate successful performance improvement strategies statewide.

History: *1Sp2019 c 9 art 4 s28; 3Sp2020 c 1 s 1,6; 1Sp2021 c 7 art 13 s 10*

256.4792 LONG-TERM SERVICES AND SUPPORTS LOAN PROGRAM.

Subdivision 1. **Long-term services and supports loan program.** The commissioner of human services shall establish a competitive loan program to provide operating loans to eligible long-term services and supports providers and facilities. The commissioner shall initiate the application process for the loan described in this section at least once annually if money is available. A second application process may be initiated each year at the discretion of the commissioner.

Subd. 2. **Eligibility.** To be an eligible applicant for a loan under this section, a provider must submit to the commissioner of human services a loan application in the form and according to the timelines established by the commissioner. In its loan application, a loan applicant must demonstrate the following:

(1) for nursing facilities with a medical assistance provider agreement that are licensed as a nursing home or boarding care home according to section 256R.02, subdivision 33:

(i) the total net income of the nursing facility is not generating sufficient revenue to cover the nursing facility's operating expenses;

(ii) the nursing facility is at risk of closure; and

(iii) additional operating revenue is necessary to either preserve access to nursing facility services within the community or support people with complex, high-acuity support needs; and

(2) for other long-term services and supports providers:

(i) demonstration that the provider is enrolled in a Minnesota health care program and provides one or more of the following services in a Minnesota health care program:

(A) home and community-based services under chapter 245D;

(B) personal care assistance services under section 256B.0659;

(C) community first services and supports under section 256B.85;

(D) early intensive developmental and behavioral intervention services under section 256B.0949;

(E) home care services as defined under section 256B.0651, subdivision 1, paragraph (d); or

(F) customized living services as defined in section 256S.02; and

(ii) additional operating revenue is necessary to preserve access to services within the community, expand services to people within the community, expand services to new communities, or support people with complex, high-acuity support needs.

Subd. 2a. **Allowable uses of loan money.** (a) A loan awarded to a nursing facility under subdivision 2, clause (1), must only be used to cover the facility's short-term operating expenses. Nursing facilities receiving loans must not use the loan proceeds to pay related organizations as defined in section 256R.02, subdivision 43.

(b) A loan awarded to a long-term services and supports provider under subdivision 2, clause (2), must only be used to cover expenses related to achieving outcomes identified in subdivision 2, clause (2), item (ii).

Subd. 3. **Approving loans.** The commissioner must evaluate all loan applications on a competitive basis and award loans to successful applicants within available appropriations for this purpose. The commissioner's decisions are final and not subject to appeal.

Subd. 4. **Disbursement schedule.** Successful loan applicants under this section may receive loan disbursements as a lump sum or on an agreed upon disbursement schedule. The commissioner shall approve disbursements to successful loan applicants through a memorandum of understanding. Memoranda of understanding must specify the amount and schedule of loan disbursements.

Subd. 5. **Loan administration.** The commissioner may contract with an independent third party to administer the loan program under this section.

Subd. 6. **Loan payments.** The commissioner shall negotiate the terms of the loan repayment, including the start of the repayment plan, the due date of the repayment, and the frequency of the repayment installments. Repayment installments must not begin until at least 18 months after the first disbursement date. The memoranda of understanding must specify the amount and schedule of loan payments. The repayment term must not exceed 72 months. If any loan payment to the commissioner is not paid within the time specified by the memoranda of understanding, the late payment must be assessed a penalty rate of 0.01 percent of the original loan amount each month the payment is past due. For nursing facilities, this late fee is not an allowable cost on the department's cost report. The commissioner shall have the power to abate penalties when discrepancies occur resulting from but not limited to circumstances of error and mail delivery.

Subd. 7. **Loan repayment.** (a) If a borrower is more than 60 calendar days delinquent in the timely payment of a contractual payment under this section, the provisions in paragraphs (b) to (e) apply.

(b) The commissioner may withhold some or all of the amount of the delinquent loan payment, together with any penalties due and owing on those amounts, from any money the department owes to the borrower. The commissioner may, at the commissioner's discretion, also withhold future contractual payments from any money the commissioner owes the provider as those contractual payments become due and owing. The

commissioner may continue this withholding until the commissioner determines there is no longer any need to do so.

(c) The commissioner shall give prior notice of the commissioner's intention to withhold by mail, facsimile, or email at least ten business days before the date of the first payment period for which the withholding begins. The notice must be deemed received as of the date of mailing or receipt of the facsimile or electronic notice. The notice must:

(1) state the amount of the delinquent contractual payment;

(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 commissioner intends to withhold future installments of the provider's contractual payments; and

(5) state other contents as the commissioner deems appropriate.

(d) The commissioner, or the commissioner's designee, may enter into written settlement agreements with a provider to resolve disputes and other matters involving unpaid loan contractual payments or future loan contractual payments.

(e) Notwithstanding any law to the contrary, all unpaid loans, plus any accrued penalties, are overpayments for the purposes of section 256B.0641, subdivision 1. The current owner of a nursing home, boarding care home, or long-term services and supports provider is liable for the overpayment amount owed by a former owner for any facility sold, transferred, or reorganized.

Subd. 8. **Audit.** Loan money allocated under this section is subject to audit to determine whether the money was spent as authorized under this section.

Subd. 8a. **Special revenue account.** A long-term services and supports loan account is created in the special revenue fund in the state treasury. Money appropriated for the purposes of this section must be transferred to the long-term services and supports loan account. All payments received under subdivision 6, along with fees, penalties, and interest, must be deposited into the special revenue account and are appropriated to the commissioner for the purposes of this section.

Subd. 9. **Carryforward.** Notwithstanding section 16A.28, subdivision 3, money in the long-term services and supports loan account for the purposes under this section carries forward and does not lapse.

Subd. 10. MS 2023 Supp [Repealed by amendment, 2024 c 125 art 2 s 16; 2024 c 127 art 47 s 16]

History: *2023 c 61 art 2 s 12; 2024 c 125 art 2 s 16,23; 2024 c 127 art 47 s 16,23*

256.4793 [Renumbered 142A.45]

256.4794 [Renumbered 142A.451]

256.48 [Repealed, 1947 c 535 s 16]

COUNCIL ON DISABILITY

256.481 PERSON WITH A DISABILITY; DEFINITION.

For the purposes of sections 256.481 to 256.482 "person with a disability" means any person who:

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

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

(3) 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; 2017 c 40 art 1 s 60,121*

256.482 COUNCIL ON DISABILITY.

Subdivision 1. **Establishment; members.** There is hereby established the Council on Disability which shall consist of 17 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; 2013 c 29 s 1*

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]

256.4835 MINNESOTA RARE DISEASE ADVISORY COUNCIL.

Subdivision 1. **Establishment.** There is established an advisory council on rare diseases to provide advice on policies, access, equity, research, diagnosis, treatment, and education related to rare diseases. The advisory council is established in honor of Chloe Barnes and her experiences in the health care system. For purposes of this section, "rare disease" has the meaning given in United States Code, title 21, section 360bb. The council shall be called the Minnesota Rare Disease Advisory Council. The Council on Disability shall provide meeting and office space and administrative support to the advisory council but does not have authority over the work of the advisory council.

Subd. 2. **Membership.** (a) The advisory council shall consist of at least 17 public members who reflect statewide representation. Except for initial members, members are appointed by the governor according to paragraph (b). Four members of the legislature are appointed according to paragraph (c).

(b) The governor shall appoint at least the following public members according to section 15.0597:

(1) three physicians licensed and practicing in the state with experience researching, diagnosing, or treating rare diseases, including one specializing in pediatrics;

(2) one registered nurse or advanced practice registered nurse licensed and practicing in the state with experience treating rare diseases;

(3) at least two hospital administrators, or their designees, from hospitals in the state that provide care to persons diagnosed with a rare disease. One administrator or designee appointed under this clause must represent a hospital in which the scope of service focuses on rare diseases of pediatric patients;

(4) three persons age 18 or older who either have a rare disease or are a caregiver of a person with a rare disease. One person appointed under this clause must reside in rural Minnesota;

(5) a representative of a rare disease patient organization that operates in the state;

(6) a social worker with experience providing services to persons diagnosed with a rare disease;

(7) a pharmacist with experience with drugs used to treat rare diseases;

(8) a dentist licensed and practicing in the state with experience treating rare diseases;

(9) a representative of the biotechnology industry;

(10) a representative of health plan companies;

(11) a medical researcher with experience conducting research on rare diseases;

(12) a genetic counselor with experience providing services to persons diagnosed with a rare disease or caregivers of those persons; and

(13) representatives with other areas of expertise as identified by the advisory council.

(c) The advisory council shall include two members of the senate, one appointed by the majority leader and one appointed by the minority leader; and two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader. Members appointed under this paragraph serve until their successors are appointed.

(d) The commissioner of health or a designee, a representative of Mayo Medical School, and a representative of the University of Minnesota Medical School shall serve as ex officio, nonvoting members of the advisory council.

(e) Members appointed according to paragraph (b) shall serve for a term of three years, except the initial members appointed according to paragraph (b). Members appointed according to paragraph (b) shall serve until their successors have been appointed.

(f) Members may be reappointed for up to two full additional terms according to the advisory council's operating procedures.

(g) Members may be removed as provided in section 15.059, subdivision 4.

(h) Public members serve without compensation, but may have expenses reimbursed as provided in section 15.059, subdivision 3. Legislative members may receive per diem according to the rules of their respective bodies.

Subd. 3. **Meetings.** The advisory council shall meet at the call of the chairperson or at the request of a majority of advisory council members. Meetings of the advisory council are subject to section 13D.01, and notice of its meetings is governed by section 13D.04.

Subd. 3a. **Chairperson; executive director; staff; executive committee.** (a) The advisory council shall elect a chairperson and other officers as it deems necessary and in accordance with the advisory council's operating procedures.

(b) The advisory council shall be governed by an executive committee elected by the members of the advisory council. One member of the executive committee must be the advisory council chairperson.

(c) The advisory council shall appoint an executive director. The executive director serves as an ex officio nonvoting member of the executive committee. The advisory council may delegate to the executive director any powers and duties under this section that do not require advisory council approval. The executive director serves in the unclassified service and may be removed at any time by a majority vote of the advisory council. The executive director may employ and direct staff necessary to carry out advisory council mandates, policies, activities, and objectives.

(d) The executive committee may appoint additional subcommittees and work groups as necessary to fulfill the duties of the advisory council.

Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

(1) in conjunction with the state's medical schools, the state's schools of public health, and hospitals in the state that provide care to persons diagnosed with a rare disease, developing resources or recommendations relating to quality of and access to treatment and services in the state for persons with a rare disease, including but not limited to:

(i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases;

(ii) identifying best practices for rare disease care implemented in other states, at the national level, and at the international level that will improve rare disease care in the state and seeking opportunities to partner with similar organizations in other states and countries;

(iii) identifying and addressing problems faced by patients with a rare disease when changing health plans, including recommendations on how to remove obstacles faced by these patients to finding a new health plan and how to improve the ease and speed of finding a new health plan that meets the needs of patients with a rare disease;

(iv) identifying and addressing barriers faced by patients with a rare disease to obtaining care, caused by prior authorization requirements in private and public health plans; and

(v) identifying, recommending, and implementing best practices to ensure health care providers are adequately informed of the most effective strategies for recognizing and treating rare diseases;

(2) advising, consulting, and cooperating with the Department of Health, including the Advisory Committee on Heritable and Congenital Disorders; the Department of Human Services, including the Drug Utilization Review Board and the Drug Formulary Committee; and other agencies of state government in developing recommendations, information, and programs for the public and the health care community relating to diagnosis, treatment, and awareness of rare diseases;

(3) advising on policy issues and advancing policy initiatives at the state and federal levels; and

(4) receiving funds and issuing grants.

(b) The advisory council shall collect additional topic areas for study and evaluation from the general public. In order for the advisory council to study and evaluate a topic, the topic must be approved for study and evaluation by the advisory council.

(c) Legislative members may not deliberate about or vote on decisions related to the issuance of grants of state money.

Subd. 5. **Conflict of interest.** Advisory council members are subject to the advisory council's conflict of interest policy as outlined in the advisory council's operating procedures.

Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the advisory council shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over higher education and health care policy on the advisory council's activities under subdivision 4 and other issues on which the advisory council may choose to report.

History: *2019 c 65 s 1; 2022 c 98 art 13 s 2,14*

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]

256.741 [Renumbered 518A.81]

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

Subd. 2. [Renumbered 142A.418, subdivision 1]

Subd. 3. [Renumbered 142A.418, subd 2]

Subd. 4. [Repealed, 2013 c 108 art 17 s 24]

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

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 [Renumbered 518A.82]

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 MS 2022 [Repealed, 2023 c 70 art 10 s 98]

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, the Direct Care and Treatment executive board, and the local social services agencies of the several counties in trust or for the benefit of children with a disability and children who are dependent, neglected, or delinquent, 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 have developmental disability, mental

illness, or substance use disorder, 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; 2017 c 40 art 1 s 121; 2022 c 98 art 4 s 51; 2024 c 125 art 5 s 25; 2024 c 127 art 50 s 25*

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 and the Direct Care and Treatment executive board as trustees for their respective beneficiaries in proportion to the beneficiaries' several interests. The commissioner of management and budget shall be responsible only to the commissioner of human services and the Direct Care and Treatment executive board for the sum total of the fund, and shall have no duties nor direct obligations toward the beneficiaries thereof individually. Subject to the applicable rules of the commissioner of human services or the Direct Care and Treatment executive board, 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; 2024 c 125 art 5 s 26; 2024 c 127 art 50 s 26*

256.90 SOCIAL WELFARE FUND; USE; DISPOSITION; DEPOSITORIES.

The commissioner of human services, in consultation with the Direct Care and Treatment executive board, 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; 2024 c 125 art 5 s 27; 2024 c 127 art 50 s 27*

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 or the Direct Care and Treatment executive board at any time may pay out such amounts as the commissioner or executive board deems proper for the support, maintenance, or other legal benefit of any of the children with a disability and children who are dependent, neglected, or delinquent, 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 disability, substance use disorder, 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 or the Direct Care and Treatment executive board, 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; 2017 c 40 art 1 s 121; 2022 c 98 art 4 s 51; 2024 c 125 art 5 s 28; 2024 c 127 art 50 s 28*

256.92 COMMISSIONER OF HUMAN SERVICES AND DIRECT CARE AND TREATMENT, ACCOUNTS.

It shall be the duty of the commissioner of human services, the Direct Care and Treatment executive board, and 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, in consultation with the Direct Care and Treatment executive board, 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 or the Direct Care and Treatment executive board, 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; 2024 c 125 art 5 s 29; 2024 c 127 art 50 s 29*

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 child with a developmental disability or who is disabled, dependent, neglected or delinquent, 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; 2017 c 40 art 1 s 121*

256.935 Subdivision 1. [Renumbered 142G.95]

Subd. 2. [Repealed, 3Sp1981 c 3 s 20]

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 HEALTH CARE COVERAGE FOR PEOPLE LIVING WITH HIV.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay the cost of health plan premiums and cost sharing for prescriptions, including co-payments, deductibles, and coinsurance for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the health insurance premiums and prescription cost sharing, including co-payments and deductibles required under section 256B.0631. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents or is paid by the individual's employer.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must meet all eligibility requirements for Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87, and enroll in the Minnesota Ryan White program.

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under this section 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 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; 2016 c 158 art 2 s 64; 2017 c 59 s 7; 1Sp2019 c 9 art 5 s 33*

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 children with developmental disabilities and 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; 2014 c 312 art 27 s 77*

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 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 meals, 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 or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a $100 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 website, the school district or charter school shall provide on its website 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 review dates.** The commissioner shall develop and implement a process by January 1, 2013, to provide eligibility review 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; 2013 c 81 s 3; 2016 c 158 art 2 s 65,66; 1Sp2019 c 9 art 7 s 8; 2023 c 55 art 9 s 19; 2023 c 70 art 16 s 8*

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.** 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.

History: *2007 c 147 art 5 s 3; 2014 c 262 art 2 s 1*

256.9631 ALTERNATIVE CARE DELIVERY MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.

Subdivision 1. **Direction to the commissioner.** (a) The commissioner, in order to deliver services to eligible individuals, achieve better health outcomes, and reduce the cost of health care for the state, shall develop implementation plans for at least three care delivery models that:

(1) are alternatives to the use of commercial managed care plans to deliver health care to Minnesota health care program enrollees; and

(2) do not shift financial risk to nongovernmental entities.

(b) One of the alternative models must be a direct payment system under which eligible individuals receive services through the fee-for-service system, county-based purchasing plans, and county-owned health maintenance organizations. At least one additional model must include county-based purchasing plans and county-owned health maintenance organizations in their design, and must allow these entities to deliver care in geographic areas on a single plan basis, if:

(1) these entities contract with all providers that agree to contract terms for network participation; and

(2) the commissioner of human services determines that an entity's provider network is adequate to ensure enrollee access and choice.

(c) Before determining the alternative models for which implementation plans will be developed, the commissioner shall consult with the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

(d) The commissioner shall present implementation plans for the selected models to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy by January 15, 2026. The commissioner may contract for technical assistance in developing the implementation plans and conducting related studies and analyses.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Eligible individuals" means all medical assistance and MinnesotaCare enrollees.

(c) "Minnesota health care programs" means the medical assistance and MinnesotaCare programs.

(d) "Qualified hospital provider" means a nonstate government teaching hospital with high medical assistance utilization and a level 1 trauma center, and all of the hospital's owned or affiliated health care professionals, ambulance services, sites, and clinics.

Subd. 3. **Implementation plans.** (a) Each implementation plan must include:

(1) a timeline for the development and recommended implementation date of the alternative model. In recommending a timeline, the commissioner must consider:

(i) timelines required by the existing contracts with managed care plans and county-based purchasing plans to sunset existing delivery models;

(ii) in counties that choose to operate a county-based purchasing plan under section 256B.692, timelines for any new procurements required for those counties to establish a new county-based purchasing plan or participate in an existing county-based purchasing plan;

(iii) in counties that choose to operate a county-owned health maintenance organization under section 256B.69, timelines for any new procurements required for those counties to establish a new county-owned health maintenance organization or to continue serving enrollees through an existing county-owned health maintenance organization; and

(iv) a recommendation on whether the commissioner should contract with a third-party administrator to administer the alternative model, and the timeline needed for procuring an administrator;

(2) the procedures to be used to ensure continuity of care for enrollees who transition from managed care to fee-for-service and any administrative resources needed to carry out these procedures;

(3) recommended quality measures for health care service delivery;

(4) any changes to fee-for-service payment rates that the commissioner determines are necessary to ensure provider access and high-quality care and to reduce health disparities;

(5) recommendations on ensuring effective care coordination under the alternative model, especially for enrollees who:

(i) are age 65 or older, blind, or have disabilities;

(ii) have complex medical conditions;

(iii) face socioeconomic barriers to receiving care; or

(iv) are from underserved populations that experience health disparities;

(6) recommendations on payment arrangements for care coordination, including:

(i) the provider types eligible for care coordination payments;

(ii) procedures to coordinate care coordination payments with existing supplemental or cost-based payment methods or to replace these existing methods; and

(iii) procedures to align care coordination initiatives funded under the alternative model with existing care coordination initiatives;

(7) recommendations on whether the alternative model should include funding to providers for outreach initiatives to patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care and treatment;

(8) recommendations for a supplemental payment to qualified hospital providers to offset any potential revenue losses resulting from the shift from managed care payments; and

(9) recommendations for statutory changes necessary to implement the alternative model.

(b) In developing each implementation plan, the commissioner shall:

(1) calculate the projected cost of the alternative model relative to the cost of the current system;

(2) assess gaps in care coordination under the current medical assistance and MinnesotaCare programs;

(3) evaluate the effectiveness of approaches other states have taken to coordinate care under a fee-for-service system, including the coordination of care provided to persons who are age 65 or older, are blind, or have disabilities;

(4) estimate the loss of revenue and cost savings from other payment enhancements based on managed care plan directed payments and pass-throughs;

(5) estimate cost trends under the alternative model for managed care payments to county-based purchasing plans and county-owned health maintenance organizations;

(6) estimate the impact of the alternative model on other revenue, including taxes, surcharges, or other federally approved in lieu of services and on other arrangements allowed under managed care;

(7) consider allowing eligible individuals to opt out of managed care as an alternative approach;

(8) consult with the commissioners of health and commerce and the contractor or contractors analyzing the Minnesota Health Plan and other health reform models on plan design and assumptions; and

(9) conduct other analyses necessary to develop the implementation plan.

History: *2023 c 70 art 16 s 9; 2024 c 127 art 54 s 1*

256.964 [Repealed, 2014 c 262 art 2 s 18]

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 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.

Subd. 3. **Prompt payment required.** (a) In paying claims under medical assistance, the commissioner shall comply with Code of Federal Regulations, title 42, section 447.45.

(b) If the commissioner does not pay or deny a clean claim within the period provided in paragraph (a), the commissioner must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the commissioner makes the payment or denies the claim.

(c) The rate of interest paid by the commissioner under this subdivision must be 1.5 percent per month or any part of a month.

History: *1988 c 689 art 2 s 138; 1992 c 513 art 7 s 14; 1995 c 234 art 8 s 56; 2016 c 158 art 2 s 67; 2023 c 70 art 1 s 3*

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.

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. MS 2016 [Repealed, 2018 c 182 art 1 s 109]

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. 2a. **Teaching hospital surcharge.** (a) Each teaching hospital shall pay to the medical assistance account a surcharge equal to 1.41 percent of its fiscal year 2021 net patient revenue for inpatient services. The initial surcharge must not be collected more than 30 days before the commissioner makes the first of the payments required under section 256.969, subdivision 2g. Subsequent surcharge payments must be paid annually in the form and manner specified by the commissioner. The surcharge must comply with all applicable federal requirements and federal laws, including but not limited to Code of Federal Regulations, title 42, section 433.68.

(b) Revenue from the surcharge must be used by the commissioner only to pay the nonfederal share of the medical assistance supplemental payments described in section 256.969, subdivision 2g, and must be used to supplement, and not supplant, medical assistance reimbursement to teaching hospitals.

(c) For purposes of this subdivision, "teaching hospital" means any Minnesota hospital with a Centers for Medicare and Medicaid Services designation of "teaching hospital" as reported on form CMS-2552-10, worksheet S-2, line 56, that is eligible for reimbursement under section 256.969, subdivision 2g.

(d) Notwithstanding paragraph (c), the following hospitals are exempt from paying the surcharge under this section:

(1) all hospitals in Minnesota designated as a children's hospital under Medicare, including Children's Health Care, doing business as Children's Minnesota, and Gillette Children's Specialty Healthcare, doing business as Gillette Children's;

(2) teaching hospitals with three or fewer full-time equivalent trainees, based on a Medicare cost report filed for the fiscal year ending in 2022;

(3) federal Indian Health Service facilities; and

(4) regional treatment centers.

(e) The teaching hospital surcharge established under this subdivision must only be assessed if the annual inpatient supplemental payments under section 256.969, subdivision 2g, are approved by the Centers for Medicare and Medicaid Services.

(f) The commissioner must reduce the surcharge percentage in paragraph (a) such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed for the nonfederal share of the annual inpatient supplemental payments authorized by section 256.969, subdivision 2g.

(g) For purposes of this subdivision, net patient revenue for inpatient services must be calculated by:

(1) determining gross inpatient hospital facility charges from the hospital's audited statements or, if not contained or segregated within the hospital's audited financial statements, using detailed internal financial income statements or schedules; and

(2) subtracting from gross inpatient hospital facility charges:

(i) all professional fee charges, home health charges, skilled nursing facility charges, hospice charges, end-stage renal disease charges, and other nonhospital charges; and

(ii) applicable contractual allowances.

(h) Teaching hospitals subject to the surcharge under this subdivision shall submit to the commissioner, in the form and manner specified by the commissioner, all documentation necessary to provide reconciliation of the net patient revenue calculation under paragraph (b).

(i) This subdivision is effective on the later of July 1, 2025, or 60 days after the end of the first legislative regular session that begins following federal approval for all of the following: (1) the amendment in this act adding section 256.9657, subdivision 2a; (2) the amendment in this act to section 256.969, subdivision 2b; and (3) the amendment in this act adding section 256.969, subdivision 2g. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(j) This subdivision is subject to the implementation requirements in Laws 2024, chapter 127, article 54, section 9.

(k) This subdivision expires June 30, 2030, or five years after federal approval is obtained, whichever is later.

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 June 15 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the 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/DD license surcharge.** (a) 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.

(b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to $3,679 per licensed bed.

Subd. 4. **Payments into the account.** (a) Payments to the commissioner under subdivision 1 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.

(b) Effective October 15, 2014, payment to the commissioner under subdivision 2 must be paid in nine monthly installments due on the 15th of the month beginning October 15, 2014, through June 15 of the following year. The monthly payment must be equal to the annual surcharge divided by nine.

(c) Effective October 1, 2014, and each October 1 thereafter, the payments in subdivision 2 must be based on revenues earned in the previous calendar year.

(d) If the commissioner of health does not provide by August 15 of any year data needed to update the base year for the hospital or April 15 of any year data needed to update the base year for the 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.

(e) 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.

(f) Payments due in July through September 2014 under subdivision 3 for revenue earned in calendar year 2012 shall be paid in a lump sum on June 15, 2014. On June 15, 2014, each health maintenance organization and community-integrated service network shall pay all payments under subdivision 3 in a lump sum for revenue earned in calendar year 2013. Effective June 15, 2015, and each June 15 thereafter, the payments in subdivision 3 shall be based on revenues earned in the previous calendar year and paid in a lump sum on June 15 of each year.

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.** (a) 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.

(b) 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; 2013 c 108 art 6 s 2,3; art 7 s 5; 1Sp2017 c 6 art 14 s 7; 2022 c 98 art 14 s 17; 2024 c 127 art 54 s 2; art 55 s 3*

256.9658 [Repealed, 2013 c 143 art 5 s 28]

256.966 Subdivision 1. [Repealed, 2016 c 158 art 1 s 215]

Subd. 2. [Repealed, 1987 c 403 art 2 s 164]

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.** The commissioner shall establish procedures for determining medical assistance 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, to be eligible for payment.

Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04, subdivision 15, the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician, advanced practice registered nurse, physician assistant, 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 45 calendar days after the date the notice of the decision was mailed. The request for reconsideration must be reviewed by at least one medical review agent that is independent of the case under reconsideration. The medical review agent shall make a recommendation to the commissioner. The commissioner's decision on reconsideration is final and not subject to appeal under chapter 14.

Subd. 1b. **Appeal of reconsideration.** The commissioner's decision under subdivision 1a is appealable by petition for writ of certiorari under chapter 606.

Subd. 1c. MS 2022 [Repealed, 2023 c 70 art 17 s 63]

Subd. 1d. MS 2022 [Repealed, 2023 c 70 art 17 s 63]

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; 2014 c 312 art 24 s 3,4; 1Sp2017 c 6 art 4 s 5,6; 2020 c 115 art 4 s 105-107; 2022 c 58 s 128-130; 2023 c 70 art 17 s 37,38*

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 or years 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 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.

Subd. 7a. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to administer medical record reviews; conduct administrative reconsiderations as defined by section 256.9685, subdivision 1a; and perform other functions as stipulated in the terms of the agent's contract with the department. Medical records reviews and administrative reconsiderations will be performed by medical professionals within their scope of expertise, including but not limited to physicians, physician assistants, advanced practice registered nurses, and registered nurses. The medical professional performing the review or reconsideration must be on staff with the medical review agent, in good standing, and licensed to practice in the state where the medical professional resides.

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31. Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June 30.

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; 2014 c 312 art 24 s 5; 2016 c 158 art 2 s 68; 1Sp2017 c 6 art 4 s 7; 2023 c 70 art 17 s 39*

256.969 PAYMENT RATES.

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

(b) Except as authorized under this section, 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.

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, such as the all patient-refined diagnosis-related groups (APR-DRGs) or other similar classification programs 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 hospital peer group. Relative values shall be recalibrated when the base year is changed. Relative value determinations shall include paid claims for admissions during

each hospital's base year. The commissioner may supplement the diagnostic classification systems data with national averages. Relative value determinations shall not include 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 recalibrate 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.

Subd. 2a. [Repealed, 1989 c 282 art 3 s 98]

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, 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 rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019. The estimated

change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

(k) Subject to subdivision 2g, effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a).

[See Note.]

Subd. 2c. [Repealed, 2014 c 312 art 24 s 48]

Subd. 2d. **Interim payments.** Notwithstanding subdivision 2b, paragraph (c), for discharges occurring on or after November 1, 2014, through March 1, 2016, the commissioner may implement an interim payment process to pay hospitals, including payments based on each hospital's average payments per claim for state fiscal years 2011 and 2012. These interim payments may be used to pay hospitals if the rebasing under subdivision 2b, paragraph (c), is not implemented by November 1, 2014, or if electronic systems changes necessary to support the conversion to the International Classification of Diseases, 10th revision (ICD-10) coding system are not completed. Claims paid at interim payment rates shall be reprocessed and paid at the rates established under subdivision 2b, paragraphs (c) and (d), upon implementation of the rebased rates.

Subd. 2e. **Alternate inpatient payment rate.** (a) If the days, costs, and revenues associated with patients who are eligible for medical assistance and also have private health insurance are required to be included in the calculation of the hospital-specific disproportionate share hospital payment limit for a rate year, then the commissioner, effective retroactively from rate years beginning on or after January 1, 2015, shall compute an alternate inpatient payment rate for a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare. The commissioner shall reimburse the hospital for a rate year at the higher of the amount calculated under the alternate payment rate or the amount calculated under subdivision 9.

(b) The alternate payment rate must meet the criteria in clauses (1) to (4):

(1) the alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to two percent less than each children's hospital's cost coverage percentage in the applicable base year for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance;

(2) costs shall be determined using the most recently available medical assistance cost report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods and applied in the same manner as the costs were in the rebasing for the applicable base year. If the medical assistance cost report is not available, costs shall be determined in the interim using the Medicare cost report;

(3) in any rate year in which payment to a hospital is made using the alternate payment rate, no payments shall be made to the hospital under subdivision 9; and

(4) if the alternate payment amount increases payments at a rate that is higher than the inflation factor applied over the rebasing period, the commissioner shall take this into consideration when setting payment rates at the next rebasing.

Subd. 2f. **Alternate inpatient payment rate.** Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6).

Subd. 2g. **Annual supplemental payment for graduate medical education.** (a) The commissioner and contracted managed care organizations shall annually pay an inpatient supplemental payment to all eligible hospitals for graduate medical education. A hospital must be an eligible hospital to receive an annual supplemental payment under this subdivision. Payments under this subdivision must comply with all applicable federal requirements and federal laws and meet the requirements of Code of Federal Regulations, title 42, section 438.60.

(b) For purposes of this subdivision, "eligible hospital" means a hospital that:

(1) is located in Minnesota;

(2) participates in Minnesota's medical assistance program;

(3) has received fee-for-service medical assistance payments in the payment year; and

(4) is either:

(i) eligible to receive graduate medical education payments from the Medicare program under Code of Federal Regulations, title 42, section 413.75; or

(ii) a hospital in Minnesota designated as a children's hospital under Medicare, including Children's Health Care, doing business as Children's Minnesota, and Gillette Children's Specialty Healthcare, doing business as Gillette Children's.

(c) The annual inpatient supplemental payment must be calculated as follows:

(1) $425,000 per full-time equivalent trained for each of the first ten full-time equivalents at a hospital;

(2) $350,000 per full-time equivalent trained for each full-time equivalent between 11 and 20 full-time equivalents at a hospital;

(3) $95,000 per full-time equivalent trained for each full-time equivalent between 21 and 30 full-time equivalents at a hospital;

(4) $70,000 per full-time equivalent trained for each full-time equivalent between 31 and 400 full-time equivalents at a hospital; and

(5) $50,000 per full-time equivalent trained for each full-time equivalent above 401 full-time equivalents at a hospital.

(d) The data source for the full-time equivalent trained under paragraph (c) must be the Medicare cost report for the fiscal year ending in calendar year 2022. The full-time equivalent is calculated by adding the two values populated on lines 10 and 11 on worksheet E, part A, of the Medicare cost report for that year, except that for eligible hospitals that are children's hospitals, the full-time equivalent is calculated based on interns and residents, as determined by adding form CMS-2552-10, worksheet E-4, lines 6, 10.01, and 15.01, or its equivalent, for that year.

(e) An eligible hospital must not accept any reimbursement under section 62J.692 if it would result in payments in excess of eligible expenditures. The surcharge paid under section 256.9657, subdivision 2a, and the payment received under this section must be reported in the application under section 62J.692.

(f) The supplemental payments under this subdivision:

(1) must not be included as public program revenue under section 62J.692; and

(2) must be deemed permissible pass-through payments for graduate medical education under Code of Federal Regulations, title 42, section 438.6(d), or when the state makes payments directly to teaching hospitals for graduate medical education costs approved under the state plan under Code of Federal Regulations, title 42, section 438.60.

(g) The total aggregate state and federal supplemental payments for hospitals under this subdivision must not exceed $203,000,000 per year. The commissioner may reduce the amount paid for each full-time

equivalent, as described in paragraph (c), on an equal basis to limit the total cost of all supplemental payments to the total dollar amounts available.

(h) This subdivision is effective the later of July 1, 2025, or 60 days after the end of the first legislative regular session that begins following federal approval for all of the following: (1) the amendment in this act adding section 256.9657, subdivision 2a; (2) the amendment in this act to section 256.969, subdivision 2b; and (3) the amendment in this act to add section 256.969, subdivision 2g. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(i) This subdivision is subject to the implementation requirements in Laws 2024, chapter 127, article 54, section 9.

(j) This subdivision expires June 30, 2030, or five years after federal approval is obtained, whichever is later.

Subd. 2h. **Alternate inpatient payment rate for a discharge.** (a) Effective retroactively from January 1, 2024, in any rate year in which a children's hospital discharge is included in the federally required disproportionate share hospital payment audit, where the patient discharged had resided in a children's hospital for over 20 years, the commissioner shall compute an alternate inpatient rate for the children's hospital. The alternate payment rate must be the rate computed under this section excluding the disproportionate share hospital payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to 99 percent of what the disproportionate share hospital payment would have been under subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

(b) In any rate year in which payment to a children's hospital is made using this alternate payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

[See Note.]

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, on a per claim basis, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. Services that have rates established under subdivision 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 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. 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 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 or corresponding APR-DRGs, 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 or corresponding APR-DRGs, 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, 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 or corresponding APR-DRGs, 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 or corresponding APR-DRGs, 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 or corresponding APR-DRGs, 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.

(j) Effective for discharges on and after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(k) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

(l) Effective for discharges on and after July 1, 2017, from hospitals paid under subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

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 identified 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 MinnesotaCare.

(c) The prohibition in paragraph (a) applies to payment for each hospital-acquired condition identified in this paragraph that is represented by an ICD-9-CM or ICD-10-CM diagnosis code. The list of conditions shall be the hospital-acquired conditions (HAC) list defined by the Centers for Medicare and Medicaid Services on an annual basis.

(d) The prohibition in paragraph (a) applies to any additional payments that result from a hospital-acquired condition identified 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 identified 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, to October 31, 2014, 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 readmission rate for admissions to all hospitals occurring within 30 days of a previous discharge using data from the Reducing Avoidable Readmissions Effectively (RARE) campaign. 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 October 31, 2014, 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.

(d) The exclusion from the rate reduction in paragraph (a) shall apply to a hospital located in Hennepin County with a licensed capacity of 1,700 beds as of September 1, 2011, for admissions of children under 18 years of age occurring on or after September 1, 2011, through August 31, 2013, but shall not apply to payments for admissions occurring on or after September 1, 2013, through October 31, 2014.

(e) Effective for discharges on or after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(f) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

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. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually submit to the commissioner medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments;

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9; or

(3) a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare.

For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The commissioner shall suspend payments to any hospital that fails to submit a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the commissioner.

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 8 to 14 exist.

Subd. 7. [Repealed, 1992 c 513 art 7 s 135]

Subd. 8. **Unusual length of stay experience.** (a) 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 and 2b. 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.

(b) Effective for admissions and transfers occurring on and after November 1, 2014, the commissioner shall establish payment rates for outlier payments that are based on Medicare methodologies.

Subd. 8a. **Neonatal admissions.** 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. [Repealed, 2014 c 312 art 24 s 48]

Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1, 2014, payments for hospital residents shall be made as follows:

(1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus any outliers; and

(2) payment for all medically necessary patient care subsequent to the first 180 days shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge ratio by the usual and customary charges.

(b) For discharges occurring on or after July 1, 2017, payment for hospital residents shall be equal to the payments under subdivision 8, paragraph (b).

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) 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; 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. 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) 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.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and one-quarter standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

(f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

Subd. 9a. [Repealed, 2014 c 312 art 24 s 48]

Subd. 9b. [Repealed, 2014 c 312 art 24 s 48]

Subd. 10. **Separate billing by certified registered nurse anesthetists.** Hospitals must exclude certified registered nurse anesthetist costs from the operating payment rate.

Subd. 11. [Repealed, 2014 c 312 art 24 s 48]

Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) 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 payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services.

(b) The commissioner shall establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for discharges occurring on and after November 1, 2014, the commissioner, to the extent possible, shall replicate the existing payment rate methodology under the new diagnostic classification system. The result must be budget neutral, ensuring that the total aggregate payments under the new system are equal to the total aggregate payments made for the same number and types of services in the base year, calendar year 2012.

(c) 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.

(d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals shall be established under subdivision 2b, paragraph (a), clause (4).

Subd. 13. [Repealed, 2014 c 312 art 24 s 48]

Subd. 14. **Transfers.** (a) 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, 3a, 4a, 5a, and 8 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, 3a, 4a, 5a, and 8 to 12.

(b) Effective for transfers occurring on and after November 1, 2014, the commissioner shall establish payment rates for acute transfers that are based on Medicare methodologies.

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 admissions in the base year or years 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 statute. 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 inpatient hospital 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. This payment increase remains in effect until the increase is fully recognized in the base year cost under subdivision 2b.

Subd. 20. [Repealed, 2014 c 312 art 24 s 48]

Subd. 21. [Repealed, 2014 c 312 art 24 s 48]

Subd. 22. [Repealed, 2014 c 312 art 24 s 48]

Subd. 23. [Repealed, 2015 c 71 art 11 s 65]

Subd. 24. [Repealed, 1995 c 207 art 6 s 124]

Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid on a per diem basis.

(b) 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.

(c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid the higher of a per diem amount computed using the methodology described in subdivision 2b, paragraph (i), or the per diem rate as of July 1, 2021.

Subd. 26. [Repealed, 2014 c 312 art 24 s 48]

Subd. 27. [Repealed, 2014 c 312 art 24 s 48]

Subd. 28. [Repealed, 2014 c 312 art 24 s 48]

Subd. 29. **Reimbursement for fee increase for early hearing detection and intervention program.** (a) 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.

(b) For admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective July 1, 2013, for the early hearing detection and intervention program under section 144.125, subdivision 1, paragraph (d), that is paid by the hospital for medical assistance and MinnesotaCare program enrollees. 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 managed care plans and county-based purchasing plans.

Subd. 30. [Repealed, 2015 c 71 art 11 s 65]

Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the inpatient hospital setting. This payment must be in addition to the diagnostic related group reimbursement for labor and delivery and shall be made consistent with section 256B.0625, subdivision 13e, paragraph (e).

(b) The commissioner must require managed care and county-based purchasing plans to comply with this subdivision when providing services to medical assistance enrollees. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

Subd. 32. **Biological products for cell and gene therapy.** (a) Effective July 1, 2025, and upon necessary federal approval of documentation required to enter into a value-based arrangement under section 256B.0625, subdivision 13k, the commissioner may provide separate reimbursement to hospitals for biological products provided in the inpatient hospital setting as part of cell or gene therapy to treat rare diseases, as defined in United States Code, title 21, section 360bb, if the drug manufacturer enters into a value-based arrangement with the commissioner.

(b) The commissioner shall establish the separate reimbursement rate for biological products provided under paragraph (a) based on the methodology used for drugs administered in an outpatient setting under section 256B.0625, subdivision 13e, paragraph (e).

[See Note.]

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; 2013 c 108 art 6 s 4; 2014 c 262 art 2 s 2; 2014 c 312 art 24 s 6-9,11-26; 2015 c 21 art 1 s 54; 2015 c 71 art 11 s 11-16; 2017 c 32 s 1,2; 1Sp2017 c 6 art 4 s 8-14; 1Sp2019 c 9 art 7 s 9-13; 2021 c 30 art 1 s 2-4; 2023 c 70 art 1 s 4-7; art 5 s 13; 2024 c 127 art 54 s 3-5; art 55 s 4*

NOTE: (a) The amendment to subdivision 2b by Laws 2024, chapter 127, article 54, section 3, is effective the later of July 1, 2025, or 60 days after the end of the first legislative session that begins following federal approval of all of the following:

(1) the amendment in Laws 2024, chapter 127, to add Minnesota Statutes, section 256.9657, subdivision 2a;

(2) the amendments in Laws 2024, chapter 127, to Minnesota Statutes, section 256.969, subdivision 2b; and

(3) the amendment in Laws 2024, chapter 127, to add Minnesota Statutes, section 256.969, subdivision 2g.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 54, section 3, the effective date.

NOTE: Subdivision 2h, as added by Laws 2024, chapter 127, article 55, section 4, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 55, section 4, the effective date.

NOTE: Subdivision 32, as added by Laws 2024, chapter 127, article 54, section 5, is effective July 1, 2025. Laws 2024, chapter 127, article 54, section 5, the effective date.

256.9691 [Repealed, 2014 c 262 art 2 s 18]

256.9692 MS 2016 [Repealed, 2018 c 182 art 1 s 109]

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, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be changed. 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.

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 preliminary 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 18 months after the last day of the calendar year that is the base year for the payment rates in dispute.

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. [Repealed, 2014 c 312 art 24 s 48]

Subd. 4. [Repealed, 2014 c 312 art 24 s 48]

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; 1Sp2017 c 6 art 4 s 15; 2021 c 30 art 1 s 5*

256.97 [Repealed, 1957 c 737 s 2]

256.971 [Repealed, 2014 c 262 art 4 s 9]

256.973 [Repealed, 1Sp2003 c 14 art 2 s 57]

256.9731 [Repealed, 2002 c 220 art 16 s 3]

OMBUDSMAN FOR LONG-TERM CARE

256.974 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE.

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, sections 3027(a)(9) and 3058g(a), and Code of Federal Regulations, title 45, parts 1321 and 1327. The office shall be a distinct entity, separately identifiable from other state agencies and 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; 2016 c 163 art 1 s 1*

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; an assisted living facility or an assisted living facility with dementia care licensed under chapter 144G; a licensed or

registered residential setting that provides or arranges for the provision of home care services; or a setting defined under section 144G.08, subdivision 7, clauses (10) to (13), 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 organizational unit established within the Minnesota Board on Aging headed by the state long-term care ombudsman.

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.

Subd. 7. **Representatives of the office.** "Representatives of the office" means employees of the office, as well as employees designated as regional ombudsmen and volunteers designated as certified ombudsman volunteers by the state long-term care ombudsman.

Subd. 8. **State long-term care ombudsman.** "State long-term care ombudsman" or "ombudsman" means the individual serving on a full-time basis and who in the individual's official capacity, or through representatives of the office, is responsible to fulfill the functions, responsibilities, and duties set forth in section 256.9742.

History: *1987 c 403 art 2 s 67; 1989 c 282 art 2 s 116-118; 2007 c 147 art 6 s 10,11; 2016 c 163 art 1 s 2-4; 2017 c 40 art 1 s 61; 2019 c 60 art 1 s 47; art 4 s 27; 2021 c 30 art 12 s 1*

256.9742 DUTIES AND POWERS OF THE OFFICE.

Subdivision 1. **Duties.** The office 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 of representatives of the office.** (a) In designating a representative of the office to perform duties under this section, the ombudsman must determine that the individual is qualified to perform the duties required by this section.

(b) A representative of the office designated as a regional ombudsman 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 representatives of the office designated as regional ombudsmen under this section, who shall complete at least 60 hours annually.

(d) A representative of the office designated as a certified 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 certified ombudsman volunteers, who shall complete a minimum of 12 hours of continuing education per year.

(f) The ombudsman may withdraw a representative's designation if the representative fails to perform duties of this section or meet continuing education requirements. The representative may request a reconsideration of such action by the Board on Aging, but any further decision of the state ombudsman about designation shall be final.

Subd. 2. **Immunity from liability.** The ombudsman and representatives of the office are 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 an assisted living facility under chapter 144G, 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 the ombudsman, representative of the office, or a client, or guardian or family member of a client, for filing in good faith a complaint with or providing information to the ombudsman or representative of the office. 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 paragraph, 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; 2016 c 163 art 1 s 5; 2017 c 40 art 1 s 62; 2024 c 85 s 61*

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]

BOARD ON AGING AND RELATED PROGRAMS

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. [Repealed, 2014 c 262 art 4 s 9]

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 persons with a disability.** 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, persons with a disability, and the public regarding consumer protection laws and consumer rights that are of particular interest to senior citizens and persons with a disability; or

(2) to underwrite educational seminars and other forms of educational projects for the benefit of senior citizens and persons with a disability.

Subd. 6. **Native American elders coordinator position.** (a) The Minnesota Board on Aging shall create a Native American elders coordinator position and shall hire staff as appropriations permit for the purposes of facilitating the coordination and development of a statewide Tribal-based service system for Native American elders.

(b) For purposes of this subdivision, the following terms have the meanings given:

(1) "Native American elder" means an individual enrolled in a federally recognized Tribe and identified as an elder according to the requirements of the individual's home Tribe; and

(2) "Tribal government" means representatives of each of the 11 federally recognized Native American Tribes located wholly or partially within the boundaries of the state of Minnesota.

(c) The statewide Tribal-based service system may include the following components:

(1) a plan to grant, or make recommendations for granting, federal and state funding for statewide Tribal-based Native American programs and services;

(2) a plan to develop business initiatives involving Tribal members that will qualify for federal- and state-funded elder service contracts;

(3) a plan for statewide Tribal-based service focal points for socialization and service accessibility for Native American elders;

(4) a plan to develop and implement statewide education and public awareness promotions, including cultural sensitivity training and public education on Native American elders;

(5) a plan for statewide culturally appropriate information and referral services for Native American elders, including legal advice and counsel and trained advocates;

(6) a plan for a coordinated statewide Tribal-based health care system including health promotion and prevention, in-home service, long-term care service, and health care services;

(7) a plan for ongoing collection of significant data on Native American elders, including population, health, socialization, mortality, homelessness, and economic status; and

(8) a plan to coordinate services with existing organizations, including but not limited to the state of Minnesota, the Minnesota Indian Affairs Council, the Minnesota Board on Aging, Wisdom Steps, and Minnesota 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, shall serve older adults as the designated Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006 in partnership

with the Disability Hub under section 256.01, subdivision 24, and must be available during business hours through a statewide toll-free number and the Internet. The Minnesota Board on Aging shall consult with, and when appropriate work through, the area agencies on aging counties, and other entities that serve aging and disabled populations of all ages, to provide and maintain the telephone infrastructure and related support for the Aging and Disability Resource Center partners which agree by memorandum to access the infrastructure, including the designated providers of the Senior LinkAge Line and the Disability Hub.

(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 and provide for regular updating of a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats that can provide search results down to the neighborhood level;

(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 home and community-based services providers developed by the commissioners of health and human services;

(9) develop an outreach plan to seniors and their caregivers with a particular focus on establishing a clear presence in places that seniors recognize and:

(i) place a significant emphasis on improved outreach and service to seniors and their caregivers by establishing annual plans by neighborhood, city, and county, as necessary, to address the unique needs of geographic areas in the state where there are dense populations of seniors;

(ii) establish an efficient workforce management approach and assign community living specialist staff and volunteers to geographic areas as well as aging and disability resource center sites so that seniors and their caregivers and professionals recognize the Senior LinkAge Line as the place to call for aging services and information;

(iii) recognize the size and complexity of the metropolitan area service system by working with metropolitan counties to establish a clear partnership with them, including seeking county advice on the establishment of local aging and disabilities resource center sites; and

(iv) maintain dashboards with metrics that demonstrate how the service is expanding and extending or enhancing its outreach efforts in dispersed or hard to reach locations in varied population centers;

(10) 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 the Uniform Checklist of Services under Minnesota Rules, part 4659.0090, 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;

(11) 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 an assessment summary;

(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;

(12) using risk management and support planning protocols, provide long-term care options counseling under clause (13) to current residents of nursing homes deemed appropriate for discharge by the commissioner who meet a profile that demonstrates that the consumer is either at risk of readmission to a nursing home or hospital, or would benefit from long-term care options counseling to age in place. The Senior LinkAge Line shall identify and contact residents or patients deemed appropriate by developing targeting criteria and creating a profile in consultation with the commissioner. The commissioner shall provide designated Senior LinkAge Line contact centers with a list of current or former nursing home residents or people discharged from a hospital or for whom Medicare home care has ended, that meet the criteria as being appropriate for long-term care options counseling through a referral 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 and, if appropriate, a 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 eligible for relocation service coordination due to high-risk factors or psychological or physical disability; and

(13) develop referral protocols and processes that will assist certified health care homes, Medicare home care, 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 or the end of Medicare home care. The commissioner shall keep a record of the number of people who choose long-term care options counseling as a result of this section.

(c) Nursing homes shall provide contact information to the Senior LinkAge Line for residents identified in paragraph (b), clause (12), to provide long-term care options counseling pursuant to paragraph (b), clause (11). The contact information for residents shall include all information reasonably necessary to contact residents, including first and last names, permanent and temporary addresses, telephone numbers, and email addresses.

(d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer who receives long-term care options counseling under paragraph (b), clause (12) or (13), and who uses an unpaid caregiver to the self-directed caregiver service under subdivision 12.

Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a) All individuals seeking admission to Medicaid-certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the need for nursing facility level of care as described in section 256B.0911, subdivision 26, and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

(c) The following criteria apply to the preadmission screening:

(1) requests for preadmission screenings must be submitted via an online form developed by the commissioner;

(2) the Senior LinkAge Line must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(3) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(d) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(e) In assessing a person's needs, the screener shall:

(1) use an automated system designated by the commissioner;

(2) consult with care transitions coordinators, physician, advanced practice registered nurse, or physician assistant; and

(3) consider the assessment of the individual's physician, advanced practice registered nurse, or physician assistant.

(f) Other personnel may be included in the level of care determination as deemed necessary by the screener.

Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician, advanced practice registered nurse, or physician assistant has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician, advanced practice registered nurse, or physician assistant has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

(e) Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

(f) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in section 256B.0911, subdivision 11. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Subd. 7c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. The Senior LinkAge Line shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face long-term care consultation assessment completed under section 256B.0911, subdivisions 17 to 21, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face long-term care consultation assessment completed under section 256B.0911, subdivisions 17 to 21, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services to determine the need for nursing facility level of care and complete activities required under subdivision 7a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 7b, but will need transition assistance after admission or in-person follow-along after a return home.

(b) The Senior LinkAge Line shall refer individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening for an in-person assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager as described in section 256B.0911, subdivision 28, paragraph (a).

(c) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(d) Screenings provided by the Senior LinkAge Line must include processes to identify persons who may require transition assistance described in subdivision 7, paragraph (b), clause (12), and section 256B.0911, subdivision 27.

Subd. 7d. **Payment for preadmission screening.** (a) The Department of Human Services shall provide funding for preadmission screening to the Minnesota Board on Aging to cover screener salaries and expenses to provide the services described in subdivisions 7a to 7c. The Minnesota Board on Aging shall:

(1) employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening and level of care determination services; and

(2) seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

(b) The Department of Human Services shall provide funding for preadmission screening follow-up to the Disability Hub for the under-60 population to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall:

(1) employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services; and

(2) seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Subd. 7e. **Long-term care options counseling at critical care transitions.** (a) The purpose of long-term care options counseling is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. Reaching people before a crisis and during care transitions is important to ensure quality of care and life, prevent unnecessary hospitalizations and readmissions, reduce the burden on the health care system, reduce costs, and support personal preferences.

(b) Counseling must be delivered by Senior LinkAge Line either by telephone or in-person. Counseling must:

(1) be performed in a manner that provides objective and complete information;

(2) include a review of the person's personal goals, discussion of the person's immediate and projected long-term care needs, and alternative community services or settings that may meet the person's needs; and

(3) include the counseling and referral protocols in subdivision 7, paragraph (b), clauses (11) to (13).

(c) An assisted living facility licensed under chapter 144G must inform each prospective resident or the prospective resident's designated or legal representative of the availability of and contact information for long-term care options counseling services under this subdivision by providing Senior LinkAge Line information at the facility tour.

(d) Prior to discharge, hospitals must refer older adults who are at risk of nursing home placement to the Senior LinkAge Line for long-term care options counseling. Hospitals must make these referrals using referral protocols and processes developed under subdivision 7.

Subd. 7f. MS 2022 [Repealed, 2024 c 108 art 3 s 7]

Subd. 7g. MS 2022 [Repealed, 2024 c 108 art 3 s 7]

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, paragraph (u); 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 Minnesota Statutes 2020, section 366.10, and sections 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.

Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging shall award competitive grants to eligible applicants for regional and local projects and initiatives targeted to a designated community, which may consist of a specific geographic area or population, to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to education and resources.

(b) The project areas for grants include:

(1) local or community-based initiatives to promote the benefits of physician, advanced practice registered nurse, or physician assistant consultations for all individuals who suspect a memory or cognitive problem;

(2) local or community-based initiatives to promote the benefits of early diagnosis of Alzheimer's disease and other dementias; and

(3) local or community-based initiatives to provide informational materials and other resources to caregivers of persons with dementia.

(c) Eligible applicants for local and regional grants may include, but are not limited to, community health boards, school districts, colleges and universities, community clinics, tribal communities, nonprofit organizations, and other health care organizations.

(d) Applicants must:

(1) describe the proposed initiative, including the targeted community and how the initiative meets the requirements of this subdivision; and

(2) identify the proposed outcomes of the initiative and the evaluation process to be used to measure these outcomes.

(e) In awarding the regional and local dementia grants, the Minnesota Board on Aging must give priority to applicants who demonstrate that the proposed project:

(1) is supported by and appropriately targeted to the community the applicant serves;

(2) is designed to coordinate with other community activities related to other health initiatives, particularly those initiatives targeted at the elderly;

(3) is conducted by an applicant able to demonstrate expertise in the project areas;

(4) utilizes and enhances existing activities and resources or involves innovative approaches to achieve success in the project areas; and

(5) strengthens community relationships and partnerships in order to achieve the project areas.

(f) The board shall divide the state into specific geographic regions and allocate a percentage of the money available for the local and regional dementia grants to projects or initiatives aimed at each geographic region.

(g) The board shall award any available grants by January 1, 2016, and each July 1 thereafter.

(h) Each grant recipient shall report to the board on the progress of the initiative at least once during the grant period, and within two months of the end of the grant period shall submit a final report to the board that includes the outcome results.

(i) The Minnesota Board on Aging shall develop the criteria and procedures to allocate the grants under this subdivision, evaluate all applicants on a competitive basis and award the grants, and select qualified providers to offer technical assistance to grant applicants and grantees. The selected provider shall provide applicants and grantees assistance with project design, evaluation methods, materials, and training.

Subd. 12. **Self-directed caregiver grants.** The Minnesota Board on Aging shall, in consultation with area agencies on aging and other community caregiver stakeholders, administer self-directed caregiver grants to support at-risk family caregivers of older adults or others eligible under the Older Americans Act of 1965,

United States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in the caregivers' roles so older adults can remain at home longer.

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 5,14; 2009 c 60 s 1; 2009 c 79 art 8 s 16,39; 2009 c 173 art 1 s 16; 1Sp2010 c 1 art 17 s 8; 1Sp2011 c 9 art 7 s 14; 2012 c 247 art 4 s 14,21-23; 2013 c 108 art 2 s 6-10,44; art 15 s 3,4; 2015 c 71 art 7 s 26; 2015 c 78 art 4 s 61; art 6 s 9; 2017 c 40 art 1 s 121; 1Sp2017 c 6 art 3 s 6,7; 2018 c 170 s 6; 2020 c 115 art 4 s 108,109; 1Sp2020 c 2 art 2 s 10; art 5 s 97; 7Sp2020 c 1 art 6 s 25; 2022 c 58 s 131-133; 2022 c 98 art 14 s 18,19; art 16 s 2-4,30; art 17 s 4-7,26; 2023 c 25 s 135; 2023 c 61 art 2 s 1; 2024 c 108 art 3 s 3*

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. 1a. **Food delivery support account; appropriation.** (a) A food delivery support account is established in the special revenue fund. The account consists of funds under section 174.49, subdivision 2, and as provided by law and any other money donated, allotted, transferred, or otherwise provided to the account.

(b) Money in the account is annually appropriated to the commissioner of human services for grants to nonprofit organizations to provide transportation of home-delivered meals, groceries, purchased food, or a combination, to Minnesotans who are experiencing food insecurity and have difficulty obtaining or preparing meals due to limited mobility, disability, age, or resources to prepare their own meals. A nonprofit organization must have a demonstrated history of providing and distributing food customized for the population that they serve.

(c) Grant funds under this subdivision must supplement, but not supplant, any state or federal funding used to provide prepared meals to Minnesotans experiencing food insecurity.

Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate to area agencies on aging the state and 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) the Supplemental Nutrition Assistance Program (SNAP) 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; 2014 c 312 art 27 s 51; 1Sp2019 c 9 art 1 s 42; 2023 c 68 art 3 s 19*

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. [Repealed, 2014 c 262 art 4 s 9]

History: *1980 c 455 s 1-4; 1996 c 305 art 1 s 57; 2002 c 220 art 10 s 33*

256.9754 LIVE WELL AT HOME GRANTS.

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) "Core home and community-based services provider" means a Faith in Action, Living at Home/Block Nurse, congregational nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical services intended to assist older adults to identify and manage risks and to maintain the older adults' community living and integration in the community.

(c) "Long-term services and supports" means any service available under the elderly waiver program or alternative care grant programs, nursing facility services, transportation services, caregiver support and respite care services, and other home and community-based services identified as necessary either to maintain lifestyle choices for older adults or to support older adults to remain in their own home.

(d) "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.

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

Subd. 2. **Creation; purpose.** (a) The live well at home grants are created under the administration of the commissioner of human services.

(b) The purpose of projects selected by the commissioner of human services under this section is to make strategic changes in the long-term services and supports system for older adults and people with dementia, including statewide capacity for local service development and technical assistance and statewide availability of home and community-based services for older adult services, caregiver support and respite care services, and other supports in Minnesota. These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

(1) reach older adults early in the progression of older adults' need for long-term services and supports, providing them with low-cost, high-impact services that will prevent or delay the use of more costly services;

(2) support older adults to live in the most integrated, least restrictive community setting;

(3) support the informal caregivers of older adults;

(4) develop and implement strategies to integrate long-term services and supports with health care services, in order to improve the quality of care and enhance the quality of life of older adults and older adults' informal caregivers;

(5) ensure cost-effective use of financial and human resources;

(6) build community-based approaches and community commitment to delivering long-term services and supports for older adults in their own homes;

(7) achieve a broad awareness and use of lower-cost in-home services as an alternative to nursing homes and other residential services;

(8) strengthen and develop additional home and community-based services and alternatives to nursing homes and other residential services; and

(9) strengthen programs that use volunteers.

(c) The services provided by these projects are available to older adults who are eligible for medical assistance and the elderly waiver under chapter 256S, the alternative care program under section 256B.0913, or the essential community supports grant under section 256B.0922, and to older adults who have their own money to pay for services.

Subd. 3. **Community services development grants.** The commissioner shall make community services development grants available to communities, providers of older adult services, or 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 individuals with a disability 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. 3a. **Priority for other grants.** The commissioner of health shall give priority to a grantee selected under subdivision 3 when awarding technology-related grants, if the grantee is using technology as part of the proposal unless that priority conflicts with existing state or federal guidance related to grant awards by the Department of Health. The commissioner of transportation shall give priority to a grantee under subdivision 3 when distributing transportation-related funds to create transportation options for older adults unless that preference conflicts with existing state or federal guidance related to grant awards by the Department of Transportation.

Subd. 3b. **State waivers.** The commissioner of health may waive applicable state laws and rules for grantees under subdivision 3 on a time-limited basis if the commissioner of health determines that a participating grantee requires a waiver in order to achieve demonstration project goals.

Subd. 3c. **Caregiver support and respite care projects.** (a) The commissioner shall establish projects to expand the availability of caregiver support and respite care services for family and other caregivers. The commissioner shall use a request for proposals to select nonprofit entities to administer the projects. Projects must:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite care services to caregivers of older adults;

(3) assure the health and safety of the older adults;

(4) identify at-risk caregivers;

(5) provide information, education, and training for caregivers in the designated community; and

(6) demonstrate the need in the proposed service area, particularly where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. Preference must be given for projects that reach underserved populations.

(b) Projects must clearly describe:

(1) how they will achieve their purpose;

(2) the process for recruiting, training, and retraining volunteers; and

(3) a plan to promote the project in the designated community, including outreach to older adults needing the services.

(c) Money for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) provide information, training, and education to caregivers;

(4) advertise the availability of the caregiver support and respite care project; and

(5) purchase equipment to maintain a system of assigning workers to clients.

(d) Volunteer and caregiver training must include resources on how to support an individual with dementia.

(e) Project money may not be used to supplant existing funding sources.

Subd. 3d. **Core home and community-based services projects.** The commissioner shall select and contract with core home and community-based services providers for projects to provide services and supports to older adults both with and without family and other informal caregivers using a request for proposals process. Projects must:

(1) have a credible public or private nonprofit sponsor providing ongoing financial support;

(2) have a specific, clearly defined geographic service area;

(3) use a practice framework designed to identify high-risk older adults and help them take action to better manage their chronic conditions and maintain their community living;

(4) have a team approach to coordination and care, ensuring that the older adult participants, participants' families, and the formal and informal providers are all part of planning and providing services;

(5) provide information, support services, homemaking services, counseling, and training for the older adults and family caregivers;

(6) encourage service area or neighborhood residents and local organizations to collaborate in meeting the needs of older adults in their geographic service areas;

(7) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to older adults and their caregivers; and

(8) provide coordination and management of formal and informal services to older adults and older adults' families using less expensive alternatives.

Subd. 3e. **Community service grants.** The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen a community's ability to provide a system of home and community-based services for elderly persons. The commissioner shall use a request for proposals process.

Subd. 3f. **Live Well at Home grant extensions.** (a) A current grantee under subdivision 3, 3c, 3d, or 3e may apply to the commissioner to receive on a noncompetitive basis up to two years of additional funding.

(b) To be eligible for a grant extension, a grant extension applicant must have been awarded a grant under this section within the previous five years and provide at least one eligible service in an underserved community. The grantee must submit to the commissioner a letter of intent to continue providing the eligible service after the expiration of a grant extension provided under this subdivision.

(c) The commissioner of human services must give priority to submitted letters of intent from grantees who have demonstrated success in providing chore services, homemaker services, transportation services,

grocery services, caregiver supports, service coordination, or other home and community-based services to older adults in underserved communities.

(d) Notwithstanding section 16B.98, subdivision 5, paragraph (b), the commissioner may from within available appropriations extend a grant agreement up to two additional years, not to exceed seven years, for grantees the commissioner determines can successfully sustain the grantee's Live Well at Home project with the additional funds made available through the grant agreement extension.

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

Subd. 5. **Grant preference.** The commissioner of human services shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. 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; 2013 c 108 art 2 s 11-13,44; art 15 s 3,4; 2017 c 40 art 1 s 121; 2023 c 61 art 2 s 2*

256.9755 CAREGIVER SUPPORT PROGRAMS.

Subdivision 1. **Program goals.** It is a goal of all area agencies on aging and caregiver support programs to support family caregivers of persons with amyotrophic lateral sclerosis (ALS) who are living in the community by:

(1) promoting caregiver support programs that serve Minnesotans in their homes and communities;

(2) providing, within the limits of available funds, the caregiver support services that enable the family caregiver to access caregiver support programs in the most cost-effective and efficient manner; and

(3) providing information, education, and training to respite caregivers and volunteers about caring for, managing, and coping with care for a person with ALS.

Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate the state funds that are received under this section for the caregiver support program. The board shall give priority to those areas where there is a high need of respite services as evidenced by the data provided by the board.

Subd. 3. **Caregiver support services.** Funds allocated under this section for caregiver support services must be used to reach family caregivers of persons with ALS and such funds may be used to provide services benefiting people under the age of 60 and their caregivers. The funds must be used to provide social, community-based services and activities that provide social interaction for participants. The funds may also be used to provide respite care.

Subd. 4. **Report.** By January 15, 2025, and every other January 15 thereafter, the Minnesota Board on Aging shall submit a progress report about the caregiver support grants in this section to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services. The progress report must include metrics of the use of the grant program.

History: *2022 c 42 s 1; 2024 c 125 art 2 s 8,9; 2024 c 127 art 47 s 8,9*

256.9756 CAREGIVER RESPITE SERVICES GRANTS.

Subdivision 1. **Caregiver respite services grant program established.** The Minnesota Board on Aging must establish a caregiver respite services grant program to increase the availability of respite services for family caregivers of people with dementia and to provide information, education, and training to respite caregivers and volunteers regarding caring for people with dementia. From the money made available for this purpose, the board must award grants on a competitive basis to respite service providers, giving priority to areas of the state where there is a high need of respite services.

Subd. 2. **Eligible uses.** Grant recipients awarded grant money under this section must use a portion of the grant award as determined by the board to provide free or subsidized respite services for family caregivers of people with dementia.

Subd. 3. **Report.** By January 15, 2026, the board shall submit a progress report about the caregiver respite services grants in this section to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services finance and policy. The progress report must include metrics of the use of grant program money. This subdivision expires upon submission of the report. The board shall notify the revisor of statutes when the report is submitted.

History: *2023 c 61 art 2 s 3; 2024 c 125 art 2 s 10,11; 2024 c 127 art 47 s 10,11*

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 children with developmental disabilities. 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; 2013 c 59 art 3 s 2*

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 adults with a disability and elderly people living in their own homes. Senior companions may also be used to provide such services to adults with a disability 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 adults with a disability 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 adults with a disability 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; 2017 c 40 art 1 s 121*

256.9772 [Repealed, 1Sp2003 c 14 art 2 s 57]

256.978 [Renumbered 518A.83]

256.979 [Renumbered 518A.84]

256.9791 [Repealed, 1Sp2011 c 9 art 1 s 35]

256.9792 [Repealed, 2014 c 262 art 1 s 12]

256.98 WRONGFULLY OBTAINING ASSISTANCE; THEFT.

Subdivision 1. **Wrongfully obtaining assistance.** (a) 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, chapter 142G, 256B, 256D, 256I, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, 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 food benefits 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.

(b) 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 formerly codified in chapter 256D, 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 142E, 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 work participation cash benefit program, the Supplemental Nutrition Assistance Program (SNAP), the general assistance program, housing support under chapter 256I, 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 SNAP. 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 142E 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 one year and two years for the first and second 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 142E is disqualified from receiving payment for child care services from the child care assistance program under chapter 142E 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 142A.27; 142E.51, subdivision 5; or 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 three years for the first 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 142E.

(d) Any person found to be guilty of wrongfully obtaining 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.

[See Note.]

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 142G, 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; 2013 c 108 art 3 s 23; 2015 c 78 art 4 s 51; 2016 c 158 art 2 s 69,70; 1Sp2017 c 6 art 2 s 39; 1Sp2019 c 9 art 1 s 42; art 2 s 108,109; 2021 c 30 art 3 s 43; 2023 c 70 art 10 s 16; 2024 c 80 art 1 s 78; art 4 s 26; art 5 s 7; art 7 s 12; 2024 c 115 art 16 s 42*

NOTE: The amendment to subdivision 8 by Laws 2023, chapter 70, article 10, section 16, is effective March 1, 2026, and applies to acts of wrongfully obtained assistance that occur on or after that date. Laws 2023, chapter 70, article 10, section 16, the effective date.

256.981 TRAINING OF WELFARE FRAUD PROSECUTORS.

The commissioners of human services and children, youth, and families 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; 2024 c 80 art 1 s 79*

256.982 TRAINING OF WELFARE FRAUD INVESTIGATORS.

The commissioners of human services and children, youth, and families 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; 2024 c 80 art 1 s 80*

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioners of human services and children, youth, and families shall require the maintenance of budget neutral fraud prevention investigation programs in the counties or Tribal agencies participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioners may also extend fraud prevention investigation programs to other counties or Tribal agencies provided the expansion is budget neutral to the state. Under any expansion, the commissioners jointly have the final authority in decisions regarding the creation and realignment of individual county, Tribal agency, or regional operations. The commissioners may establish a joint office or interagency agreement to facilitate joint oversight and administration of sections 256.981 to 256.9861 and 256.9866.

Subd. 2. **County and Tribal agency proposals.** Each participating county and Tribal agency shall develop and submit an annual staffing and funding proposal to the commissioners 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 or Tribal agency unit, training programs for case workers, and the operational requirements which may be directed by the commissioners. The proposal shall be approved, to include any changes directed or negotiated by the commissioners, no later than June 30 of each year.

Subd. 3. **Department responsibilities.** The commissioners shall establish training programs which shall be attended by all investigative and supervisory staff of the involved county and Tribal agencies. The commissioners shall also develop the necessary operational guidelines, forms, and reporting mechanisms that shall be used by the involved county or Tribal 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 and Tribal agency reimbursement shall be made through the settlement provisions applicable to the Supplemental Nutrition Assistance Program (SNAP), MFIP, child care assistance programs, the medical assistance program, and other federal and state-funded programs.

(b) The commissioners will maintain program compliance if for any three consecutive month period, a county or Tribal agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioners. This result is contingent on the commissioners 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 or Tribal agency shall be required to submit a corrective action plan to the commissioners 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 or Tribal agency for fraud prevention investigation (FPI) service provided by the commissioners, or reallocation of program grant funds, or investigative resources, or both, to other counties or Tribal agencies. The denial of funding shall apply to the general settlement received by the county or Tribal agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

Subd. 5. **Child care providers; financial misconduct.** (a) A county or Tribal agency may conduct investigations of financial misconduct by child care providers as described in sections 142E.50 to 142E.58. Prior to opening an investigation, a county or Tribal agency must contact the commissioners to determine whether an investigation under this chapter may compromise an ongoing investigation.

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or Tribe materially false information on the provider's billing forms, provided false attendance records to a county, Tribe, or the commissioners, or committed financial misconduct as described in section 142E.50, subdivision 8, the county or Tribal agency may recommend that the commissioners suspend a provider's payment pursuant to sections 142E.50 to 142E.58, or deny or revoke a provider's authorization pursuant to section 142E.17, subdivision 9, paragraph (d), clause (2), prior to pursuing other available remedies.

[See Note.]

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; 1Sp2019 c 9 art 1 s 42; art 2 s 110; 2021 c 30 art 1 s 6; 2023 c 70 art 13 s 24; 2024 c 80 art 1 s 81; art 5 s 7

NOTE: The amendment to subdivision 5 by Laws 2023, chapter 70, article 13, section 24, is effective April 28, 2025. Laws 2023, chapter 70, article 13, section 24, the effective date.

256.9831 Subdivision 1. [Renumbered 142A.13, subd 14]

Subd. 2. MS 2022 [Repealed, 2024 c 80 art 1 s 97]

Subd. 3. MS 2022 [Repealed, 2024 c 80 art 1 s 97]

256.984 DECLARATION AND PENALTY.

Subdivision 1. **Declaration.** Every application for public assistance under this chapter or chapters 142G, 256B, 256D, and 256L; child care programs under chapter 142E; and the Supplemental Nutrition Assistance Program (SNAP) benefits 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; 1Sp2019 c 9 art 1 s 42; 2024 c 80 art 4 s 26; art 5 s 7; art 7 s 12; 2024 c 115 art 16 s 42*

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 commissioners of human services and children, youth, and families 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 commissioners 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; 2024 c 80 art 1 s 83*

256.9861 FRAUD CONTROL; PROGRAM INTEGRITY REINVESTMENT PROJECT.

Subdivision 1. **Program established.** Within the limits of available state and federal appropriations, the commissioners of human services and children, youth, and families 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 commissioners 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 commissioners 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 commissioners shall establish training programs which shall be attended by fraud control staff of all involved counties. The commissioners shall also develop the necessary operational guidelines, forms, and reporting mechanisms which shall be used by the involved counties.

Subd. 4. **Standards.** The commissioners 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 Departments of Human Services and Children, Youth, and Families. 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, Supplemental Nutrition Assistance Program (SNAP), and medical assistance program.

(b) Should a county agency fail to comply with the standards set, or fail to meet cost-effectiveness standards developed by the commissioners for any three-month period, the commissioners 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 commissioners 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 commissioners 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 commissioners 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; 1Sp2019 c 9 art 1 s 42; 2024 c 80 art 1 s 84*

256.9862 Subdivision 1. [Renumbered 142A.13, subd 10]

Subd. 2. [Renumbered 142A.13, subd 11]

256.9863 [Renumbered 142A.13, subd 5]

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*

NOTE: This section is repealed by Laws 2023, chapter 70, article 10, section 98, effective March 1, 2025. Laws 2023, chapter 70, article 10, section 98, the effective date.

256.9865 Subdivision 1. [Renumbered 142A.13, subd 6]

Subd. 2. [Renumbered 142A.13, subd 7]

Subd. 3. [Renumbered 142A.13, subd 8]

Subd. 4. [Renumbered 142A.13, subd 9]

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 142G must be issued on an EBT card that meets the requirements in section 142A.13.

Subd. 2. [Renumbered 142A.13, subd 2]

Subd. 3. [Renumbered 142A.13, subd 3]

Subd. 4. [Renumbered 142A.13, subd 4]

History: *1Sp2011 c 9 art 1 s 10; 2012 c 247 art 3 s 6-9; 1Sp2019 c 9 art 1 s 42; 2023 c 70 art 10 s 17; 2024 c 80 art 1 s 85; art 7 s 12*

256.9871 [Renumbered 142A.13, subd 12]

256.9872 [Renumbered 142A.13, subd 13]

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, 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; 2016 c 158 art 2 s 71*

256.991 RULES.

The commissioner of human services may promulgate rules as necessary to implement sections 142A.418, subdivision 2; 256.01, subdivision 2; 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; 2016 c 158 art 2 s 72; 2017 c 40 art 1 s 63; 2024 c 80 art 1 s 96; 2024 c 115 art 16 s 34*

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 have substance use disorder;

(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 142D.091.

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 substance use disorder 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; 2022 c 98 art 4 s 51; 2024 c 80 art 4 s 26; 2024 c 115 art 16 s 42*

256.996 [Repealed, 1997 c 245 art 2 s 12]

256.997 [Renumbered 142A.30]

256.998 [Renumbered 142A.29]