CHAPTER 256

HUMAN SERVICES

256.014 STATE AND COUNTY SYSTEMS.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Report.** The commissioner of human services shall report to the chair of the house ways and means committee and the chair of the senate finance committee on January 1 of each year detailing project expenditures to date, methods used to maximize county participation, and the fiscal impact on programs, counties, and clients.

History: *1993 c 4 s 24*

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

[For text of subds 1 to 3, see M.S.1992]

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 person who is 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 before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

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

[For text of subds 5 to 7, see M.S.1992]

History: *1Sp1993 c 1 art 5 s 9*

256.019 RECOVERY OF MONEY; APPORTIONMENT.

When an amount is recovered from any source for assistance given under the provisions governing public assistance programs including aid to families with dependent children, emergency assistance, general assistance, work readiness, and Minnesota supplemental aid, there shall be paid to the United States the amount due under the terms of the Social Security Act and the balance must be paid into the treasury of the state or county in accordance with current rates of financial participation; except 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. 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.

History: *1993 c 306 s 2*

256.025 PAYMENT PROCEDURES.

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

(b) "Base amount" means the calendar year 1990 county share of county agency expenditures for all of the programs specified in subdivision 2, except for the programs in subdivision 2, clauses (4), (7), and (13). The 1990 base amount for subdivision 2, clause (4), shall be reduced by one-seventh for each county, and the 1990 base amount for subdivision 2, clause (7), shall be reduced by seven-tenths for each county, and those amounts in total shall be the 1990 base amount for group residential housing in subdivision 2, clause (13).

(c) "County agency expenditure" means the total expenditure or cost incurred by the county of financial responsibility for the benefits and services for each of the programs specified in subdivision 2. The term includes the federal, state, and county share of costs for programs in which there is federal financial participation. For programs in which there is no federal financial participation, the term includes the state and county share of costs. The term excludes county administrative costs, unless otherwise specified.

(d) "Nonfederal share" means the sum of state and county shares of costs of the programs specified in subdivision 2.

(e) The "county share of county agency expenditures growth amount" is the amount by which the county share of county agency expenditures in calendar years 1991 to 2000 has increased over the base amount.

Subd. 2. **Covered programs and services.** The procedures in this section govern payment of county agency expenditures for benefits and services distributed under the following programs:

(1) aid to families with dependent children under sections 256.82, subdivision 1, and 256.935, subdivision 1;

(2) medical assistance under sections 256B.041, subdivision 5, and 256B.19, subdivision 1;

(3) general assistance medical care under section 256D.03, subdivision 6;

(4) general assistance under section 256D.03, subdivision 2;

(5) work readiness under section 256D.03, subdivision 2;

(6) emergency assistance under section 256.871, subdivision 6;

(7) Minnesota supplemental aid under section 256D.36, subdivision 1;

(8) preadmission screening and alternative care grants;

(9) work readiness services under section 256D.051;

(10) case management services under section 256.736, subdivision 13;

(11) general assistance claims processing, medical transportation and related costs;

(12) medical assistance, medical transportation and related costs; and

(13) group residential housing under section 256I.05, subdivision 8, transferred from programs in clauses (4) and (7).

Subd. 3. **Payment methods.** (a) Beginning July 1, 1991, the state will reimburse counties for the county share of county agency expenditures for benefits and services distributed under subdivision 2.

(b) Payments under subdivision 4 are only for client benefits and services distributed under subdivision 2 and do not include reimbursement for county administrative expenses.

(c) The state and the county agencies shall pay for assistance programs as follows:

(1) Where the state issues payments for the programs, the county shall monthly or quarterly pay to the state, as required by the department of human services, the portion of program costs not met by federal and state funds. The payment shall be an estimate that is based on actual expenditures from the prior period and that is sufficient to compensate for the county share of disbursements as well as state and federal shares of recoveries;

(2) Where the county agencies issue payments for the programs, the state shall monthly or quarterly pay to counties all federal funds available for those programs together with an amount of state funds equal to the state share of expenditures; and

(3) Payments made under this paragraph are subject to section 256.017. Adjustment of any overestimate or underestimate in payments shall be made by the state agency in any succeeding month.

Subd. 4. **Payment schedule.** Except as provided for in subdivision 3, beginning July 1, 1991, the state will reimburse counties, according to the following payment schedule, for the county share of county agency expenditures for the programs specified in subdivision 2.

(a) Beginning July 1, 1991, the state will reimburse or pay the county share of county agency expenditures according to the reporting cycle as established by the commissioner, for the programs identified in subdivision 2. Payments for the period of January 1 through July 31, for calendar years 1991, 1992, 1993, 1994, and 1995 shall be made on or before July 10 in each of those years. Payments for the period August through December for calendar years 1991, 1992, 1993, 1994, and 1995 shall be made on or before the third of each month thereafter through December 31 in each of those years.

(b) Payment for 1/24 of the base amount and the January 1996 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before January 3, 1996. For the period of February 1, 1996 through July 31, 1996, payment of the base amount shall be made on or before July 10, 1996, and payment of the growth amount over the base amount shall be made on or before July 10, 1996. Payments for the period August 1996 through December 1996 shall be made on or before the third of each month thereafter through December 31, 1996.

(c) Payment for the county share of county agency expenditures during January 1997 shall be made on or before January 3, 1997. Payment for 1/24 of the base amount and the February 1997 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before February 3, 1997. For the period of March 1, 1997 through July 31, 1997, payment of the base amount shall be made on or before July 10, 1997, and payment of the growth amount over the base amount shall be made on or before July 10, 1997. Payments for the period August 1997 through December 1997 shall be made on or before the third of each month thereafter through December 31, 1997.

(d) Monthly payments for the county share of county agency expenditures from January 1998 through February 1998 shall be made on or before the third of each month through February 1998. Payment for 1/24 of the base amount and the March 1998 county share of county agency expenditures growth amount for the programs

identified in subdivision 2 shall be made on or before March 1998. For the period of April 1, 1998 through July 31, 1998, payment of the base amount shall be made on or before July 10, 1998, and payment of the growth amount over the base amount shall be made on or before July 10, 1998. Payments for the period August 1998 through December 1998 shall be made on or before the third of each month thereafter through December 31, 1998.

(e) Monthly payments for the county share of county agency expenditures from January 1999 through March 1999 shall be made on or before the third of each month through March 1999. Payment for 1/24 of the base amount and the April 1999 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before April 3, 1999. For the period of May 1, 1999 through July 31, 1999, payment of the base amount shall be made on or before July 10, 1999, and payment of the growth amount over the base amount shall be made on or before July 10, 1999. Payments for the period August 1999 through December 1999 shall be made on or before the third of each month thereafter through December 31, 1999.

(f) Monthly payments for the county share of county agency expenditures from January 2000 through April 2000 shall be made on or before the third of each month through April 2000. Payment for 1/24 of the base amount and the May 2000 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before May 3, 2000. For the period of June 1, 2000 through July 31, 2000, payment of the base amount shall be made on or before July 10, 2000, and payment of the growth amount over the base amount shall be made on or before July 10, 2000. Payments for the period August 2000 through December 2000 shall be made on or before the third of each month thereafter through December 31, 2000.

(g) Monthly payments for the county share of county agency expenditures from January 2001 through May 2001 shall be made on or before the third of each month through May 2001. Payment for 1/24 of the base amount and the June 2001 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before June 3, 2001. Payments for the period July 2001 through December 2001 shall be made on or before the third of each month thereafter through December 31, 2001.

(h) Effective January 1, 2002, monthly payments for the county share of county agency expenditures shall be made subsequent to the first of each month.

Payments under this subdivision are subject to the provisions of section 256.017.

[For text of subd 5, see M.S.1992]

History: *1993 c 306 s 3; 1Sp1993 c 1 art 2 s 1,2; art 8 s 1,2*

NOTE: The amendments to subdivisions 1 and 2 by Laws 1993, First Special Session chapter 1, article 8, sections 1 and 2, are effective July 1, 1994, contingent upon federal recognition that group residential housing payments qualify as optional state supplement payments to the supplemental security income program under title XVI of the Social Security Act and confer categorical eligibility for medical assistance under the state plan for medical assistance. See Laws 1993, First Special Session chapter 1, article 8, section 30, subdivision 2.

256.026 ANNUAL APPROPRIATION.

(a) There shall be appropriated from the general fund to the commissioner of human services in fiscal year 1994 and each fiscal year thereafter the amount of $142,339,359, which is the sum of the amount of human services aid determined for all counties in Minnesota for calendar year 1992 under Minnesota Statutes 1992, section 273.1398, subdivision 5a, before any adjustments for calendar year 1991.

(b) In addition to the amount in paragraph (a), there shall also be annually appropriated from the general fund to the commissioner of human services in fiscal years 1996, 1997, 1998, 1999, 2000, and 2001 the amount of $5,930,807.

(c) The amounts appropriated under paragraphs (a) and (b) shall be used with other appropriations to make payments required under section 256.025 for fiscal year 1994 and thereafter.

History: *1Sp1993 c 1 art 2 s 3*

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. For purposes of prescribing these procedures, the commissioner is exempt from the provisions of chapter 14. 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*

256.031 MINNESOTA FAMILY INVESTMENT PLAN.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Authorization for the demonstration.** (a) The commissioner of human services, in consultation with the commissioners of education, finance, jobs and training, health, and planning, and the director of the higher education coordinating board, is authorized to proceed with the planning and designing of the Minnesota family investment plan and to implement the plan to test policies, methods, and cost impact on an experimental basis by using field trials. The commissioner, under the authority in section 256.01, subdivision 2, shall implement the plan according to sections 256.031 to 256.0361 and Public Law Numbers 101-202 and 101-239, section 8015, as amended. If major and unpredicted costs to the program occur, the commissioner may take corrective action consistent with Public Law Numbers 101-202 and 101-239, which may include termination of the program. Before taking such corrective action, the commissioner shall consult with the chairs of the senate family services committee, the house health and human services committee, the health care and family services division of the senate family services and health care committees and the human services division of the house health and human services committee, or, if the legislature is not in session, consult with the legislative advisory commission.

(b) The field trials shall be conducted as permitted under federal law, for as many years as necessary, and in different geographical settings, to provide reliable instruction about the desirability of expanding the program statewide.

(c) The commissioner shall select the counties which shall serve as field trial or comparison sites based on criteria which ensure reliable evaluation of the program.

(d) The commissioner is authorized to determine the number of families and characteristics of subgroups to be included in the evaluation.

(i) A family that applies for or is currently receiving financial assistance from aid to families with dependent children; family general assistance or work readiness; or food stamps may be tested for eligibility for aid to families with dependent children or family general assistance and may be assigned by the commissioner to a test or a comparison group for the purposes of evaluating the family investment plan. A family found not eligible for aid to families with dependent children or family general assistance will be tested for eligibility for the food stamp program. If found eligible for the food stamp program, the commissioner may randomly assign the family to a test group, comparison group, or neither group. Families assigned to a test group receive benefits and services through the family investment plan. Families assigned to a comparison group receive benefits and services through existing programs. A family may not select the group to which it is assigned. Once assigned to a group, an eligible family must remain in that group for the duration of the project.

(ii) To evaluate the effectiveness of the family investment plan, the commissioner may designate a subgroup of families from the test group who shall be exempt from section 256.035, subdivision 1, and shall not receive case management services under sec-

tion 256.035, subdivision 6a. Families are eligible for services under section 256.736 to the same extent as families receiving AFDC.

[For text of subds 4 and 5, see M.S.1992]

History: *1993 c 4 s 25*

256.032 DEFINITIONS.

[For text of subds 1 to 10, see M.S.1992]

Subd. 11. **Significant change.** "Significant change" means a decline in gross income of 38 percent or more from the income used to determine the grant for the current month.

[For text of subds 11a to 13, see M.S.1992]

History: *1Sp1993 c 1 art 6 s 3*

256.033 ELIGIBILITY FOR THE MINNESOTA FAMILY INVESTMENT PLAN.

Subdivision 1. **Eligibility conditions.** (a) A family is entitled to assistance under the Minnesota family investment plan if the family is assigned to a test group in the evaluation as provided in section 256.031, subdivision 3, paragraph (d), and:

(1) the family meets the definition of assistance unit under section 256.032, subdivision 1a;

(2) the family's resources not excluded under subdivision 3 do not exceed $2,000;

(3) the family can verify citizenship or lawful resident alien status; and

(4) the family provides or applies for a social security number for each member of the family receiving assistance under the family investment plan.

(b) A family is eligible for the family investment plan if the net income is less than the transitional standard as defined in section 256.032, subdivision 13, for that size and composition of family. In determining available net income, the provisions in subdivision 2 shall apply.

(c) Upon application, a family is initially eligible for the family investment plan if the family's gross income does not exceed the applicable transitional standard of assistance for that family as defined under section 256.032, subdivision 13, after deducting:

(1) 18 percent to cover taxes;

(2) actual dependent care costs up to the maximum disregarded under United States Code, title 42, section 602(a)(8)(A)(iii); and

(3) $50 of child support collected in that month.

(d) A family can remain eligible for the program if:

(1) it meets the conditions in subdivision 1a; and

(2) its income is below the transitional standard in section 256.032, subdivision 13, allowing for income exclusions in subdivision 2 and after applying the family investment plan treatment of earnings under subdivision 1a.

[For text of subds 1a to 5, see M.S.1992]

History: *1993 c 306 s 4*

256.034 PROGRAM SIMPLIFICATION.

Subdivision 1. **Consolidation of types of assistance.** Under the Minnesota family investment plan, assistance previously provided to families through the AFDC, food stamp, and general assistance programs must be combined into a single cash assistance program. As authorized by Congress, families receiving assistance through the Minnesota family investment plan are automatically eligible for and entitled to medical assis-

tance under chapter 256B. Federal, state, and local funds that would otherwise be allocated for assistance to families under the AFDC, food stamp, and general assistance programs must be transferred to the Minnesota family investment plan. The provisions of the Minnesota family investment plan prevail over any provisions of sections 245.771, 256.72 to 256.87, 256D.01 to 256D.21, or 393.07, subdivisions 10 and 10a, and any rules implementing those sections with which they are irreconcilable. The food stamp, general assistance, and work readiness programs for single persons and couples who are not responsible for the care of children are not replaced by the Minnesota family investment plan. Unless stated otherwise in statutes or rules governing the Minnesota family investment plan, participants in the Minnesota family investment plan shall be considered to be recipients of aid under aid to families with dependent children, family general assistance, and food stamps for the purposes of statutes and rules affecting such recipients or allocations of funding based on the assistance status of the recipients.

[For text of subds 2 to 5, see M.S.1992]

History: *1993 c 306 s 5*

256.0361 FIELD TRIAL OPERATION.

Subdivision 1. **Local plan.** A county that is selected to serve as a field trial or control site shall carry out the activities necessary to perform the evaluation for the duration of the field trials.

Field trial counties and Indian tribes providing Minnesota family investment plan case management services must submit service delivery plans to the commissioner annually during the field trial period. The service delivery plan must describe the case management services in the county in a manner prescribed by the commissioner.

In counties in which a federally recognized Indian tribe is operating Minnesota family investment plan case management services under an agreement with the commissioner of human services, the service delivery plans of the tribe and the county must provide that the parties will coordinate to provide tribal case management services, including developing a system for referrals, sanctions, and the provision of supporting services such as access to child care funds and transportation. Written agreement on these provisions will be provided in the service delivery plans of the tribe and county. If the county and Indian tribe cannot agree on these provisions, the county or tribe shall notify the commissioners of human services and jobs and training who shall resolve the dispute.

[For text of subd 2, see M.S.1992]

History: *1993 c 306 s 6*

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICE MATTERS.

[For text of subds 1 to 4, see M.S.1992]

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 shall designate a representative to be present at the conciliation conference to assist in the resolution of the dispute without the need for a hearing. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and

when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management services have been provided in accordance with applicable laws and rules or whether the county agency has assured that the services identified in the recipient's individual service plan have been delivered in accordance with the laws and rules governing the provision of those services. The state human services referee shall recommend an order to the commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The order may direct the county agency to take those actions necessary to comply with applicable laws or rules. The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

[For text of subds 5 to 9, see M.S.1992]

Subd. 10. **Payments pending appeal.** If the commissioner of human services or district court orders monthly assistance or aid or services paid or provided in any proceeding under this section, it shall be paid or provided pending appeal to the commissioner of human services, district court, court of appeals, or supreme court. The human services referee may order the local human services agency to reduce or terminate medical assistance or general assistance medical care to a recipient before a final order is issued under this section if: (1) the human services referee determines at the hearing that the sole issue on appeal is one of a change in state or federal law; and (2) the commissioner or the local agency notifies the recipient before the action. The state or county agency has a claim for food stamps, cash payments, medical assistance, general assistance medical care, and MinnesotaCare plan payments made to or on behalf of a recipient or former recipient while an appeal is pending if the recipient or former recipient is determined ineligible for the food stamps, cash payments, medical assistance, general assistance medical care, or MinnesotaCare as a result of the appeal, except for medical assistance and general assistance medical care made on behalf of a recipient pursuant to a court order. In enforcing a claim on MinnesotaCare plan 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.

History: *1993 c 247 art 4 s 1; 1993 c 339 s 9*

256.486 ASIAN-AMERICAN JUVENILE CRIME INTERVENTION AND PREVENTION GRANT PROGRAM.

Subdivision 1. **Grant program.** The commissioner of human services shall establish a grant program for coordinated, family-based crime intervention and prevention services for Asian-American youth. The commissioners of human services, education, and public safety shall work together to coordinate grant activities.

Subd. 2. **Grant recipients.** The commissioner shall award grants in amounts up to $150,000 to agencies based in the Asian-American community that have experience providing coordinated, family-based community services to Asian-American youth and families.

Subd. 3. **Project design.** Projects eligible for grants under this section must provide coordinated crime intervention, prevention, and educational services that include:

(1) education for Asian-American parents, including parenting methods in the United States and information about the United States legal and educational systems;

(2) crime intervention and prevention programs for Asian-American youth, including employment and career-related programs and guidance and counseling services;

(3) family-based services, including support networks, language classes, programs to promote parent-child communication, access to education and career resources, and conferences for Asian-American children and parents;

(4) coordination with public and private agencies to improve communication between the Asian-American community and the community at large; and

(5) hiring staff to implement the services in clauses (1) to (4).

Subd. 4. **Use of grant money to match federal funds.** Grant money awarded under this section may be used to satisfy any state or local match requirement that must be satisfied in order to receive federal funds.

Subd. 5. **Annual report.** Grant recipients must report to the commissioner by June 30 of each year on the services and programs provided, expenditures of grant money, and an evaluation of the program's success in reducing crime among Asian-American youth.

History: *1993 c 326 art 12 s 3*

256.73 ASSISTANCE, RECIPIENTS.

[For text of subd 1, see M.S.1992]

Subd. 2. **Allowance barred by ownership of property.** Ownership by an assistance unit of property as follows is a bar to any allowance under sections 256.72 to 256.87:

(1) The value of real property other than the homestead, which when combined with other assets exceeds the limits of paragraph (2), unless the assistance unit is making a good faith effort to sell the nonexcludable real property. The time period for disposal must not exceed nine consecutive months. The assistance unit must sign an agreement to dispose of the property and to repay assistance received during the nine months that would not have been paid had the property been sold at the beginning of such period, but not to exceed the amount of the net sale proceeds. The family has five working days from the date it realizes cash from the sale of the property to repay the overpayment. If the property is not sold within the required time or the assistance unit becomes ineligible for any reason during the nine-month period, the amount payable under the agreement will not be determined and recovery will not begin until the property is in fact sold. If the property is intentionally sold at less than fair market value or if a good faith effort to sell the property is not being made, the overpayment amount shall be computed using the fair market value determined at the beginning of the nine-month period. For the purposes of this section, "homestead" means the home that is owned by, and is the usual residence of, the child, relative, or other member of the assistance unit together with the surrounding property which is not separated from the home by intervening property owned by others. "Usual residence" includes the home from which the child, relative, or other members of the assistance unit is temporarily absent due to an employability development plan approved by the local human service agency, which includes education, training, or job search within the state but outside of the immediate geographic area. Public rights-of-way, such as roads which run through the surrounding property and separate it from the home, will not affect the exemption of the property; or

(2) Personal property of an equity value in excess of $1,000 for the entire assistance unit, exclusive of personal property used as the home, one motor vehicle of an equity value not exceeding $1,500 or the entire equity value of a motor vehicle determined to be necessary for the operation of a self-employment business, one burial plot for each member of the assistance unit, one prepaid burial contract with an equity value of no more than $1,000 for each member of the assistance unit, clothing and necessary

household furniture and equipment and other basic maintenance items essential for daily living, in accordance with rules promulgated by and standards established by the commissioner of human services.

Subd. 3a. **Persons ineligible.** No assistance shall be given under sections 256.72 to 256.87:

(1) on behalf of any person who is receiving supplemental security income under title XVI of the Social Security Act unless permitted by federal regulations;

(2) for any month in which the assistance unit's gross income, without application of deductions or disregards, exceeds 185 percent of the standard of need for a family of the same size and composition; except that the earnings of a dependent child who is a full-time student may be disregarded for six months per calendar year and the earnings of a dependent child that are derived from the jobs training and partnership act (JTPA) may be disregarded for six months per calendar year. These two earnings disregards cannot be combined to allow more than a total of six months per calendar year when the earned income of a full-time student is derived from participation in a program under the JTPA. If a stepparent's income is taken into account in determining need, the disregards specified in section 256.74, subdivision 1a, shall be applied to determine income available to the assistance unit before calculating the unit's gross income for purposes of this paragraph;

(3) to any assistance unit for any month in which any caretaker relative with whom the child is living is, on the last day of that month, participating in a strike;

(4) on behalf of any other individual in the assistance unit, nor shall the individual's needs be taken into account for any month in which, on the last day of the month, the individual is participating in a strike;

(5) on behalf of any individual who is the principal earner in an assistance unit whose eligibility is based on the unemployment of a parent when the principal earner, without good cause, fails or refuses to accept employment, or to register with a public employment office, unless the principal earner is exempt from these work requirements.

Subd. 5. **Aid for pregnant women.** (a) For the purposes of sections 256.72 to 256.87, assistance payments shall be made to a pregnant woman with no other children who are receiving assistance. It must be medically verified that the unborn child is expected to be born in the month the payment is made or within the three-month period following the month of payment. Eligibility must be determined as if the unborn child had been born and was living with her, considering the needs, income, and resources of all individuals in the filing unit. If eligibility exists for this fictional unit, the pregnant woman is eligible and her payment amount is determined based solely on her needs, income, including deemed income, and resources. No payments shall be made for the needs of the unborn or for any special needs occasioned by the pregnancy except as provided in paragraph (b). The commissioner of human services shall promulgate, pursuant to the administrative procedure act, rules to implement this subdivision.

(b) The commissioner may, according to rules, make payments for the purpose of meeting special needs occasioned by or resulting from pregnancy both for a pregnant woman with no other children receiving assistance as well as for a pregnant woman receiving assistance as provided in sections 256.72 to 256.87. The special needs payments shall be dependent upon the needs of the pregnant woman and the resources allocated to the county by the commissioner and shall be limited to payments for medically recognized special or supplemental diet needs and the purchase of a crib and necessary clothing for the future needs of the unborn child at birth.

[For text of subd 6, see M.S.1992]

Subd. 8. **Recovery of overpayments.** (a) If an amount of aid to families with dependent children assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) When an overpayment occurs, the county agency shall recover the overpay-

ment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member for one or more monthly assistance payments until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need or the amount of the monthly payment, whichever is less, for all overpayments whether or not the overpayment is due solely to agency error. If the overpayment is due solely to having wrongfully obtained assistance, whether based on a court order, the finding of an administrative fraud disqualification hearing or a waiver of such a hearing, or a confession of judgment containing an admission of an intentional program violation, the amount of this reduction shall be ten percent. In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(c) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the above aid reductions, until the total amount of the overpayment is repaid.

(d) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance in accordance with standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of fraud under section 256.98.

[For text of subds 9 to 11, see M.S.1992]

History: *1Sp1993 c 1 art 6 s 4-7*

256.734 WAIVER OF AFDC BARRIERS TO EMPLOYMENT.

Subdivision 1. **Request.** (a) The commissioner of human services shall seek from the United States Department of Health and Human Services a waiver of the existing requirements of the AFDC program as described below, in order to eliminate barriers to employment for AFDC recipients.

(b) The commissioner shall seek a waiver to set the maximum equity value of a licensed motor vehicle which can be excluded as a resource under United States Code, title 42, section 602(a)(7)(B), at $4,500 because of the need of AFDC recipients for reliable transportation to participate in education, work, and training to become economically self-sufficient.

(c) The commissioner shall seek a waiver of the counting of the earned income of dependent children and minor caretakers who are attending school at least half time, in order to encourage them to save at least part of their earnings for future education or employment needs. Savings set aside in a separate account under this paragraph shall be excluded from the AFDC resource limits in Code of Federal Regulations, title 45, section 233.20(a)(3).

Subd. 2. **Implementation.** If approval from the Department of Health and Human Services indicates that the requested program changes are cost neutral to the federal government and the state, the commissioner shall implement the program changes authorized by this section promptly. If approval indicates that the program changes are not cost neutral, the commissioner shall report the costs to the 1994 legislature and delay implementation until such time as an appropriation to cover additional costs becomes available.

Subd. 3. **Evaluation.** If the federal waiver is granted, the commissioner shall evaluate the program changes according to federal waiver requirements and submit a report to the legislature within a time frame consistent with the evaluation criteria that are established.

History: *1Sp1993 c 1 art 6 s 8*

256.736 EMPLOYMENT AND TRAINING PROGRAMS.

[For text of subds 1a and 3, see M.S.1992]

Subd. 3a. **Participation.** (a) Except as provided under paragraphs (b) and (c), participation in employment and training services under this section is limited to the following recipients:

(1) caretakers who are required to participate in a job search under subdivision 14;

(2) custodial parents who are subject to the school attendance or case management participation requirements under subdivision 3b;

(3) caretakers whose participation in employment and training services began prior to May 1, 1990, if the caretaker's AFDC eligibility has not been interrupted for 30 days or more and the caretaker's employability development plan has not been completed;

(4) recipients who are members of a family in which the youngest child is within two years of being ineligible for AFDC due to age;

(5) custodial parents under the age of 24 who: (i) have not completed a high school education and who, at the time of application for AFDC, were not enrolled in high school or in a high school equivalency program; or (ii) have had little or no work experience in the preceding year;

(6) recipients who have received AFDC for 36 or more months out of the last 60 months;

(7) recipients who are participants in the self-employment investment demonstration project under section 268.95; and

(8) recipients who participate in the new chance research and demonstration project under contract with the department of human services.

(b) If the commissioner determines that participation of persons listed in paragraph (a) in employment and training services is insufficient either to meet federal performance targets or to fully utilize funds appropriated under this section, the commissioner may, after notifying the chairs of the senate family services committee, the house health and human services committee, the family services division of the senate family services and health care committees, and the human services division of the house health and human services committee, permit additional groups of recipients to participate until the next meeting of the legislative advisory commission, after which the additional groups may continue to enroll for participation unless the legislative advisory commission disapproves the continued enrollment. The commissioner shall allow participation of additional groups in the following order only as needed to meet performance targets or fully utilize funding for employment and training services under this section:

(1) recipients who have received 24 or more months of AFDC out of the previous 48 months; and

(2) recipients who have not completed a high school education or a high school equivalency program.

(c) To the extent of money appropriated specifically for this paragraph, the commissioner may permit AFDC caretakers who are not eligible for participation in employment and training services under the provisions of paragraph (a) or (b) to participate. Money must be allocated to county agencies based on the county's percentage of participants statewide in services under this section in the prior calendar year. Caretakers must be selected on a first-come, first-served basis from a waiting list of caretakers who volunteer to participate. The commissioner may, on a quarterly basis, reallocate unused allocations to county agencies that have sufficient volunteers. If funding under this paragraph is discontinued in future fiscal years, caretakers who began participating under this paragraph must be deemed eligible under paragraph (a), clause (3).

[For text of subds 3b to 7, see M.S.1992]

Subd. 9. **Changes in state plan and rules; waivers.** The commissioner of human services shall make changes in the state plan and rules or seek any waivers or demonstration authority necessary to minimize barriers to participation in the employment and training services or to employment. Changes must be sought in at least the following areas: allowances, child care, work expenses, the amount and duration of earnings incentives, medical care coverage, limitations on the hours of employment, and administrative standards and procedures. The commissioner shall implement each change as soon as possible. Before implementing any demonstration project or a program that is a result of a waiver, the conditions under section 256.01, subdivision 1, clause (12), must be met, and the chair of the senate family services committee and the chair of the house of representatives health and human services committee must be notified.

Subd. 10. **County duties.** (a) To the extent of available state appropriations, county boards shall:

(1) refer all mandatory and eligible volunteer caretakers permitted to participate under subdivision 3a to an employment and training service provider for participation in employment and training services;

(2) identify to the employment and training service provider the target group of which the referred caretaker is a member;

(3) provide all caretakers with an orientation which meets the requirements in subdivisions 10a and 10b;

(4) work with the employment and training service provider to encourage voluntary participation by caretakers in the target groups;

(5) work with the employment and training service provider to collect data as required by the commissioner;

(6) to the extent permissible under federal law, require all caretakers coming into the AFDC program to attend orientation;

(7) encourage nontarget caretakers to develop a plan to obtain self-sufficiency;

(8) notify the commissioner of the caretakers required to participate in employment and training services;

(9) inform appropriate caretakers of opportunities available through the head start program and encourage caretakers to have their children screened for enrollment in the program where appropriate;

(10) provide transportation assistance using available funds to caretakers who participate in employment and training programs;

(11) ensure that orientation, job search, services to custodial parents under the age of 20, educational activities and work experience for AFDC-UP families, and case management services are made available to appropriate caretakers under this section, except that payment for case management services is governed by subdivision 13;

(12) explain in its local service unit plan under section 268.88 how it will ensure that target caretakers determined to be in need of social services are provided with such social services. The plan must specify how the case manager and the county social service workers will ensure delivery of needed services;

(13) to the extent allowed by federal laws and regulations, provide a job search program as defined in subdivision 14, a community work experience program as defined in section 256.737, grant diversion as defined in section 256.739, and on-the-job training as defined in section 256.738. A county may also provide another work and training program approved by the commissioner and the secretary of the United States Department of Health and Human Services. Planning and approval for employment and training services listed in this clause must be obtained through submission of the local service unit plan as specified under section 268.88. A county is not required to provide a community work experience program if the county agency is successful in placing at least 40 percent of the monthly average of all caretakers who are subject to the job search requirements of subdivision 14 in grant diversion or on-the-job training program;

(14) prior to participation, provide an assessment of each AFDC recipient who is required or volunteers to participate in an approved employment and training service. The assessment must include an evaluation of the participant's (i) educational, child care, and other supportive service needs; (ii) skills and prior work experience; and (iii) ability to secure and retain a job which, when wages are added to child support, will support the participant's family. The assessment must also include a review of the results of the early and periodic screening, diagnosis and treatment (EPSDT) screening and preschool screening under chapter 123, if available; the participant's family circumstances; and, in the case of a custodial parent under the age of 18, a review of the effect of a child's development and educational needs on the parent's ability to participate in the program;

(15) develop an employability development plan for each recipient for whom an assessment is required under clause (14) which: (i) reflects the assessment required by clause (14); (ii) takes into consideration the recipient's physical capacity, skills, experience, health and safety, family responsibilities, place of residence, proficiency, child care and other supportive service needs; (iii) is based on available resources and local employment opportunities; (iv) specifies the services to be provided by the employment and training service provider; (v) specifies the activities the recipient will participate in, including the worksite to which the caretaker will be assigned, if the caretaker is subject to the requirements of section 256.737, subdivision 2; (vi) specifies necessary supportive services such as child care; (vii) to the extent possible, reflects the preferences of the participant; and (viii) specifies the recipient's long-term employment goal which shall lead to self-sufficiency;

(16) obtain the written or oral concurrence of the appropriate exclusive bargaining representatives with respect to job duties covered under collective bargaining agreements to assure that no work assignment under this section or sections 256.737, 256.738, and 256.739 results in: (i) termination, layoff, or reduction of the work hours of an employee for the purpose of hiring an individual under this section or sections 256.737, 256.738, and 256.739; (ii) the hiring of an individual if any other person is on layoff from the same or a substantially equivalent job; (iii) any infringement of the promotional opportunities of any currently employed individual; (iv) the impairment of existing contracts for services or collective bargaining agreements; or (v) except for on-the-job training under section 256.738, a participant filling an established unfilled position vacancy; and

(17) assess each caretaker in an AFDC-UP family who is under age 25, has not completed high school or a high school equivalency program, and who would otherwise be required to participate in a work experience placement under section 256.737 to determine if an appropriate secondary education option is available for the caretaker. If an appropriate secondary education option is determined to be available for the caretaker, the caretaker must, in lieu of participating in work experience, enroll in and meet the educational program's participation and attendance requirements. "Secondary education" for this paragraph means high school education or education designed to prepare a person to qualify for a high school equivalency certificate, basic and remedial education, and English as a second language education. A caretaker required to participate in secondary education who, without good cause, fails to participate shall be subject to the provisions of subdivision 4a and the sanction provisions of subdivision 4, clause (6). For purposes of this clause, "good cause" means the inability to obtain licensed or legal nonlicensed child care services needed to enable the caretaker to attend, inability to obtain transportation needed to attend, illness or incapacity of the caretaker or another member of the household which requires the caretaker to be present in the home, or being employed for more than 30 hours per week.

(b) Funds available under this subdivision may not be used to assist, promote, or deter union organizing.

(c) A county board may provide other employment and training services that it considers necessary to help caretakers obtain self-sufficiency.

(d) Notwithstanding section 256G.07, when a target caretaker relocates to another

county to implement the provisions of the caretaker's case management contract or other written employability development plan approved by the county human service agency, its case manager or employment and training service provider, the county that approved the plan is responsible for the costs of case management and other services required to carry out the plan, including employment and training services. The county agency's responsibility for the costs ends when all plan obligations have been met, when the caretaker loses AFDC eligibility for at least 30 days, or when approval of the plan is withdrawn for a reason stated in the plan, whichever occurs first. Responsibility for the costs of child care must be determined under chapter 256H. A county human service agency may pay for the costs of case management, child care, and other services required in an approved employability development plan when the nontarget caretaker relocates to another county or when a target caretaker again becomes eligible for AFDC after having been ineligible for at least 30 days.

Subd. 10a. **Orientation.** (a) Each county agency must provide an orientation to all caretakers within its jurisdiction in the time limits described in this paragraph:

(1) within 60 days of being determined eligible for AFDC for caretakers with a continued absence or incapacitated parent basis of eligibility; or

(2) within 30 days of being determined eligible for AFDC for caretakers with an unemployed parent basis of eligibility.

(b) Caretakers are required to attend an in-person orientation if the caretaker is a member of one of the groups listed in subdivision 3a, paragraph (a), unless the caretaker is exempt from registration under subdivision 3 and the caretaker's exemption basis will not expire within 60 days of being determined eligible for AFDC, or the caretaker is enrolled at least half time in any recognized school, training program, or institution of higher learning and the in-person orientation cannot be scheduled at a time that does not interfere with the caretaker's school or training schedule. The county agency shall require attendance at orientation of caretakers described in subdivision 3a, paragraph (b) or (c), if the commissioner determines that the groups are eligible for participation in employment and training services.

(c) The orientation must consist of a presentation that informs caretakers of:

(1) the identity, location, and phone numbers of employment and training and support services available in the county;

(2) the types and locations of child care services available through the county agency that are accessible to enable a caretaker to participate in educational programs or employment and training services;

(3) the child care resource and referral program designated by the commissioner providing education and assistance to select child care services and a referral to the child care resource and referral when assistance is requested;

(4) the obligations of the county agency and service providers under contract to the county agency;

(5) the rights, responsibilities, and obligations of participants;

(6) the grounds for exemption from mandatory employment and training services or educational requirements;

(7) the consequences for failure to participate in mandatory services or requirements;

(8) the method of entering educational programs or employment and training services available through the county;

(9) the availability and the benefits of the early and periodic, screening, diagnosis and treatment (EPSDT) program and preschool screening under chapter 123;

(10) their eligibility for transition year child care assistance when they lose eligibility for AFDC due to their earnings;

(11) their eligibility for extended medical assistance when they lose eligibility for AFDC due to their earnings; and

(12) the availability and benefits of the Head Start program.

(d) Orientation must encourage recipients to view AFDC as a temporary program providing grants and services to individuals who set goals and develop strategies for supporting their families without AFDC assistance. The content of the orientation must not imply that a recipient's eligibility for AFDC is time limited. Orientation may be provided through audio-visual methods, but the caretaker must be given an opportunity for face-to-face interaction with staff of the county agency or the entity providing the orientation, and an opportunity to express the desire to participate in educational programs and employment and training services offered through the county agency.

(e) County agencies shall not require caretakers to attend orientation for more than three hours during any period of 12 continuous months. The county agency shall also arrange for or provide needed transportation and child care to enable caretakers to attend.

The county or, under contract, the county's employment and training service provider shall mail written orientation materials containing the information specified in paragraph (c), clauses (1) to (3) and (8) to (12), to each caretaker exempt from attending an in-person orientation or who has good cause for failure to attend after at least two dates for their orientation have been scheduled. The county or the county's employment and training service provider shall follow up with a phone call or in writing within two weeks after mailing the material.

(f) Persons required to attend orientation must be informed of the penalties for failure to attend orientation, support services to enable the person to attend, what constitutes good cause for failure to attend, and rights to appeal. Persons required to attend orientation must be offered a choice of at least two dates for their first scheduled orientation. No person may be sanctioned for failure to attend orientation until after a second failure to attend.

(g) Good cause for failure to attend an in-person orientation exists when a caretaker cannot attend because of:

(1) temporary illness or injury of the caretaker or of a member of the caretaker's family that prevents the caretaker from attending an orientation during the hours when the orientation is offered;

(2) a judicial proceeding that requires the caretaker's presence in court during the hours when orientation is scheduled; or

(3) a nonmedical emergency that prevents the caretaker from attending an orientation during the hours when orientation is offered. "Emergency" for the purposes of this paragraph means a sudden, unexpected occurrence or situation of a serious or urgent nature that requires immediate action.

(h) Caretakers must receive a second orientation only when:

(1) there has been a 30-day break in AFDC eligibility; and

(2) the caretaker has not attended an orientation within the previous 12-month period, excluding the month of reapplication for AFDC.

[For text of subds 10b to 13, see M.S.1992]

Subd. 14. **Job search.** (a) Each county agency must establish and operate a job search program as provided under this section. Unless exempt, the principal wage earner in an AFDC-UP assistance unit must be referred to and begin participation in the job search program within 30 days of being determined eligible for AFDC. If the principal wage earner is exempt from participation in job search, the other caretaker must be referred to and begin participation in the job search program within 30 days of being determined eligible for AFDC. The principal wage earner or the other caretaker is exempt from job search participation if:

(1) the caretaker is exempt from registration under subdivision 3; or

(2) the caretaker is under age 25, has not completed a high school diploma or an equivalent program, and is participating in a secondary education program as defined in subdivision 10, paragraph (a), clause (17), which is approved by the employment and training service provider in the employability development plan.

(b) The job search program must provide four consecutive weeks of job search activities for no less than 20 hours per week but not more than 32 hours per week. The employment and training service provider shall specify for each participating caretaker the number of weeks and hours of job search to be conducted and shall report to the county agency if the caretaker fails to cooperate with the job search requirement.

(c) The job search program may provide services to non-AFDC-UP caretakers.

(d) After completion of job search requirements in this section, nonexempt caretakers shall be placed in and must participate in and cooperate with the work experience program under section 256.737, the on-the-job training program under section 256.738, or the grant diversion program under section 256.739. Caretakers must be offered placement in a grant diversion or on-the-job training program, if either such employment is available, before being required to participate in a community work experience program under section 256.737.

[For text of subd 15, see M.S.1992]

Subd. 16. **Allocation and use of money.** (a) State money appropriated for employment and training services under this section must be allocated to counties as specified in paragraphs (b) to (j).

(b) For purposes of this subdivision, "targeted caretaker" means a recipient who:

(1) is a custodial parent under the age of 24 who: (i) has not completed a high school education and at the time of application for AFDC is not enrolled in high school or in a high school equivalency program; or (ii) had little or no work experience in the preceding year;

(2) is a member of a family in which the youngest child is within two years of being ineligible for AFDC due to age; or

(3) has received 36 months or more of AFDC over the last 60 months.

(c) One hundred percent of the money appropriated for case management services as described in subdivision 1 l must be allocated to counties based on the average number of cases in each county described in clause (1). Money appropriated for employment and training services as described in subdivision 1a, paragraph (d), other than case management services, must be allocated to counties as follows:

(1) Forty percent of the state money must be allocated based on the average number of cases receiving AFDC in the county which either have been open for 36 or more consecutive months or have a caretaker who is under age 24 and who has no high school or general equivalency diploma. The average number of cases must be based on counts of these cases as of March 31, June 30, September 30, and December 31 of the previous year.

(2) Twenty percent of the state money must be allocated based on the average number of cases receiving AFDC in the county which are not counted under clause (1). The average number of cases must be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous year.

(3) Twenty-five percent of the state money must be allocated based on the average monthly number of assistance units in the county receiving AFDC-UP for the period ending December 31 of the previous year.

(4) Fifteen percent of the state money must be allocated at the discretion of the commissioner based on participation levels for target group members in each county.

(d) No more than 15 percent of the money allocated under paragraph (b) and no more than 15 percent of the money allocated under paragraph (c) may be used for administrative activities.

(e) At least 55 percent of the money allocated to counties under paragraph (c) must be used for employment and training services for caretakers in the target groups, and up to 45 percent of the money may be used for employment and training services for nontarget caretakers. One hundred percent of the money allocated to counties for case management services must be used to provide those services to caretakers in the target groups.

(f) Money appropriated to cover the nonfederal share of costs for bilingual case management services to refugees for the employment and training programs under this section are allocated to counties based on each county's proportion of the total statewide number of AFDC refugee cases. However, counties with less than one percent of the statewide number of AFDC refugee cases do not receive an allocation.

(g) Counties, the department of jobs and training, and entities under contract with either the department of jobs and training or the department of human services for provision of Project STRIDE related services shall bill the commissioner of human services for any expenditures incurred by the county, the county's employment and training service provider, or the department of jobs and training that may be reimbursed by federal money. The commissioner of human services shall bill the United States Department of Health and Human Services and the United States Department of Agriculture for the reimbursement and appropriate the reimbursed money to the county, the department of jobs and training, or employment and training service provider that submitted the original bill. The reimbursed money must be used to expand employment and training services.

(h) The commissioner of human services shall review county expenditures of case management and employment and training block grant money at the end of the third quarter of the biennium and each quarter after that, and may reallocate unencumbered or unexpended money allocated under this section to those counties that can demonstrate a need for additional money. Reallocation of funds must be based on the formula set forth in paragraph (a), excluding the counties that have not demonstrated a need for additional funds.

(i) The county agency may continue to provide case management and supportive services to a participant for up to 90 days after the participant loses AFDC eligibility and may continue providing a specific employment and training service for the duration of that service to a participant if funds for the service are obligated or expended prior to the participant losing AFDC eligibility.

(j) One hundred percent of the money appropriated for an unemployed parent work experience program under section 256.737 must be allocated to counties based on the average monthly number of assistance units in the county receiving AFDC-UP for the period ending December 31 of the previous year.

[For text of subd 18, see M.S.1992]

Subd. 19. **Evaluation.** In order to evaluate the services provided under this section, the commissioner may randomly assign no more than 2,500 families to a control group. Families assigned to the control group shall not participate in services under this section, except that families participating in services under this section at the time they are assigned to the control group may continue such participation. Recipients assigned to the control group who are included under subdivision 3a, paragraph (a), shall be guaranteed child care assistance under chapter 256H for an educational plan authorized by the county. Once assigned to the control group, a family must remain in that group for the duration of the evaluation period. The evaluation period shall coincide with the demonstration authorized in section 256.031, subdivision 3.

History: *1993 c 4 s 26,27; 1Sp1993 c 1 art 6 s 9-13*

256.7366 FEDERAL WAIVER.

The commissioner of human services shall make changes in the state plan and seek waivers or demonstration authority needed to minimize the barriers to effective and efficient use of grant diversion under section 256.739 as a method of placing AFDC recipients in suitable employment. The commissioner shall implement the federally approved changes as soon as possible.

History: *1Sp1993 c 1 art 6 s 14*

256.737 COMMUNITY WORK EXPERIENCE PROGRAM.

Subdivision 1. **Establishment and purpose.** To the degree required by federal law or regulation, each county agency must establish and operate a community work experience program to assist nonexempt caretakers in AFDC-UP households achieve self-sufficiency by enhancing their employability through participation in meaningful work experience and training, the development of job search skills and the development of marketable job skills. This subdivision does not apply to AFDC recipients participating in the Minnesota family investment plan under sections 256.031 to 256.0361.

Subd. 1a. **Commissioner's duties.** The commissioner shall: (a) assist counties in the design and implementation of these programs; (b) promulgate, in accordance with chapter 14, emergency rules necessary for the implementation of this section, except that the time restrictions of section 14.35 shall not apply and the rules may be in effect until June 30, 1993, unless superseded by permanent rules; (c) seek any federal waivers necessary for proper implementation of this section in accordance with federal law; and (d) prohibit the use of participants in the programs to do work that was part or all of the duties or responsibilities of an authorized public employee bargaining unit position established as of January 1, 1993. The exclusive bargaining representative shall be notified no less than 14 days in advance of any placement by the community work experience program. Written or oral concurrence with respect to job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative within seven days. The appropriate oversight committee shall be given monthly lists of all job placements under a community work experience program.

Subd. 2. **Program requirements.** (a) Worksites developed under this section are limited to projects that serve a useful public service such as: health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged or disabled citizens, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(b) As a condition to placing a person receiving aid to families with dependent children in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256.736, subdivision 14; or

(2) for placement in suitable employment through participation in on-the-job training under section 256.738 or grant diversion under section 256.739, if such employment is available.

(c) A caretaker referred to job search under section 256.736, subdivision 14, and who has failed to secure suitable employment must participate in a community work experience program.

(d) The county agency shall limit the maximum number of hours any participant under this section may work in any month to:

(1) for counties operating an approved mandatory community work experience program as of January 1, 1993, who elect this method for countywide operations, a number equal to the amount of the aid to families with dependent children payable to the family divided by the greater of the federal minimum wage or the applicable state minimum wage; or

(2) for all other counties, a caretaker must participate in any week 20 hours with no less than 16 hours spent participating in a work experience placement and no more than four of the hours spent in alternate activities as described in the caretaker's employability development plan. Placement in a work experience worksite must be based on the assessment required under section 256.736 and the caretaker's employability development plan. Caretakers participating under this clause may be allowed excused absences from the assigned job site of up to eight hours per month. For the pur-

poses of this clause, "excused absence" means absence due to temporary illness or injury of the caretaker or a member of the caretaker's family, the unavailability of licensed child care or transportation needed to participate in the work experience placement, a job interview, or a nonmedical emergency. For purposes of this clause, "emergency" has the meaning given it in section 256.736, subdivision 10a, paragraph (g).

(e) After a participant has been assigned to a position under paragraph (d), clause (1), for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the aid to families with dependent children payable with respect to the family divided by the higher of (1) the federal minimum wage or the applicable state minimum wage, whichever is greater, or (2) the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(f) After each six months of a recipient's participation in an assignment, and at the conclusion of each assignment under this section, the county agency shall reassess and revise, as appropriate, each participant's employability development plan.

(g) Structured, supervised volunteer work with an agency or organization which is monitored by the county service provider may, with the approval of the commissioner of jobs and training, be used as a work experience placement.

Subd. 3. **Exemptions.** A caretaker is exempt from participation in a work experience placement under this section if the caretaker is exempt from participation in job search under section 256.736, subdivision 14, or the caretaker is suitably employed in a grant diversion or an on-the-job training placement. Caretakers who, as of October 1, 1993, are participating in an education or training activity approved under a Project STRIDE employability development plan are exempt from participation in a work experience placement until July 1, 1994.

Subd. 4. **Good cause.** A caretaker shall have good cause for failure to cooperate if:

(1) the worksite participation adversely affects the caretaker's physical or mental health as verified by a physician, licensed or certified psychologist, physical therapist, vocational expert, or by other sound medical evidence; or

(2) the caretaker does not possess the skill or knowledge required for the work.

Subd. 5. **Failure to comply.** A caretaker required to participate under this section who has failed without good cause to participate shall be provided with notices, appeal opportunities, and offered a conciliation conference under the provisions of section 256.736, subdivision 4a, and shall be subject to the sanction provisions of section 256.736, subdivision 4, clause (6).

Subd. 6. **Federal requirements.** If the Family Support Act of 1988, Public Law Number 100-485, is revised or if federal implementation of that law is revised so that Minnesota is no longer obligated to operate a mandatory work experience program for AFDC-UP families, the commissioner shall operate the work experience program under this section as a volunteer program, and shall utilize the funding authorized for work experience to improve and expand the availability of other employment and training services authorized under this section.

History: *1Sp1993 c 1 art 6 s 15-21*

256.74 ASSISTANCE.

Subdivision 1. **Amount.** The amount of assistance which shall be granted to or on behalf of any dependent child and mother or other needy eligible relative caring for the dependent child shall be determined by the county agency in accordance with rules promulgated by the commissioner and shall be sufficient, when added to all other income and support available to the child, to provide the child with a reasonable subsistence compatible with decency and health. The amount shall be based on the method of budgeting required in Public Law Number 97-35, section 2315, United States Code, title 42, section 602, as amended and federal regulations at Code of Federal Regulations, title 45, section 233. Nonrecurring lump sum income received by an AFDC family must be budgeted in the normal retrospective cycle. When the family's income, after applica-

tion of the applicable disregards, exceeds the need standard for the family because of receipt of earned or unearned lump sum income, the family will be ineligible for the full number of months derived by dividing the sum of the lump sum income and other income by the monthly need standard for a family of that size. Any income remaining from this calculation is income in the first month following the period of ineligibility. The first month of ineligibility is the payment month that corresponds with the budget month in which the lump sum income was received. For purposes of applying the lump sum provision, family includes those persons defined in the Code of Federal Regulations, title 45, section 233.20(a)(3)(ii)(F). A period of ineligibility must be shortened when the standard of need increases and the amount the family would have received also changes, an amount is documented as stolen, an amount is unavailable because a member of the family left the household with that amount and has not returned, an amount is paid by the family during the period of ineligibility to cover a cost that would otherwise qualify for emergency assistance, or the family incurs and pays for medical expenses which would have been covered by medical assistance if eligibility existed. In making its determination the county agency shall disregard the following from family income:

(1) all the earned income of each dependent child applying for AFDC if the child is a full-time student and all of the earned income of each dependent child receiving AFDC who is a full-time student or is a part-time student who is not a full-time employee. A student is one who is attending a school, college, or university, or a course of vocational or technical training designed to fit students for gainful employment and includes a participant in the Job Corps program under the Job Training Partnership Act (JTPA). The county agency shall also disregard all income of each dependent child applying for or receiving AFDC when the income is derived from a program carried out under JTPA, except that disregard of earned income may not exceed six months per calendar year;

(2) all educational grants and loans;

(3) the first $90 of each individual's earned income. For self-employed persons, the expenses directly related to producing goods and services and without which the goods and services could not be produced shall be disregarded pursuant to rules promulgated by the commissioner;

(4) thirty dollars plus one-third of each individual's earned income for individuals found otherwise eligible to receive aid or who have received aid in one of the four months before the month of application. With respect to any month, the county welfare agency shall not disregard under this clause any earned income of any person who has: (a) reduced earned income without good cause within 30 days preceding any month in which an assistance payment is made; (b) refused without good cause to accept an offer of suitable employment; (c) left employment or reduced earnings without good cause and applied for assistance so as to be able later to return to employment with the advantage of the income disregard; or (d) failed without good cause to make a timely report of earned income in accordance with rules promulgated by the commissioner of human services. Persons who are already employed and who apply for assistance shall have their needs computed with full account taken of their earned and other income. If earned and other income of the family is less than need, as determined on the basis of public assistance standards, the county agency shall determine the amount of the grant by applying the disregard of income provisions. The county agency shall not disregard earned income for persons in a family if the total monthly earned and other income exceeds their needs, unless for any one of the four preceding months their needs were met in whole or in part by a grant payment. The disregard of $30 and one-third of earned income in this clause shall be applied to the individual's income for a period not to exceed four consecutive months. Any month in which the individual loses this disregard because of the provisions of subclauses (a) to (d) shall be considered as one of the four months. An additional $30 work incentive must be available for an eight-month period beginning in the month following the last month of the combined $30 and one-third work incentive. This period must be in effect whether or not the person

has earned income or is eligible for AFDC. To again qualify for the earned income disregards under this clause, the individual must not be a recipient of aid for a period of 12 consecutive months. When an assistance unit becomes ineligible for aid due to the fact that these disregards are no longer applied to income, the assistance unit shall be eligible for medical assistance benefits for a 12-month period beginning with the first month of AFDC ineligibility;

(5) an amount equal to the actual expenditures for the care of each dependent child or incapacitated individual living in the same home and receiving aid, not to exceed: (a) $175 for each individual age two and older, and $200 for each individual under the age of two. The dependent care disregard must be applied after all other disregards under this subdivision have been applied;

(6) the first $50 per assistance unit of the monthly support obligation collected by the support and recovery (IV-D) unit. The first $50 of periodic support payments collected by the public authority responsible for child support enforcement from a person with a legal obligation to pay support for a member of the assistance unit must be paid to the assistance unit within 15 days after the end of the month in which the collection of the periodic support payments occurred and must be disregarded when determining the amount of assistance. A review of a payment decision under this clause must be requested within 30 days after receiving the notice of collection of assigned support or within 90 days after receiving the notice if good cause can be shown for not making the request within the 30-day limit;

(7) that portion of an insurance settlement earmarked and used to pay medical expenses, funeral and burial costs, or to repair or replace insured property; and

(8) all earned income tax credit payments received by the family as a refund of federal income taxes or made as advance payments by an employer.

All payments made pursuant to a court order for the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support, provided that, if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for a modification of the support order.

[For text of subds 1a to 5, see M.S.1992]

History: *1Sp1993 c 1 art 6 s 22*

256.78 ASSISTANCE GRANTS RECONSIDERED.

All assistance granted under sections 256.72 to 256.87 shall be reconsidered as frequently as may be required by the rules of the state agency. After such further investigation as the county agency may deem necessary or the state agency may require, the amount of assistance may be changed or assistance may be entirely withdrawn if the state or county agency find that the child's circumstances have altered sufficiently to warrant such action.

The county agency may for cause at any time revoke, modify, or suspend any order for assistance previously made. When assistance is thus revoked, modified, or suspended the county agency shall at once report to the state agency such decision together with supporting evidence required by the rules of the state agency. All such decisions shall be subject to appeal and review by the state agency as provided in section 256.045.

History: *1Sp1993 c 1 art 6 s 23*

256.87 CONTRIBUTION BY PARENTS.

Subdivision 1. **Actions against parents for assistance furnished.** A parent of a child is liable for the amount of assistance furnished under sections 256.031 to 256.0361, 256.72 to 256.87, or under Title IV-E of the Social Security Act or medical assistance under chapter 256, 256B, or 256D to and for the benefit of the child, including any assistance furnished for the benefit of the caretaker of the child, which the parent has

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

Subd. 1a. **Continuing support contributions.** In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing support contributions by a parent found able to reimburse the county or state agency. The order shall be effective for the period of time during which the recipient receives public assistance from any county or state agency and thereafter. The order shall require support according to chapter 518. An order for continuing contributions is reinstated without further hearing upon notice to the parent by any county or state agency that assistance is again being provided for the child of the parent under sections 256.031 to 256.0361, 256.72 to 256.87, or under Title IV-E of the Social Security Act or medical assistance under chapter 256, 256B, or 256D. The notice shall be in writing and shall indicate that the parent may request a hearing for modification of the amount of support or maintenance.

Subd. 3. **Continuing contributions to former recipient.** The order for continuing support contributions shall remain in effect following the period after public assistance granted under sections 256.72 to 256.87 is terminated unless the former recipient files an affidavit with the court requesting termination of the order.

Subd. 5. **Child not receiving assistance.** A person or entity having physical and legal custody of a dependent child not receiving assistance under sections 256.72 to 256.87 has a cause of action for child support against the child's absent parents. Upon an order to show cause and a motion served on the absent parent, the court shall order child support payments from the absent parent under chapter 518.

[For text of subds 6 and 7, see M.S.1992]

History: *1993 c 340 s 3-6*

256.8711 EMERGENCY ASSISTANCE; INTENSIVE FAMILY PRESERVATION SERVICES.

Subdivision 1. **Scope of services.** For a family experiencing an emergency as defined in subdivision 2, and for whom the county authorizes services under subdivision 3, intensive family preservation services authorized under this section are:

(1) crisis family-based services;

(2) counseling family-based services; and

(3) mental health family-based services.

Intensive family preservation services also include family-based life management skills when it is provided in conjunction with any of the three family-based services in this subdivision. The intensive family preservation services in clauses (1), (2), and (3) and life management skills have the meanings given in section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e).

Subd. 2. **Definition of emergency.** For the purposes of this section, an emergency is a situation in which the dependent children are at risk for out-of-home placement due to abuse, neglect, or delinquency; or when the children are returning home from placements but need services to prevent another placement; or when the parents are unable to provide care.

Subd. 3. **County authorization.** The county agency shall assess current and prospective client families with a dependent under 21 years of age to determine if there is an

emergency, as defined in subdivision 2, and to determine if there is a need for intensive family preservation services. Upon such determinations, during the period October 1, 1993 to September 30, 1995, counties shall authorize intensive family preservation services for up to 90 days for eligible families under this section and under section 256.871, subdivisions 1 and 3. Effective October 1, 1995, the counties' obligations to continue the base level of expenditures and to expand family preservation services as defined in section 256F.03, subdivision 5, are eliminated, with the termination of the federal revenue earned under this section.

Subd. 4. **Cost to families.** Family preservation services provided under this section or sections 256F.01 to 256F.07 shall be provided at no cost to the client and without regard to the client's available income or assets.

Subd. 5. **Emergency assistance reserve.** The commissioner shall establish an emergency assistance reserve for families who receive intensive family preservation services under this section. A family is eligible to receive assistance once from the emergency assistance reserve if it received intensive family preservation services under this section within the past 12 months, but has not received emergency assistance under section 256.871 during that period. The emergency assistance reserve shall cover the cost of the federal share of the assistance that would have been available under section 256.871, except for the provision of intensive family preservation services provided under this section. The emergency assistance reserve shall be authorized and paid in the same manner as emergency assistance is provided under section 256.871. Funds set aside for the emergency assistance reserve that are not needed as determined by the commissioner shall be distributed by the terms of subdivision 6, paragraph (a).

Subd. 6. **Distribution of new federal revenue.** (a) All federal funds not set aside under paragraph (b), and at least 50 percent of all federal funds earned under this section and earned through assessment activity under subdivision 3, shall be paid to each county based on its earnings and assessment activity, respectively, and shall be used by each county to expand family preservation services as defined in section 256F.03, subdivision 5, and may be used to expand crisis nursery services. If a county joins a local children's mental health collaborative as authorized by the 1993 legislature, then the federal reimbursement received under this paragraph by the county for providing intensive family preservation services to children served by the local collaborative shall be transferred by the county to the integrated fund. The federal reimbursement transferred to the integrated fund by the county must be used for intensive family preservation services as defined in section 256F.03, subdivision 5, to the target population.

(b) The commissioner shall set aside a portion, not to exceed 50 percent, of the federal funds earned under this section and earned through assessment activity described under subdivision 3. The set aside funds shall be used to expand intensive family preservation services statewide and establish an emergency assistance reserve as provided in subdivision 5. Except for the portion needed for the emergency assistance reserve provided in subdivision 5, the commissioner may distribute the funds set aside through grants to a county or counties to establish and maintain approved intensive family preservation services statewide. Funds available for crisis family-based services through section 256F.05, subdivision 8, shall be considered in establishing intensive family preservation services statewide. The commissioner may phase in intensive family preservation services in a county or group of counties as new federal funds become available. The commissioner's priority is to establish a minimum level of intensive family preservation services statewide.

Subd. 7. **Expansion of services and base level of expenditures.** (a) Counties must continue the base level of expenditures for family preservation services as defined in section 256F.03, subdivision 5, from any state, county, or federal funding source, which, in the absence of federal funds earned under this section and earned through assessment activity described under subdivision 3, would have been available for these services. The commissioner shall review the county expenditures annually, using reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8, to ensure that the base level of expenditures for family preser-

vation services as defined in section 256F.03, subdivision 5, is continued from sources other than the federal funds earned under this section and earned through assessment activity described under subdivision 3.

(b) The commissioner may reduce, suspend, or eliminate either or both of a county's obligations to continue the base level of expenditures and to expand family preservation services as defined in section 256F.03, subdivision 5, if the commissioner determines that one or more of the following conditions apply to that county:

(1) imposition of levy limits that significantly reduce available social service funds;

(2) reduction in the net tax capacity of the taxable property within a county that significantly reduces available social service funds;

(3) reduction in the number of children under age 19 in the county by 25 percent when compared with the number in the base year using the most recent data provided by the state demographer's office; or

(4) termination of the federal revenue earned under this section.

(c) The commissioner may suspend for one year either or both of a county's obligations to continue the base level of expenditures and to expand family preservation services as defined in section 256F.03, subdivision 5, if the commissioner determines that in the previous year one or more of the following conditions applied to that county:

(1) the unduplicated number of families who received family preservation services under section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e), equals or exceeds the unduplicated number of children who entered placement under sections 257.071 and 393.07, subdivisions 1 and 2, during the year;

(2) the total number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, has been reduced by 50 percent from the total number in the base year; or

(3) the average number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, on the last day of each month is equal to or less than one child per 1,000 children in the county.

(d) For the purposes of this section, the base year is calendar year 1992. For the purposes of this section, the base level of expenditures is the level of county expenditures in the base year for eligible family preservation services under section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e).

Subd. 8. **County responsibilities.** (a) Notwithstanding section 256.871, subdivision 6, for intensive family preservation services provided under this section, the county agency shall submit quarterly fiscal reports as required under section 256.01, subdivision 2, clause (17), and provide the nonfederal share.

(b) County expenditures eligible for federal reimbursement under this section must not be made from federal funds or funds used to match other federal funds.

(c) The commissioner may suspend, reduce, or terminate the federal reimbursement to a county that does not meet the reporting or other requirements of this section.

Subd. 9. **Payments.** Notwithstanding section 256.025, subdivision 2, payments to counties for social service expenditures for intensive family preservation services under this section shall be made only from the federal earnings under this section and earned through assessment activity described under subdivision 3. Counties may use up to ten percent of federal earnings received under subdivision 6, paragraph (a), to cover costs of income maintenance activities related to the operation of this section and sections 256B.094 and 256F.10.

Subd. 10. **Commissioner responsibilities.** The commissioner in consultation with counties shall analyze state funding options to cover costs of counties' base level expenditures and any expansion of the nonfederal share of intensive family preservation services resulting from implementation of this section. The commissioner shall also study problems of implementation, barriers to maximizing federal revenue, and the impact on out-of-home placements of implementation of this section. The commissioner shall

report to the legislature on the results of this analysis and study, together with recommendations, by February 15, 1995.

History: *1Sp1993 c 1 art 3 s 22*

256.9351 DEFINITIONS.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

[For text of subd 4, see M.S.1992]

History: *1993 c 345 art 9 s 1*

256.9352 PLAN ADMINISTRATION.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Financial management.** The commissioner shall manage spending for the health right plan in a manner that maintains a minimum reserve equal to five percent of the expected cost of state premium subsidies. The commissioner must make a quarterly assessment of the expected expenditures for the covered services for the remainder of the current fiscal year and for the following two fiscal years. The estimated expenditure shall be compared to an estimate of the revenues that will be deposited in the health care access fund. Based on this comparison, and after consulting with the chairs of the house ways and means committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall make adjustments as necessary to ensure that expenditures remain within the limits of available revenues. The adjustments the commissioner may use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the health right plan; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the health right plan. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner may further limit enrollment or decrease premium subsidies.

The reserve referred to in this subdivision is appropriated to the commissioner but may only be used upon approval of the commissioner of finance, if estimated costs will exceed the forecasted amount of available revenues after all adjustments authorized under this subdivision have been made.

By February 1, 1994, the department of human services and the department of health shall develop a plan to adjust benefit levels, eligibility guidelines, or other steps necessary to ensure that expenditures for the MinnesotaCare program are contained within the two percent provider tax and the one percent HMO gross premiums tax for the 1996-1997 biennium. Notwithstanding any law to the contrary, no further enrollment in MinnesotaCare, and no additional hiring of staff for the departments shall take place after June 1, 1994, unless a plan to balance the MinnesotaCare budget for the 1996-1997 biennium has been passed by the 1994 legislature.

[For text of subd 4, see M.S.1992]

History: *1993 c 4 s 28; 1993 c 345 art 9 s 2*

256.9353 COVERED HEALTH SERVICES.

Subdivision 1. **Covered health services.** "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than preventive services, orthodontic services, medical transportation services, personal care assistant and case management services, hospice care services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the health right plan are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy. Covered health services shall be expanded as provided in this section.

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the department of human services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare plan after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Subd. 3. **Inpatient hospital services.** (a) Beginning July 1, 1993, covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spend-down. The inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of $10,000. The commissioner shall provide enrollees with at least 60 days' notice of coverage for inpatient hospital services and any premium increase associated with the inclusion of this benefit.

(b) Enrollees shall apply for and cooperate with the requirements of medical assistance by the last day of the third month following admission to an inpatient hospital. If an enrollee fails to apply for medical assistance within this time period, the enrollee and the enrollee's family shall be disenrolled from the plan within one calendar month. Enrollees and enrollees' families disenrolled for not applying for or not cooperating with medical assistance may not reenroll.

Subd. 4. [Renumbered subd 5]

Subd. 4. **Hospice.** Beginning July 1, 1993, covered health services shall include hospice care services.

Subd. 5. [Renumbered subd 6]

Subd. 5. **Emergency medical transportation services.** Beginning July 1, 1993, covered health services shall include emergency medical transportation services.

Subd. 6. [Renumbered subd 7]

Subd. 6. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the health right plan with enrollee eligibility under the medical assistance spend-down, and shall apply to the secretary of health and human services for any necessary federal waivers or approvals.

Subd. 7. **Copayments and coinsurance.** The MinnesotaCare benefit plan shall include the following copayments and coinsurance requirements:

(1) ten percent of the charges submitted for inpatient hospital services for adult enrollees not eligible for medical assistance, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees; and

(3) $25 for eyeglasses for adult enrollees.

Enrollees who would be eligible for medical assistance with a spend-down shall be financially responsible for the coinsurance amount up to the spend-down limit or the coinsurance amount, whichever is less, in order to become eligible for the medical assistance program.

Subd. 8. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015.

History: *1993 c 247 art 4 s 2-4; 1993 c 345 art 9 s 3; 1993 c 366 s 26*

256.9354 ELIGIBLE PERSONS.

Subdivision 1. **Children; expansion and continuation of eligibility.** (a) **Children.** "Eligible persons" means children who are one year of age or older but less than 18 years of age who have gross family incomes that are equal to or less than 150 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old.

(b) **Expansion of eligibility.** Eligibility for MinnesotaCare shall be expanded as provided in subdivisions 2 to 5, except children who meet the criteria in this subdivision shall continue to be enrolled pursuant to this subdivision. The enrollment requirements in this paragraph apply to enrollment under subdivisions 1 to 5. Parents who enroll in the MinnesotaCare plan must also enroll their children and dependent siblings, if the children and their dependent siblings are eligible. Children and dependent siblings may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members. For purposes of this section, a "dependent sibling" means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon a parent. Proof of school enrollment will be required.

(c) **Continuation of eligibility.** Individuals who initially enroll in the MinnesotaCare plan under the eligibility criteria in subdivisions 2 to 5 remain eligible for the MinnesotaCare plan, regardless of age, place of residence, or the presence or absence of children in the same household, as long as all other eligibility criteria are met and residence in Minnesota and continuous enrollment in the MinnesotaCare plan or medical assistance are maintained. In order for either parent or either spouse in a household to remain enrolled, both must remain enrolled, unless other insurance is available.

Subd. 1a. **Cooperation.** To be eligible for MinnesotaCare, individuals must cooperate with the state agency to identify potentially liable third party payers and assist the

state in obtaining third party payments. "Cooperation" includes, but is not limited to, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third party payments.

Subd. 2. **Families with children.** Beginning October 1, 1992, "eligible persons" means children eligible under subdivision 1, and parents and dependent siblings residing in the same household as a child eligible under subdivision 1.

Subd. 3. **Continuation of eligibility.** Beginning October 1, 1992, individuals who initially enrolled in the MinnesotaCare plan under the eligibility criteria in subdivision 1 or 2 remain eligible even if their gross income after enrollment exceeds 185 percent of the federal poverty guidelines, subject to any premium required under section 256.9357, as long as all other eligibility requirements are met and continuous enrollment in the MinnesotaCare plan or medical assistance is maintained.

Subd. 4. **Families with children; eligibility based on percentage of income paid for health coverage.** Beginning January 1, 1993, "eligible persons" means children, parents, and dependent siblings residing in the same household who are not eligible for medical assistance under chapter 256B. Children who meet the criteria in subdivision 1 shall continue to be enrolled pursuant to subdivision 1. Persons who are eligible under this subdivision or subdivision 2, 3, or 5 must pay a premium as determined under sections 256.9357 and 256.9358, and children eligible under subdivision 1 must pay the premium required under section 256.9356, subdivision 1. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in MinnesotaCare.

Subd. 5. **Addition of single adults and households with no children.** Beginning July 1, 1994, "eligible persons" means all families and individuals who are not eligible for medical assistance under chapter 256B. These persons are eligible for coverage through the MinnesotaCare plan but must pay a premium as determined under sections 256.9357 and 256.9358. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in the MinnesotaCare plan.

Subd. 6. **Applicants potentially eligible for medical assistance.** Individuals who apply for MinnesotaCare, but who are potentially eligible for medical assistance shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer such individuals to their county social service agency. The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not apply for and cooperate with medical assistance within the 60-day enrollment period, and their other family members, shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination for the family member or members who were referred to the county agency. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination. The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

History: *1993 c 247 art 4 s 5; 1993 c 345 art 9 s 4-6*

256.9355 APPLICATION PROCEDURES.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Effective date of coverage.** The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for eligible newborns or eligible newly adoptive children added to a family receiving covered health services is the

date of entry into the family. The effective date of coverage for other new recipients added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage. Notwithstanding any other law to the contrary, benefits under sections 256.9351 to 256.9361 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

History: *1993 c 247 art 4 s 6*

256.9356 PREMIUM FEES AND PAYMENTS.

Subdivision 1. **Premium fees.** An annual premium fee of $48 is required from all MinnesotaCare enrollees eligible under section 256.9354, subdivision 1.

Subd. 2. **Premium payments.** The commissioner shall require MinnesotaCare enrollees eligible under section 256.9354, subdivisions 2 to 5, to pay a premium based on a sliding scale, as established under section 256.9358. The following applicants are exempt from this requirement until July 1, 1993:

(1) applicants who are eligible under section 256.9354, subdivision 1, if the application is received by MinnesotaCare staff on or before September 30, 1992; and

(2) children who enroll in the children's health plan after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17.

Subd. 3. **Administration and commissioner's duties.** Premiums are dedicated to the commissioner for MinnesotaCare. The commissioner shall make an annual redetermination of continued eligibility and identify people who may become eligible for medical assistance. The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or annual basis, with the first payment due upon notice from the commissioner of the premium amount required. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Nonpayment of the premium will result in disenrollment from the plan within one calendar month after the due date. Persons disenrolled for nonpayment may not reenroll until four calendar months have elapsed.

History: *1993 c 247 art 4 s 7; 1993 c 345 art 9 s 7*

256.9357 ELIGIBILITY FOR SUBSIDIZED PREMIUMS BASED ON SLIDING SCALE.

Subdivision 1. **General requirements.** Families and individuals are eligible for subsidized premium payments based on a sliding scale under section 256.9358 only if the family or individual meets the requirements in subdivisions 2 and 3.

Families and individuals who initially enrolled in MinnesotaCare under section 256.9354, and whose income increases above the limits established in section 256.9358, may continue enrollment and pay the full cost of coverage.

Subd. 2. **Must not have access to employer-subsidized coverage.** To be eligible for subsidized premium payments based on a sliding scale, a family or individual must not have access to subsidized health coverage through an employer, and must not have had access to subsidized health coverage through an employer for the 18 months prior to application for subsidized coverage under the MinnesotaCare plan. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does not apply if employer-subsidized coverage was lost for reasons that would not disqualify the individual for unemployment benefits under

section 268.09 and the family or individual has not had access to employer-subsidized coverage since the layoff. For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee, excluding dependent coverage, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Subd. 3. **Period uninsured.** To be eligible for subsidized premium payments based on a sliding scale, families and individuals initially enrolled in the MinnesotaCare plan under section 256.9354, subdivisions 4 and 5, must have had no health coverage for at least four months prior to application. The commissioner may change this eligibility criterion for sliding scale premiums without complying with rulemaking requirements in order to remain within the limits of available appropriations. The requirement of at least four months of no health coverage prior to application for the MinnesotaCare plan does not apply to families, children, and individuals who want to apply for the MinnesotaCare plan upon termination from the medical assistance program, general assistance medical care program, or coverage under a regional demonstration project for the uninsured funded under section 256B.73, the Hennepin county assured care program, or the Group Health, Inc., community health plan. This subdivision does not apply to families and individuals initially enrolled under sections 256.9354, subdivisions 1 and 2, or to children enrolled pursuant to Laws 1992, chapter 549, article 4, section 17.

History: *1993 c 345 art 9 s 8*

NOTE: Subdivision 1 was also amended by Laws 1993, chapter 247, article 4, section 8, to read as follows:

"Subdivision 1. **General requirements.** Families and individuals who enroll on or after October 1, 1992, are eligible for subsidized premium payments based on a sliding scale under section 256.9358 only if the family or individual meets the requirements in subdivisions 2 and 3. Children already enrolled in the MinnesotaCare plan as of September 30, 1992, and children who enroll in the children's health plan after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the MinnesotaCare plan or medical assistance.

Families and individuals who initially enrolled in the MinnesotaCare plan under section 256.9354, and whose income increases above the limits established in section 256.9358, may continue enrollment and pay the full cost of coverage."

256.9362 PROVIDER PAYMENT.

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under sections 256.9351 to 256.9362 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under section 256.9353, subdivision 3, shall be paid for as provided in subdivisions 4 to 6.

Subd. 4. **Definition of medical assistance rate for inpatient hospital services.** The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive aid to families with dependent children.

Subd. 5. **Enrollees younger than 18.** Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b).

(a) If the medical assistance rate minus any copayment required under section 256.9353, subdivision 6, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256.9353, subdivision 3, payment must be the medical assistance rate minus any copayment required under section 256.9353, subdivision 6. The hospital must not seek payment from the enrollee in addition to the copayment. The MinnesotaCare payment plus the copayment must be treated as payment in full.

(b) If the medical assistance rate minus any copayment required under section 256.9353, subdivision 6, is greater than the amount remaining in the enrollee's benefit limit under section 256.9353, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any copayment established under section 256.9353, subdivision 6.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph.

History: *1993 c 345 art 9 s 9*

256.9363 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Managed care plans may include integrated service networks as defined in section 62N.02.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the department of human services and prepaid health plans or integrated service networks to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance or general assistance medical care will remain in the same managed care plan if the managed care plan has a contract for that population. Contracts between the department of human services and managed care plans must include MinnesotaCare, and medical assistance and may also include general assistance medical care.

Subd. 6. **Copayments and benefit limits.** Enrollees are responsible for all copayments in section 256.9353, subdivision 6, and shall pay copayments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit to the managed care plan or its participating providers.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the department of human services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256.9353 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee copayments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D;

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services; and

(9) shall submit to the commissioner claims in the format specified by the commissioner of human services for all hospital services provided to enrollees for the purpose of determining whether enrollees meet medical assistance spend-down requirements and shall provide to the enrollee, upon the enrollee's request, information on the cost of services provided to the enrollee by the managed care plan for the purpose of establishing whether the enrollee has met medical assistance spend-down requirements.

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9. **Rate setting.** Rates will be prospective, per capita, where possible. The commissioner shall consult with an independent actuary to determine appropriate rates.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the department of human services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

History: *1993 c 345 art 9 s 10*

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.

[For text of subd 1a, see M.S.1992]

Subd. 1b. **Physician surcharge waiver request.** (a) The commissioner shall request a waiver from the secretary of health and human services to exclude from the surcharge under section 147.01, subdivision 6, a physician whose license is issued or renewed on or after April 1, 1993, and who:

(1) provides physician services at a free clinic, community clinic, or in an underdeveloped foreign nation and does not charge for any physician services;

(2) has taken a leave of absence of at least one year from the practice of medicine but who intends to return to the practice in the future;

(3) is unable to practice medicine because of terminal illness or permanent disability as certified by an attending physician;

(4) is unemployed; or

(5) is retired.

(b) If a waiver is approved under this subdivision, the commissioner shall direct the board of medical practice to adjust the physician license surcharge under section 147.01, subdivision 6, accordingly.

Subd. 1c. **Waiver implementation.** If a waiver is approved under subdivision 1b, the commissioner shall implement subdivision 1b as follows:

(a) The commissioner, in cooperation with the board of medical practice, shall notify each physician whose license is scheduled to be issued or renewed between April 1 and September 30 that an application to be excused from the surcharge must be received by the commissioner prior to September 1 of that year for the period of 12 consecutive calendar months beginning December 15. For each physician whose license is scheduled to be issued or renewed between October 1 and March 31, the application must be received from the physician by March 1 for the period of 12 consecutive calendar months beginning June 15. For each physician whose license is scheduled to be issued or renewed between April 1 and September 30, the commissioner shall make the notification required in this paragraph by July 1. For each physician whose license is scheduled to be issued or renewed between October 1 and March 31, the commissioner shall make the notification required in this paragraph by January 1.

(b) The commissioner shall establish an application form for waiver applications. Each physician who applies to be excused from the surcharge under subdivision 1b, paragraph (a), clause (1), must include with the application:

(1) a statement from the operator of the facility at which the physician provides services, that the physician provides services without charge; and

(2) a statement by the physician that the physician will not charge for any physician services during the period for which the exemption from the surcharge is granted.

Each physician who applies to be excused from the surcharge under subdivision 1b, paragraph (a), clauses (2) to (5), must include with the application:

(i) the physician's own statement certifying that the physician does not intend to practice medicine and will not charge for any physician services during the period for which the exemption from the surcharge is granted;

(ii) the physician's own statement describing in general the reason for the leave of absence from the practice of medicine and the anticipated date when the physician will resume the practice of medicine, if applicable;

(iii) an attending physician's statement certifying that the applicant has a terminal illness or permanent disability, if applicable; and

(iv) the physician's own statement indicating on what date the physician retired or became unemployed, if applicable.

(c) The commissioner shall notify in writing the physicians who are excused from the surcharge under subdivision 1b.

(d) A physician who decides to charge for physician services prior to the end of the period for which the exemption from the surcharge has been granted under subdivision 1b, paragraph (a), clause (1), or to return to the practice of medicine prior to the end of the period for which the exemption from the surcharge has been granted under subdivision 1b, paragraph (a), clause (2), (4), or (5), may do so by notifying the commissioner and shall be responsible for payment of the full surcharge for that period.

(e) Whenever the commissioner determines that the number of physicians likely to be excused from the surcharge under subdivision 1b may cause the physician surcharge to violate the requirements of Public Law Number 102-234 or regulations adopted under that law, the commissioner shall immediately notify the chairs of the senate health care committee and health care and family services funding division and the house of representatives human services committee and human services funding division.

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

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

Subd. 3. **Health maintenance organization; integrated service network surcharge.** (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 integrated service network licensed by the commissioner under sections 62N.01 to 62N.22 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 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 from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization and the health care financing administration of the federal Department of Health and Human Services, for services to a Medicare beneficiary; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization 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 for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

[For text of subds 4 and 6, see M.S.1992]

Subd. 7. **Collection; civil penalties.** The provisions of sections 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 and section 147.01, subdivision 6. The commissioner of human services shall impose civil penalties for violation of this section or section 147.01, subdivision 6, as provided in section 289A.60, and the tax and penalties are subject to interest at the rate provided in section 270.75. 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 and section 147.01, subdivision 6.

[For text of subd 8, see M.S.1992]

History: *1993 c 345 art 1 s 21; 1Sp1993 c 1 art 5 s 11-16*

256.9685 ESTABLISHMENT OF INPATIENT HOSPITAL PAYMENT SYSTEM.

Subdivision 1. **Authority.** The commissioner shall establish procedures for determining medical assistance and general assistance medical care payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. The medical assistance payment rates must be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of recipients in efficiently and economically operated hospitals. Services must meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), to be eligible for payment except the commissioner may establish exemptions to specific requirements based on diagnosis, procedure, or service after notice in the State Register and a 30-day comment period.

Subd. 1a. **Administrative reconsideration.** Notwithstanding sections 256B.04, subdivision 15, and 256D.03, subdivision 7, the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by physicians that are independent of the case under reconsideration. A majority decision by the physicians is necessary to make a determination that the services were not medically necessary.

Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the commissioner may recover inpatient hospital payments for services that have been determined to be medically unnecessary after the reconsideration and determinations. A physician or hospital may appeal the result of the reconsideration process by submitting a written request for review to the commissioner within 30 days after receiving notice of the action. The commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner shall issue an order upholding or reversing the decision of the reconsideration process based on the review. A hospital or physician who is aggrieved by an order of the commissioner may appeal the order to the district court of the county in which the physician or hospital is located by serving a written copy of the notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order.

[For text of subd 2, see M.S.1992]

History: *1Sp1993 c 1 art 5 s 17*

256.9686 DEFINITIONS.

[For text of subds 1 to 5, see M.S.1992]

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.

[For text of subds 7 to 9, see M.S.1992]

History: *1993 c 339 s 10*

256.969 PAYMENT RATES.

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be obtained from an independent source and shall represent a weighted average of historical, as limited to statutory maximums, and projected cost change estimates determined for expense categories to include wages and salaries, employee benefits, medical and professional fees, raw food, utilities, insurance including malpractice insurance, and other applicable expenses as determined by the commissioner. The index shall reflect Minnesota cost category weights. Individual indices shall be specific to Minnesota if the commissioner determines that sufficient accuracy of the hospital cost index is achieved. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis. Notwithstanding section 256.9695, subdivision 3, paragraph (c), the hospital cost index shall not be effective under the general assistance medical care program and shall be limited to five percent under the medical assistance program for admissions occurring during the biennium ending June 30, 1995.

(b) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance and general assistance medical care, based upon the hospital cost index.

[For text of subds 2 to 6a, see M.S.1992]

Subd. 8. **Unusual length of stay experience.** The commissioner shall establish day outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2, 2b, and 2c. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn diagnostic categories shall be established at one standard deviation beyond the mean length of stay, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of 60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission.

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the fed-

eral Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service.

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class; and

(3) for a hospital that (i) had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume; or (ii) had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and is affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,010,000 due on the 15th of each month after noon, beginning July 15, 1993.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).

(d) If federal matching funds are not available for all adjustments under paragraph

(b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Subd. 9a. **Disproportionate population adjustments until July 1, 1993.** For admissions occurring between January 1, 1993 and June 30, 1993, the adjustment under this subdivision shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of one standard deviation above the arithmetic mean. The adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, and the result must be multiplied by 1.1.

The provisions of this paragraph are effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 9b. **Implementation of ratable reductions.** Notwithstanding the provisions in subdivision 9, any ratable reductions required under that subdivision or subdivision 9a for fiscal year 1993 shall be implemented as follows:

(1) no ratable reductions shall be applied to admissions occurring between October 1, 1992, and December 31, 1992; and

(2) sufficient ratable reductions shall be taken from hospitals receiving a payment under subdivision 9a for admissions occurring between January 1, 1993, and June 30, 1993, to ensure that all state payments under subdivisions 9 and 9a during federal fiscal year 1993 qualify for federal match.

[For text of subds 10 to 19, see M.S.1992]

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivi-

sion 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

[For text of subd 21, see M.S.1992]

Subd. 22. **Hospital payment adjustment.** For admissions occurring from January 1, 1993 until June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1. Any payment under this clause must be reduced by the amount of any payment received under subdivision 9a. For purposes of this subdivision, medical assistance does not include general assistance medical care.

This subdivision is effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 23. **Hospital payment adjustment after June 30, 1993.** (a) For admissions occurring after June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1.

(b) Any payment under this subdivision must be reduced by the amount of any

payment received under subdivision 9, paragraph (b), clause (1) or (2). For purposes of this subdivision, medical assistance does not include general assistance medical care.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in this section. The adjustment must be made on a nondiscounted hospital-specific basis.

Subd. 24. **Hospital peer groups.** For admissions occurring on or after the later of July 1, 1994, or the implementation date of the upgrade to the Medicaid management information system, payment rates of each hospital shall be limited to the payment rates within its peer group so that the statewide payment level is reduced by ten percent under the medical assistance program and by 15 percent under the general assistance medical care program. For subsequent rate years, the limits shall be adjusted by the hospital cost index. The commissioner shall contract for the development of criteria for and the establishment of the peer groups. Peer groups must be established based on variables that affect medical assistance cost such as scope and intensity of services, acuity of patients, location, and capacity. Rates shall be standardized by the case mix index and adjusted, if applicable, for the variable outlier percentage. The peer groups may exclude and have separate limits or be standardized for operating cost differences that are not common to all hospitals in order to establish a minimum number of groups.

History: *1993 c 20 s 1-5; 1Sp1993 c 1 art 5 s 18-25; 1Sp1993 c 6 s 7,8*

256.9695 APPEALS OF RATES; PROHIBITED PRACTICES FOR HOSPITALS; TRANSITION RATES.

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values shall not be recalculated. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the office of administrative hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

(a) To appeal a payment rate or payment determination or a determination made from base year information, the hospital shall file a written appeal request to the commissioner within 60 days of the date the payment rate determination was mailed. The appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or rule upon which the hospital relies for each disputed item; and (iii) the name and address of the person to contact regarding the appeal. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information. In the case of Medicare settled appeals, the 60-day appeal period shall begin on the mailing date of the notice by the Medicare program or the date the medical assistance payment rate determination notice is mailed, whichever is later.

(b) To appeal a payment rate or payment change that results from a difference in case mix between the base year and a rate year, the procedures and requirements of paragraph (a) apply. However, the appeal must be filed with the commissioner within 120 days after the end of a rate year. A case mix appeal must apply to the cost of services to all medical assistance patients that received inpatient services from the hospital during the rate year appealed.

[For text of subd 2, see M.S.1992]

Subd. 3. **Transition.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

[For text of subds 4 and 5, see M.S.1992]

History: *1993 c 339 s 11; 1Sp1993 c 1 art 5 s 26*

NOTE: Subdivision 3 was also amended by Laws 1993, chapter 339, section 12, to read as follows:

"Subd. 3. **Transition.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be based on the change in rates from July 1, 1992, to the rebased rates in effect under the systems upgrade. The adjustment shall reflect payments under clause (1), differences in the hospital cost index and dissimilar rate establishment procedures such as the variable outlier and the treatment of transfers, births, and rehabilitation units of hospitals. The adjustment shall be in effect until the amount due or owed on a per admission basis from July 1, 1992, to the systems upgrade is fully paid."

256.9745 [Repealed, 1993 c 337 s 20]

256.978 LOCATION OF PARENTS, ACCESS TO RECORDS.

Subdivision 1. **Request for information.** The commissioner of human services, in order to locate a person to establish paternity, child support, or to enforce a child support obligation in arrears, may request information reasonably necessary to the inquiry from the records of all departments, boards, bureaus, or other agencies of this state, which shall, notwithstanding the provisions of section 268.12, subdivision 12, or any other law to the contrary, provide the information necessary for this purpose. Employers, utility companies, insurance companies, financial institutions, and labor associations doing business in this state shall provide information as provided under subdivision 2 upon written request by an agency responsible for child support enforcement regarding individuals owing or allegedly owing a duty to support. Information requested and used or transmitted by the commissioner pursuant to the authority conferred by this section may be made available only to public officials and agencies of this state and its political subdivisions and other states of the union and their political subdivisions who are seeking to enforce the support liability of parents or to locate parents. The commissioner may not release the information to an agency or political subdivision of another state unless the agency or political subdivision is directed to maintain the data consistent with its classification in this state. Information obtained under this section may not be released except to the extent necessary for the administration of the child support enforcement program or when otherwise authorized by law.

Subd. 2. **Access to information.** (a) A written request for information by the public authority responsible for child support may be made to:

(1) employers when there is reasonable cause to believe that the subject of the inquiry is or was an employee of the employer. Information to be released by employers is limited to place of residence, employment status, wage information, and social security number;

(2) utility companies when there is reasonable cause to believe that the subject of the inquiry is or was a retail customer of the utility company. Customer information to be released by utility companies is limited to place of residence, home telephone, work telephone, source of income, employer and place of employment, and social security number;

(3) insurance companies when there is an arrearage of child support and there is reasonable cause to believe that the subject of the inquiry is or was receiving funds either in the form of a lump sum or periodic payments. Information to be released by insurance companies is limited to place of residence, home telephone, work telephone, employer, and amounts and type of payments made to the subject of the inquiry;

(4) labor organizations when there is reasonable cause to believe that the subject of the inquiry is or was a member of the labor association. Information to be released by labor associations is limited to place of residence, home telephone, work telephone, and current and past employment information; and

(5) financial institutions when there is an arrearage of child support and there is reasonable cause to believe that the subject of the inquiry has or has had accounts,

stocks, loans, certificates of deposits, treasury bills, life insurance policies, or other forms of financial dealings with the institution. Information to be released by the financial institution is limited to place of residence, home telephone, work telephone, identifying information on the type of financial relationships, current value of financial relationships, and current indebtedness of the subject with the financial institution.

(b) For purposes of this subdivision, utility companies include companies that provide electrical, telephone, natural gas, propane gas, oil, coal, or cable television services to retail customers. The term financial institution includes banks, savings and loans, credit unions, brokerage firms, mortgage companies, and insurance companies.

Subd. 3. **Immunity.** A person who releases information to the public authority as authorized under this section is immune from liability for release of the information.

History: *1993 c 340 s 7*

256.979 CHILD SUPPORT INCENTIVES.

Subdivision 1. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 2. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 3. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

Subd. 4. [Repealed, 1993 c 340 s 60; 1Sp1993 c 6 s 35]

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

(b) A bonus must be awarded to a county child support agency for each child for which the agency completes a paternity establishment through judicial, administrative, or expedited processes and for each instance in which the agency reviews a case for a modification of the child support order.

(c) The rate of bonus incentive is $100 for each paternity establishment and $50 for each review for modification of a child support order.

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

(b) Only one county agency may receive a bonus per paternity establishment or child support order modification. The county agency making the initial preparations for the case resulting in the establishment of paternity or modification of an order is the county agency entitled to claim the bonus incentive, even if the case is transferred to another county agency prior to the time the order is established or modified.

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

(d) For purposes of this section, "case" means a family unit for whom the county agency is providing child support enforcement services.

Subd. 7. **Distribution.** (a) Bonus incentives must be issued to the county agency quarterly, within 45 days after the last day of each quarter for which a bonus incentive is being claimed, and must be paid in the order in which claims are received.

(b) Bonus incentive funds under this section must be reinvested in the county child support enforcement program and a county may not reduce funding of the child support enforcement program by the amount of the bonus earned.

(c) The county agency shall repay any bonus erroneously issued.

(d) A county agency shall maintain a record of bonus incentives claimed and received for each quarter.

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

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

(c) The office of vital statistics shall make the bonus payment of $25 to each medical provider and notify the department of human services quarterly of the numbers of completed forms received and the amounts paid.

(d) The department of human services shall remit quarterly to the office of vital statistics the sums paid to each medical provider for the number of signed recognition of parentage forms completed by that medical provider and sent to the office of vital statistics.

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

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

History: *1993 c 340 s 8-11*

256.9791 MEDICAL SUPPORT BONUS INCENTIVES.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Eligibility; reporting requirements.** (a) In order for a county to be eligible to claim a bonus incentive payment, the county agency must provide the required information for each public assistance case no later than June 30 of each year to determine eligibility. The public authority shall use the information to establish for each county the number of cases in which (1) the court has established an obligation for coverage by the obligor, and (2) coverage was in effect as of June 30.

(b) A county that fails to provide the required information by June 30 of each fiscal year is not eligible for any bonus payments under this section for that fiscal year.

Subd. 4. **Rate of bonus incentive.** The rate of the bonus incentive shall be determined according to paragraph (a).

(a) When a county agency has identified or enforced coverage, the county shall receive $50 for each additional person for whom coverage is identified or enforced.

(b) Bonus payments according to paragraph (a) are limited to one bonus for each covered person each time the county agency identifies or enforces previously unidentified health insurance coverage and apply only to coverage identified or enforced after July 1, 1990.

[For text of subds 5 and 6, see M.S.1992]

History: *1993 c 340 s 12,13*

256.9792 ARREARAGE COLLECTION PROJECTS.

Subdivision 1. **Arrearage collections.** Arrearage collection projects are created to increase the revenue to the state and counties, reduce AFDC expenditures for former public assistance cases, and increase payments of arrearages to persons who are not receiving public assistance by submitting cases for arrearage collection to collection entities, including but not limited to, the department of revenue and private collection agencies.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section:

(b) "Public assistance arrearage case" means a case where current support may be due, no payment, with the exception of tax offset, has been made within the last 90 days, and the arrearages are assigned to the public agency pursuant to section 256.74, subdivision 5.

(c) "Public authority" means the public authority responsible for child support enforcement.

(d) "Nonpublic assistance arrearage case" means a support case where arrearages have accrued that have not been assigned pursuant to section 256.74, subdivision 5.

Subd. 3. **Agency participation.** (a) The collection remedy under this section is in addition to and not in substitution for any other remedy available by law to the public

authority. The public authority remains responsible for the case even after collection efforts are referred to the department of revenue, a private agency, or other collection entity.

(b) The department of revenue, a private agency, or other collection entity may not claim collections made on a case submitted by the public authority for a state tax offset under chapter 270A as a collection for the purposes of this project.

Subd. 4. **Eligible cases.** (a) For a case to be eligible for a collection project, the criteria in paragraphs (b) and (c) must be met. Any case from a county participating in the collections project meeting the criteria under this subdivision must be subcommitted for collection.

(b) Notice must be sent to the debtor, as defined in section 270A.03, subdivision 4, at the debtor's last known address at least 30 days before the date the collections effort is transferred. The notice must inform the debtor that the department of revenue or a private collections agency will use enforcement and collections remedies and may charge a fee of up to 30 percent of the arrearages. The notice must advise the debtor of the right to contest the debt on grounds limited to mistakes of fact. The debtor may contest the debt by submitting a written request for review to the public authority within 21 days of the date of the notice.

(c) The arrearages owed must be based on a court or administrative order. The arrearages to be collected must be at least $100 and must be at least 90 days past due. For nonpublic assistance cases referred to private agencies, the arrearages must be a docketed judgment under sections 548.09 and 548.091.

Subd. 5. **County participation.** (a) The commissioner of human services shall designate the counties to participate in the projects, after requesting counties to volunteer for the projects.

(b) The commissioner of human services shall designate which counties shall submit cases to the department of revenue, a private collection agency, or other collection entity.

Subd. 6. **Fees.** A collection fee set by the commissioner of human services shall be charged to the person obligated to pay the arrearages. The collection fee is in addition to the amount owed, and must be deposited by the commissioner of revenue in the state treasury and credited to the general fund to cover the costs of administering the program or retained by the private agency or other collection entity to cover the costs of administering the collection services.

Subd. 7. **Contracts.** (a) The commissioner of human services may contract with the commissioner of revenue, private agencies, or other collection entities to implement the projects, charge fees, and exchange necessary information.

(b) The commissioner of human services may provide an advance payment to the commissioner of revenue for collection services to be repaid to the department of human services out of subsequent collection fees.

(c) Summary reports of collections, fees, and other costs charged shall be submitted monthly to the state office of child support enforcement.

Subd. 8. **Remedies.** (a) The commissioner of revenue is authorized to use the tax collection remedies in sections 270.06, clause (7), 270.69 to 270.72, and 290.92, subdivision 23, and tax return information to collect arrearages.

(b) Liens arising under paragraph (a) shall be perfected under the provisions of section 270.69. The lien may be filed as long as the time period allowed by law for collecting the arrearages has not expired. The lien shall attach to all property of the debtor within the state, both real and personal under the provisions of section 270.69. The lien shall be enforced under the provisions in section 270.69 relating to state tax liens.

History: *1993 c 340 s 14*

256.983 FRAUD PREVENTION INVESTIGATIONS.

[For text of subds 1 and 2, see M.S.1992]

Subd. 3. **Department responsibilities.** The commissioner shall establish training programs which shall be attended by all investigative and supervisory staff of the involved county agencies. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms, which shall be used by the involved county agencies. An individual's application or redetermination form shall 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 would be effective until six months after public assistance benefits have ceased.

[For text of subd 4, see M.S.1992]

History: *1Sp1993 c 1 art 6 s 24*

256.985 [Repealed, 1Sp1993 c 1 art 6 s 56]