CHAPTER 256

HUMAN SERVICES

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

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

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

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

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

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

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

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

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

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

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

(3) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the state board of control.

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

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

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

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

(8) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as mentally retarded.

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

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

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

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

(a) The proposed comprehensive plan, including estimated project costs and the proposed order establishing the waiver, shall be filed with the secretary of the senate and chief clerk of the house of representatives at least 60 days prior to its effective date.

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

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

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

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

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

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

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

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

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

(a) The commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced.

(b) The county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar

days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner.

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

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

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

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

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

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

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

Subd. 4. **Duties as state agency.** The state agency shall:

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

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

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

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

(5) cooperate with the federal government and its public welfare agencies in any reasonable manner as may be necessary to qualify for federal aid for aid to dependent children and in conformity with the provisions of Laws 1937, chapter 438, including the making of such reports and such forms and containing such information as the Federal Social Security Board may from time to time require, and comply with such provisions as such board may from time to time find necessary to assure the correctness and verification of such reports;

(6) may cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving aid to dependent children moves or contemplates moving into or out of the state, in order that such child may continue to receive supervised aid from the state moved from until the child shall have resided for one year in the state moved to;

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

(8) enter into agreements with other departments of the state as necessary to meet all requirements of the federal government.

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

Subd. 6. **Advisory task forces.** The commissioner may appoint advisory task forces to provide consultation on any of the programs under the commissioner's administration and supervision. A task force shall expire and the compensation, terms of office and removal of members shall be as provided in section 15.059.

Subd. 7. **Special consultant on aging.** The commissioner of human services may appoint a special consultant on aging in the classified service. Within the limits of appropriations available therefor, the commissioner may appoint such other employees in the classified service as the commissioner deems necessary to carry out the purposes of Laws 1961, Chapter 466. Such special consultant and staff shall encourage cooperation among agencies, both public and private, including the departments of the state government, in providing services for the aging. They shall provide consultation to local social services agencies in developing local services for the aging, shall promote volunteer services programs and stimulate public interest in the problem of the aging.

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

Subd. 9. **Staff assistance to the Minnesota board on aging.** The board shall be provided staff assistance from the department of human services through the special consultant on aging, who shall serve as the executive secretary to the board and its committees.

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

Subd. 11. **Centralized disbursement system.** The state agency may establish a system for the centralized disbursement of food coupons, assistance payments, and related documents. Benefits shall be issued by the state or county and funded under this section according to section 256.025, subdivision 3, and subject to section 256.017.

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

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

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

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

(d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state child mortality review panel in the exercise of its duties is protected nonpublic or confidential data as defined in section 13.02, but may be disclosed as necessary to carry out the purposes of the review panel. The data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on

decedents, under section 13.10, or private, confidential, or protected nonpublic data in the disseminating agency.

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

History: *(3199-102, 8688-4) 1937 c 438 s 2; 1939 c 431 art 7 s 2(a)(c); 1943 c 7 s 1; 1943 c 177 s 1; 1943 c 570 s 1; 1943 c 612 s 1,2; 1949 c 40 s 1; 1949 c 512 s 5,6; 1949 c 618 s 1; 1949 c 704 s 1; 1951 c 330 s 1; 1951 c 403 s 1; 1951 c 713 s 27; 1953 c 30 s 1; 1953 c 593 s 2; 1955 c 534 s 1; 1955 c 627 s 1; 1955 c 847 s 21; 1957 c 287 s 3; 1957 c 641 s 1; 1957 c 762 s 1,2; 1957 c 791 s 1; 1959 c 43 s 1; 1959 c 609 s 1; 1961 c 466 s 3-6; 1963 c 794 s 1; 1967 c 122 s 1; 1967 c 148 s 2; 1969 c 365 s 1; 1969 c 493 s 2; 1969 c 703 s 1; 1969 c 1157 s 1; 1971 c 24 s 26; 1973 c 540 s 4; 1973 c 717 s 12; 1974 c 536 s 2; 1975 c 271 s 6; 1975 c 437 art 2 s 1; 1976 c 2 s 89; 1976 c 107 s 1; 1976 c 149 s 52; 1976 c 163 s 55; 1977 c 400 s 1; 1980 c 357 s 21; 1980 c 618 s 8; 1983 c 7 s 3; 1983 c 10 s 1; 1983 c 243 s 5 subd 3; 1983 c 312 art 5 s 3; 1984 c 654 art 5 s 21,58; 1985 c 21 s 48,49; 1985 c 248 s 70; 1Sp1985 c 14 art 9 s 15; 1986 c 444; 1987 c 270 s 1; 1987 c 343 s 1; 1987 c 403 art 2 s 60; art 3 s 2; 1988 c 689 art 2 s 121; 1988 c 719 art 8 s 1; 1989 c 89 s 5; 1989 c 209 art 1 s 22; 1989 c 282 art 2 s 111,112; 1990 c 568 art 4 s 84; 1991 c 292 art 3 s 6; art 5 s 6,7; 1994 c 631 s 31*

256.011 ADMINISTRATION OF FEDERAL GRANTS-IN-AID.

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

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

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

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

256.012 MINNESOTA MERIT SYSTEM.

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

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

History: *1980 c 614 s 129; 1984 c 654 art 5 s 58; 1986 c 444; 1994 c 631 s 31*

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

256.014 STATE AND COUNTY SYSTEMS.

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

(1) management and administration of the food stamp and income maintenance programs;

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

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

The commissioner shall distribute the nonfederal share of the costs of operating and maintaining the systems to the commissioner and to the counties participating in the system in a manner that reflects actual system usage, except that the nonfederal share of the costs of the MAXIS computer system and child support enforcement systems shall be borne entirely by the commissioner. Development costs must not be assessed against county agencies.

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

Subd. 3. **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: *1Sp1986 c 1 art 8 s 4; 1989 c 282 art 5 s 5; 1990 c 568 art 4 s 84; 1993 c 4 s 24*

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

Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the agency has a lien for the cost of the care and payments on all causes of action that accrue to the person to whom the care or payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments.

Subd. 2. **Perfection; enforcement.** The state agency may perfect and enforce its lien under sections 514.69, 514.70, and 514.71, and must file the verified lien statement

with the appropriate court administrator in the county of financial responsibility. The verified lien statement must contain the following: the name and address of the person to whom medical care, subsistence, or other payment was furnished; the date of injury; the name and address of vendors furnishing medical care; the dates of the service or payment; the amount claimed to be due for the care or payment; and to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries.

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

Subd. 3. **Prosecutor.** The attorney general, or the appropriate county attorney acting at the direction of the attorney general, shall represent the state agency to enforce the lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on behalf of the state agency against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

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

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

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

(c) A 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).

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

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

Subd. 7. **Cooperation required.** Upon the request of the department of human services, any state agency or third party payer shall cooperate with the department in furnishing information to help establish a third party liability. The department of human services shall limit its use of information gained from agencies and third party payers to purposes directly connected with the administration of its public assistance programs. The provision of information by agencies and third party payers to the depart-

ment under this subdivision is not a violation of any right of confidentiality or data privacy.

History: *1987 c 370 art 2 s 3; 1988 c 689 art 2 s 122; 1990 c 568 art 4 s 84; 1Sp1993 c 1 art 5 s 9*

256.016 PLAIN LANGUAGE IN WRITTEN MATERIALS.

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

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

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

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

(e) The commissioner shall report annually to the chairs of the health and human services divisions of the senate finance committee and the house of representatives appropriations committee on the number and outcome of cases that raise the issue of the commissioner's compliance with this section.

History: *1988 c 689 art 2 s 123*

256.017 COMPLIANCE SYSTEM.

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

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

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

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

(b) "Quality control case penalty" means an adjustment against the county agency's federal administrative reimbursement and state and federal benefit reimbursement when the commissioner determines through a quality control review that the county agency has made incorrect payments, terminations, or denials of benefits as determined by state quality control procedures for the aid to families with dependent children, food stamp, or medical assistance programs, or any other programs for which the commissioner has developed a quality control system. Quality control case penalties apply only to agency errors as defined by state quality control procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 9. **Timing and disposition of penalty and case disallowance funds.** Quality control case penalty and administrative penalty amounts shall be disallowed or withheld from the next regular reimbursement made to the county agency for state and federal benefit reimbursements and federal administrative reimbursements for all programs covered in this section, according to procedures established in statute, but shall not be imposed sooner than 30 calendar days from the date of written notice of such penalties. All penalties must be deposited in the county incentive fund provided in section 256.018. All penalties must be imposed according to this provision until a decision is made regarding the status of a written exception. Penalties must be returned to county agencies when a review of a written exception results in a decision in their favor.

Subd. 10. **County obligation to make benefit payments.** Counties subject to fiscal

penalties shall not reduce or withhold benefits from eligible recipients of programs listed in subdivision 1 in order to cover the cost of penalties under this section. County funds shall be used to cover the cost of any penalties.

History: *1988 c 719 art 8 s 2; 1990 c 568 art 4 s 84*

256.018 COUNTY PUBLIC ASSISTANCE INCENTIVE FUND.

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

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

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

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

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

256.019 RECOVERY OF MONEY; APPORTIONMENT.

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: *1988 c 719 art 8 s 29; 1993 c 306 s 2*

256.02 INVESTIGATIONS; EXAMINATIONS; SUPERVISION.

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

Subd. 2. [Temporary]

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

256.023 ONE HUNDRED PERCENT COUNTY ASSISTANCE.

The commissioner of human services may maintain client records and issue public assistance benefits that are over state and federal standards or that are not required by state or federal law, providing the cost of benefits is paid by the counties to the department of human services. Payment methods for this section shall be according to section 256.025, subdivision 3.

History: *1991 c 292 art 5 s 8*

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.

Subd. 5. **Comparison of expenditures.** By October 1 of each year beginning with 1991, the department shall determine actual county share of county agency expenditures reported under subdivision 4 for the previous state fiscal year and compare these actual county share expenditures to actual state payments made under the schedule in subdivision 4 for the same period. Adjustment of any difference shall be paid upon the direction of the state agency.

History: *1Sp1989 c 1 art 16 s 1; 1990 c 568 art 4 s 84; 1990 c 604 art 4 s 1; 1991 c 292 art 5 s 9-11; art 7 s 4; 1992 c 511 art 1 s 5,6; 1993 c 306 s 3; 1Sp1993 c 1 art 2 s 1,2; art 8 s 1,2*

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*

256.03 [Repealed, 1961 c 561 s 17]

MINNESOTA FAMILY INVESTMENT PLAN

256.031 MINNESOTA FAMILY INVESTMENT PLAN.

Subdivision 1. **Citation.** Sections 256.031 to 256.0361 may be cited as the Minnesota family investment plan.

Subd. 2. **Legislative findings.** The legislature recognizes the need to fundamentally change the way government supports families. The legislature finds that many features of the current system of public assistance do not help families carry out their two basic functions: the economic support of the family unit and the care and nurturing of children. The legislature recognizes that the Minnesota family investment plan is an investment strategy that will support and strengthen the family's social and financial functions. This investment in families will provide long-term benefits through stronger and more independent families.

Subd. 3. **Authorization for the demonstration.** (a) The commissioner of human services, in consultation with the commissioners of education, finance, economic security, 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 section 256.035, subdivision 6a. Families are eligible for services under section 256.736 to the same extent as families receiving AFDC.

Subd. 4. **Goals of the Minnesota family investment plan.** The commissioner shall design the program to meet the following goals:

(1) to support families' transition to financial independence by emphasizing options, removing barriers to work and education, providing necessary support services, and building a supportive network of education, employment and training, health, social, counseling, and family-based services;

(2) to allow resources to be more effectively and efficiently focused on investing in families by removing the complexity of current rules and procedures and consolidating public assistance programs;

(3) to prevent long-term dependence on public assistance through paternity establishment, child support enforcement, emphasis on education and training, and early intervention with minor parents; and

(4) to provide families with an opportunity to increase their living standard by rewarding efforts aimed at transition to employment and by allowing families to keep a greater portion of earnings when they become employed.

Subd. 5. **Federal waivers.** In accordance with sections 256.031 to 256.0361 and federal laws authorizing the program, the commissioner shall seek waivers of federal requirements of: United States Code, title 42, section 601 et seq., and United States Code, title 7, section 2011 et seq., needed to implement the Minnesota family investment plan in a manner consistent with the goals and objectives of the program. The commissioner shall seek terms from the federal government that are consistent with the goals of the Minnesota family investment plan. The commissioner shall also seek terms from the federal government that will maximize federal financial participation so that the extra costs to the state of implementing the program are minimized, to the extent that those terms are consistent with the goals of the Minnesota family investment plan. An agreement with the federal government under this section shall provide that the agreements may be canceled by the state or federal government upon 180 days' notice or immediately upon mutual agreement. If the agreement is canceled, families which cease receiving assistance under the Minnesota family investment plan who are eligible for the aid to families with dependent children, general assistance, medical assistance, general assistance medical care, or the food stamp program must be placed with their consent on the programs for which they are eligible.

History: *1989 c 282 art 5 s 6; 1991 c 292 art 5 s 12; 1992 c 513 art 8 s 2; 1993 c 4 s 25*

256.032 DEFINITIONS.

Subdivision 1. **Scope of definitions.** The terms used in sections 256.031 to 256.0361 have the meanings given them unless otherwise provided or indicated by the context.

Subd. 1a. **Assistance unit.** (a) "Assistance unit" means the following individuals when they are living together: a minor child; the minor child's blood-related siblings; and the minor child's natural and adoptive parents. The income and assets of members

of the assistance unit must be considered in determining eligibility for the family investment plan.

(b) A nonparental caregiver, as defined in subdivision 2, may elect to be included in the assistance unit. A nonparental caregiver who does not elect to be included under this paragraph must apply for assistance with the minor child.

(c) A stepparent of the minor child may elect to be included in the assistance unit. If the stepparent does not choose to be included, the county agency shall not count the stepparent's resources or income, if the stepparent's income is less than 275 percent of the federal poverty guidelines for a family of one. If the stepparent's income is more than 275 percent of the federal poverty guidelines for a family of one and the stepparent does not choose to be included, the county agency shall not count the stepparent's resources, but shall count the stepparent's income in accordance with section 256.033, subdivision 2, clause (5).

(d) A stepsibling of the minor child may elect to be included in the assistance unit.

(e) A parent of a minor caregiver may elect to be included in the minor caregiver's assistance unit. If the parent of the minor caregiver does not choose to be included, the county agency shall not count the resources of the parent of the minor caregiver, but shall count the income of the parent of the minor caregiver, in accordance with section 256.033, subdivision 2, clause (5).

Subd. 2. **Caregiver.** "Caregiver" means a minor child's natural or adoptive parent or parents who live in the home with the minor child. For purposes of determining eligibility for this program, "caregiver" also means any of the following individuals, if adults, who live with and provide care and support to a minor child when the minor child's natural or adoptive parent or parents do not reside in the same home: grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, persons of preceding generations as denoted by prefixes of "great" or "great-great," or a spouse of any person named in the above groups even after the marriage ends by death or divorce.

Subd. 3. **Case management.** "Case management" means the assessment of family needs, the development of the employability plan and family support agreement, and the coordination of services necessary to support the family in its social and economic roles, according to section 256.035, subdivision 6a.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of human services or a designee.

Subd. 5. [Repealed, 1991 c 292 art 5 s 82]

Subd. 5a. **County agency.** "County agency" means the agency designated by the county board to implement financial assistance for current programs and for the Minnesota family investment plan and the agency responsible for enforcement of child support collection.

Subd. 5b. **County board.** "County board" means the county board of commissioners; a local social services agency as defined in chapter 393; a board established under the joint powers act, section 471.59; or a human services board under chapter 402.

Subd. 6. **Department.** "Department" means the department of human services.

Subd. 6a. **Employability plan.** "Employability plan" means the plan developed by the case manager and the caregiver according to section 256.035, subdivision 6b, which meets the requirements for an employability development plan under section 256.736, subdivision 10, paragraph (a), clause (15).

Subd. 7. **Family.** "Family" includes the following individuals who live together: a minor child or a group of minor children related to each other as siblings, half siblings, stepsiblings, or adopted siblings, together with their natural or adoptive parents, or their caregiver as defined in subdivision 2. "Family" also includes a pregnant woman in the third trimester of pregnancy with no children.

Subd. 7a. **Family support agreement.** "Family support agreement" means the agreement developed by the case manager and the caregiver under section 256.035, subdivision 6c.

Subd. 8. **Family wage level.** "Family wage level" means 120 percent of the transitional standard, as defined in subdivision 13.

Subd. 8a. **Minor child.** "Minor child" means a child who is living in the same home of a parent or other caregiver, who is in financial need, and who is either less than 18 years of age or is under the age of 19 years and is regularly attending as a full-time student and is expected to complete a high school or a secondary level course of vocational or technical training designed to fit students for gainful employment before reaching age 19.

Subd. 9. [Repealed, 1991 c 292 art 5 s 82]

Subd. 10. **Program.** "Program" means the Minnesota family investment plan.

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.

Subd. 11a. **Suitable employment.** "Suitable employment" has the meaning given in section 256.736, subdivision 1a, paragraph (h).

Subd. 12. **Transitional status.** "Transitional status" means the status of caregivers who are independently pursuing self-sufficiency or caregivers who are complying with the terms of a family support agreement with a county.

Subd. 13. **Transitional standard.** "Transitional standard" means the sum of the AFDC standard of assistance and the full cash value of food stamps for a family of the same size and composition in effect for the remainder of the state during implementation of the Minnesota family investment plan field trials. This standard applies only to families in which the parental caregiver is in transitional status and to families in which the caregiver is exempt from developing or has good cause for not complying with the terms of the family support agreement. Full cash value of food stamps is the amount of the cash value of food stamps to which a family of a given size would be entitled for a month, determined by assuming unearned income equal to the AFDC standard for a family of that size and composition and subtracting the standard deduction and maximum shelter deduction from gross family income, as allowed under the Food Stamp Act of 1977, as amended, and Public Law Number 100-435. The assistance standard for a family consisting of a pregnant woman in the third trimester of pregnancy with no children must equal the assistance standard for one adult and one child.

History: *1989 c 282 art 5 s 7; 1991 c 292 art 5 s 13; 1Sp1993 c 1 art 6 s 3; 1994 c 631 s 31*

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.

Subd. 1a. **Treatment of income for the purposes of continued eligibility.** To help families during their transition from the Minnesota family investment plan to self-sufficiency, the following income supports are available:

(a) The $30 and one-third and $90 disregards allowed under section 256.74, subdivision 1, and the 20 percent earned income deduction allowed under the federal Food Stamp Act of 1977, as amended, are replaced with a single disregard of not less than 35 percent of gross earned income to cover taxes and other work-related expenses and to reward the earning of income. This single disregard is available for the entire time a family receives assistance through the Minnesota family investment plan.

(b) The dependent care deduction, as prescribed under section 256.74, subdivision 1, and United States Code, title 7, section 2014(e), is replaced for families with earned income who need assistance with dependent care with an entitlement to a dependent care subsidy from money appropriated for the Minnesota family investment plan.

(c) The family wage level, as defined in section 256.032, subdivision 8, allows families to supplement earned income with assistance received through the Minnesota family investment plan. If, after earnings are adjusted according to the disregard described in paragraph (a), earnings have raised family income to a level equal to or greater than the family wage level, the amount of assistance received through the Minnesota family investment plan must be reduced.

(d) The first $50 of any timely support payment for a month received by the public agency responsible for child support enforcement shall be paid to the family and disregarded in determining eligibility and the amount of assistance in accordance with United States Code, title 42, sections 602(a)(8)(A)(vi) and 657(b)(1). This paragraph applies regardless of whether the caregiver is in transitional status, is exempt from developing or complying with the terms of a family support agreement, or has had a sanction imposed under subdivision 3.

Subd. 2. **Determination of family income.** The aid to families with dependent children income exclusions listed in Code of Federal Regulations, title 45, sections 233.20(a)(3) and 233.20(a)(4), must be used when determining a family's available income, except that:

(1) all earned income of a minor child receiving assistance through the Minnesota family investment plan is excluded when the child is attending school at least half-time;

(2) all earned income tax credit payments received by the family as a refund of federal income taxes or made as advance payments are excluded in accordance with United States Code, title 42, section 602(a)(8)(A)(viii);

(3) educational grants and loans as provided in section 256.74, subdivision 1, clause (2), are excluded;

(4) all other income listed in Minnesota Rules, part 9500.2380, subpart 2, is excluded; and

(5) when determining income available from members of the family who do not elect to be included in the assistance unit under section 256.032, subdivision 1a, paragraphs (c) and (e), the county agency shall count the remaining income after disregarding:

(i) the first 18 percent of the excluded family member's gross earned income;

(ii) an amount for the support of any stepparent or any parent of a minor caregiver

and any other individuals whom the stepparent or parent of the minor caregiver claims as dependents for determining federal personal income tax liability and who live in the same household but whose needs are not considered in determining eligibility for assistance under sections 256.031 to 256.033. The amount equals the transitional standard in section 256.032, subdivision 13, for a family of the same size and composition;

(iii) amounts the stepparent or parent of the minor caregiver actually paid to individuals not living in the same household but whom the stepparent claims as dependents for determining federal personal income tax liability; and

(iv) alimony or child support, or both, paid by the stepparent or parent of the minor caregiver for individuals not living in the same household.

Subd. 3. **Determination of family resources.** When determining a family's resources, the following are excluded:

(1) the family's home, together with surrounding property not separated from the home by intervening property owned by others;

(2) one burial plot for each family member;

(3) one prepaid burial contract with an equity value of no more than $1,500 for each member of the family;

(4) licensed automobiles, trucks, or vans up to a total equity value of $4,500;

(5) personal property needed to produce earned income, including tools, implements, farm animals, and inventory;

(6) the entire equity value of a motor vehicle determined to be necessary for the operation of a self-employment business; and

(7) clothing, necessary household furniture, equipment, and other basic maintenance items essential for daily living.

Subd. 4. **Treatment of SSI and MSA.** The monthly benefits and any other income received through the supplemental security income or Minnesota supplemental aid program and any real or personal property of an assistance unit member who receives supplemental security income or Minnesota supplemental aid must be excluded in determining the family's eligibility for the Minnesota family investment plan and the amount of assistance. In determining the amount of assistance to be paid to the family, the needs of the person receiving supplemental security income or Minnesota supplemental aid must not be taken into account.

Subd. 5. **Ability to apply for food stamps.** A family that is ineligible for assistance through the Minnesota family investment plan due to income or resources or has not been assigned to a test group in the evaluation as provided in section 256.031, subdivision 3, paragraph (d), may apply for, and if eligible receive, benefits under the food stamp program.

History: *1989 c 282 art 5 s 8; 1991 c 292 art 5 s 14,83; 1992 c 513 art 8 s 3-6; 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 assistance 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 fam-

ily 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.

Subd. 2. **Coupon option.** Families have the option to receive a standardized amount of assistance as described in Public Law Number 101-202, section 22(a)(3)(D), designated by the commissioner, in the form of food coupons or vendor payments.

Subd. 3. **Modification of eligibility tests.** (a) A needy family is eligible and entitled to receive assistance under the program if the family is assigned to a test group in the evaluation as provided in section 256.031, subdivision 3, paragraph (d), even if its children are not found to be deprived of parental support or care by reason of death, continued absence from the home, physical or mental incapacity of a parent, or unemployment of a parent, provided the family's income and resources do not exceed the eligibility requirements in section 256.033. In addition, a caregiver who is in the assistance unit who is physically and mentally fit, who is between the ages of 18 and 60 years, who is enrolled at least half time in an institution of higher education, and whose family income and resources do not exceed the eligibility requirements in section 256.033, is eligible for 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), even if the conditions for eligibility as prescribed under the federal Food Stamp Act of 1977, as amended, are not met.

(b) An applicant for, or a person receiving, assistance under the Minnesota family investment plan is considered to have assigned to the public agency responsible for child support enforcement at the time of application all rights to child support, health care benefits coverage, and maintenance from any other person the applicant may have in the applicant's own behalf or on behalf of any other family member for whom application is made under the Minnesota family investment plan. The provisions of section 256.74, subdivision 5, govern the assignment. An applicant for, or a person receiving, assistance under the Minnesota family investment plan shall cooperate with the efforts of the county agency to collect child and spousal support. The county agency is entitled to any child support and maintenance received by or on behalf of the person receiving assistance or another member of the family for which the person receiving assistance is responsible. Failure by an applicant or a person receiving assistance to cooperate with the efforts of the county agency to collect child and spousal support without good cause must be sanctioned according to section 256.035, subdivision 3.

(c) An applicant for, or a person receiving, assistance under the Minnesota family investment plan is not required to comply with the employment and training requirements prescribed under sections 256.736, subdivisions 3, 3a, and 14; and 256D.05, subdivision 1; section 402(a)(19) of the Social Security Act; the federal Food Stamp Act of 1977, as amended; Public Law Number 100-485; or any other state or federal employment and training program, unless and to the extent compliance is specifically required in a family support agreement with the county agency or its designee.

Subd. 4. **Simplification of budgeting procedures.** The monthly amount of assistance provided by the Minnesota family investment plan must be calculated by taking into account actual income or circumstances that existed in a previous month and other relevant information to predict income and circumstances for the next month or months. When a family has a significant change in circumstances, the budgeting cycle must be interrupted and the amount of assistance for the payment month must be based on the county agency's best estimate of the family's income and circumstances for that month. Families may be required to report their income monthly, but income may be averaged over a period of more than one month.

Subd. 5. **Simplification of verification procedures.** Verification procedures must be reduced to the minimum that is workable and consistent with the goals and requirements of the Minnesota family investment plan as determined by the commissioner.

History: *1989 c 282 art 5 s 9; 1991 c 292 art 5 s 15; 1992 c 513 art 8 s 7; 1993 c 306 s 5*

256.035 INCOME SUPPORT AND TRANSITION.

Subdivision 1. **Expectations.** All families eligible for assistance under the family investment plan who are assigned to a test group in the evaluation as provided in section 256.031, subdivision 3, paragraph (d), are expected to be in transitional status as defined in section 256.032, subdivision 12. To be considered in transitional status, families must meet the following expectations:

(a) For a family headed by a single adult parental caregiver, the expectation is that the parental caregiver will independently pursue self-sufficiency until the family has received assistance for 24 months within the preceding 36 months. Beginning with the 25th month of assistance, the parent must be developing or complying with the terms of the family support agreement.

(b) For a family with a minor parental caregiver or a family whose parental caregiver is 18 or 19 years of age and does not have a high school diploma or its equivalent, the expectation is that, concurrent with the receipt of assistance, the parental caregiver must be developing or complying with a family support agreement. The terms of the family support agreement must include compliance with section 256.736, subdivision 3b. However, if the assistance unit does not comply with section 256.736, subdivision 3b, the sanctions in subdivision 3 apply.

(c) For a family with two adult parental caregivers, the expectation is that at least one parent will independently pursue self-sufficiency until the family has received assistance for six months within the preceding 12 months. Beginning with the seventh month of assistance, one parent must be developing or complying with the terms of the family support agreement.

Subd. 2. **Exemptions.** (a) A caregiver is exempt from the requirement of developing and complying with the terms of the family support agreement, or engaging in transitional activities, if:

(1) the caregiver is not the natural or adoptive parent of a minor child; or

(2) the caregiver is exempt under United States Code, title 7, section 2031(c)(1)(A)(B)(C)(D)(E) or (F).

(b) A parental caregiver exempt under paragraph (a), clause (2), may meet with a case manager and develop an employability plan if the parental caregiver fits one of the categories of expectations in subdivision 1, and may receive support services including child care if needed to participate in activities identified in the employability plan.

Subd. 2a. **Good cause.** The county agency shall not impose the sanction in subdivision 3 if it determines that the parental caregiver has good cause for not meeting the expectations of developing and complying with the terms of a family support agreement developed with the county agency. Good cause exists when:

(1) needed child care is not available;

(2) the job does not meet the definition of suitable employment in section 256.032, subdivision 11a;

(3) the parental caregiver is ill or injured;

(4) a family member is ill and needs care by the parental caregiver that prevents the parental caregiver from complying with the family support agreement;

(5) the parental caregiver is unable to secure the necessary transportation;

(6) the parental caregiver is in an emergency situation which prevents compliance with the family support agreement;

(7) the schedule of compliance with the family support agreement conflicts with judicial proceedings;

(8) the parental caregiver is already participating in acceptable activities;

(9) the family support agreement requires an educational program for a parent under age 20, but the educational program is not offered in the school district;

(10) activities identified in the family support agreement are not available;

(11) the parental caregiver is willing to accept suitable employment as defined in section 256.032, subdivision 11a, but employment is not available; or

(12) the parental caregiver documents other verifiable impediments to compliance with the family support agreement beyond the parental caregiver's control.

Subd. 3. **Sanctions.** A family whose parental caregiver is not exempt from the expectations in subdivision 1 and who is not complying with those expectations by developing or complying with the family support agreement must have assistance reduced by a value equal to ten percent of the transitional standard as defined in section 256.032, subdivision 13. This reduction is effective with the month following the finding of noncompliance and continues until the beginning of the month after failure to comply ceases. The county must provide written notice to the parental caregiver of its intent to implement this sanction and the opportunity to have a conciliation conference, upon request, before the sanction is implemented. Implementation of the sanction shall be postponed pending resolution of the conciliation conference under section 256.036, subdivision 5, or hearing under section 256.045.

Subd. 4. [Renumbered 256.033 subd 1a]

Subd. 5. **Orientation.** The county agency must provide orientation which supplies information to caregivers about the Minnesota family investment plan, and must encourage parental caregivers to engage in activities to stabilize the family and lead to employment and self-support.

Subd. 6. [Repealed, 1991 c 292 art 5 s 82]

Subd. 6a. **Case management services.** (a) The county agency will provide case management services to caregivers required to develop and comply with a family support agreement as provided in subdivision 1. For minor parents, the responsibility of the case manager shall be as defined in section 256.736, subdivision 3b. Sanctions for failing to develop or comply with the terms of a family support agreement shall be imposed according to subdivision 3. When a minor parent reaches age 17, or earlier if determined necessary by the social service agency, the minor parent shall be referred for case management services.

(b) Case managers shall provide the following services:

(1) the case manager shall provide or arrange for an assessment of the family and caregiver's needs, interests, and abilities according to section 256.736, subdivision 11, paragraph (a), clause (1);

(2) the case manager shall coordinate services according to section 256.736, subdivision 11, paragraph (a), clause (3);

(3) the case manager shall develop an employability plan according to subdivision 6b;

(4) the case manager shall develop a family support agreement according to subdivision 6c; and

(5) the case manager shall monitor the caregiver's compliance with the employability plan and the family support agreement as required by the commissioner.

(c) Case management may continue for up to six months following the caregiver's achievement of employment goals.

Subd. 6b. **Employability plan.** (a) The case manager shall develop an employability plan with the caregiver according to this subdivision and section 256.736, subdivision 11, paragraph (a), clause (2), which will be based on the assessment in subdivision 6a of the caregiver's needs, interests, and abilities.

(b) An employability plan must identify the caregiver's employment goal or goals and explain what steps the family must take to pursue self-sufficiency.

(c) Activities in the employability plan may include preemployment activities such as: programs, activities, and services related to job training and job placement. These preemployment activities may include, based on availability and resources, participation in dislocated worker services, chemical dependency treatment, mental health services, self-esteem enhancement activities, peer group networks, displaced homemaker programs, education programs leading toward the employment goal, parenting education, and other programs to help the families reach their employment goals and enhance their ability to care for their children.

Subd. 6c. **Family support agreement.** (a) The family support agreement is the enforceable component of the employability plan as described in subdivision 6b and section 256.736, subdivision 10, paragraph (a), clause (15). A parental caregiver's failure to comply with any part of the family support agreement without good cause as provided in subdivision 2a is subject to sanction as provided in subdivision 3.

(b) A family support agreement must identify the parental caregiver's employment goal or goals and outline the steps which the parental caregiver and case manager mutually determined are necessary to achieve each goal. Activities are limited to:

(1) employment;

(2) employment and training activities; or

(3) education up to a baccalaureate degree.

(c) A family support agreement shall include only those activities described in paragraph (b). Social services or activities, such as mental health or chemical dependency services, parenting education, or budget management, can be included in the employability plan and not in the family support agreement and are not subject to a sanction under subdivision 3.

(d) For a parental caregiver whose employability plan is composed entirely of services described in paragraph (c), the family support agreement shall designate a date for reassessment of the activities needed to reach the parental caregiver's employment goal and this date shall be considered as the content of the family support agreement. The parental caregiver and case manager shall meet at least semiannually to review and revise the family support agreement.

(e) The family support agreement must identify the services that the county agency will provide to the family to enable the parental caregiver to comply with the family support agreement, including support services such as transportation and child care.

(f) The family support agreement must state the parental caregiver's obligations and the conditions under which the county agency will recommend a sanction be applied to the grant and withdraw the services.

(g) The family support agreement will specify a date for completion of activities leading to the employment goal.

(h) The family support agreement must be signed and dated by the case manager and parental caregiver. In all cases, the case manager must assist the parental caregiver in reviewing and understanding the family support agreement and must assist the caregiver in setting realistic goals in the agreement which are consistent with the ultimate goal of financial support for the caregiver's family. The case manager must inform the caregiver of the right to seek conciliation as provided in subdivision 6e.

(i) The caregiver may revise the family support agreement with the case manager when good cause indicates revision is warranted. Revisions for reasons other than good cause to employment goals or steps toward self-support may be made in the first six months after the signing of the family support agreement with the approval of the case manager. After that, the revision must be approved by the case management supervisor or other persons responsible for review of case management decisions.

Subd. 6d. **Length of job search.** When the family support agreement specifies a date when job search should begin, the parental caregiver must participate in employment search activities. If, after three months of search, the parental caregiver does not find a job that is consistent with the parental caregiver's employment goal, the parent must accept any suitable employment. The search may be extended for up to three months if the parental caregiver seeks and needs additional job search assistance.

Subd. 6e. **Conciliation.** A conciliation procedure shall be available as provided in section 256.736, subdivision 11, paragraph (c). The conciliation conference will be available to parental caregivers who cannot reach agreement with the case manager about the contents or interpretation of the family support agreement, or who have received a notice of intent to implement a sanction as required under subdivision 3. Implementation of the sanction will be postponed pending the outcome of conciliation. The conciliation conference will be facilitated by a neutral mediator, and the goal will

be to achieve mutual agreement between the parental caregiver and case manager. The conciliation conference is an optional procedure preceding the hearing process under section 256.045.

Subd. 7. [Repealed, 1991 c 292 art 5 s 82]

Subd. 8. **Child care.** The commissioner shall ensure that each Minnesota family investment plan caregiver who is employed or is developing or is engaged in activities identified in an employability plan under subdivision 6b and who needs assistance with child care costs to be employed or to develop or comply with the terms of an employability plan receives a child care subsidy through child care money appropriated for the Minnesota family investment plan. The subsidy must cover all actual child care costs for eligible hours up to the maximum rate allowed under section 256H.15. A caregiver who is in the assistance unit who leaves the program as a result of increased earnings from employment and who needs child care assistance to remain employed is entitled to extended child care assistance as provided under United States Code, title 42, section 602(g)(1)(A)(ii) on a copayment basis.

Subd. 9. **Health care.** A family leaving the program as a result of increased earnings from employment is eligible for extended medical assistance as provided under Public Law Number 100-485, section 303, as amended and Public Law Number 101-239, section 8015(b)(7).

History: *1989 c 282 art 5 s 10; 1991 c 199 art 2 s 17; 1991 c 292 art 5 s 16,83; 1992 c 513 art 8 s 8*

256.036 PROTECTIONS.

Subdivision 1. **Support services.** If assistance with child care or transportation is necessary to enable a parental caregiver to work, obtain training or education, attend orientation, or comply with the terms of a family support agreement with the county agency, and the county agency determines that child care or transportation is not available, the family's applicable standard of assistance continues to be the transitional standard.

Subd. 2. **Volunteers.** For caregivers receiving assistance under the Minnesota family investment plan who are not currently employed but who are independently pursuing self-sufficiency, case management, support services, and child care are available to the extent that resources permit. A caregiver who volunteers is not subject to a sanction under section 256.035, subdivision 3.

Subd. 3. **Notification requirement.** The county agency shall contact a family headed by a single adult parent when the family has received assistance through the Minnesota family investment plan for 18 months within the preceding 36 months. The county agency shall remind the family that beginning with the 24th month of assistance, receipt of the transitional standard is contingent upon transitional status. The county agency shall encourage the family to begin preparing for the change in expectations.

Subd. 4. **Timely assistance.** Applications must be processed in a timely manner according to the processing standards of the federal Food Stamp Act of 1977, as amended, and no later than 30 days following the date of application, unless the county agency has requested information that the applicant has not yet supplied. Financial assistance must be provided at least monthly to eligible families.

Subd. 5. **Due process.** Any family that applies for or receives assistance under the Minnesota family investment plan whose application for assistance is denied or not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid, is entitled, upon request, to a hearing under section 256.045. A parental caregiver may request a conciliation conference, as provided under section 256.035, subdivision 6e, when the caregiver disputes the terms of a family support agreement developed under the Minnesota family investment plan or disputes a decision regarding failure or refusal to comply with the terms of a family support agreement. The disputes are not subject to administrative review under section 256.045, unless they result in a denial, suspension, reduction, or termination,

and the parental caregiver complies with section 256.045. A caregiver need not request a conciliation conference to request a hearing according to section 256.045.

Subd. 6. **Treatment of food assistance.** The portion of cash assistance provided under the Minnesota family investment plan that the commissioner designates as representing food assistance must be disregarded for other local, state, or federal programs.

Subd. 7. **Adjustment of food assistance amount.** The commissioner shall assure that increases in the federal food stamp allotments and deductions are reflected in the food assistance portion of the assistance provided under the Minnesota family investment plan.

Subd. 8. **Expedited benefits.** Provisions for expedited benefits under the Minnesota family investment plan may not be less restrictive than provisions for expedited benefits under the Food Stamp Act of 1977, as amended, and state food stamp policy and include either expediting issuance of a predesignated portion of assistance provided through the Minnesota family investment plan or through the existing food stamp program.

Subd. 9. **Special rights of migrant and seasonal farm workers and homeless people.** Federally prescribed procedures, means of applying for and obtaining assistance, reporting and verification requirements, and other similar provisions specifically for migrant and seasonal farmworkers or homeless people under the Food Stamp Act of 1977, as amended, continue to be available to eligible migrant, seasonal farmworker, or homeless families. The commissioner shall comply with the bilingual requirements of United States Code, title 7, section 2020(e)(1)(B).

Subd. 10. [Repealed, 1991 c 292 art 5 s 82]

History: *1989 c 282 art 5 s 11; 1991 c 292 art 5 s 17-20*

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 economic security who shall resolve the dispute.

Subd. 2. **Financial reimbursement.** (a) Up to the limit of the state appropriation, a county selected by the commissioner to serve as a field trial or a comparison site for the Minnesota family investment plan shall be reimbursed by the state for the nonfederal share of administrative costs that were incurred during the development, implementation, and operation of the program and that exceed the administrative costs that would have been incurred in the absence of the program.

(b) Minnesota family investment plan assistance is included as covered programs and services under section 256.025, subdivision 2.

Subd. 3. **Evaluation data.** The commissioner may access data maintained by the department of economic security under sections 268.03 to 268.231 for the purpose of evaluating the Minnesota family investment plan for persons randomly assigned to a test or comparison group as part of the evaluation. This subdivision authorizes access

to data concerning the three years before the time of random assignment for persons randomly assigned to a test or comparison group and data concerning the five years after random assignment.

History: *1991 c 292 art 5 s 21; 1992 c 513 art 8 s 9; 1993 c 306 s 6; 1994 c 483 s 1; 1994 c 618 art 1 s 30*

256.04 [Temporary]

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICE MATTERS.

Subdivision 1. **Powers of the state agency.** The commissioner of human services may appoint one or more state human services referees to conduct hearings and recommend orders in accordance with subdivisions 3, 3a, 4a, and 5. Human services referees designated pursuant to this section may administer oaths and shall be under the control and supervision of the commissioner of human services and shall not be a part of the office of administrative hearings established pursuant to sections 14.48 to 14.56.

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

Subd. 3. **State agency hearings.** Any person applying for, receiving or having received public assistance or a program of social services granted by the state agency or a county agency under sections 252.32, 256.031 to 256.036, and 256.72 to 256.879, chapters 256B, 256D, 256E, 261, or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid, or any patient or relative aggrieved by an order of the commissioner under section 252.27, or a party aggrieved by a ruling of a prepaid health plan, may contest that action or decision before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action or decision, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

Except for a prepaid health plan, a vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing under this section.

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

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

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised

by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

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

Subd. 4. **Conduct of hearings.** All hearings held pursuant to subdivision 3, 3a, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, or former recipient objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, or former recipient shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county agency at the hearing at a reasonable time before the date of the hearing and during the hearing. Upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3.

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.

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

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

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

Except for a prepaid health plan, a vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing or seek judicial review of an order issued under this section.

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

(b) Any party to a hearing held pursuant to subdivision 3, 3a, or 4a may request that the commissioner issue a subpoena to compel the attendance of witnesses at the hearing. The issuance, service, and enforcement of subpoenas under this subdivision is governed by section 357.22 and the Minnesota Rules of Civil Procedure.

(c) The commissioner may issue a temporary order staying a proposed demission

by a residential facility licensed under chapter 245A while an appeal by a recipient under subdivision 3 is pending or for the period of time necessary for the county agency to implement the commissioner's order.

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

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

Subd. 9. **Appeal.** Any party aggrieved by the order of the district court may appeal the order as in other civil cases. No costs or disbursements shall be taxed against any party nor shall any filing fee or bond be required of any party.

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

History: *1976 c 131 s 1; 1978 c 560 s 7; 1982 c 424 s 130; 1983 c 247 s 108,109; 1983 c 312 art 5 s 4; 1984 c 534 s 14-18; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 148 s 1-8; 1987 c 403 art 2 s 61; 1989 c 282 art 5 s 12-20; 1990 c 568 art 4 s 84; 1991 c 94 s 11; 1991 c 292 art 4 s 16; art 6 s 58 subd 2; 1993 c 247 art 4 s 1; 1993 c 339 s 9; 1994 c 625 art 8 s 72*

256.046 ADMINISTRATIVE FRAUD DISQUALIFICATION HEARINGS.

Subdivision 1. **Hearing authority.** A local agency may initiate an administrative fraud disqualification hearing for individuals accused of wrongfully obtaining assis-

tance or intentional program violations in the aid to families with dependent children or food stamp programs. The hearing is subject to the requirements of section 256.045 and the requirements in Code of Federal Regulations, title 7, section 273.16, for the food stamp program and title 45, section 235.112, for the aid to families with dependent children program.

Subd. 2. **Combined hearing.** The referee may combine a fair hearing and administrative fraud disqualification hearing into a single hearing if the factual issues arise out of the same, or related, circumstances and the individual receives prior notice that the hearings will be combined. If the administrative fraud disqualification hearing and fair hearing are combined, the time frames for administrative fraud disqualification hearings set forth in Code of Federal Regulations, title 7, section 273.16, and title 45, section 235.112, apply. If the individual accused of wrongfully obtaining assistance is charged under section 256.98 for the same act or acts which are the subject of the hearing, the individual may request that the hearing be delayed until the criminal charge is decided by the court or withdrawn.

History: *1992 c 513 art 8 s 10*

256.05 SUPERVISION OVER PAROLED PATIENTS; STATE AGENTS APPOINTED.

The commissioner of human services so far as possible shall exercise supervision over paroled patients of the state hospitals for the mentally ill and of the state schools and hospitals for mentally retarded persons and persons having epilepsy; and, when deemed necessary for that purpose, may appoint one or more state agents and fix their salary. The commissioner may appoint suitable persons in any part of the state for the same purpose. Every such agent or person shall perform such duties as the commissioner of human services may prescribe in behalf or in supervision of patients paroled from any such institution, including assistance in obtaining employment and the return of paroled patients when necessary. The duty of the commissioner of human services or the superintendent of any state institution exercising such supervision over any patient who has been or may be paroled to the custody of the superintendent or other proper officer or authority in charge or control of any United States veterans bureau neuropsychiatric hospital shall cease to exist upon acceptance of the patient's custody thereby.

History: *(4419, 4420) 1907 c 292 s 1,2; 1917 c 208 s 1; 1925 c 308; 1965 c 45 s 36; 1983 c 10 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.06 GUARDIANSHIP OF INMATES.

The commissioner of human services shall be deemed the guardian of the persons of the inmates of any state hospital or asylum for the insane or of any school for feebleminded and colony for persons having epilepsy for the purpose of consenting to any surgical operation necessary to save the life, health, eyesight, hearing, or a limb of any inmate committed thereto.

History: *(4422) 1907 c 145 s 2; 1983 c 10 s 1; 1984 c 654 art 5 s 58*

256.07 [Repealed, 1975 c 208 s 35]

256.08 INSANE PERSONS IN STATE HOSPITALS; CONSENT TO OPERATION.

When any person has been committed as insane to the custody of the superintendent of a state hospital for the insane and has been an inmate of such hospital for at least six consecutive months, the commissioner of human services, after consultation with the superintendent of the hospital wherein such person is an inmate, a reputable physician, and psychologist selected by the commissioner of human services, and after a careful investigation of all the circumstances of the case, may, with the written consent of the patient and of the spouse or nearest kin, or the duly appointed guardian of

such insane person, cause such insane person to be sterilized by a competent surgeon by the operation of vasectomy or tubectomy.

History: *(4422-2) 1925 c 154 s 2; 1984 c 654 art 5 s 58*

256.09 NO CIVIL OR CRIMINAL LIABILITY.

Sterilization, as outlined in section 256.08, shall be lawful and shall not render the commissioner of human services, or department employees, or other persons participating in the examination or operation, liable either civilly or criminally.

History: *(4422-3) 1925 c 154 s 3; 1980 c 509 s 99; 1984 c 654 art 5 s 58; 1986 c 444*

256.10 RECORDS KEPT.

A complete record of the case shall be made and kept as a permanent file in the office of the commissioner of human services.

History: *(4422-4) 1925 c 154 s 4; 1984 c 654 art 5 s 58*

256.11 [Repealed, 1973 c 717 s 33]

256.12 DEFINITIONS.

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

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

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

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

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

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

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

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

Subd. 9. **County agency.** As used in sections 256.72 to 256.87, "county agency" means the county board of public welfare as established by law.

Subd. 10. **State agency.** As used in sections 256.72 to 256.87, the term "state agency" means the commissioner of human services in the department of human services.

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

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

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

Subd. 14. **Dependent child.** (a) "Dependent child," as used in sections 256.72 to 256.87, means a child under the age of 18 years, or a child under the age of 19 years who is regularly attending as a full-time student, and is expected to complete before reaching age 19, a high school or a secondary level course of vocational or technical training designed to fit students for gainful employment, who is found to be deprived of parental support or care by reason of the death, continued absence from the home, physical or mental incapacity of a parent, or who is a child of an unemployed parent as that term is defined by the commissioner of human services, such definition to be consistent with and not to exceed minimum standards established by the Congress of the United States and the Secretary of Health and Human Services. When defining "unemployed parent," the commissioner shall count up to four calendar quarters of full-time attendance in any of the following toward the requirement that a principal earner have six or more quarters of work in any 13 calendar quarter period ending within one year before application for aid to families with dependent children:

(1) an elementary or secondary school;

(2) a federally approved vocational or technical training course designed to prepare the parent for gainful employment; or

(3) full-time participation in an education or training program established under the job training partnership act.

(b) Dependent child also means a child:

(1) whose relatives are liable under the law for the child's support and are not able to provide adequate care and support of the child; and

(2) who is living with father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece in a place of residence maintained by one or more of these relatives as a home.

(c) Dependent child also means a child who has been removed from the home of a relative after a judicial determination that continuance in the home would be contrary to the welfare and best interests of the child and whose care and placement in a foster home or a private licensed child care institution is, in accordance with the rules of the commissioner, the responsibility of the state or county agency under sections 256.72 to 256.87. This child is eligible for benefits only through the foster care and adoption assistance program contained in Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and is not entitled to benefits under sections 256.72 to 256.87.

Subd. 15. **Continued absence from the home.** "Continued absence from the home," as used in sections 256.72 to 256.87, means the absence from the home of the parent, whether or not entitled to the custody of the child, by reason of being an inmate of a penal institution or a fugitive after escape therefrom, or absence from the home by the parent for a period believed to be, and declared by applicant to be, of a continuous duration together with failure on the part of the absent parent to support the child, provided that prior to the granting of such aid all reasonable efforts have been made to secure support for such child.

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

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

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

Subd. 19. **Intermediate care facility.** An intermediate care facility is any facility so defined by the state department of health pursuant to rules adopted under the state administrative procedure act.

Subd. 20. **Assistance unit.** "Assistance unit" means the group of individuals who are applying for or receiving assistance and whose needs are included in the grant of assistance as determined under sections 256.72 to 256.87.

Subd. 21. **Caretaker relative.** "Caretaker relative" means a relative specified by rule to be an eligible relative and who exercises responsibility for the care and control of the dependent child.

Subd. 22. **Principal earner.** "Principal earner" means, in a home where both parents of the dependent child live, the parent who earned the greater amount of income in the 24-month period immediately preceding the month of application.

Subd. 23. **In-kind income.** "In-kind income," as used in sections 256.72 to 256.87, means income, benefits, or payments provided in a form other than money or liquid assets. In-kind income includes goods, produce, services, privileges, or payments on behalf of a person by a third party. Retirement Survivors and Disability Insurance (RSDI) benefits of an applicant or recipient, paid to a representative payee, and spent on behalf of the applicant or recipient, are not in-kind income, but are considered available income of the applicant or recipient.

History: *(3199-63, 8688-3) Ex1936 c 95 s 2; 1937 c 324 s 1; 1937 c 438 s 1; 1939 c 195 s 1; 1943 c 6 s 1; 1947 c 628 s 1; 1951 c 229 s 1; 1951 c 600 s 1,2; 1951 c 618 s 1; 1953 c 639 s 1; 1953 c 725 s 1; 1955 c 711 s 1; 1957 c 690 s 1; 1963 c 794 s 2; 1965 c 51 s 50; 1967 c 879 s 1; 1969 c 387 s 1; 1969 c 740 s 1; 1969 c 1026 s 1; 1973 c 191 s 1; 1973 c 717 s 13; 3Sp1981 c 3 s 1-4; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 5; 1986 c 444; 1987 c 384 art 2 s 61; 1989 c 282 art 5 s 21; 1992 c 513 art 8 s 11*

256.13 [Repealed, 1973 c 717 s 33]

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

Subd. 2. [Repealed, 1959 c 622 s 7]
Subd. 3. [Repealed, 1959 c 622 s 7]
Subd. 4. [Repealed, 1959 c 622 s 7]
Subd. 5. [Repealed, 1959 c 622 s 7]

256.15 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1973 c 717 s 33]
Subd. 3. [Repealed, 1951 c 92 s 1]
Subd. 4. [Repealed, 1973 c 717 s 33]

256.151 [Repealed, 1951 c 92 s 2]

256.16 [Repealed, 1973 c 717 s 33]

256.17 [Repealed, 1973 c 717 s 33]

256.18 [Repealed, 1973 c 717 s 33]

256.183 MS 1949 [Expired]

256.184 MS 1949 [Expired]

256.185 MS 1949 [Expired]

256.19 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1973 c 717 s 33]
Subd. 3. [Repealed, 1973 c 717 s 33]
Subd. 4. [Repealed, 1971 c 681 s 5]

256.20 [Repealed, 1973 c 717 s 33]

256.21 [Repealed, 1973 c 717 s 33]

256.22 [Repealed, 1973 c 717 s 33]

256.23 [Repealed, 1973 c 717 s 33]

256.24 [Repealed, Ex1971 c 16 s 6]

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

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

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

256.26 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1973 c 717 s 33]

Subd. 3. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 4. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 5. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 6. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 7. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 8. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 9. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 10. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 11. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

256.263 LAND ACQUIRED BY STATE UNDER OLD AGE ASSISTANCE LIENS.

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

Subd. 2. **Management.** While the state owns such real estate, if the county board by resolution stating the price to be paid in cash shall recommend the sale and conveyance thereof, and transmit a copy of such resolution to the state agency, the state agency shall make an order approving the sale for the price recommended and transmit a copy thereof to the county auditor, in the county where the land is situated. Thereupon, when the purchase price is paid by the purchaser to the treasurer of such county, the chair of the county board shall execute a deed in the name of the state, which shall be attested by the county auditor, conveying such land to the purchaser.

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

256.27 [Repealed, 1973 c 717 s 33]
256.28 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1967 c 89 s 2; 1967 c 885 s 6]
256.29 [Repealed, 1973 c 717 s 33]
256.30 [Repealed, 1973 c 717 s 33]
256.31 [Repealed, 1971 c 550 s 2]
256.32 [Repealed, 1973 c 717 s 33]
256.33 [Repealed, 1973 c 717 s 33]
256.34 [Repealed, 1973 c 717 s 33]
256.35 [Repealed, 1973 c 717 s 33]
256.36 [Repealed, 1973 c 717 s 33]

256.362 REPORTS AND IMPLEMENTATION.

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

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

Subd. 3. **Coordination of medical assistance and the MinnesotaCare program.** The commissioner shall develop and implement a plan to combine medical assistance and

MinnesotaCare program application and eligibility procedures. The plan may include the following changes: (1) use of a single mail-in application; (2) elimination of the requirement for personal interviews; (3) postponing notification of paternity disclosure requirements; (4) modifying verification requirements for pregnant women and children; (5) using shorter forms for recertifying eligibility; (6) expedited and more efficient eligibility determinations for applicants; (7) expanded outreach efforts, including combined marketing of the two plans; and (8) other changes that improve access to services provided by the two programs. The plan may include seeking the following changes in federal law: (1) extension and expansion of exemptions for different eligibility groups from Medicaid quality control sanctions; (2) changing requirements for the redetermination of eligibility; (3) eliminating asset tests for all children; and (4) other changes that improve access to services provided by the two programs. The commissioner shall seek any necessary federal approvals, and any necessary changes in federal law. The commissioner shall implement each element of the plan as federal approval is received, and shall report to the legislature by January 1, 1993, on progress in implementing this plan.

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

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

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

256.37 [Repealed, Ex1971 c 16 s 6]
256.38 [Repealed, 1973 c 717 s 33]
256.39 [Repealed, 1973 c 717 s 33]
256.40 [Repealed, 1973 c 717 s 33]
256.41 [Repealed, 1973 c 717 s 33]
256.42 [Repealed, 1973 c 717 s 33]
256.43 [Repealed, 1973 c 717 s 33]
256.431-256.434 MS 1949 [Expired]
256.44 [Repealed, 1947 c 535 s 16]
256.45 [Repealed, 1947 c 535 s 16]
256.451 [Repealed, 1973 c 717 s 33]
256.452 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1973 c 717 s 33]
Subd. 3. [Repealed, 1973 c 717 s 33]
Subd. 4. [Repealed, 1973 c 717 s 33]
Subd. 5. [Repealed, 1973 c 717 s 33]
Subd. 6. [Repealed, 1973 c 717 s 33]
Subd. 7. [Repealed, 1973 c 717 s 33]
Subd. 8. [Repealed, 1967 c 885 s 6]
Subd. 9. [Repealed, 1967 c 885 s 6]
Subd. 10. [Repealed, 1967 c 885 s 6]
Subd. 11. [Repealed, 1973 c 717 s 33]
Subd. 12. [Repealed, 1973 c 717 s 33]
256.453 [Repealed, 1973 c 717 s 33]
256.454 [Repealed, 1973 c 717 s 33]
256.455 [Repealed, 1973 c 717 s 33]

256.456 [Repealed, 1973 c 717 s 33]
256.457 [Repealed, 1973 c 717 s 33]
256.458 [Repealed, 1973 c 717 s 33]
256.459 [Repealed, 1973 c 717 s 33]
256.46 [Repealed, 1947 c 535 s 16]
256.461 [Repealed, 1973 c 717 s 33]

256.462 APPLICABILITY OF OTHER LAW; RECOVERY AND DISBURSEMENT OF ASSISTANCE FURNISHED.

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

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

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

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

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

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

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

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

256.463 [Repealed, 1973 c 717 s 33]
256.464 [Repealed, 1973 c 717 s 33]
256.465 Subdivision 1. [Repealed, 1971 c 550 s 2]
Subd. 2. [Repealed, 1973 c 717 s 33]
256.466 [Repealed, 1973 c 717 s 33]
256.467 [Repealed, 1973 c 717 s 33]
256.468 [Repealed, 1973 c 717 s 33]
256.469 [Repealed, 1973 c 717 s 33]
256.47 [Repealed, 1947 c 535 s 16]
256.471 [Repealed, 1973 c 717 s 33]
256.472 [Repealed, 1973 c 717 s 33]
256.473 [Repealed, 1973 c 717 s 33]
256.474 [Repealed, 1973 c 717 s 33]
256.475 [Repealed, 1973 c 717 s 33]
256.48 [Repealed, 1947 c 535 s 16]

COUNCIL ON DISABILITY

256.481 HANDICAPPED PERSON; DEFINITION.

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

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

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

(c) is regarded as having such an impairment.

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

256.482 COUNCIL ON DISABILITY.

Subdivision 1. **Establishment; members.** There is hereby established the council on disability which shall consist of 21 members appointed by the governor. Members shall be appointed from the general public and from organizations which provide services for persons who have a disability. A majority of council members shall be persons with a disability or parents or guardians of persons with a disability. There shall be at least one member of the council appointed from each of the state development regions. The commissioners of the departments of education, human services, health, economic security, and human rights and the directors of the division of rehabilitation services and state services for the blind or their designees shall serve as ex officio members of the council without vote. In addition, the council may appoint ex officio members from other bureaus, divisions, or sections of state departments which are directly concerned with the provision of services to persons with a disability.

Notwithstanding the provisions of section 15.059, each member of the council appointed by the governor shall serve a three-year term and until a successor is appointed and qualified. The compensation and removal of all members shall be as provided in section 15.059. The governor shall appoint a chair of the council from among the members appointed from the general public or who are persons with a disability or their parents or guardians. Vacancies shall be filled by the authority for the remainder of the unexpired term.

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

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

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

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

(1) to advise and otherwise aid the governor; appropriate state agencies, including but not limited to the departments of education, human services, economic security, and human rights and the divisions of rehabilitation services and services for the blind; the state legislature; and the public on matters pertaining to public policy and the

administration of programs, services, and facilities for persons who have a disability in Minnesota;

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

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

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

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

(6) to advise the departments of labor and industry and economic security on the administration and improvement of the workers' compensation law as it relates to programs, facilities and personnel providing assistance to workers who are injured and disabled;

(7) to advise the workers' compensation division of the department of labor and industry and the workers' compensation court of appeals as to the necessity and extent of any alteration or remodeling of an existing residence or the building or purchase of a new or different residence which is proposed by a licensed architect under section 176.137;

(8) to initiate or seek to intervene as a party in any administrative proceeding and judicial review thereof to protect and advance the right of all persons who are disabled to an accessible physical environment as provided in section 16B.67; and

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

Subd. 5a. **Technology for people with disabilities.** The council has the following duties related to technology for people with disabilities:

(1) to identify individuals with disabilities, including individuals from underserved groups, who reside in the state and conduct an ongoing evaluation of their needs for technology-related assistance;

(2) to identify and coordinate state policies, resources, and services relating to the provision of assistive technology devices and assistive technology services to individuals with disabilities, including entering into interagency agreements;

(3) to provide assistive technology devices and assistive technology services to individuals with disabilities and payment for the provision of assistive technology devices and assistive technology services;

(4) to disseminate information relating to technology-related assistance and sources of funding for assistive technology devices and assistive technology services to individuals with disabilities, the families or representatives of individuals with disabilities, individuals who work for public agencies, and private entities that have contact with individuals with disabilities, including insurers, employers, and other appropriate individuals;

(5) to provide training and technical assistance relating to assistive technology devices and assistive technology services to individuals with disabilities, the families or representatives of individuals with disabilities, individuals who work for public agencies, and private entities that have contact with individuals with disabilities, including insurers, employers, and other appropriate individuals;

(6) to conduct a public awareness program focusing on the efficacy and availability of assistive technology devices and assistive technology services for individuals with disabilities;

(7) to assist statewide and community-based organizations or systems that provide assistive technology services to individuals with disabilities;

(8) to support the establishment or continuation of partnerships and cooperative initiatives between the public sector and the private sector;

(9) to develop standards, or where appropriate, apply existing standards to ensure the availability of qualified personnel for assistive technology devices;

(10) to compile and evaluate appropriate data relating to the program; and

(11) to establish procedures providing for the active involvement of individuals with disabilities, the families or representatives of the individuals, and other appropriate individuals in the development and implementation of the program, and for individuals with disabilities who use assistive technology devices and assistive technology services, for their active involvement, to the maximum extent appropriate in decisions relating to the assistive technology devices and assistive technology services.

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

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

History: *1973 c 254 s 3; 1973 c 757 s 2; 1975 c 61 s 1; 1975 c 271 s 6; 1975 c 315 s 18; 1975 c 359 s 23; 1977 c 177 s 2; 1977 c 305 s 45; 1977 c 430 s 14; 1983 c 216 art 2 s 5; 1983 c 260 s 56; 1983 c 277 s 2; 1983 c 299 s 25; 1984 c 654 art 5 s 58; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 354 s 6; 1988 c 629 s 50; 1989 c 335 art 1 s 185,186; art 4 s 67; 1991 c 292 art 3 s 7; 1994 c 483 s 1*

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

SOCIAL ADJUSTMENT SERVICES TO REFUGEES

256.484 SOCIAL ADJUSTMENT SERVICES TO REFUGEES.

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

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

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

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

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

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

(1) use existing resources when possible;

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

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

(4) provide bilingual services; and

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

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

History: *1989 c 282 art 5 s 22*

256.485 CHILD WELFARE SERVICES TO MINOR REFUGEES.

Subdivision 1. **Special projects.** The commissioner of human services shall establish a grant program to provide specialized child welfare services to Asian and Amerasian refugees under the age of 18 who reside in Minnesota.

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

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

(b) "Child welfare services" means treatment or services, including workshops or training regarding independent living skills, coping skills, and responsible parenting, and family or individual counseling regarding career planning, intergenerational relationships and communications, and emotional or psychological stress.

Subd. 3. **Project selection.** The commissioner shall select projects for funding under this section. Projects selected must be administered by service providers who have experience in providing child welfare services to minor Asian and Amerasian refugees.

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

(1) use existing resources when possible;

(2) provide bilingual services;

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

(4) identify support services, social services, and referral procedures to be used; and

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

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

History: *1989 c 282 art 5 s 23*

ASIAN JUVENILE CRIME PREVENTION

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: *1992 c 571 art 10 s 16; 1993 c 326 art 12 s 3*

256.49 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1955 c 711 s 3]
256.50 [Repealed, 1973 c 717 s 33]
256.51 [Repealed, 1973 c 717 s 33]
256.515 [Repealed, 1973 c 717 s 33]
256.52 [Repealed, 1973 c 717 s 33]
256.53 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, Ex1971 c 16 s 6]
256.54 [Repealed, 1973 c 717 s 33]
256.55 [Repealed, 1973 c 717 s 33]
256.56 [Repealed, 1973 c 717 s 33]
256.57 [Repealed, 1973 c 717 s 33]
256.58 [Repealed, 1973 c 717 s 33]
256.59 [Repealed, 1973 c 717 s 33]
256.60 [Repealed, 1973 c 717 s 33]
256.61 [Repealed, 1973 c 717 s 33]
256.62 [Repealed, 1973 c 717 s 33]
256.63 [Repealed, 1973 c 717 s 33]
256.64 [Repealed, 1973 c 717 s 33]
256.65 [Repealed, 1973 c 574 s 2]
256.66 [Repealed, 1973 c 717 s 33]
256.67 [Repealed, 1973 c 717 s 33]
256.68 [Repealed, 1971 c 550 s 2]
256.69 [Repealed, 1973 c 717 s 33]
256.70 [Repealed, 1973 c 717 s 33]
256.71 [Repealed, 1973 c 717 s 33]

AID TO FAMILIES WITH DEPENDENT CHILDREN

256.72 DUTIES OF COUNTY AGENCIES.

The county agencies shall:

(1) Administer the provisions of sections 256.72 to 256.87 in the respective coun-

ties subject to the rules prescribed by the state agency pursuant to the provisions of those sections and to the supervision of the commissioner of human services specified in section 256.01.

(2) Report to the state agency at such times and in such manner and form as required under section 256.01, subdivision 2, paragraph (17).

(3) Submit quarterly and annually to the county board of commissioners a budget containing an estimate and supporting data setting forth the amount of money needed to carry out the provisions of those sections.

(4) In addition to providing financial assistance, provide such services as will help to maintain and strengthen family life and promote the support and personal independence of parents and relatives insofar as such help is consistent with continuing parental care and protection.

History: *(8688-5) 1937 c 438 s 3; 1963 c 794 s 3; 1985 c 248 s 70; 1988 c 719 art 8 s 4; 1989 c 89 s 6*

256.73 ASSISTANCE, RECIPIENTS.

Subdivision 1. **Dependent children.** Assistance shall be given under sections 256.72 to 256.87 to or on behalf of any dependent child who:

(1) Resides in Minnesota;

(2) Is otherwise eligible; the child shall not be denied aid because of conditions of the home in which the child resides.

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

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. 4. [Repealed, 1987 c 363 s 14]

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.

Subd. 6. **Reports by recipient.** (a) An assistance unit with a recent work history or with earned income shall report monthly to the county agency on income received and other circumstances affecting eligibility or assistance amounts. All other assistance units shall report on income and other circumstances affecting eligibility and assistance amounts at less frequent intervals, as specified by the state agency.

(b) An assistance unit required to submit a report on the form designated by the commissioner is considered to have continued its application for assistance effective the date the required report is received by the county agency, if a complete report is

received within a calendar month after the month in which assistance was received, except that no assistance shall be paid for the period beginning with the end of the month in which the report was due and ending with the date the report was received by the county agency.

Subd. 7. [Repealed, 1989 c 343 s 7]

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 overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member for one or more monthly assistance payments until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need 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.

Subd. 9. **Appeal of overpayment determinations.** The recipient may appeal the agency's determination that an overpayment has occurred in accordance with section 256.045.

Subd. 10. **Underpayments.** The county agency shall promptly repay the recipient for any underpayment. The county agency shall disregard that payment when determining the assistance unit's income and resources in the month when the payment is made and the following month.

Subd. 11. **Compliance with federal law and regulation.** None of the provisions in this section shall be implemented to the extent that they violate federal law or regulation.

History: *(8688-6) 1937 c 438 s 4; 1939 c 195 s 2; 1943 c 7 s 2; 1951 c 229 s 2; 1953 c 140 s 1,2; 1953 c 639 s 2; 1955 c 414 s 1; 1955 c 743 s 1; 1957 c 690 s 2; 1963 c 794 s 4; 1965 c 799 s 4; 1973 c 26 s 4; 1974 c 575 s 18; 1977 c 412 s 1,3-5; 1977 c 448 s 5; 1979 c 50 s 71; 1980 c 614 s 130; 1981 c 360 art 2 s 19; 1Sp1981 c 4 art 4 s 63; 3Sp1981 c 3 s 5-8; 1984 c 654 art 5 s 58; 1985 c 45 s 1; 1985 c 248 s 70; 1985 c 252 s 6-8; 1986 c 398 art 5 s 1; 1986 c 444; 1987 c 403 art 3 s 3; 1988 c 629 s 51; 1988 c 689 art 2 s 124-129,268; 1989 c 282 art 5 s 24; 1990 c 568 art 4 s 1,2,84; 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*

256.735 [Repealed, 1969 c 334 s 2]

256.736 EMPLOYMENT AND TRAINING PROGRAMS.

Subdivision 1. [Repealed, 1Sp1985 c 14 art 9 s 78 subd 1]

Subd. 1a. **Definitions.** As used in this section and section 256.7365, the following words have the meanings given them:

(a) "AFDC" means aid to families with dependent children.

(b) "AFDC-UP" means that group of AFDC clients who are eligible for assistance by reason of unemployment as defined by the commissioner under section 256.12, subdivision 14.

(c) "Caretaker" means a parent or eligible adult, including a pregnant woman, who is part of the assistance unit that has applied for or is receiving AFDC.

(d) "Employment and training services" means programs, activities, and services related to job training, job placement, and job creation, including job service programs, job training partnership act programs, wage subsidies, remedial and secondary education programs, post-secondary education programs excluding education leading to a post-baccalaureate degree, vocational education programs, work readiness programs, job search, counseling, case management, community work experience programs, displaced homemaker programs, self-employment programs, grant diversion, employment experience programs, youth employment programs, community investment programs, refugee employment and training programs, and counseling and support activities necessary to stabilize the caretaker or the family.

(e) "Employment and training service provider" means a public, private, or nonprofit agency certified by the commissioner of economic security to deliver employment and training services under section 268.0122, subdivision 3, and section 268.871, subdivision 1.

(f) "Minor parent" means a caretaker relative who is the parent of the dependent child or children in the assistance unit and who is under the age of 18.

(g) "Targeted groups" or "targeted caretakers" means recipients of AFDC or AFDC-UP designated as priorities for employment and training services under subdivision 16.

(h) "Suitable employment" means employment which:

(1) is within the recipient's physical and mental capacity;

(2) meets health and safety standards established by the Occupational Safety and Health Administration and the department of economic security;

(3) pays hourly gross earnings which are not less than the federal or state minimum wage for that type of employment, whichever is applicable;

(4) does not result in a net loss of income. Employment results in a net loss of income when the income remaining after subtracting necessary work-related expenses from the family's gross income, which includes cash assistance, is less than the cash assistance the family was receiving at the time the offer of employment was made. For purposes of this definition, "work expenses" means the amount withheld or paid for; state and federal income taxes; social security withholding taxes; mandatory retirement fund deductions; dependent care costs; transportation costs to and from work at the amount allowed by the Internal Revenue Service for personal car mileage; costs of work uniforms, union dues, and medical insurance premiums; costs of tools and equipment used on the job; $1 per work day for the costs of meals eaten during employment; public liability insurance required by an employer when an automobile is used in employment and the cost is not reimbursed by the employer; and the amount paid by an employee from personal funds for business costs which are not reimbursed by the employer;

(5) offers a job vacancy which is not the result of a strike, lockout, or other bona fide labor dispute;

(6) requires a round trip commuting time from the recipient's residence of less than two hours by available transportation, exclusive of the time to transport children to and from child care;

(7) does not require the recipient to leave children under age 12 unattended in order to work, or if child care is required, such care is available; and

(8) does not discriminate at the job site on the basis of age, sex, race, color, creed, marital status, status with regard to public assistance, disability, religion, or place of national origin.

(i) "Support services" means programs, activities, and services intended to stabilize families and individuals or provide assistance for family needs related to employment or participation in employment and training services, including child care, transportation, housing assistance, personal and family counseling, crisis intervention services, peer support groups, chemical dependency counseling and treatment, money management assistance, and parenting skill courses.

Subd. 1b. [Repealed, 1990 c 568 art 4 s 85]

Subd. 2. [Repealed, 1Sp1985 c 14 art 9 s 78 subd 1]

Subd. 2a. [Repealed, 1990 c 568 art 4 s 85]

Subd. 3. **Registration.** (a) To the extent permissible under federal law, every caretaker or child is required to register for employment and training services, as a condition of receiving AFDC, unless the caretaker or child is:

(1) a child who is under age 16, a child age 16 or 17 who is attending elementary or secondary school or a secondary level vocational or technical school full time;

(2) ill, incapacitated, or age 60 or older;

(3) a person for whom participation in an employment and training service would require a round trip commuting time by available transportation of more than two hours;

(4) a person whose presence in the home is required because of illness or incapacity of another member of the household;

(5) a caretaker or other caretaker relative of a child under the age of three who personally provides full-time care for the child. In AFDC-UP cases, only one parent or other relative may qualify for this exemption;

(6) a caretaker or other caretaker relative personally providing care for a child under six years of age, except that when child care is arranged for or provided, the caretaker or caretaker relative may be required to register and participate in employment and training services up to a maximum of 20 hours per week. In AFDC-UP cases, only one parent or other relative may qualify for this exemption;

(7) a pregnant woman, if it has been medically verified that the child is expected to be born within the next six months; or

(8) employed at least 30 hours per week.

(b) To the extent permissible by federal law, applicants for benefits under the AFDC program are registered for employment and training services by signing the application form. Applicants must be informed that they are registering for employment and training services by signing the form. Persons receiving benefits on or after July 1, 1987, shall register for employment and training services to the extent permissible by federal law. The caretaker has a right to a fair hearing under section 256.045 with respect to the appropriateness of the registration.

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).

Subd. 3b. **Mandatory assessment and school attendance for certain custodial parents.** This subdivision applies to the extent permitted under federal law and regulation.

(a) **Definitions.** The definitions in this paragraph apply to this subdivision.

(1) "Custodial parent" means a recipient of AFDC who is the natural or adoptive parent of a child living with the custodial parent.

(2) "School" means:

(i) an educational program which leads to a high school diploma. The program or coursework may be, but is not limited to, a program under the post-secondary enrollment options of section 123.3514, a regular or alternative program of an elementary or secondary school, a technical college, or a college;

(ii) coursework for a general educational development (GED) diploma of not less than six hours of classroom instruction per week; or

(iii) any other post-secondary educational program that is approved by the public school or the county agency under subdivision 11.

(b) **Assessment and plan; requirement; content.** The county agency must examine the educational level of each custodial parent under the age of 20 to determine if the recipient has completed a high school education or its equivalent. If the custodial parent has not completed a high school education or its equivalent and is not exempt from the requirement to attend school under paragraph (c), the county agency must complete an individual assessment for the custodial parent. The assessment must be performed as soon as possible but within 60 days of determining AFDC eligibility for the custodial parent. The assessment must provide an initial examination of the custodial parent's educational progress and needs, literacy level, child care and supportive service needs, family circumstances, skills, and work experience. In the case of a custodial parent under the age of 18, the assessment must also consider the results of the early and periodic screening, diagnosis and treatment (EPSDT) screening, if available, and the effect of a child's development and educational needs on the parent's ability to participate in the program. The county agency must advise the parent that the parent's first goal must be to complete an appropriate educational option if one is identified for the parent through the assessment and, in consultation with educational agencies, must review the various school completion options with the parent and assist the parent in selecting the most appropriate option.

(c) **Responsibility for assessment and plan.** For custodial parents who are under age 18, the assessment and the employability plan must be completed by the county social services agency, as specified in section 257.33. For custodial parents who are age 18 or 19, the assessment and employability plan must be completed by the case manager. The social services agency or the case manager shall consult with representatives of educational agencies required to assist in developing educational plans under section 126.235.

(d) **Education determined to be appropriate.** If the case manager or county social services agency identifies an appropriate educational option, it must develop an employability plan in consultation with the custodial parent which reflects the assessment. The plan must specify that participation in an educational activity is required, what school or educational program is most appropriate, the services that will be pro-

vided, the activities the parent will take part in including child care and supportive services, the consequences to the custodial parent for failing to participate or comply with the specified requirements, and the right to appeal any adverse action. The employability plan must, to the extent possible, reflect the preferences of the participant.

(e) **Education determined to be not appropriate.** If the case manager determines that there is no appropriate educational option for a custodial parent who is age 18 or 19, the case manager shall indicate the reasons for the determination. The case manager shall then notify the county agency which must refer the custodial parent to case management services under subdivision 11 for completion of an employability plan and services. If the custodial parent fails to participate or cooperate with case management services and does not have good cause for the failure, the county agency shall apply the sanctions listed in subdivision 4, beginning with the first payment month after issuance of notice. If the county social services agency determines that school attendance is not appropriate for a custodial parent under age 18, the county agency shall refer the custodial parent to social services for services as provided in section 257.33.

(f) **School attendance required.** Notwithstanding subdivision 3, a custodial parent must attend school if all of the following apply:

(1) the custodial parent is less than 20 years of age;

(2) transportation services needed to enable the custodial parent to attend school are available;

(3) licensed or legal nonlicensed child care services needed to enable the custodial parent to attend school are available;

(4) the custodial parent has not already received a high school diploma or its equivalent; and

(5) the custodial parent is not exempt because the custodial parent:

(i) is ill or incapacitated seriously enough to prevent attendance at school;

(ii) is needed in the home because of the illness or incapacity of another member of the household; this includes a custodial parent of a child who is younger than six weeks of age;

(iii) works 30 or more hours a week; or

(iv) is pregnant if it has been medically verified that the child's birth is expected within the next six months.

(g) **Enrollment and attendance.** The custodial parent must be enrolled in school and meeting the school's attendance requirements. If enrolled, the custodial parent is considered to be attending when the school is not in regular session, including during holiday and summer breaks.

(h) **Good cause for not attending school.** The county agency shall not impose the sanctions in subdivision 4 if it determines that a custodial parent has good cause for not being enrolled or for not meeting the school's attendance requirements. The county agency shall determine whether good cause for not attending or not enrolling in school exists, according to this paragraph:

(1) Good cause exists when the county agency has verified that the only available school program requires round trip commuting time from the custodial parent's residence of more than two hours by available means of transportation, excluding the time necessary to transport children to and from child care.

(2) Good cause exists when the custodial parent has indicated a desire to attend school, but the public school system is not providing for the education and alternative programs are not available.

(i) **Failure to comply.** The case manager and social services agency shall establish ongoing contact with appropriate school staff to monitor problems that custodial parents may have in pursuing their educational plan and shall jointly seek solutions to prevent parents from failing to complete education. If the school notifies the county agency that the custodial parent is not enrolled or is not meeting the school's attendance requirements, or appears to be facing barriers to completing education, the information

must be conveyed to the case manager for a custodial parent age 18 or 19, or to the social services agency for a custodial parent under age 18. The case manager or social services agency shall reassess the appropriateness of school attendance as specified in paragraph (f). If after consultation, school attendance is still appropriate and the case manager or social services agency determines that the custodial parent has failed to enroll or is not meeting the school's attendance requirements and the custodial parent does not have good cause, the case manager or social services agency shall inform the custodial parent's financial worker who shall apply the sanctions listed in subdivision 4 beginning with the first payment month after issuance of notice.

(j) **Notice and hearing.** A right to notice and fair hearing shall be provided in accordance with section 256.045 and the Code of Federal Regulations, title 45, section 205.10.

(k) **Social services.** When a custodial parent under the age of 18 has failed to attend school, is not exempt, and does not have good cause, the county agency shall refer the custodial parent to the social services agency for services, as provided in section 257.33.

(l) **Verification.** No less often than quarterly, the financial worker must verify that the custodial parent is meeting the requirements of this subdivision. Notwithstanding section 13.32, subdivision 3, when the county agency notifies the school that a custodial parent is subject to this subdivision, the school must furnish verification of school enrollment, attendance, and progress to the county agency. The county agency must not impose the sanctions in paragraph (i) if the school fails to cooperate in providing verification of the minor parent's education, attendance, or progress.

Subd. 3c. **Minor parents not living with relatives.** (a) This subdivision applies to a minor parent who is not living with a parent or other adult relative and who is not living in a group or foster home licensed by the commissioner.

(b) For purposes of this subdivision, the following terms have the meanings given them:

(1) "Minor parent" means an applicant for or recipient of AFDC who is under age 18, and who is the natural or adoptive parent of a child living with the minor parent.

(2) "Other adult relative" means a person who qualifies to be an eligible relative caretaker for AFDC, as specified in federal regulations.

(c) The agency shall determine, for each minor parent who applies for or receives AFDC, whether this section applies. For a minor parent to whom this section applies, the county agency shall refer the minor parent to its social services unit within 30 days of the date the application for assistance is approved for development of a social service plan as required in section 257.33. The agency shall notify the minor parent of the referral to social services and that cooperation in developing and participating in a social service plan is required in order for AFDC eligibility to continue.

(d) In addition to meeting the requirements of section 257.33, the social service plan may, based upon the social service unit's evaluation of the minor caretaker's needs and parenting abilities, and the health, safety, and parenting needs of the minor caretaker's child, require the minor caretaker to live in a group or foster home or participate in available programs which teach skills in parenting or independent living.

(e) If the minor parent fails to cooperate in developing or participating in the social service plan, the social services unit shall notify the income maintenance unit of the county agency, which shall then notify the minor parent of the determination and of the sanctions in subdivision 4 that will be applied.

Subd. 4. **Conditions of certification.** The commissioner of human services shall:

(1) Arrange for or provide any caretaker or child required to participate in employment and training services pursuant to this section with child-care services, transportation, and other necessary family services;

(2) Provide that in determining a recipient's needs the additional expenses attributable to participation in a program are taken into account in grant determination to the extent permitted by federal regulation;

(3) Provide that the county board shall impose the sanctions in clause (4) when the county board:

(a) determines that a custodial parent under the age of 16 who is required to attend school under subdivision 3b has, without good cause, failed to attend school; or

(b) determines that subdivision 3c applies to a minor parent and the minor parent has, without good cause, failed to cooperate with development of a social service plan or to participate in execution of the plan, to live in a group or foster home, or to participate in a program that teaches skills in parenting and independent living;

(4) To the extent permissible by federal law, impose the following sanctions for a recipient's failure to participate in the requirements of subdivision 3b or 3c:

(a) For the first failure, 50 percent of the grant provided to the family for the month following the failure shall be made in the form of protective or vendor payments;

(b) For the second and subsequent failures, the entire grant provided to the family must be made in the form of protective or vendor payments. Assistance provided to the family must be in the form of protective or vendor payments until the recipient complies with the requirement; and

(c) When protective payments are required, the county agency may continue payments to the caretaker if a protective payee cannot reasonably be found;

(5) Provide that the county board shall impose the sanctions in clause (6) when the county board:

(a) determines that a caretaker or child required to participate in employment and training services has been found by the employment and training service provider to have failed without good cause to participate in appropriate employment and training services or to have failed without good cause to accept, through the job search program described in subdivision 14, or the provisions of an employability development plan if the caretaker is a custodial parent age 18 or 19 and subject to the requirements of subdivision 3b, a bona fide offer of public or other employment;

(b) determines that a custodial parent aged 16 to 19 who is required to attend school under subdivision 3b has, without good cause, failed to enroll or attend school; or

(c) determines that a caretaker has, without good cause, failed to attend orientation;

(6) To the extent required by federal law, impose the following sanctions for a recipient's failure to participate in required employment and training services, to accept a bona fide offer of public or other employment, to enroll or attend school under subdivision 3b, or to attend orientation:

(a) For the first failure, the needs of the noncompliant individual shall not be taken into account in making the grant determination, until the individual complies with the requirements;

(b) For the second failure, the needs of the noncompliant individual shall not be taken into account in making the grant determination until the individual complies with the requirement or for three consecutive months, whichever is longer;

(c) For subsequent failures, the needs of the noncompliant individual shall not be taken into account in making the grant determination until the individual complies with the requirement or for six consecutive months, whichever is longer;

(d) Aid with respect to a dependent child who has been sanctioned under this paragraph shall be continued for the parent or parents of the child if the child is the only child receiving aid in the family, the child continues to meet the conditions of section 256.73, and the family is otherwise eligible for aid;

(e) If the noncompliant individual is a parent or other relative caretaker, payments of aid for any dependent child in the family must be made in the form of protective or vendor payments. When protective payments are required, the county agency may continue payments to the caretaker if a protective payee cannot reasonably be found. When protective payments are imposed on assistance units whose basis of eligibility

is unemployed parent or incapacitated parent, cash payments may continue to the nonsanctioned caretaker in the assistance unit, subject to paragraph (g);

(f) If, after removing a caretaker's needs from the grant, only dependent children remain eligible for AFDC, the standard of assistance shall be computed using the special children standard;

(g) If the noncompliant individual is a principal wage earner in a family whose basis of eligibility is the unemployment of a parent and the nonprincipal wage earner is not participating in an approved employment and training service, the needs of both the principal and nonprincipal wage earner must not be taken into account in making the grant determination; and

(7) Request approval from the secretary of health and human services to use vendor payment sanctions for persons listed in paragraph (5), clause (b). If approval is granted, the commissioner must begin using vendor payment sanctions as soon as changes to the state plan are approved.

Subd. 4a. **Notice and right of appeal.** If the employment and training service provider determines that the caretaker has failed or refused, without good cause, to cooperate or accept employment, the employment and training service provider shall issue to the caretaker a written notice of its determination of noncooperation or refusal to accept employment. The notice must include a detailed explanation of the reason for the determination and must specify the consequences for failure or refusal to cooperate or accept employment, the actions which the employment and training service provider believes are necessary for the caretaker to comply with the employment and training program, and the right to request, within ten days of receipt of the notice, a conciliation conference. If the dispute between the employment and training service provider and the caretaker is not resolved in the conciliation conference or a request for a conciliation conference is not made within the required time, then the employment and training service provider shall notify the county board of a caretaker's failure without good cause to cooperate or accept employment. Any determination, action, or inaction on the part of the county board relating to a caretaker's participation under section 256.736 is subject to the notice and hearing procedures in section 256.045, and Code of Federal Regulations, title 45, section 205.10.

Subd. 5. **Extension of employment and training opportunities.** The commissioner of human services shall cooperate with the commissioner of economic security to extend the availability of training and employment opportunities on a statewide basis.

Subd. 6. **Protection from garnishment.** Earnings of a caretaker while participating in full or part-time employment or training shall be protected from garnishment. This protection shall extend for a period of six months from the date of termination of a caretaker's grant of assistance.

Subd. 7. **Rulemaking.** The commissioner of human services, in cooperation with the commissioner of economic security, may adopt permanent and emergency rules necessary to qualify for any federal funds available under this section and to carry out this section.

Subd. 8. [Repealed, 1990 c 568 art 4 s 85]

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.

Subd. 10b. **Informing.** Each county agency must provide written information concerning the topics identified in subdivision 10a, paragraph (b), to all AFDC caretakers within the county agency's jurisdiction who are exempt from the requirement to attend orientation, except those under age 16, and to recipients who have good cause for failing to attend orientation as specified in rules adopted by the commissioner. The written materials must tell the individual how the individual may indicate the desire to participate in educational programs and employment and training services offered through the county. The written materials must be mailed or hand delivered to the recipient at the time the recipient is determined to be exempt or have good cause for failing to attend an orientation.

Subd. 11. **Case management services.** (a) The county agency may, to the extent of available resources, enroll targeted caretakers described in subdivision 16 in case management services and for those enrolled shall:

(1) Provide an assessment as described in subdivision 10, paragraph (a), clause (14). As part of the assessment, the case manager shall inform caretakers of the screenings available through the early periodic screening, diagnosis and treatment (EPSDT) program under chapter 256B and preschool screening under chapter 123, and encourage caretakers to have their children screened. The case manager must work with the caretaker in completing this task;

(2) Develop an employability development plan as described in subdivision 10, paragraph (a), clause (15). The case manager must work with the caretaker in completing this task. For caretakers who are not literate or who have not completed high school, the first goal for the caretaker should be to complete literacy training or a general equivalency diploma. Caretakers who are literate and have completed high school shall be counseled to set realistic attainable goals, taking into account the long-term needs of both the caretaker and the caretaker's family;

(3) Coordinate services such as child care, transportation, and education assis-

tance necessary to enable the caretaker to work toward the goals developed in clause (2). The case manager shall refer caretakers to resource and referral services, if available, and shall assist caretakers in securing appropriate child care services. When a client needs child care services in order to attend a Minnesota public or nonprofit college, university or technical college, the case manager shall contact the appropriate agency to reserve child care funds for the client. A caretaker who needs child care services in order to complete high school or a general equivalency diploma is eligible for child care under sections 256H.01 to 256H.19;

(4) Develop, execute, and monitor a contract between the county agency and the caretaker. The contract must be based upon the employability development plan described in subdivision 10, paragraph (a), clause (15), but must be a separate document. It must include: (a) specific goals of the caretaker including stated measurements of progress toward each goal, the estimated length of participation in the program, and the number of hours of participation per week; (b) educational, training, and employment activities and support services provided by the county agency, including child care; and (c) the participant's obligations and the conditions under which the county will withdraw the services provided;

The contract must be signed and dated by the case manager and participant and may include other terms as desired or needed by either party. In all cases, however, the case manager must assist the participant in reviewing and understanding the contract and must ensure that the caretaker has set forth in the contract realistic goals consistent with the ultimate goal of self-sufficiency for the caretaker's family; and

(5) Develop and refer caretakers to counseling or peer group networks for emotional support while participating in work, education, or training.

(b) In addition to the duties in paragraph (a), for minor parents and pregnant minors, the case manager shall:

(1) Ensure that the contract developed under paragraph (a), clause (4), considers all factors set forth in section 257.33, subdivision 2;

(2) Assess the housing and support systems needed by the caretaker in order to provide the dependent children with adequate parenting. The case manager shall encourage minor parents and pregnant minors who are not living with friends or relatives to live in a group home or foster care setting. If minor parents and pregnant minors are unwilling to live in a group home or foster care setting or if no group home or foster care setting is available, the case manager shall assess their need for training in parenting and independent living skills and when appropriate shall refer them to available counseling programs designed to teach needed skills; and

(3) Inform minor parents or pregnant minors of, and assist them in evaluating the appropriateness of, the high school graduation incentives program under section 126.22, including post-secondary enrollment options, and the employment-related and community-based instruction programs.

(c) A caretaker may request a conciliation conference to attempt to resolve disputes regarding the contents of a contract developed under this section or a housing and support systems assessment conducted under this section. The caretaker may request a hearing pursuant to section 256.045 to dispute the contents of a contract or assessment developed under this section. The caretaker need not request a conciliation conference in order to request a hearing pursuant to section 256.045.

Subd. 12. **Case managers.** (a) Counties may directly employ case managers if certified as an employment and training service provider under section 268.0122, or may contract for case management services with a certified employment and training service provider. Uncertified counties and contracting agencies may provide case management services only if they demonstrate the ability to coordinate employment, training, education, and support services. The commissioner of economic security shall determine whether or not an uncertified county or agency has demonstrated such ability.

(b) Counties that employ case managers must ensure that the case managers have the skills and knowledge necessary to perform the variety of tasks described in subdivi-

sion 11. Counties that contract with another agency for case management services must specify in the contract the skills and knowledge needed by the case managers. At a minimum, case managers must:

(1) have a thorough knowledge of training, education, and employment opportunities;

(2) have training or experience in understanding the needs of AFDC clients and their families; and

(3) be able to formulate creative individualized contracts.

Subd. 13. **State share.** The state must pay 75 percent of the nonfederal share of costs incurred by counties under subdivision 11.

Beginning July 1, 1991, the state will reimburse counties, up to the limit of state appropriations, according to the payment schedule in section 256.025, for the county share of county agency expenditures made under subdivision 11 from January 1, 1991, on. Payment to counties under this subdivision is subject to the provisions of section 256.017.

If the state appropriation is not sufficient to fund the cost of case management services for all caretakers identified in subdivision 2a, the commissioner must define a statewide subgroup of caretakers which includes all caretakers in subdivision 2a, clause (1), and as many caretakers as possible from subdivision 2a, clauses (2) and (3).

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.

Subd. 15. **Reporting.** The commissioner of human services, in cooperation with the commissioner of economic security shall develop reporting requirements for county agencies and employment and training service providers according to section 256.01, subdivision 2, paragraph (17). Reporting requirements must, to the extent possible, use existing client tracking systems and must be within the limits of funds available. The requirements must include summary information necessary for state agencies and the legislature to evaluate the effectiveness of the services.

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 11 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 economic security, and entities under contract with either the department of economic security 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 ecomonic security 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 ecomonic security, 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.

Subd. 17. [Repealed, 1990 c 568 art 4 s 85]

Subd. 18. **Program operation by Indian tribes.** (a) The commissioner may enter into agreements with any federally recognized Indian tribe with a reservation in the state to provide employment and training programs under this section to members of the Indian tribe receiving AFDC. For purposes of this section, "Indian tribe" means a tribe, band, nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians; and for which a reservation exists as is consistent with Public Law Number 100-485, as amended.

(b) Agreements entered into under this subdivision must require the governing body of the Indian tribe to fulfill all county responsibilities required under this section in operation of the employment and training services covered by the contract, excluding the county share of costs in subdivision 13 and any county function related to AFDC eligibility determination or grant payment. The commissioner may enter into an agreement with a consortium of Indian tribes providing the governing body of each Indian tribe in the consortium agrees to these conditions.

(c) Agreements entered into under this subdivision must require the Indian tribe to operate the employment and training services within a geographic service area not to exceed the counties within which a border of the reservation falls. Indian tribes may also operate services in Hennepin and Ramsey counties or other geographic areas as approved by the commissioner of human services in consultation with the commissioner of economic security.

(d) Agreements entered into under this section must require the Indian tribe to operate a federal jobs program under Public Law Number 100-485, section 482(i).

(e) Agreements entered into under this section must require conformity with section 13.46 and any applicable federal regulations in the use of data about AFDC recipients.

(f) Agreements entered into under this section must require financial and program participant activity record keeping and reporting in the manner and using the forms and procedures specified by the commissioner and that federal reimbursement received must be used to expand operation of the employment and training services.

(g) Agreements entered into under this section must require that the Indian tribe coordinate operation of the programs with county employment and training programs, Indian Job Training Partnership Act programs, and educational programs in the counties in which the tribal unit's program operates.

(h) Agreements entered into under this section must require the Indian tribe to allow inspection of program operations and records by representatives of the department.

(i) Agreements entered into under this subdivision must require the Indian tribe to have its employment and training service provider certified by the commissioner of economic security for operation of the programs.

(j) Agreements entered into under this subdivision must require the Indian tribe to specify a starting date for each program with a procedure to enable tribal members participating in county-operated employment and training services to make the transition to the program operated by the tribal unit. Programs must begin on the first day of a month specified by the agreement.

(k) If the commissioner and Indian tribe enter into an agreement, the commissioner, after consulting with the commissioner of economic security regarding tribal plan status, may immediately reallocate county case management and employment and training block grant money from the counties in the Indian tribe's service area to the Indian tribe, prorating each county's annual allocations according to that percentage of the number of adult tribal unit members receiving AFDC residing in the county compared to the total number of adult AFDC recipients residing in the county and also prorating the annual allocation according to the month in which the Indian tribe program starts. If the Indian tribe cancels the agreement or fails, in the commissioner's judgment, to fulfill any requirement of the agreement, the commissioner shall reallocate money back to the counties in the Indian tribe's service area.

(l) Indian tribe members receiving AFDC and residing in the service area of an Indian tribe operating employment and training services under an agreement with the commissioner must be referred by county agencies in the service area to the Indian tribe for employment and training services.

(m) The Indian tribe shall bill the commissioner of human services for services performed under the contract. The commissioner shall bill the United States Department of Health and Human Services for reimbursement. Federal receipts are appropriated to the commissioner to be provided to the Indian tribe that submitted the original bill.

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: *1969 c 567 s 1; 1969 c 750 s 1; 1973 c 254 s 3; 1974 c 498 s 1,2; 1977 c 430 s 15-18; 1980 c 509 s 100; 3Sp1981 c 3 s 9,10; 1984 c 654 art 5 s 58; 1985 c 252 s 9,10; 1Sp1985 c 14 art 9 s 17-22; 1986 c 444; 1987 c 403 art 3 s 4-21; 1Sp1987 c 4 art 2 s 4; 1988 c 689 art 2 s 130-134; 1989 c 89 s 7; 1989 c 246 s 2; 1989 c 282 art 5 s 25-34; 1Sp1989 c 1 art 16 s 2; 1990 c 426 art 2 s 1; 1990 c 568 art 4 s 3-13,84; 1991 c 292 art 5 s 22; 1993 c 4 s 26,27; 1Sp1993 c 1 art 6 s 9-13; art 9 s 16; 1994 c 465 art 3 s 7; 1994 c 483 s 1*

256.7365 SPECIAL PROJECTS TO ADDRESS DEPENDENCE ON AFDC.

Subdivision 1. **Establishment and purpose.** The commissioner shall establish a grant program for projects to serve AFDC caretakers who have received AFDC for at least 36 months, AFDC caretakers with substantial barriers to employment, or individuals at risk of long-term dependency on AFDC. The projects shall assist individuals to escape or avoid long-term dependency on AFDC.

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

(a) "Substantial barriers to employment" means disabilities, chemical dependency, having children with disabilities, lack of a high school degree, lack of a marketable occupational skill, three or more children, or lack of regular work experience in the previous five years.

(b) "Case management" means case management as defined in section 256.736, subdivision 11.

Subd. 3. **Application.** Counties, employment and training service providers, cities, local and state agencies, federally recognized Indian reservations, educational institutions, job training agencies, community-based organizations, displaced homemaker programs, supported work programs, and other nonprofit agencies may apply for grants under this section.

Subd. 4. **Selection.** A committee consisting of the commissioner of human services, the commissioner of economic security, and the chancellor of the state board of technical colleges, or their designees, shall review the project proposals and select projects to receive grants under this section. The first set of projects must be selected by March 1, 1988. At least two projects must be selected that are operated by or in cooperation with tribes or organizations representing ethnic minorities, except that the committee may reject any project proposal that does not meet the design requirements established in subdivision 5.

Subd. 5. **Project design.** Projects selected under this section must:

(1) use existing resources whenever possible;

(2) serve one of the three groups listed in subdivision 1;

(3) meet financial and administrative standards established by the commissioner;

(4) participate in reporting and evaluation requirements as specified by the commissioner; and

(5) provide matching funds, including in-kind matches, but not including income maintenance grants, medical assistance, food stamps, or state job training funds. Preference shall be given to projects which include multiagency participation or coordination.

Subd. 6. **Allowable expenditures.** (a) Projects may use money received under this section for education, employment, social services, child care, transportation, support services, rehabilitation services, relocation assistance, job development, work experience, on-the-job training, case management, medical services, and other appropriate services.

(b) Projects may use up to 15 percent of the money received under this section for administrative expenses. Administrative expenses do not include expenses for activities in paragraph (a).

(c) The commissioner may establish limits on the use of money for particular purposes or services.

Subd. 7. **Demonstration and evaluation.** For the biennium ending June 30, 1989, projects are demonstration projects to test the effectiveness of differing approaches to serving populations with acute needs. The commissioner of human services shall submit to the governor and the legislature a progress report by February 1, 1989, and shall submit subsequent program evaluation reports as part of the biennial plan.

Subd. 8. [Repealed, 1990 c 568 art 4 s 85]

Subd. 9. **Carryover authority.** Money appropriated in one fiscal year may be carried forward into the next year to ensure continuity of services and funding for follow-up services.

History: *1987 c 403 art 3 s 22; 1990 c 375 s 3; 1990 c 568 art 4 s 14; 1994 c 483 s 1*

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 economic security, 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: *1983 c 249 s 1; 1984 c 640 s 32; 1984 c 654 art 5 s 22,58; 1Sp1985 c 9 art 2 s 30; 1Sp1985 c 14 art 9 s 23; 1987 c 403 art 2 s 62; 1989 c 282 art 5 s 35; 1990 c 568 art 4 s 15-17; 1Sp1993 c 1 art 6 s 15-21; 1994 c 483 s 1*

256.738 ON-THE-JOB TRAINING.

(a) County agencies may, in accordance with section 256.736, subdivision 10, develop on-the-job training programs that permit voluntary participation by AFDC recipients. A county agency that chooses to provide on-the-job training as one of its optional employment and training services may make payments to employers for on-the-job training costs that, during the period of the training, must not exceed 50 percent of the wages paid by the employer to the participant. The payments are deemed to be in compensation for the extraordinary costs associated with training participants under this section and in compensation for the costs associated with the lower productivity of the participants during training.

(b) County agencies shall limit the length of training based on the complexity of the job and the recipient's previous experience and training. Placement in an on-the-job training position with an employer is for the purpose of training and employment with the same employer, who has agreed to retain the person upon satisfactory completion of training.

(c) Placement of any recipient in an on-the-job training position must be compatible with the assessment and employability development plan established for the recipient under section 256.736, subdivision 10, paragraph (a), clauses (14) and (15).

(d) Provision of an on-the-job training program under the job training partnership act, in and of itself, does not qualify as an on-the-job training program under section 256.736, subdivision 10, paragraph (a), clause (13).

History: *1989 c 282 art 5 s 36*

256.739 GRANT DIVERSION.

(a) County agencies may, according to section 256.736, subdivision 10, develop grant diversion programs that permit voluntary participation by AFDC recipients. A county agency that chooses to provide grant diversion as one of its optional employment and training services may divert to an employer part or all of the AFDC payment for the participant's assistance unit, in compliance with federal regulations and laws. Such payments to an employer are to subsidize employment for AFDC recipients as an alternative to public assistance payments.

(b) County agencies shall limit the length of training to nine months. Placement in a grant diversion training position with an employer is for the purpose of training and employment with the same employer, who has agreed to retain the person upon satisfactory completion of training.

(c) Placement of any recipient in a grant diversion subsidized training position must be compatible with the assessment and employability development plan established for the recipient under section 256.736, subdivision 10, paragraph (a), clauses (14) and (15).

(d) No grant diversion participant may be assigned to fill any established, unfilled position vacancy with an employer.

(e) In addition to diverting the AFDC grant to the employer, employment and training block grant funds may be used to subsidize the grant diversion placement.

History: *1990 c 568 art 4 s 18*

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 application 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.

Subd. 1a. **Stepparent's income.** In determining income available, the county agency shall take into account the remaining income of the dependent child's stepparent who lives in the same household after disregarding:

(1) the first $90 of the stepparent's gross earned income;

(2) an amount for support of the stepparent and any other individuals whom the stepparent claims as dependents for determining federal personal income tax liability and who live in the same household but whose needs are not considered in determining eligibility for assistance under sections 256.72 to 256.87. The amount equals the standard of need for a family of the same composition as the stepparent and these other individuals;

(3) amounts the stepparent actually paid to individuals not living in the same household but whom the stepparent claims as dependents for determining federal personal income tax liability; and

(4) alimony or child support, or both, paid by the stepparent for individuals not living in the same household.

Subd. 1b. **Review of standard of need.** The commissioner of human services shall develop a household budget sufficient to maintain a family in Minnesota. The budget must be based on a market survey of the cost of items needed by families raising children to the extent these factors are consistent with the requirements of federal regulations. The commissioner shall develop recommendations for an AFDC standard of need and level of payment that are based on the budget. The commissioner shall submit to the legislature by January 1, 1990, a report identifying the methods proposed for the conduct of the market survey, the funds required for the survey, and a timetable for completion of the survey, establishment of a family budget, and recommendation of an AFDC standard of need.

Subd. 2. **Application.** Application for assistance under sections 256.72 to 256.87 shall be made to the county agency of the county in which the dependent child lives. If the child is not living within the state at the time of application but is eligible for assistance, the application may be made to the agency of the county where the child is present and forwarded to the agency of the county where the child last lived. The application shall be in writing or reduced to writing in the manner and upon the form prescribed by the state agency and verified by the oath of the applicant or in lieu thereof shall contain the following declaration which shall be signed by the applicant: "I declare

that this application has been examined by me and to the best of my knowledge and belief is a true and correct statement of every material point." The application shall be made by the person with whom the child will live and contain information as to the age and residence of the child and such other information as may be required by the rules of the state agency. One application may be made for several children of the same family if they live with the same person.

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

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

Subd. 5. **Assignment of support and maintenance rights.** An applicant for assistance, or a recipient of assistance, under sections 256.72 to 256.87 or an applicant or recipient for whom foster care maintenance is provided under Title IV-E of the Social Security Act is considered to have assigned to the public agency responsible for child support enforcement at the time of application all rights to child support and maintenance from any other person the applicant may have in the applicant's own behalf or in the behalf of any other family member for whom application is made under sections 256.72 to 256.87 or Title IV-E. The assignment:

(1) is effective as to both current and accrued child support and maintenance obligations;

(2) takes effect upon a determination that the applicant is eligible for assistance under sections 256.72 to 256.87 or that the applicant or family member is eligible for foster care maintenance under Title IV-E of the Social Security Act;

(3) terminates when an applicant ceases to receive assistance under sections 256.72 to 256.87 or when the applicant or family member ceases to receive foster care maintenance under Title IV-E of the Social Security Act, except with respect to the amount of any unpaid support or maintenance obligation, or both, under the assignment.

History: *(8688-7, 8688-8) 1937 c 438 s 5,6; 1943 c 580 s 1; 1945 c 320 s 1; 1947 c 192 s 1; 1949 c 606 s 1; 1951 c 229 s 3; 1955 c 763 s 1,2; 1957 c 690 s 3; 1963 c 296 s 1; 1963 c 794 s 5; 1967 c 653 s 1; 1969 c 478 s 1; 1969 c 747 s 1; 1979 c 250 s 1; 3Sp1981 c 3 s 11,12; 1982 c 640 s 1,2; 1983 c 308 s 1; 1984 c 654 art 5 s 58; 1985 c 131 s 1,2; 1985 c 248 s 70; 1985 c 252 s 11-13; 1986 c 444; 1987 c 403 art 3 s 23; 1989 c 282 art 5 s 37-39; 1990 c 568 art 2 s 61; 1Sp1993 c 1 art 6 s 22; 1994 c 529 s 7*

256.745 SERVICE DELIVERY IMPROVEMENT PILOT PROJECT.

Subdivision 1. **STEP.** "STEP" means the strive toward excellence program administered by the department of administration.

Subd. 2. **Pilot project established; goals.** The service delivery improvement project, consisting of six pilot projects selected under subdivision 4, is established to use STEP productivity improvement technology to achieve the following goals: redesign of employment and training and income maintenance delivery systems as required under Laws 1985, First Special Session chapter 14, article 9; and improvement of the quality and cost-effectiveness of employment and training and income maintenance services provided to clients.

Subd. 3. **Committee.** The commissioner shall establish and select a committee to administer the service delivery improvement project. The committee consists of the commissioner, the commissioner of economic security, the commissioner of human services, one member of the senate, one member of the house of representatives, one public member representing the private sector, and other public members considered necessary by the commissioner. The commissioner may reimburse the public members for actual expenses in the same manner and amount as authorized by the commissioner's plan under section 43A.18, subdivision 2.

Subd. 4. **Duties.** The committee shall solicit from local service units or consortia of local service units proposals to conduct innovative pilot projects to redesign the employment and training and income maintenance delivery system. By December 1, 1987, the committee shall evaluate the proposals and select six pilot projects to receive training and technical assistance as provided in subdivision 6.

Subd. 5. **Evaluation.** The committee shall evaluate each proposal based upon the extent to which the proposed pilot project uses STEP productivity improvement technology, addresses the goals set forth under subdivision 2, and involves members of the private sector in joint financing of delivery system innovations.

Subd. 6. **Training and technical assistance.** The commissioner shall contract with the department of administration to provide staff training, technical assistance, and detailed periodic reports of the day-to-day operation of a pilot project to affected local service units.

Subd. 7. **Cooperation of agencies.** The commissioner of human services and the commissioner of economic security shall cooperate fully with local service units undertaking pilot projects under this section. If requested by a local service unit which has had a pilot project selected under subdivision 4, the commissioner shall reduce, to the extent possible, reporting and other requirements which may be applicable under state law to that pilot project.

History: *1987 c 403 art 3 s 24; 1994 c 483 s 1*

256.75 INVESTIGATIONS TO BE MADE BY COUNTY AGENCIES.

When a county agency receives a notification of the dependency of a child or an application for assistance an investigation and record shall be made within a reasonable time of the circumstances to ascertain the dependency of the child or the facts supporting the application made under sections 256.72 to 256.87 and such other information as may be required by the rules of the state agency.

History: *(8688-9) 1937 c 438 s 7*

256.76 ASSISTANCE, DETERMINATION OF AMOUNT.

Subdivision 1. Upon the completion of the investigation the county agency shall decide whether the child is eligible for assistance under the provisions of sections 256.72 to 256.87 and determine the amount of the assistance and the date on which the assistance begins. A decision on an application for assistance must be made as promptly as possible and no more than 30 days from the date of application. Notwithstanding section 393.07, the county agency shall not delay approval or issuance of assistance pending formal action of the county board of commissioners. The first month's grant shall be based upon that portion of the month from the date of application, or from the date that the applicant meets all eligibility factors, whichever occurs later, provided that on the date that assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, or other emergency assistance. If an emergency need is found to exist, the applicant shall be granted assistance pursuant to section 256.871 within a reasonable period of time. It shall make a grant of assistance which shall be binding upon the county and be complied with by the county until the grant is modified or vacated. The county agency shall notify the applicant of its decision in writing. The assistance shall be paid monthly to the applicant or to the vendor of medical care upon order of the county agency from funds appropriated to the county agency for this purpose. The county agency shall, upon the granting of assistance under these sections, file an order on the form to be approved by the state agency with the auditor of the county. After the order is filed, warrants shall be drawn and payments made only in accordance with this order to or for recipients of this assistance or in accordance with any subsequent order.

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

History: *(8688-10) 1937 c 438 s 8; 1951 c 229 s 4; 1957 c 690 s 4; 1971 c 681 s 4; 1980 c 509 s 101; 1981 c 360 art 2 s 20; 1985 c 252 s 14; 1988 c 689 art 2 s 135; 1990 c 568 art 4 s 84*

256.77 [Repealed, 1976 c 131 s 2]

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: *(8688-12) 1937 c 438 s 10; 1980 c 509 s 102; 1985 c 252 s 15; 1988 c 689 art 2 s 268; 1Sp1993 c 1 art 6 s 23*

256.79 [Repealed, 1987 c 363 s 14]

256.80 COUNTY BOARD TO APPROPRIATE MONEY; MANDATORY.

The county board of commissioners in each county in this state shall appropriate annually such sum as may be needed to carry out the provisions of sections 256.72 to 256.87, including expenses of administration based upon a budget prepared by the county agency, after taking into account state aid, and to include in the tax levy for such county the sum or sums appropriated for that purpose. Should the sum so appropriated be expended or exhausted during the year and for the purpose for which it was appropriated additional sums shall be appropriated by the board of county commissioners.

History: *(8688-14) 1937 c 438 s 12*

256.81 COUNTY AGENCY, DUTIES.

(1) The county agency shall keep such records, accounts, and statistics in relation to aid to families with dependent children as the state agency shall prescribe.

(2) Each grant of aid to families with dependent children shall be paid to the recipient by the county agency unless paid by the state agency. Payment must be by check or electronic means except in those instances in which the county agency, subject to the rules of the state agency, determines that payments for care shall be made to an individual other than the parent or relative with whom the dependent child is living or to vendors of goods and services for the benefit of the child because such parent or relative is unable to properly manage the funds in the best interests and welfare of the child. At the request of a recipient, the state or county may make payments directly to vendors of goods and services, but only for goods and services appropriate to maintain the health and safety of the child, as determined by the county.

(3) The state or county may ask the recipient to give written consent authorizing the state or county to provide advance notice to a vendor before vendor payments of rent are reduced or terminated. Whenever possible under state and federal laws and regulations and if the recipient consents, the state or county shall provide at least 30 days notice to vendors before vendor payments of rent are reduced or terminated. If 30 days notice cannot be given, the state or county shall notify the vendor within three working days after the date the state or county becomes aware that vendor payments of rent will be reduced or terminated. When the county notifies a vendor that vendor payments of rent will be reduced or terminated, the county shall include in the notice that it is illegal to discriminate on the grounds that a person is receiving public assistance and the penalties for violation. The county shall also notify the recipient that it is illegal to discriminate on the grounds that a person is receiving public assistance and the procedures for filing a complaint. The county agency may develop procedures, including using the MAXIS system, to implement vendor notice and may charge vendors a fee not exceeding $5 to cover notification costs.

(4) A vendor payment arrangement is not a guarantee that a vendor will be paid by the state or county for rent, goods, or services furnished to a recipient, and the state and county are not liable for any damages claimed by a vendor due to failure of the state or county to pay or to notify the vendor on behalf of a recipient, except under a specific written agreement between the state or county and the vendor or when the state or county has provided a voucher guaranteeing payment under certain conditions.

(5) The county shall be paid from state and federal funds available therefor the amount provided for in section 256.82.

(6) Federal funds available for administrative purposes shall be distributed between the state and the counties in the same proportion that expenditures were made except as provided for in section 256.017.

History: *(8688-15) 1937 c 438 s 13; 1943 c 619 s 2; 1951 c 229 s 5; 1963 c 794 s 6; 1967 c 885 s 5; 1969 c 451 s 1; 1969 c 749 s 4; 1985 c 248 s 70; 1988 c 719 art 8 s 5; 1990 c 568 art 4 s 19; 1992 c 513 art 8 s 12*

256.82 PAYMENTS BY STATE.

Subdivision 1. **Division of costs and payments.** Based upon estimates submitted by the county agency to the state agency, which shall state the estimated required expenditures for the succeeding month, upon the direction of the state agency, payment shall be made monthly in advance by the state to the counties of all federal funds available for that purpose for such succeeding month. The state share of the nonfederal portion of county agency expenditures shall be 85 percent and the county share shall be 15 percent. Benefits shall be issued to recipients by the state or county and funded according to section 256.025, subdivision 3, subject to provisions of section 256.017. Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of county agency expenditures under this subdivision from January 1, 1991, on. Payment to counties under this subdivision is subject to the provisions of section 256.017. Adjustment of any overestimate or underestimate made by any county shall be paid upon the direction of the state agency in any succeeding month.

Subd. 2. **Foster care maintenance payments.** Notwithstanding subdivision 1, for the purposes of foster care maintenance payments under Title IV-E of the federal Social Security Act, United States Code, title 42, sections 670 to 676, during the period beginning July 1, 1985, and ending December 31, 1985, the county paying the maintenance costs shall be reimbursed for the costs from those federal funds available for that purpose together with an amount of state funds equal to a percentage of the difference between the total cost and the federal funds made available for payment. This percentage shall not exceed the percentage specified in subdivision 1 for the aid to families with dependent children program. In the event that the state appropriation for this purpose is less than the state percentage set in subdivision 1, the reimbursement shall be ratably reduced to the county. Beginning January 1, 1986, for the purpose of foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the county paying the maintenance costs must be reimbursed for the costs from the federal money available for the purpose.

Subd. 3. **Setting foster care standard rates.** The commissioner shall annually establish minimum standard maintenance rates for foster care maintenance and difficulty of care payments for all children in foster care.

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

History: *(8688-16) 1937 c 438 s 14; 1943 c 619 s 1; 1951 c 229 s 6; 1977 c 423 art 3 s 3; 1979 c 303 art 2 s 1; 1980 c 607 art 2 s 2; 1982 c 553 s 1; 1983 c 312 art 5 s 5; 1Sp1985 c 9 art 2 s 31; 1987 c 235 s 1,2; 1988 c 719 art 8 s 6; 1989 c 277 art 2 s 5; 1Sp1989 c 1 art 16 s 3; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 23*

256.83 [Repealed, 1971 c 550 s 2]

256.84 UNITED STATES GOVERNMENT ASSISTANCE NOT TO BAR AID.

The receipt or possession by any person of sums received from United States government war risk insurance or any government compensation shall not be a bar to the granting of an allowance provided for in sections 256.72 to 256.87 if, in the opinion of the county agency having jurisdiction to order the allowance, such insurance or compensation is not sufficient to maintain the children, in whose behalf an allowance is requested, in their own home.

History: *(8688-18) 1937 c 438 s 16*

256.85 LIBERAL CONSTRUCTION.

Sections 256.031 to 256.036 and 256.72 to 256.87 shall be liberally construed with a view to accomplishing their purpose, which is to enable the state and its several counties to cooperate with responsible primary caretakers of children in rearing future citizens, when the cooperation is necessary on account of relatively permanent conditions, in order to keep the family together in the same household, reasonably safeguard the health of the children's primary caretaker and secure personal care and training to the children during their tender years.

History: *(8688-19) 1937 c 438 s 17; 1981 c 31 s 6; 1989 c 282 art 5 s 40*

256.851 RULES.

The commissioner of human services shall promulgate emergency and permanent rules necessary to implement Laws 1981, Third Special Session chapter 3, sections 1 to 19, and sections 256.72 to 256.871.

History: *3Sp1981 c 3 s 13; 1984 c 640 s 32; 1984 c 654 art 5 s 23,58*

256.86 UNITED STATES FUNDS TO BE APPROPRIATED TO STATE AGENCY.

All moneys received, or to be received, from the United States government for aid to dependent children are hereby appropriated to the state agency for the purpose of carrying out the provisions of sections 256.72 to 256.87.

History: *(8688-20) 1937 c 438 s 18*

256.863 RECOVERY OF MONEYS; APPORTIONMENT.

When any amount shall be recovered from any source for assistance furnished under the provisions of sections 256.72 to 256.87, except as provided in sections 256.019 and 256.98, subdivision 7, there shall be paid to the United States the amount which shall be due under the terms of the Social Security Act and the balance thereof shall be paid into the treasury of the state or county substantially in the proportion in which they have respectively contributed toward the total assistance paid.

History: *1953 c 55 s 1; 1959 c 24 s 1; 1976 c 239 s 80; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1988 c 719 art 8 s 7*

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

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

Subd. 3. **Continuing contributions to former recipient.** The order for continuing support contributions shall remain in effect following the period after public assistance 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. 4. [Repealed, 1989 c 282 art 2 s 219]

Subd. 5. **Child not receiving assistance.** A person or entity having physical custody of a dependent child not receiving assistance under sections 256.72 to 256.87 has a cause of action for child support against the child's absent parents. Upon a motion served on the absent parent, the court shall order child support payments from the absent parent under chapter 518. This subdivision applies only if the person or entity has physical custody with the consent of a custodial parent or approval of the court.

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

Subd. 7. **Notice of docketing of maintenance judgment.** Every order for maintenance issued under this section shall provide for a conspicuous notice that, if the obligor fails to make the maintenance payments, the obligee or public agency responsible for maintenance enforcement may obtain docketing of a judgment for the unpaid amount under the provisions of section 548.091. The notice shall enumerate the conditions that must be met before the judgment can be docketed.

History: *(8688-21, 8688-22, 8688-23) 1937 c 438 s 19-21; 1953 c 639 s 3; 1977 c 282 s 1; 1980 c 408 s 1; 1981 c 360 art 2 s 21; 1983 c 308 s 2; 1984 c 547 s 2; 1985 c 131 s 3,4; 1Sp1985 c 9 art 2 s 32; 1988 c 593 s 1-4; 1989 c 282 art 2 s 114; 1993 c 340 s 3-6; 1994 c 630 art 11 s 4*

256.871 EMERGENCY ASSISTANCE TO NEEDY FAMILIES WITH CHILDREN UNDER AGE 21.

Subdivision 1. **County welfare agency; duties.** The county welfare agency shall grant emergency financial assistance and services to any needy family with a child under the age of 21 years who is or was within six months prior to application living with an eligible relative specified in section 256.12, subdivision 14.

Subd. 2. **Eligibility for emergency assistance.** Notwithstanding any other eligibility

provision of this chapter, any child without resources immediately available to meet emergency needs shall be furnished assistance for a period not in excess of 30 days during any 12-month period. Assistance shall be furnished under the following conditions:

(a) The child is without resources immediately available to meet emergency needs.

(b) Assistance is necessary to avoid destitution or provide emergency shelter arrangements.

(c) The child's destitution or need for living arrangements did not arise because the child or the relative refused without good cause to accept employment or training for employment.

(d) Assistance shall be in the form of money payments, vendor payments, payments in kind or interest free loans for tools, equipment or expenses required for return to employment. Such loans shall not exceed $100 and shall be considered only when other private or public resources are not immediately available.

Subd. 3. **County of responsibility.** No state or county durational residence is required to qualify for such assistance. The county which shall be financially responsible and grant assistance shall be the county wherein the child lives who is found to be in emergency need.

Subd. 4. **Emergency defined.** An emergency is a situation or set of circumstances which endangers or threatens to endanger the health or safety of a child or the child's relative caretaker. Examples of emergencies which create the need for such assistance include natural disasters such as floods, fires, or storms; civil disorders; strikes; illness; accident; death; eviction from shelter; migrant families in necessitous circumstances; or other crises, as defined by the commissioner, in accordance with directives of the United States Secretary of Health and Human Services. The commissioner shall limit, entirely or in part, emergency assistance payments for utilities and housing when eligible families do not demonstrate that they have made a good faith effort to meet those payments.

Subd. 5. **Authorization to grant emergency assistance.** The local social services agency shall designate a person or persons who shall be authorized to immediately grant emergency assistance pursuant to this section.

Subd. 6. **Reports of estimated expenditures; payments.** The county agency shall submit to the state agency reports required under section 256.01, subdivision 2, paragraph (17). Fiscal reports shall estimate expenditures for each succeeding month in such form as required by the state agency. The state share of the nonfederal portion of eligible expenditures shall be ten percent and the county share shall be 90 percent. Benefits shall be issued to recipients by the state or county and funded according to section 256.025, subdivision 3, subject to provisions of section 256.017. Beginning July 1, 1991, the state will reimburse counties according to the payment schedule set forth in section 256.025 for the county share of county agency expenditures made under this subdivision from January 1, 1991, on. Payment under this subdivision is subject to the provisions of section 256.017. Adjustment of any overestimate or underestimate made by any county shall be paid upon the direction of the state agency in any succeeding month.

Subd. 7. **Authority of the commissioner.** The commissioner is hereby authorized, subject to the provisions of chapter 14, to promulgate permanent rules and may promulgate emergency rules not inconsistent with this section as necessary to qualify for maximum federal funds to implement sections 256.72 to 256.871.

History: *1971 c 943 s 1; 1983 c 216 art 1 s 38; 1984 c 580 s 1; 1984 c 640 s 32; 1985 c 252 s 17; 1Sp1985 c 9 art 2 s 33; 1986 c 444; 1988 c 719 art 8 s 8; 1989 c 89 s 8; 1989 c 277 art 2 s 6; 1Sp1989 c 1 art 16 s 4; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 24; 1994 c 631 s 31*

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 preservation 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*

256.872 [Repealed, 1983 c 308 s 32]
256.873 [Repealed, 1983 c 308 s 32]
256.874 [Repealed, 1982 c 488 s 8]
256.875 [Repealed, 1982 c 488 s 8]
256.876 [Repealed, 1983 c 308 s 32]
256.877 [Repealed, 1982 c 488 s 8]
256.878 [Repealed, 1982 c 488 s 8]

256.879 SUPPLEMENTAL HOUSING ALLOWANCE.

Subdivision 1. The commissioner of human services may, with the approval of the federal department of health, education and welfare, provide an annual supplemental housing allowance for recipients of the aid to families with dependent children program who would otherwise qualify for the refund provided in sections 290A.01 to 290A.22.

Subd. 2. The amount of the supplemental housing allowance, if any, shall be calculated in the same manner as the property tax refund provided in sections 290A.01 to 290A.22. Recipients may apply for this supplement in the same manner as claims submitted to the department of revenue under sections 290A.01 to 290A.22. The supplemental allowance shall be paid by local welfare agencies.

Subd. 3. The supplemental housing allowance shall be financed from funds appropriated to the department of revenue pursuant to chapter 290A. The commissioner of human services and the commissioner of revenue shall cooperate with the federal department of health, education and welfare in any reasonable manner as may be necessary to qualify for reimbursement under the aid to families with dependent children program for costs incurred in the provision of the supplemental housing allowance.

History: *1976 c 334 s 1; 1984 c 654 art 5 s 58; 1994 c 416 art 1 s 5,6*

SOCIAL WELFARE FUND

256.88 SOCIAL WELFARE FUND ESTABLISHED.

Except as otherwise expressly provided, all moneys and funds held by the commissioner of human services and the local social services agencies of the several counties in trust or for the benefit of handicapped, dependent, neglected, and delinquent children, children born to mothers who were not married to the children's fathers at the

times of the conception nor at the births of the children, persons determined to be mentally retarded, mentally ill or chemically dependent, or other wards or beneficiaries, under any law, shall be kept in a single fund to be known as the "social welfare fund" which shall be deposited at interest, held, or disbursed as provided in sections 256.89 to 256.92.

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

256.89 FUND DEPOSITED IN STATE TREASURY.

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

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

256.90 SOCIAL WELFARE FUND; USE; DISPOSITION; DEPOSITORIES.

The commissioner of human services at least 30 days before the first day of January and the first day of July in each year shall file with the state treasurer an estimate of the amount of the social welfare fund to be held in the treasury during the succeeding six-month period, subject to current disbursement. Such portion of the remainder thereof as may be at any time designated by the request of the commissioner of human services may be invested by the state treasurer in bonds in which the permanent trust funds of the state of Minnesota may be invested, upon approval by the state board of investment. The portion of such remainder not so invested shall be placed by the treasurer at interest for the period of six months, or when directed by the commissioner of human services, for the period of 12 months thereafter at the highest rate of interest obtainable in a bank, or banks, designated by the board of deposit as a suitable depository therefor. All the provisions of law relative to the designation and qualification of depositories of other state funds shall be applicable to sections 256.88 to 256.92, except as herein otherwise provided. Any bond given, or collateral assigned or both, to secure a deposit hereunder may be continuous in character to provide for the repayment of any moneys belonging to the fund theretofore or thereafter at any time deposited in such bank until its designation as such depository is revoked and the security thereof shall be not impaired by any subsequent agreement or understanding as to the rate of interest to be paid upon such deposit, or as to time for its repayment. The amount of money belonging to the fund deposited in any bank, including other state deposits, shall not at any time exceed the amount of the capital stock thereof. In the event of the closing of the bank any sum deposited therein shall immediately become due and payable.

History: *(4464) 1923 c 106 s 3; 1925 c 253; 1943 c 236 s 1; 1984 c 654 art 5 s 58*

256.91 PURPOSES.

From that part of the social welfare fund held in the state treasury subject to disbursement as provided in section 256.90 the commissioner of human services at any time may pay out such amounts as the commissioner deems proper for the support, maintenance, or other legal benefit of any of the handicapped, dependent, neglected, and delinquent children, children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children, persons with mental retardation, chemical dependency, or mental illness, or other wards or per-

sons entitled thereto, not exceeding in the aggregate to or for any person the principal amount previously received for the benefit of the person, together with the increase in it from an equitable apportionment of interest realized from the social welfare fund.

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

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

256.92 COMMISSIONER OF HUMAN SERVICES, ACCOUNTS.

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

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

History: *(4466, 4467) 1923 c 106 s 5,6; 1984 c 654 art 5 s 58; 1994 c 631 s 31*

256.925 OPTIONAL VOTER REGISTRATION FOR PUBLIC ASSISTANCE APPLICANTS AND RECIPIENTS.

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

History: *1988 c 689 art 2 s 136*

256.93 COMMISSIONER OF HUMAN SERVICES, POSSESSION OF ESTATES.

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

Subd. 2. **Annual report.** The commissioner of human services shall annually or at such other times as the probate court may direct file with the court an account of mon-

eys received and disbursed by the commissioner for wards and conservatees, pursuant to subdivision 1. Upon petition of the ward or conservatee or of any person interested in such estate and upon notice to the commissioner the probate court may terminate such trust and require final accounting thereof.

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

256.935 FUNERAL EXPENSES, PAYMENT BY COUNTY AGENCY.

Subdivision 1. On the death of any person receiving public assistance through aid to dependent children, the county agency shall pay an amount for funeral expenses not exceeding the amount paid for comparable services under section 261.035 plus actual cemetery charges. No funeral expenses shall be paid if the estate of the deceased is sufficient to pay such expenses or if the spouse, who was legally responsible for the support of the deceased while living, is able to pay such expenses; provided, that the additional payment or donation of the cost of cemetery lot, interment, religious service, or for the transportation of the body into or out of the community in which the deceased resided, shall not limit payment by the county agency as herein authorized. Freedom of choice in the selection of a funeral director shall be granted to persons lawfully authorized to make arrangements for the burial of any such deceased recipient. In determining the sufficiency of such estate, due regard shall be had for the nature and marketability of the assets of the estate. The county agency may grant funeral expenses where the sale would cause undue loss to the estate. Any amount paid for funeral expenses shall be a prior claim against the estate, as provided in section 524.3-805, and any amount recovered shall be reimbursed to the agency which paid the expenses. The commissioner shall specify requirements for reports, including fiscal reports, according to section 256.01, subdivision 2, paragraph (17). The state share of county agency expenditures shall be 50 percent and the county share shall be 50 percent. Benefits shall be issued to recipients by the state or county and funded according to section 256.025, subdivision 3, subject to provisions of section 256.017.

Beginning July 1, 1991, the state will reimburse counties according to the payment schedule set forth in section 256.025 for the county share of county agency expenditures made under this subdivision from January 1, 1991, on. Payment under this subdivision is subject to the provisions of section 256.017.

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

History: *Ex1971 c 16 s 4,5; 1973 c 717 s 15; 1976 c 239 s 81; 1986 c 444; 1988 c 719 art 8 s 9; 1989 c 89 s 9; 1Sp1989 c 1 art 16 s 5; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 25; 1992 c 513 art 8 s 13*

CHILDREN'S HEALTH PLAN

256.9351 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 256.9351 to 256.9361, the following terms shall have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

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.

Subd. 4. **Gross family income.** "Gross family income" for farm and nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged. Applicants shall report the most recent financial situation of the family if it has changed from the period of time

covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 33; 1990 c 568 art 3 s 14; 1992 c 549 art 4 s 2,19; 1993 c 345 art 9 s 1*

256.9352 PROGRAM ADMINISTRATION.

Subdivision 1. **Purpose.** The MinnesotaCare program is established to promote access to appropriate health care services to assure healthy children and adults.

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all eligible providers. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the department of human services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program 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 MinnesotaCare program; 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 MinnesotaCare program. 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, 1995, 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 taxes imposed under section 295.52 and the gross premiums tax imposed under section 60A.15, subdivision 1, paragraph (e), for fiscal year 1997.

(b) Notwithstanding paragraph (a), the commissioner shall proceed with the enrollment of single adults and households without children in accordance with section 256.9354, subdivision 5, paragraph (a), even if the expenditures do not remain within the limits of available revenues through fiscal year 1997 to allow the departments of human services and health to develop the plan required under paragraph (a).

Subd. 4. **Emergency rules.** The commissioner may adopt emergency rules to govern implementation of sections 256.9351 to 256.9361. Notwithstanding section 14.35, the emergency rules adopted under sections 256.9351 to 256.9361 shall remain in effect for 720 days.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art*

3 s 34; 1992 c 549 art 4 s 3,19; 1993 c 4 s 28; 1993 c 247 art 4 s 11; 1993 c 345 art 9 s 2; 1994 c 625 art 8 s 72; art 13 s 1

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 MinnesotaCare program 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 program 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 spenddown. 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 determined by the commissioner to have a basis of eligibility for medical assistance 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.

(c) Admissions for inpatient hospital services paid for under section 256.9362, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256.9362, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

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

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

Subd. 6. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown, 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 are not eligible for medical assistance with or without a spenddown shall be financially responsible for the coinsurance amount and amounts which exceed the $10,000 benefit limit. MinnesotaCare shall be financially responsible for the spenddown amount up to the $10,000 benefit limit for enrollees who are eligible for medical assistance with a spenddown; enrollees who are eligible for medical assistance with a spenddown are financially responsible for amounts which exceed the $10,000 benefit limit.

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: *1986 c 444; 1992 c 549 art 4 s 4,19; 1992 c 603 s 31; 1993 c 247 art 4 s 2-4,11; 1993 c 345 art 9 s 3; 1993 c 366 s 26; 1994 c 625 art 8 s 50,51,72*

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 without a spenddown 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 program 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 avail-

able. 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 program under the eligibility criteria in subdivisions 2 to 5 remain eligible for the MinnesotaCare program, 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 program 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 program 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 program 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 without a spenddown 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.** (a) Beginning October 1, 1994, "eligible persons" shall include all individuals and households with no children who have gross family incomes that are equal to or less than 125 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown under chapter 256B.

(b) Beginning October 1, 1995, "eligible persons" means all individuals and families who are not eligible for medical assistance without a spenddown under chapter 256B.

(c) All eligible persons under paragraphs (a) and (b) are eligible for coverage through the MinnesotaCare program 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 program.

Subd. 6. **Applicants potentially eligible for medical assistance.** Individuals who apply for MinnesotaCare, but who are potentially eligible for medical assistance with-

out a spenddown 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.

Subd. 7. **General assistance medical care.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month, except that a MinnesotaCare enrollee may be eligible for retroactive general assistance medical care according to section 256D.03, subdivision 3, paragraph (b).

History: *1986 c 444; 1992 c 549 art 4 s 5,19; 1993 c 247 art 4 s 5; 1993 c 345 art 9 s 4-6; 1994 c 625 art 13 s 2; 1994 c 625 art 8 s 52-55,72*

256.9355 APPLICATION PROCEDURES.

Subdivision 1. **Application and information availability.** Applications and other information must be made available to provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, and Women, Infants and Children (WIC) program sites. These sites may accept applications, collect the enrollment fee or initial premium fee, and forward the forms and fees to the commissioner. Otherwise, applicants may apply directly to the commissioner.

Subd. 2. **Commissioner's duties.** The commissioner shall use individuals' social security numbers as identifiers for purposes of administering the plan and conduct data matches to verify income. Applicants shall submit evidence of family income, earned and unearned, that is necessary to verify income eligibility. The commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the department of revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

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.

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the department of human services. This requirement

shall be suspended for four months following the dates in which single adults and families without children become eligible for the program.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1992 c 549 art 4 s 6,19; 1993 c 247 art 4 s 6; 1994 c 625 art 8 s 72; art 13 s 3*

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. Persons disenrolled for nonpayment may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 35; 1992 c 549 art 4 s 7,19; 1993 c 247 art 4 s 7; 1993 c 345 art 9 s 7; 1994 c 625 art 13 s 4*

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.** (a) 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 program. 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. If employer-subsidized coverage was lost for reasons that disqualify an individual for unemployment benefits under section

268.09, children of that individual are exempt from the requirement of no access to employer subsidized coverage for the 18 months prior to application, as long as the children have not had access to employer subsidized coverage since the disqualifying event.

(b) 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 program 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 program does not apply to families, children, and individuals who want to apply for the MinnesotaCare program 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: *1986 c 444; 1992 c 549 art 4 s 8,19; 1993 c 345 art 9 s 8; 1994 c 625 art 8 s 56,72*

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."

256.9358 PREMIUMS.

Subdivision 1. **Premium determination.** Each individual or family enrolled in the MinnesotaCare program shall pay a premium determined according to a sliding fee based on the cost of coverage as a percentage of the individual's or family's gross family income.

Subd. 2. **Sliding scales to determine percentage of gross family income.** The commissioner shall establish sliding scales to determine the percentage of gross family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding scale must be based on the enrollee's gross family income, as defined in section 256.9351, subdivision 4, during the previous four months. The sliding scale must provide separate sliding scales for individuals, two-person households, and households of three or more.

Subd. 3. **Sliding scales after June 30, 1993.** Beginning July 1, 1993, the sliding scales begin with a premium of 1.5 percent of gross family income for individuals with incomes below the limits for the medical assistance program set at 133-1/3 percent of the AFDC payment standard and proceed through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit to a gross monthly income of $1,600 for an individual, $2,160 for a household of two, $2,720 for a household of three, $3,280 for a household of four, $3,840 for a household of five, and $4,400

for households of six or more persons. For the period October 1, 1992 through June 30, 1993, the commissioner shall employ a sliding scale that sets required premiums at percentages of gross family income equal to two-thirds of the percentages specified in this subdivision.

Subd. 4. **Ineligibility.** Families with children whose gross monthly income is above the amount specified in subdivision 3 are not eligible for the plan. Beginning October 1, 1994, an individual or households with no children whose gross monthly income is greater than $767 for a single individual and $1,025 for a married couple without children are ineligible for the plan. Beginning October 1, 1995, an individual or families whose gross monthly income is above the amount specified in subdivision 3 are not eligible for the plan.

Subd. 5. **Premium collection through wage withholding.** The premium for coverage under the MinnesotaCare program may be collected through wage withholding with the consent of the employer and the employee.

Subd. 6. **Exclusion from chapter 14.** The sliding fee scale and percentages are not subject to the provisions of chapter 14.

History: *1986 c 444; 1992 c 549 art 4 s 9,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72; art 13 s 5*

256.9359 RESIDENCY.

Subdivision 1. **Findings and purpose.** The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, families and individuals must be permanent residents of Minnesota.

Subd. 3. **Permanent Minnesota resident.** For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

Subd. 4. **Eligibility as Minnesota resident.** To be eligible, all applicants must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address other than a place of public accommodation, through the use of evidence of residence described in section 256D.02, subdivision 12a, clause (1);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

Subd. 5. **Persons excluded as permanent residents.** An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 6. **12-month preexisting exclusion.** If the 180-day requirement in subdivision 4, clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. **Effect of a court determination.** If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

History: *1986 c 444; 1992 c 549 art 4 s 10,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

256.936 Subdivision 1. MS 1991 Supp [Renumbered 256.9351]
Subd. 2. MS 1990 [Renumbered 256.9352]
Subd. 2a. MS 1990 [Renumbered 256.9353]
Subd. 2b. MS 1990 [Renumbered 256.9354]
Subd. 3. MS 1990 [Renumbered 256.9355]
Subd. 4. MS 1990 [Renumbered 256.9356]
Subd. 4a. MS 1990 [Renumbered 256.9357]
Subd. 4b. MS 1990 [Renumbered 256.9358]
Subd. 4c. MS 1990 [Renumbered 256.9359]
Subd. 5. MS 1991 Supp [Renumbered 256.9361]

256.9361 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

History: *1986 c 444; 1991 c 292 art 4 s 17; 1992 c 549 art 4 s 11,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

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. If payment is reduced under section 256.9353, subdivision 3, paragraph (c), the hospital may not seek payment from the enrollee for the amount of the reduction.

History: *1993 c 345 art 9 s 9; 1994 c 625 art 8 s 57*

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.

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; and

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

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 may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. 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; 1994 c 625 art 8 s 58-60*

256.9365 PURCHASE OF CONTINUATION COVERAGE FOR AIDS PATIENTS.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall: (1) pay the eligible person's group plan premium for the period of continuation coverage provided in the Consolidated Omnibus Budget Reconciliation Act of 1985; or (2) pay the eligible person's individual plan premium for 24 months.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must satisfy the following requirements:

(1) the applicant must provide a physician's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;

(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;

(3) the applicant must not own assets with a combined value of more than $25,000;

(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan and be eligible to purchase continuation coverage; and

(5) if applying for payment of individual plan premiums, the applicant must be covered by an individual health plan whose coverage and premium costs satisfy additional requirements established by the commissioner in rule.

Subd. 3. **Rules.** The commissioner shall establish rules as necessary to implement the program. Special requirements for the payment of individual plan premiums under subdivision 2, clause (5), must be designed to ensure that the state cost of paying an individual plan premium over a two-year period does not exceed the estimated state cost that would otherwise be incurred in the medical assistance or general assistance medical care program.

History: *1990 c 568 art 3 s 15; 1991 c 292 art 4 s 18,19*

256.94 CONFERENCES OF VARIOUS OFFICIALS.

For the purpose of promoting economy and efficiency in the enforcement of laws relating to children, and particularly of laws relating to defective, delinquent, dependent, and neglected children, the commissioner of human services may, at such times and places as the commissioner deems advisable, call an annual conference with officials responsible for the enforcement of such laws. When practicable such conference shall be held at the same time and place as the state conference of social work.

History: *(4468) 1917 c 224 s 1; 1921 c 403 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.95 EXPENSE OF ATTENDANCE AT CONFERENCE.

The necessary expenses of all probate judges and of one member of the county child welfare board in each county invited to attend such conference shall be paid out of the funds of their respective counties.

History: *(4469) 1917 c 224 s 2; 1921 c 403 s 2*

256.96 COOPERATION WITH OTHER BOARDS.

The commissioner of human services and the several county child welfare boards within their respective jurisdictions, upon request of county boards, city councils, town boards, or other public boards or authorities charged by law with the administration of the laws relating to the relief of the poor, may cooperate with such boards and authorities in the administration of such laws.

History: *(4461) 1923 c 152 s 1; 1973 c 123 art 5 s 7; 1984 c 654 art 5 s 58*

256.965 [Repealed, 1988 c 719 art 8 s 33]

256.9655 PAYMENTS TO MEDICAL PROVIDERS.

Subdivision 1. **Duties of commissioner.** The commissioner shall establish procedures to analyze and correct problems associated with medical care claims preparation and processing under the medical assistance, general assistance medical care, and children's health plan programs. At a minimum, the commissioner shall:

(1) designate a full-time position as a liaison between the department of human services and providers;

(2) analyze impediments to timely processing of claims, provide information and consultation to providers, and develop methods to resolve or reduce problems;

(3) provide to each acute care hospital a quarterly listing of claims received and identify claims that have been suspended and the reason the claims were suspended;

(4) provide education and information on reasons for rejecting and suspending claims and identify methods that would avoid multiple submissions of claims; and

(5) for each acute care hospital, identify and prioritize claims that are in jeopardy of exceeding time factors that eliminate payment.

Subd. 2. **Electronic claim submission.** Medical providers designated by the commissioner of human services are permitted to purchase authorized materials through commodity contracts administered by the commissioner of administration for the purpose of submitting electronic claims to the medical programs designated in subdivision 1. Providers so designated must be actively enrolled and participating in the medical programs and must sign a hardware purchase and electronic biller agreement with the commissioner of human services prior to purchase from the contract.

History: *1988 c 689 art 2 s 138; 1992 c 513 art 7 s 14*

256.9656 DEPOSITS INTO THE GENERAL FUND.

All money collected under section 256.9657 shall be deposited in the general fund. Deposits do not cancel and are available until expended.

History: *1991 c 292 art 4 s 20; 1992 c 513 art 7 s 15*

256.9657 PROVIDER SURCHARGES.

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

Subd. 1a. **Waiver request.** The commissioner shall request a waiver from the secretary of health and human services to: (1) exclude from the surcharge under subdivision 1 a nursing home that provides all services free of charge; (2) make a pro rata reduction in the surcharge paid by a nursing home that provides a portion of its services free of charge; (3) limit the hospital surcharge to acute care hospitals only; and (4) limit the physician license surcharge under section 147.01, subdivision 6, to physicians licensed in Minnesota and residing in Minnesota or a state contiguous to Minnesota. If a waiver

is approved under this subdivision, the commissioner shall adjust the nursing home surcharge accordingly or shall direct the board of medical practice to adjust the physician license surcharge under section 147.01, subdivision 6, accordingly. Any waivers granted by the federal government shall be effective on or after October 1, 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 and community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization, integrated service network, or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization, integrated service network, or community integrated service network 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, an integrated service network, or a community integrated service network 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, integrated service network, or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization, integrated service network, or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Subd. 4. **Payments into the account.** Payments to the commissioner under subdivisions 1 to 3 must be paid in monthly installments due on the 15th of the month beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. Payments to the commissioner under subdivisions 2 and 3 for fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues earned in the second previous calendar year.

Subd. 5. [Repealed, 1992 c 513 art 7 s 135]

Subd. 6. **Notice; appeals.** At least 30 days prior to the date the payment is due, the commissioner shall give each provider a written notice of each payment due. A provider may request a contested case hearing under chapter 14 within 30 days of receipt of the notice. The decision of the commissioner regarding the amount due stands until the appeal is decided. The provider shall pay the contested payment at the time of appeal with settle-up at the time of appeal resolution.

Subd. 7. **Collection; civil penalties.** The provisions of sections 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.

Subd. 8. **Commissioner's duties.** The commissioner of human services shall report to the legislature quarterly on the first day of January, April, July, and October regarding the provider surcharge program. The report shall include information on total billings, total collections, and administrative expenditures. The report on January 1, 1993, shall include information on all surcharge billings, collections, federal matching payments received, efforts to collect unpaid amounts, and administrative costs pertaining to the surcharge program in effect from July 1, 1991, to September 30, 1992. The surcharge shall be adjusted by inflationary and caseload changes in future bienniums to maintain reimbursement of health care providers in accordance with the requirements of the state and federal laws governing the medical assistance program, including the requirements of the Medicaid moratorium amendments of 1991 found in Public Law No. 102-234. The commissioner shall request the Minnesota congressional delegation to support a change in federal law that would prohibit federal disallowances for any state that makes a good faith effort to comply with Public Law Number 102-234 by enacting conforming legislation prior to the issuance of federal implementing regulations.

History: *1991 c 292 art 4 s 21; 1992 c 513 art 7 s 16-21,133; 1993 c 345 art 1 s 21; 1Sp1993 c 1 art 5 s 11-16; 1994 c 625 art 8 s 61*

256.966 MEDICAL CARE PAYMENTS; ALLOWABLE INCREASE IN COST PER SERVICE UNIT.

Subdivision 1. **In general.** For the biennium ending June 30, 1985, the annual increase in the cost per service unit paid to any vendor under medical assistance and general assistance medical care shall not exceed five percent, except that the five percent annual increase limitation applied to vendors under this subdivision does not apply to nursing homes licensed under chapter 144A or boarding care homes licensed under sections 144.50 to 144.56. The estimated acquisition cost of prescription drug ingredients is not subject to the five percent increase limit, any general state payment reduction, or cost limitation described in this section, except as required under federal law or regulation. For vendors enrolled in the general assistance medical care program, the annual increase in cost per service unit allowable during state fiscal year 1984 shall not exceed five percent. The basis for measuring growth shall be the cost per service unit that would have been reimbursable in state fiscal year 1983 if payments had not been ratably reduced and if payments had been based on the 50th percentile of usual and customary billings for medical assistance in 1978. The increase in cost per service unit allowable for vendors in the general assistance medical care program during state fiscal year 1985 shall not exceed five percent. The basis for measuring growth shall be state fiscal year 1984.

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

History: *1981 c 360 art 2 s 1; 1982 c 640 s 9; 1983 c 312 art 5 s 6; 1984 c 580 s 2; 1984 c 654 art 5 s 58*

256.967 [Repealed, 1Sp1985 c 9 art 2 s 104]

256.968 [Repealed, 1987 c 299 s 25]

INPATIENT HOSPITAL PAYMENT SYSTEM

256.9685 ESTABLISHMENT OF INPATIENT HOSPITAL PAYMENT SYSTEM.

Subdivision 1. **Authority.** 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.

Subd. 2. **Federal requirements.** If it is determined that a provision of this section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare limitations.

History: *1989 c 282 art 3 s 36; 1991 c 292 art 4 s 22; 1992 c 513 art 7 s 22; 1Sp1993 c 1 art 5 s 17*

256.9686 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this section and sections 256.969 and 256.9695, the following terms and phrases have the meanings given.

Subd. 2. **Base year.** "Base year" means a hospital's fiscal year that is recognized by the Medicare program or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information by the Medicare program from which cost and statistical data are used to establish medical assistance and general assistance medical care payment rates.

Subd. 3. **Case mix index.** "Case mix index" means a hospital's distribution of relative values among the diagnostic categories.

Subd. 4. **Charges.** "Charges" means the usual and customary payment requested of the general public.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Hospital.** "Hospital" means a facility defined in section 144.696, subdivision 3, and licensed under sections 144.50 to 144.58, an out-of-state facility licensed to provide acute care under the requirements of that state in which it is located, or an Indian health service facility designated to provide acute care by the federal government.

Subd. 7. **Medical assistance.** "Medical assistance" means the program established under chapter 256B and Title XIX of the Social Security Act. Medical assistance includes general assistance medical care established under chapter 256D, unless otherwise specifically stated.

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.

Subd. 9. **Relative value.** "Relative value" means the average allowable cost of inpatient services provided within a diagnostic category divided by the average allowable cost of inpatient services provided in all diagnostic categories.

History: *1989 c 282 art 3 s 37; 1991 c 292 art 4 s 23,24; 1993 c 339 s 10*

256.969 PAYMENT RATES.

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be 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.

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, including the system used by the Medicare program to determine the relative values of inpatient services and case mix indices. The commissioner may combine diagnostic classifications into diagnostic categories and may establish separate categories and numbers of categories based on program eligibility or hospital peer group. Relative values shall be recalculated when the base year is

changed. Relative value determinations shall include paid claims for admissions during each hospital's base year. The commissioner may extend the time period forward to obtain sufficiently valid information to establish relative values. Relative value determinations shall not include property cost data, Medicare crossover data, and data on admissions that are paid a per day transfer rate under subdivision 14. The computation of the base year cost per admission must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs recognized in outlier payments beyond that point. The commissioner may recategorize the diagnostic classifications and recalculate relative values and case mix indices to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register and a 30-day comment period.

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

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Subd. 2c. **Property payment rates.** For each hospital's first two consecutive fiscal years beginning on or after July 1, 1988, the commissioner shall limit the annual increase in property payment rates for depreciation, rents and leases, and interest expense to the annual growth in the hospital cost index derived from the methodology in effect on the day before July 1, 1989. When computing budgeted and settlement property payment rates, the commissioner shall use the annual increase in the hospital cost index forecasted by Data Resources, Inc., consistent with the quarter of the hospital's fiscal year end. For admissions occurring on or after the rate year beginning January 1, 1991, the commissioner shall obtain property data from an updated base year and establish property payment rates per admission for each hospital. Property payment rates shall be derived from data from the same base year that is used to establish operating payment rates. The property information shall include cost categories not subject to the hospital cost index and shall reflect the cost-finding methods and allowable costs of the Medicare program. The base year property payment rates shall be adjusted for increases in the property cost by increasing the base year property payment rate 85 percent of the percentage change from the base year through the year for which a Medicare cost report has been submitted to the Medicare program and filed with the department by the October 1 before the rate year. The property rates shall only reflect inpatient services covered by medical assistance. The commissioner shall adjust rates for the rate year beginning January 1, 1991, to ensure that all hospitals are subject to the hospital cost index limitation for two complete years.

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

Subd. 3a. **Payments.** Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. To establish interim rates, the commissioner is exempt from the requirements of chapter 14. Medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. The commissioner may selectively contract with hospitals for services within the diagnostic categories relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipi-

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

Subd. 4. [Repealed, 1989 c 282 art 3 s 98]

Subd. 4a. **Reports.** If, under this section or section 256.9685, 256.9686, or 256.9695, a hospital is required to report information to the commissioner by a specified date, the hospital must report the information on time. If the hospital does not report the information on time, the commissioner may determine the information that will be used and may disregard the information that is reported late. If the Medicare program does not require or does not audit information that is needed to establish medical assistance rates, the commissioner may, after consulting the affected hospitals, require reports to be provided, in a format specified by the commissioner, that are based on allowable costs and cost-finding methods of the Medicare program in effect during the base year. The commissioner may require any information that is necessary to implement this section and sections 256.9685, 256.9686, and 256.9695 to be provided by a hospital within a reasonable time period.

Subd. 5. [Repealed, 1989 c 282 art 3 s 98]

Subd. 5a. **Audits and adjustments.** Inpatient hospital rates and payments must be established under this section and sections 256.9685, 256.9686, and 256.9695. The commissioner may adjust rates and payments based on the findings of audits of payments to hospitals, hospital billings, costs, statistical information, charges, or patient records performed by the commissioner or the Medicare program that identify billings, costs, statistical information, or charges for services that were not delivered, never ordered, in excess of limits, not covered by the medical assistance program, paid separately from rates established under this section and sections 256.9685, 256.9686, and 256.9695, or for charges that are not consistent with other payor billings. Charges to the medical assistance program must be less than or equal to charges to the general public. Charges to the medical assistance program must not exceed the lowest charge to any other payor. The audit findings may be based on a statistically valid sample of hospital

information that is needed to complete the audit. If the information the commissioner uses to establish rates or payments is not audited by the Medicare program, the commissioner may require an audit using Medicare principles and may adjust rates and payments to reflect any subsequent audit.

Subd. 6. [Repealed, 1989 c 282 art 3 s 98]

Subd. 6a. **Special considerations.** In determining the payment rates, the commissioner shall consider whether the circumstances in subdivisions 7 to 14 exist.

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

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

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

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

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

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

(1) for a hospital with a medical assistance inpatient utilization rate above the

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

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

Subd. 10. **Separate billing by certified registered nurse anesthetists.** Hospitals may exclude certified registered nurse anesthetist costs from the operating payment rate as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of the year preceding the rate year of the request to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services. Payments made through separate claims for certified registered nurse anesthetist services shall not be paid directly through the hospital provider number or indirectly by the certified registered nurse anesthetist to the hospital or related organizations.

For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.

Subd. 11. **Special rates.** The commissioner may establish special rate-setting methodologies, including a per day operating and property payment system, for hospice, ventilator dependent, and other services on a hospital and recipient specific basis taking into consideration such variables as federal designation, program size, and admission from a medical assistance waiver or home care program. The data and rate calculation method shall conform to the requirements of subdivision 13, except that rates shall not be standardized by the case mix index or adjusted by relative values and hospice rates shall not exceed the amount allowed under federal law. Rates and payments established under this subdivision must meet the requirements of section 256.9685, subdivisions 1 and 2. The cost and charges used to establish rates shall only reflect inpatient medical assistance covered services. Hospital and claims data that are used to establish rates under this subdivision shall not be used to establish payments or relative values under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 12. **Rehabilitation distinct parts.** Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating and property payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services. The commissioner may establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

Subd. 13. **Neonatal transfers.** For admissions occurring on or after July 1, 1989, neonatal diagnostic category transfers shall have operating and property payment rates established at receiving hospitals which have neonatal intensive care units on a per day payment system that is based on the cost finding methods and allowable costs of the Medicare program during the base year. Other neonatal diagnostic category transfers shall have rates established according to subdivision 14. The rate per day for the neonatal service setting within the hospital shall be determined by dividing base year neonatal allowable costs by neonatal patient days. The operating payment rate portion of the rate shall be adjusted by the hospital cost index and the disproportionate population adjustment. For admissions occurring after the transition period specified in section 256.9695, subdivision 3, the operating payment rate portion of the rate shall be standardized by the case mix index and adjusted by relative values. The cost and charges used to establish rates shall only reflect inpatient services covered by medical assistance. Hospital and claims data used to establish rates under this subdivision shall not be used to establish rates under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 14. **Transfers.** Except as provided in subdivisions 11 and 13, operating and property payment rates for admissions that result in transfers and transfers shall be established on a per day payment system. The per day payment rate shall be the sum of the adjusted operating and property payment rates determined under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 12, divided by the arithmetic mean length of stay for the diagnostic category. Each admission that results in a transfer and each transfer is considered a separate admission to each hospital, and the total of the admission and transfer payments to each hospital must not exceed the total per admission payment that would otherwise be made to each hospital under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 13.

Subd. 15. **Routine service cost limitation; applicability.** The computation of each hospital's payment rate and the relative values of the diagnostic categories are not subject to the routine service cost limitation imposed under the Medicare program.

Subd. 16. **Indian health service facilities.** Indian health service facilities are exempt from the rate establishment methods required by this section and shall be reimbursed at charges as limited to the amount allowed under federal law. This exemption is not effective for payments under general assistance medical care.

Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are located within a Minnesota local trade area shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by rule. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Subd. 18. **Out-of-state hospitals outside local trade areas.** Hospitals that are not located within Minnesota or a Minnesota local trade area shall have operating and property rates established at the average of statewide and local trade area rates or, at the commissioner's discretion, at an amount negotiated by the commissioner. Relative values shall not include data from hospitals that have rates established under this subdivision. Payments, including third party and recipient liability, established under this subdivision may not exceed the charges on a claim specific basis for inpatient services that are covered by medical assistance.

Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical assistance inpatient payment rates must include the cost incurred by hospitals to pay the department of health for metabolic disorder testing of newborns who are medical assistance recipients, if the cost is not recognized by another payment source.

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (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, exclud-

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

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if: (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.

Subd. 21. **Mental health or chemical dependency admissions; rates.** Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

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

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

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

the adjustment under clause (1) for that hospital by 1.1. Any payment under this clause must be reduced by the amount of any payment received under subdivision 9a. For purposes of this subdivision, medical assistance does not include general assistance medical care.

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

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

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

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

(b) Any payment under this subdivision must be reduced by the amount of any payment received under subdivision 9, paragraph (b), clause (1) or (2). For purposes of this subdivision, medical assistance does not include general assistance medical care.

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

Subd. 24. **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: *1983 c 312 art 5 s 9; 1984 c 534 s 20,21; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1Sp1985 c 9 art 2 s 34-36; 1986 c 420 s 6; 1Sp1986 c 3 art 2 s 51; 1987 c 403 art 2 s 64,65; 1988 c 435 s 1; 1988 c 689 art 2 s 139,140; 1989 c 282 art 3 s 38; 1990 c 568 art 3 s 16,17; 1991 c 292 art 4 s 25-29; 1992 c 464 art 1 s 27,28; 1992 c 513 art 7 s 23-27; 1992 c 603 s 34,35; 1993 c 20 s 1-5; 1Sp1993 c 1 art 5 s 18-25; 1Sp1993 c 6 s 7,8*

256.9691 TECHNOLOGY ASSISTANCE REVIEW PANEL.

Subdivision 1. **Establishment.** The commissioner of health shall establish a technology assistance review panel to resolve disputes over the provision of health care benefits for technology-assisted persons who receive benefits under a policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under chapter 62A, a subscriber contract of a nonprofit health service plan corporation regulated under chapter 62C, or a certificate of coverage of a health maintenance organization regulated under chapter 62D.

Subd. 2. **Definition.** For purposes of this section, "technology-assisted person" means a person who:

(1) has a chronic health condition;

(2) requires the routine use of a medical device to compensate for the loss of a life-sustaining body function; and

(3) requires ongoing care or monitoring by trained personnel on a daily basis.

Subd. 3. **Steering committee.** The commissioner shall appoint a seven-member steering committee to appoint the review panel members, develop policies and procedures for the review process, including the replacement of review panel members, serve as a liaison between the regulatory agencies and the review panel, and provide the review panel with technical assistance. The steering committee shall consist of representatives of the departments of health, human services, and commerce; a health maintenance organization regulated under chapter 62D; an insurer regulated under chapter 62A or a health service plan corporation regulated under chapter 62C; an advocacy organization representing persons who are technology assisted; and a tertiary care center that serves technology-assisted persons. The steering committee shall not be reimbursed for any expenses as defined under section 15.0575, subdivision 3. The steering committee shall dissolve no later than June 30, 1992.

Subd. 4. **Composition of review panel.** (a) The review panel shall be appointed by the members of the steering committee that do not represent state agencies and must include:

(1) a medical director from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(2) a contract benefits analyst from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(3) a consumer board member of an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(4) a physician with expertise in providing care for technology-assisted persons in a nonhospital setting;

(5) a registered nurse with expertise in providing care for technology-assisted persons in a nonhospital setting; and

(6) a consumer of health care benefits regulated under chapter 62A, 62C, or 62D who is a technology-assisted person or the parent or guardian of a technology-assisted person.

(b) The term of service for review panel members is three years except that, for the initial appointment, the steering committee shall establish procedures to assure that the terms of the members are staggered. Members are eligible to serve two consecutive terms.

Subd. 5. **Authority.** The review panel may review cases involving disputes over the provision of contract benefits regarding discharge planning, home health care benefits eligibility and coverage, or changes in the level of home health care services for technology-assisted persons. The review may be requested by a third-party payor, a health or social service professional, or a parent or guardian of a technology-assisted child or a technology-assisted adult. For the case to be eligible for review by the panel, the parent or guardian of a technology-assisted child or technology-assisted adult must consent to the review. The review panel may not review cases involving discharge to a long-term care facility or cases involving coverage by title 18 or 19 of the Social Security Act or other public funding sources. The review panel may seek advice from experts outside the membership of the panel as necessary. The internal grievance process within an insurer, health service plan corporation, or health maintenance organization, except binding arbitration, must be exhausted before requesting a review by the review panel. The recommendations of the review panel are not binding. If, following a review by the

review panel, a complaint is filed with the appropriate state agency regarding the same subject matter, the findings of the review panel must be made available to the agency upon request and with the consent of the parent or guardian of a technology-assisted child or technology-assisted adult. The information must be maintained by the agency as nonpublic information under chapter 13. The steering committee may establish policies for reimbursement of expenses for review panel members consistent with the provisions of section 15.0575, subdivision 3.

Subd. 6. **Confidentiality.** All proceedings of the review organization are nonpublic under chapter 13. All data, information, and findings acquired and developed by the review panel in the exercise of its duties or functions must be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review panel or as described in subdivision 5, and are not subject to subpoena or discovery. Members of the review panel may not disclose what transpired at a meeting of the review panel except to the extent necessary to carry out one or more of the purposes of the review panel. The proceedings and record of the review panel are not subject to discovery or introduction into evidence in any civil action against a health care professional or insurer, health service plan corporation, or health maintenance organization, arising out of the matter or matters that are the subject of consideration by the review panel.

Subd. 7. **Limitation on liability for members of steering committee and review panel.** A person who is a member of, or who acts in an advisory capacity to or who gives counsel or services to, the steering committee or review panel is not liable for damages or other relief in any action brought by a person or persons whose case has been reviewed by the panel, by reason of the performance of any duty, function, or activity of the review panel, unless the performance of the duty, function, or activity was motivated by malice toward the person affected. A member is not liable for damages or other relief in any action by reason of the performance of the member of any duty, function, or activity as a member of the steering committee or review panel or by reason of any recommendation or action of the review committee when the member acts in the reasonable belief that the action or recommendation is warranted by the facts known to the member or review panel after reasonable efforts to ascertain the facts.

History: *1990 c 534 s 1*

256.9695 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.

Subd. 2. **Prohibited practices.** (a) Hospitals that have a provider agreement with the department may not limit medical assistance admissions to percentages of certified capacity or to quotas unless patients from all payors are limited in the same manner. This requirement does not apply to certified capacity that is unavailable due to contracts with payors for specific occupancy levels.

(b) Hospitals may not transfer medical assistance patients to or cause medical assistance patients to be admitted to other hospitals without the explicit consent of the receiving hospital when service needs of the patient are available and within the scope of the transferring hospital. The transferring hospital is liable to the receiving hospital for patient charges and ambulance services without regard to medical assistance payments plus the receiving hospital's reasonable attorney fees if found in violation of this prohibition.

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

During the transition period:

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

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

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

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

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

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

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or

owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Subd. 4. **Study.** The commissioner shall contract for an evaluation of the inpatient and outpatient hospital payment systems. The study shall include recommendations concerning:

(1) more effective methods of assigning operating and property payment rates to specific services or diagnoses;

(2) effective methods of cost control and containment;

(3) fiscal impacts of alternative payment systems;

(4) the relationships of the use of and payment for inpatient and outpatient hospital services;

(5) methods to relate reimbursement levels to the efficient provision of services; and

(6) methods to adjust reimbursement levels to reflect cost differences between geographic areas.

The commissioner shall report the findings to the legislature by January 15, 1991, along with recommendations for implementation.

Subd. 5. **Rules.** The commissioner of human services shall adopt permanent rules to implement this section and sections 256.9685, 256.9686, and 256.969 under chapter 14, the administrative procedure act.

History: *1989 c 282 art 3 s 39; 1990 c 568 art 3 s 18,19; 1991 c 292 art 4 s 30,78; 1992 c 513 art 7 s 28; 1993 c 339 s 11,12; 1Sp1993 c 1 art 5 s 26; 1994 c 465 art 3 s 571*

256.97 [Repealed, 1957 c 737 s 2]

256.971 SERVICES FOR DEAF.

The commissioner of human services shall provide such services for the deaf and hard of hearing in the state as will best promote their personal, economic and social well being. The commissioner shall maintain a register of all such persons, with such information as the commissioner deems necessary to improve services for them. The commissioner shall gather and disseminate information relating to the causes of deafness , collect statistics on the deaf and ascertain what trades or occupations are most suitable for them, and use best efforts to aid them in securing vocational rehabilitation and employment, through cooperation with other agencies, both public and private.

History: *1957 c 737 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.974 OFFICE OF OMBUDSMAN FOR OLDER MINNESOTANS; LOCAL PROGRAMS.

The ombudsman for older Minnesotans serves in the classified service under section 256.01, subdivision 7, in an office within the Minnesota board on aging that incorporates the long-term care ombudsman program required by the Older Americans Act, Public Law Number 100-75, United States Code, title 42, section 3027(a)(12), and established within the Minnesota board on aging. The Minnesota board on aging may make grants to and designate local programs for the provision of ombudsman services to clients in county or multicounty areas. The local program may not be an agency engaged in the provision of nursing home care, hospital care, or home care services either directly or by contract, or have the responsibility for planning, coordinating, funding, or administering nursing home care, hospital care, or home care services.

History: *1987 c 403 art 2 s 66; 1989 c 282 art 2 s 115*

256.9741 DEFINITIONS.

Subdivision 1. "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10 or boarding care home licensed under sections 144.50 to 144.56.

Subd. 2. "Acute care facility" means a facility licensed as a hospital under sections 144.50 to 144.56.

Subd. 3. "Client" means an individual who requests, or on whose behalf a request is made for, ombudsman services and is (a) a resident of a long-term care facility or (b) a Medicare beneficiary who requests assistance relating to access, discharge, or denial of inpatient or outpatient services, or (c) an individual reserving or requesting a home care service.

Subd. 4. "Area agency on aging" means an agency responsible for coordinating a comprehensive aging services system within a planning and service area that has been designated an area agency on aging by the Minnesota board on aging.

Subd. 5. "Office" means the office of ombudsman established within the Minnesota board on aging or local ombudsman programs that the board on aging designates.

Subd. 6. "Home care service" means health, social, or supportive services provided to an individual for a fee in the individual's residence and in the community to promote, maintain, or restore health, or maximize the individual's level of independence, while minimizing the effects of disability and illness.

History: *1987 c 403 art 2 s 67; 1989 c 282 art 2 s 116-118*

256.9742 DUTIES AND POWERS OF THE OFFICE.

Subdivision 1. **Duties.** The ombudsman shall:

(1) gather information and evaluate any act, practice, policy, procedure, or administrative action of a long-term care facility, acute care facility, home care service provider, or government agency that may adversely affect the health, safety, welfare, or rights of any client;

(2) mediate or advocate on behalf of clients;

(3) monitor the development and implementation of federal, state, or local laws, rules, regulations, and policies affecting the rights and benefits of clients;

(4) comment on and recommend to the legislature and public and private agencies regarding laws, rules, regulations, and policies affecting clients;

(5) inform public agencies about the problems of clients;

(6) provide for training of volunteers and promote the development of citizen participation in the work of the office;

(7) conduct public forums to obtain information about and publicize issues affecting clients;

(8) provide public education regarding the health, safety, welfare, and rights of clients; and

(9) collect and analyze data relating to complaints, conditions, and services.

Subd. 1a. **Designation; local ombudsman representatives.** (a) In designating an individual to perform duties under this section, the ombudsman must determine that the individual is qualified to perform the duties required by this section.

(b) An individual designated under this section must successfully complete an orientation training conducted under the direction of the ombudsman or approved by the ombudsman. Orientation training shall be at least 20 hours and will consist of training in: investigation, dispute resolution, health care regulation, confidentiality, resident and patients' rights, and health care reimbursement.

(c) The ombudsman shall develop and implement a continuing education program for individuals designated under this section. The continuing education program shall be at least 60 hours annually.

(d) The ombudsman may withdraw an individual's designation if the individual

fails to perform duties of this section or meet continuing education requirements. The individual may request a reconsideration of such action by the board on aging whose decision shall be final.

Subd. 2. **Immunity from liability.** The ombudsman or designee under this section is immune from civil liability that otherwise might result from the person's actions or omissions if the person's actions are in good faith, are within the scope of the person's responsibilities as an ombudsman, and do not constitute willful or reckless misconduct.

Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a conspicuous place the address and telephone number of the office. A home care service provider shall provide all recipients with the address and telephone number of the office. The posting or notice is subject to approval by the ombudsman.

Subd. 4. **Access to long-term care and acute care facilities and clients.** The ombudsman or designee may:

(1) enter any long-term care facility without notice at any time;

(2) enter any acute care facility without notice during normal business hours;

(3) enter any acute care facility without notice at any time to interview a patient or observe services being provided to the patient as part of an investigation of a matter that is within the scope of the ombudsman's authority, but only if the ombudsman's or designee's presence does not intrude upon the privacy of another patient or interfere with routine hospital services provided to any patient in the facility;

(4) communicate privately and without restriction with any client in accordance with section 144.651;

(5) inspect records of a long-term care facility, home care service provider, or acute care facility that pertain to the care of the client according to sections 144.335 and 144.651; and

(6) with the consent of a client or client's legal guardian, have access to review records pertaining to the care of the client according to sections 144.335 and 144.651. If a client cannot consent and has no legal guardian, access to the records is authorized by this section.

A person who denies access to the ombudsman or designee in violation of this subdivision or aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

Subd. 5. **Access to state records.** The ombudsman or designee has access to data of a state agency necessary for the discharge of the ombudsman's duties, including records classified confidential or private under chapter 13, or any other law. The data requested must be related to a specific case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the ombudsman or designee shall first obtain the individual's consent. If the individual cannot consent and has no legal guardian, then access to the data is authorized by this section.

Each state agency responsible for licensing, regulating, and enforcing state and federal laws and regulations concerning long-term care, home care service providers, and acute care facilities shall forward to the ombudsman on a quarterly basis, copies of all correction orders, penalty assessments, and complaint investigation reports, for all long-term care facilities, acute care facilities, and home care service providers.

Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a patient, resident, or guardian or family member of a patient, resident, or guardian for filing in good faith a complaint with or providing information to the ombudsman or designee. A person who violates this subdivision or who aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

(b) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose of this clause, the term "adverse action" refers to action taken by the entity involved in a report against the person making the report or the person with respect

to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from a facility;

(2) termination of service;

(3) restriction or prohibition of access to the facility or its residents;

(4) discharge from or termination of employment;

(5) demotion or reduction in remuneration for services; and

(6) any restriction of rights set forth in section 144.651 or 144A.44.

History: *1987 c 403 art 2 s 68; 1989 c 282 art 2 s 119*

256.9743 REPORTING.

By February 1, 1989, the board on aging shall recommend methods for expanding and funding local ombudsman programs to serve clients receiving in-home services or care in acute care facilities.

History: *1987 c 403 art 2 s 69*

256.9744 OFFICE DATA.

Subdivision 1. **Classification.** Except as provided in this section, data maintained by the office under sections 256.974 to 256.9744 are private data on individuals or nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained in accordance with the requirements of Public Law Number 100-75, United States Code, title 42, section 3027(a)(12)(D).

Subd. 2. **Release.** Data maintained by the office that does not relate to the identity of a complainant or a resident of a long-term facility may be released at the discretion of the ombudsman responsible for maintaining the data. Data relating to the identity of a complainant or a resident of a long-term facility may be released only with the consent of the complainant or resident or by court order.

History: *1987 c 403 art 2 s 70; 1989 c 282 art 2 s 120*

256.9745 [Repealed, 1993 c 337 s 20]

256.975 MINNESOTA BOARD ON AGING.

Subdivision 1. **Creation.** There is created a Minnesota board on aging consisting of 25 members to be appointed by the governor. At least one member shall be appointed from each congressional district and the remaining members shall be appointed at large. No member shall be appointed for more than two consecutive terms of four years each. In making appointments, the governor shall give consideration to individuals having a special interest in aging, and so far as practicable, shall include persons affiliated with agriculture, labor, industry, education, social work, health, housing, religion, recreation, and voluntary citizen groups, including senior citizens.

The governor shall designate the chair. Other officers, including vice-chair and secretary, shall be elected by the board members.

Subd. 1a. **Removal; vacancies.** The membership terms, compensation, removal of members, and filling of vacancies on the board shall be as provided in section 15.0575.

Subd. 2. **Duties.** The board shall carry out the following duties:

(a) to advise the governor and heads of state departments and agencies regarding policy, programs, and services affecting the aging;

(b) to provide a mechanism for coordinating plans and activities of state departments and citizens' groups as they pertain to aging;

(c) to create public awareness of the special needs and potentialities of older persons;

(d) to gather and disseminate information about research and action programs, and to encourage state departments and other agencies to conduct needed research in the field of aging;

(e) to stimulate, guide, and provide technical assistance in the organization of local councils on aging;

(f) to provide continuous review of ongoing services, programs and proposed legislation affecting the elderly in Minnesota;

(g) to administer and to make policy relating to all aspects of the older Americans act of 1965, as amended, including implementation thereof; and

(h) to award grants, enter into contracts, and adopt rules the Minnesota board on aging deems necessary to carry out the purposes of this section.

Subd. 3. **Policy.** The board shall recommend to the state legislature no later than January 1, 1977, a proposed state policy for citizens dependent on long term care and services. The proposed state policy shall address, but need not be limited to, the following:

(a) Developing alternatives to institutionalization in long term care facilities and other programs which will assist each citizen dependent on long term care and services to maintain the highest level of self-sufficiency and independence which the citizen's mental and physical condition allows;

(b) Developing methods for ensuring citizens dependent on long term care and services an effective voice in determining which programs and services are made available to them;

(c) Protecting citizens dependent on long term care and services from unnecessary governmental interference in private and personal affairs; and

(d) Informing citizens dependent on long term care and services of the programs and services for which they are eligible.

Subd. 4. **Home-delivered meals.** The board on aging shall take appropriate action to secure reimbursement from public and private medical care programs, health plans, and health insurers for home-delivered meals that are a necessary part of medical treatment for the elderly.

Subd. 5. **Programs for senior citizens and handicapped persons.** Any sums collected under section 325F.71 must be deposited into the state treasury and credited to the account of the state board on aging. The money credited to the account of the state board on aging is annually appropriated to the state board on aging and shall be expended for the following purposes:

(1) to prepare and distribute educational materials to inform senior citizens, handicapped persons, and the public regarding consumer protection laws and consumer rights that are of particular interest to senior citizens and handicapped persons; or

(2) to underwrite educational seminars and other forms of educational projects for the benefit of senior citizens and handicapped persons.

History: *1961 c 466 s 1,2; 1974 c 536 s 1; 1975 c 271 s 6; 1976 c 134 s 59,60; 1976 c 275 s 1; 1986 c 404 s 10; 1986 c 444; 1989 c 282 art 2 s 121; 1989 c 294 s 1*

256.9751 CONGREGATE HOUSING SERVICES PROJECTS.

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

(a) **Congregate housing.** "Congregate housing" means federally or locally subsidized housing, designed for the elderly, consisting of private apartments and common areas which can be used for activities and for serving meals.

(b) **Congregate housing services projects.** "Congregate housing services project" means a project in which services are or could be made available to older persons who live in subsidized housing and which helps delay or prevent nursing home placement. To be considered a congregate housing services project, a project must have: (1) an on-site coordinator, and (2) a plan for assuring the availability of one meal per day, seven days a week, for each elderly participant in need.

(c) **On-site coordinator.** "On-site coordinator" means a person who works on-site in a building or buildings and who serves as a contact for older persons who need services, support, and assistance in order to delay or prevent nursing home placement.

(d) **Congregate housing services project participants or project participants.** "Congregate housing services project participants" or "project participants" means elderly persons 60 years old or older, who are currently residents of, or who are applying for residence in housing sites, and who need support services to remain independent.

Subd. 2. [Repealed, 1994 c 480 s 9]

Subd. 3. **Grant program.** The Minnesota board on aging shall establish a congregate housing services grant program which will enable communities to provide on-site coordinators to serve as a contact for older persons who need services and support, and assistance to access services in order to delay or prevent nursing home placement.

Subd. 4. **Use of grant funds.** Grant funds shall be used to develop and fund on-site coordinator positions. Grant funds shall not be used to duplicate existing funds, to modify buildings, or to purchase equipment.

Subd. 5. **Grant eligibility.** A public or nonprofit agency or housing unit may apply for funds to provide a coordinator for congregate housing services to an identified population of frail elderly persons in a subsidized multiunit apartment building or buildings in a community. The board shall give preference to applicants that meet the requirements of this section, and that have a common dining site. Local match may be required. State money received may also be used to match federal money allocated for congregate housing services. Grants shall be awarded to urban and rural sites.

Subd. 6. **Criteria for selection.** The Minnesota board on aging shall select projects under this section according to the following criteria:

(1) the extent to which the proposed project assists older persons to age-in-place to prevent or delay nursing home placement;

(2) the extent to which the proposed project identifies the needs of project participants;

(3) the extent to which the proposed project identifies how the on-site coordinator will help meet the needs of project participants;

(4) the extent to which the proposed project plan assures the availability of one meal a day, seven days a week, for each elderly participant in need;

(5) the extent to which the proposed project demonstrates involvement of participants and family members in the project; and

(6) the extent to which the proposed project demonstrates involvement of housing providers and public and private service agencies, including area agencies on aging.

Subd. 7. **Grant applications.** The Minnesota board on aging shall request proposals for grants and award grants using the criteria in subdivision 6. Grant applications shall include:

(1) documentation of the need for congregate services so the residents can remain independent;

(2) a description of the resources, such as social services and health services, that will be available in the community to provide the necessary support services;

(3) a description of the target population, as defined in subdivision 1, paragraph (d);

(4) a performance plan that includes written performance objectives, outcomes, timelines, and the procedure the grantee will use to document and measure success in meeting the objectives; and

(5) letters of support from appropriate public and private agencies and organizations, such as area agencies on aging and county human service departments that demonstrate an intent to work with and coordinate with the agency requesting a grant.

Subd. 8. **Report.** By January 1, 1993, the Minnesota board on aging shall submit a report to the legislature evaluating the programs. The report must document the project costs and outcomes that helped delay or prevent nursing home placement. The report must describe steps taken for quality assurance and must also include recommendations based on the project findings.

History: *1991 c 292 art 7 s 7; 1992 c 513 art 7 s 29,30*

256.9753 VOLUNTEER PROGRAMS FOR RETIRED SENIOR CITIZENS.

Subdivision 1. **Policy.** The legislature finds that the services of volunteers are crucial to the effectiveness of public and private human services programs in the state. The legislature further finds that retired senior citizens are an excellent source of volunteer services, and that by recognizing and supporting retired senior volunteer programs the state will be serving the interests of human services as well as the interests of those senior citizens who participate in the volunteer programs.

Subd. 2. **State support.** The board on aging, with the cooperation of heads of other affected state agencies, shall provide staff and material support and shall make financial grants consistent with the purposes of subdivisions 1 to 4, to retired senior volunteer programs in the state. This support may include reimbursement of expenses incurred by program participants in the performance of their volunteer activities.

Subd. 3. **Expenditures.** The board shall consult with the office of volunteer services prior to expending money available for the retired senior volunteer programs. Expenditures shall be made (1) to strengthen and expand existing retired senior volunteer programs, and (2) to encourage the development of new programs in areas in the state where these programs do not exist. Grants shall be made consistent with applicable federal guidelines.

Subd. 4. **Report.** The board shall report to the governor and the legislature by July 1, 1981, on (1) the number, type and location of human services activities assisted by retired senior volunteer programs supported pursuant to subdivisions 1 to 4; (2) the number of retired seniors participating in these activities; (3) the sources and recipients of direct support for the volunteer programs; and (4) any other information which the board believes will assist the governor and the legislature in evaluating the programs.

History: *1980 c 455 s 1-4*

256.976 FOSTER GRANDPARENTS PROGRAM.

Subdivision 1. There is established a foster grandparents program which will engage the services of low income persons aged 60 or over to provide supportive person to person assistance in health, education, welfare, and related fields to persons receiving care in resident group homes for dependent and neglected persons, day care centers or other public or private nonprofit institutions or agencies providing care for neglected and disadvantaged persons who lack close personal relationships.

Subd. 2. Persons employed as foster grandparents shall be compensated for no more than 20 hours per week and at an hourly rate not to exceed the federal minimum wage by more than 20 percent. In addition to such compensation foster grandparents shall be eligible for protective clothing, including replacement of glasses; transportation assistance, not to exceed mileage payments for 20 miles per day or chartered transportation service, for travel between residence and place of employment; workers' compensation; annual physical examinations; food services during employment, generally provided by the employing agency or institution; and such other assistance as the Minnesota board on aging may prescribe. No person employed as a foster grandparent shall be terminated because of redefinition of income standards, or a change of income, marital status, or number of dependents.

Subd. 3. The Minnesota board on aging, hereinafter called the board, may make grants-in-aid for the employment of foster grandparents to qualified resident group homes for dependent and neglected persons, day care centers and other public or nonprofit private institutions and agencies providing care for neglected and disadvantaged persons who lack close personal relationships. Agencies and institutions seeking aid shall apply on a form prescribed by the board. Priority shall be given to agencies and institutions providing care for retarded children. Grants shall not be made to local public or nonprofit agencies until 40 percent of the recognized need for foster grandparents within state institutions has been met. Grants shall be for a period of 12 months or less, and grants to local public and nonprofit agencies or institutions shall be based on 90 percent state, and ten percent local sharing of program expenditures authorized by the

board. Grants shall not be used to match other state funds nor shall any person paid from grant funds be used to replace any staff member of the grantee. Grants may be used to match federal funds. Each grantee shall file a semiannual report with the board at the time and containing such information as the board shall prescribe.

Subd. 4. The board is authorized, subject to the provisions of chapter 14, to make rules necessary to the operation of the foster grandparent program and to employ assistance in performing its administrative duties. In adopting rules the board shall give consideration to applicable federal guidelines.

History: *1971 c 938 s 1; 1973 c 302 s 1,2; 1975 c 271 s 6; 1975 c 359 s 23; 1983 c 216 art 1 s 39*

256.977 SENIOR COMPANION PROGRAM.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota senior companion act."

Subd. 2. **Establishment of program.** There is established a senior companion program to engage the services of low income persons aged 60 or over to provide supportive person to person assistance in health, education, welfare and related fields primarily to handicapped adults and elderly people living in their own homes. Senior companions may also be used to provide such services to handicapped adults and elderly persons living or receiving care in resident group homes for dependent and neglected persons, nursing homes, private homes, or other public or private nonprofit institutions or agencies providing care for handicapped adults or elderly persons. Foster grandparents currently serving individuals over 21 years of age pursuant to section 256.976 shall, after July 1, 1976, be called senior companions.

Subd. 3. **Compensation.** Persons serving as senior companions shall be compensated for no more than 20 hours per week at an hourly rate not to exceed the rate established under the older americans act. In addition, senior companions shall receive such other assistance as the Minnesota board on aging may prescribe. No person serving as a senior companion shall be terminated as a result of a change in the eligibility requirements set by the Minnesota board on aging, nor as a result of a change in income, marital status, or number of dependents.

Subd. 4. **Grants.** The Minnesota board on aging may make grants-in-aid for the purchase of senior companion services by nonprofit agencies and institutions and individuals who have access to or responsibility for handicapped adults and the elderly. Applications to provide senior companion services to individuals in their homes shall have priority over applications to provide services to individuals living in group homes, nursing homes, or other institutions. Applications for grants shall be made on forms prescribed by the Minnesota board on aging.

Grants shall be paid as follows: 90 percent of the program expenditures authorized by the Minnesota board on aging shall be paid by the state and ten percent shall be paid by local matching funds. Grants shall be for a period of 12 months or less. Grants shall not be used to match other state funds nor shall any person paid from grant funds be used to replace any staff members of the grantee. Each grantee shall file a semiannual report with the Minnesota board on aging at the time and containing the information as the board shall prescribe.

Subd. 5. **Rules.** The Minnesota board on aging shall promulgate rules necessary to implement the provisions of this section and may employ necessary assistance in performing its administrative duties. Rules adopted shall be consistent with applicable federal guidelines.

History: *1976 c 323 s 1-2; 1986 c 444*

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: *1963 c 401 s 1; 1982 c 488 s 1; 1984 c 654 art 5 s 58; 1988 c 668 s 3; 1989 c 184 art 2 s 10; 1993 c 340 s 7*

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 notify the department of human services quarterly of the numbers of completed forms received and the amounts paid.

(d) The department of human services shall remit quarterly to each medical provider a payment for the number of signed recognition of parentage forms completed by that medical provider and sent to the office of 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: *1987 c 403 art 3 s 25; 1993 c 340 s 8-11; 1994 c 529 s 8*

256.9791 MEDICAL SUPPORT BONUS INCENTIVES.

Subdivision 1. **Bonus incentive.** (a) A bonus incentive program is created to increase the identification and enforcement by county agencies of dependent health insurance coverage for persons who are receiving medical assistance under section

256B.055 and for whom the county agency is providing child support enforcement services.

(b) The bonus shall be awarded to a county child support agency for each person for whom coverage is identified and enforced by the child support enforcement program when the obligor is under a court order to provide dependent health insurance coverage.

Subd. 2. **Definitions.** For the purpose of this section, the following definitions apply.

(a) "Case" means a family unit that is receiving medical assistance under section 256B.055 and for whom the county agency is providing child support enforcement services.

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

(c) "County agency" means the county child support enforcement agency.

(d) "Coverage" means initial dependent health insurance benefits for a case or individual member of a case.

(e) "Enforce" or "enforcement" means obtaining proof of current or future dependent health insurance coverage through an overt act by the county agency.

(f) "Enforceable order" means a child support court order containing the statutory language in section 518.171 or other language ordering an obligor to provide dependent health insurance coverage.

(g) "Identify" or "identification" means obtaining proof of dependent health insurance coverage through an overt act by the county agency.

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.

Subd. 5. **Claims for bonus incentive.** (a) Beginning July 1, 1990, county agencies shall file a claim for a medical support bonus payment by reporting to the commissioner the following information for each case where dependent health insurance is identified or enforced as a result of an overt act of the county agency:

(1) child support enforcement system case number or county specific case number;

(2) names and dates of birth for each person covered; and

(3) the effective date of coverage.

(b) The report must be made upon enrollment in coverage but no later than September 30 for coverage identified or established during the preceding fiscal year.

(c) The county agency making the initial contact resulting in the establishment of coverage is the county agency entitled to claim the bonus incentive even if the case is transferred to another county agency prior to the time coverage is established.

(d) Disputed claims must be submitted to the commissioner and the commissioner's decision is final.

Subd. 6. **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 up to the limit of the appropriation in the order in which claims are received.

(b) Total bonus incentives must be computed by multiplying the number of persons included in claims submitted in accordance with this section by the applicable bonus payment as determined in subdivision 4.

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

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

History: *1990 c 568 art 2 s 62; 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*

256.98 WRONGFULLY OBTAINING ASSISTANCE; THEFT.

Subdivision 1. **Wrongfully obtaining assistance.** A person who obtains, or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of a material fact, or by impersonation or other fraudulent device, assistance to which the person is not entitled or assistance greater than that to which the person is entitled, or who knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency with intent to defeat the purposes of sections 256.12, 256.72 to 256.871, and chapter 256B, or all of these sections is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3, clauses (2), (3)(a) and (c), (4), and (5).

Subd. 2. **Joint trials.** When two or more defendants are jointly charged with the same offense under subdivision 1, or are jointly charged with different offenses under subdivision 1 arising from the same course of conduct, they shall be tried jointly; however, if it appears to the court that a defendant or the state is substantially prejudiced by the joinder for trial, the court may order an election or separate trial of counts, grant a severance of defendants, or provide other relief.

Subd. 3. **Amount of assistance incorrectly paid.** The amount of the assistance incorrectly paid under this section is the difference between the amount of assistance actually received on the basis of misrepresented or concealed facts and the amount to which the recipient would have been entitled had the specific concealment or misrepresentation not occurred. Unless required by law, rule, or regulation, earned income disregards shall not be applied to earnings not reported by the recipient.

Subd. 4. **Recovery of assistance.** The amount of assistance determined to have been incorrectly paid is recoverable from the recipient or the recipient's estate by the county or the state as a debt due the county or the state or both in proportion to the contribution of each.

Subd. 5. **Criminal or civil action.** To prosecute or to recover assistance wrongfully

obtained under this section, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general, may institute a criminal or civil action or both.

Subd. 6. **Rule superseded.** Rule 17.03, subdivision 2, of the Minnesota Rules of Criminal Procedures that relates to joint trials is superseded by this section to the extent that it conflicts with this section.

Subd. 7. **Division of recovered amounts.** If the state is responsible for the recovery, the amounts recovered shall be paid to the appropriate units of government as provided under section 256.863. If the recovery is directly attributable to a county, the county may retain one-half of the nonfederal share of any recovery from a recipient or the recipient's estate. This subdivision does not apply to recoveries from medical providers or to recoveries involving the department of human services, surveillance and utilization review division, state hospital collections unit, and the benefit recoveries division.

Subd. 8. **Disqualification from program.** Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, in either the aid to families with dependent children program or the food stamp program, shall be disqualified from that program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for six months after the first offense;

(2) for 12 months after the second offense; and

(3) permanently after the third or subsequent offense.

Any period for which sanctions are imposed is effective, without possibility of administrative stay, until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

History: *1971 c 550 s 1; 1973 c 348 s 1; 1973 c 717 s 16; 1975 c 437 art 2 s 2; 1977 c 225 s 1; 1986 c 444; 1987 c 254 s 6; 1987 c 403 art 2 s 72; 1988 c 712 s 2; 1990 c 566 s 6; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 26; 1992 c 513 art 8 s 14*

256.981 TRAINING OF WELFARE FRAUD PROSECUTORS.

The commissioner of human services shall, to the extent an appropriation is provided for this purpose, contract with the county attorney's council or other public or private entity experienced in providing training for prosecutors to conduct quarterly workshops and seminars focusing on current aid to families with dependent children program issues, other income maintenance program changes, recovery issues, alternative sentencing methods, use of technical aids for interviews and interrogations, and other matters affecting prosecution of welfare fraud cases.

History: *1987 c 403 art 2 s 154*

256.982 TRAINING OF WELFARE FRAUD INVESTIGATORS.

The commissioner of human services shall, to the extent an appropriation is provided for this purpose, establish a pilot project for further education and training of welfare fraud investigators. The commissioner may enter into contractual agreements with other state, federal, or county agencies as part of cooperative projects employing experienced investigators to provide on-the-job training to county investigators.

History: *1987 c 403 art 2 s 155*

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, and to the extent required or authorized by applicable federal regulations, the commissioner of human services shall require the establishment of fraud prevention investiga-

tion programs in the seven counties participating in the fraud prevention investigation pilot project established under section 256.983, and in 11 additional Minnesota counties with the largest aid to families with dependent children program caseloads as of July 1, 1991. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties that have welfare fraud control programs already in place based on enhanced funding contracts covering the fraud investigation function.

Subd. 2. **County proposals.** Each participating county agency shall develop and submit an annual staffing and funding proposal to the commissioner no later than April 30 of each year. Each proposal shall include, but not be limited to, the staffing and funding of the fraud prevention investigation program, a job description for investigators involved in the fraud prevention investigation program, and the organizational structure of the county agency unit, training programs for case workers, and the operational requirements which may be directed by the commissioner. The proposal shall be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

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

Subd. 4. **Funding.** Every involved county agency shall either have in place or obtain an approved contract which meets all federal requirements necessary to obtain enhanced federal funding for its welfare fraud control and fraud prevention investigation programs. County agency reimbursement shall be made through the settlement provisions applicable to the aid to families with dependent children and food stamp programs.

History: *1989 c 282 art 5 s 41; 1991 c 292 art 5 s 27; 1Sp1993 c 1 art 6 s 24*

256.984 DECLARATION AND PENALTY.

Subdivision 1. **Declaration.** Every application for food stamps under chapter 393 shall be in writing or reduced to writing as prescribed by the state agency and shall contain the following declaration which shall be signed by the applicant:

> "I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or to payment of a fine of not more than $10,000, or both."

Subd. 2. **Penalty.** Any person who willfully and falsely makes the declaration in subdivision 1 is guilty of perjury and shall be subject to the penalties prescribed in section 609.48.

History: *1991 c 292 art 5 s 28*

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

256.99 REVERSE MORTGAGE PROCEEDS DISREGARDED.

All reverse mortgage loan proceeds received pursuant to section 47.58, including interest or earnings thereon, shall be disregarded and shall not be considered available to the borrower for purposes of determining initial or continuing eligibility for, or amount of, medical assistance, Minnesota supplemental assistance, general assistance, general assistance medical care, or a federal or state low interest loan or grant. This sec-

tion applies regardless of the time elapsed since the loan was made or the disposition of the proceeds.

For purposes of medical assistance eligibility provided under sections 256B.055, 256B.056, and 256B.06, proceeds from a reverse mortgage must be disregarded as income in the month of receipt but are a resource if retained after the month of receipt.

History: *1979 c 265 s 2; 3Sp1981 c 3 s 16; 1985 c 252 s 18; 1988 c 689 art 2 s 268*

256.991 RULES.

The commissioner of human services may promulgate emergency and permanent rules as necessary to implement sections 256.01, subdivision 2; 256.82, subdivision 3; 256.966, subdivision 1; 256D.03, subdivisions 3, 4, 6, and 7; and 261.23. The commissioner shall promulgate emergency and permanent rules to establish standards and criteria for deciding which medical assistance services require prior authorization and for deciding whether a second medical opinion is required for an elective surgery. The commissioner shall promulgate permanent and emergency rules as necessary to establish the methods and standards for determining inappropriate utilization of medical assistance services.

The commissioner of human services shall adopt emergency rules which meet the requirements of sections 14.29 to 14.36 for the medical assistance demonstration project. Notwithstanding the provisions of section 14.35, the emergency rules promulgated to implement section 256B.69 shall be effective for 360 days and may be continued in effect for an additional 900 days if the commissioner gives notice by publishing a notice in the State Register and mailing notice to all persons registered with the commissioner to receive notice of rulemaking proceedings in connection with the project. The emergency rules shall not be effective beyond December 31, 1986, without meeting the requirements of sections 14.131 to 14.20.

History: *1983 c 312 art 5 s 38; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1987 c 384 art 2 s 1; 1988 c 719 art 8 s 10; 1989 c 209 art 2 s 28*

256.995 SCHOOL-LINKED SERVICES FOR AT-RISK CHILDREN AND YOUTH.

Subdivision 1. **Program established.** In order to enhance the delivery of needed services to at-risk children and youth and maximize federal funds available for that purpose, the commissioners of human services and education shall design a statewide program of collaboration between providers of health and social services for children and local school districts, to be financed, to the greatest extent possible, from federal sources. The commissioners of health and public safety shall assist the commissioners of human services and education in designing the program.

Subd. 2. **At-risk children and youth.** The program shall target at-risk children and youth, defined as individuals, whether or not enrolled in school, who are under 21 years of age and who:

(1) are school dropouts;

(2) have failed in school;

(3) have become pregnant;

(4) are economically disadvantaged;

(5) are children of drug or alcohol abusers;

(6) are victims of physical, sexual, or psychological abuse;

(7) have committed a violent or delinquent act;

(8) have experienced mental health problems;

(9) have attempted suicide;

(10) have experienced long-term physical pain due to injury;

(11) are at risk of becoming or have become drug or alcohol abusers or chemically dependent;

(12) have experienced homelessness;

(13) have been excluded or expelled from school under sections 127.26 to 127.39; or

(14) have been adjudicated children in need of protection or services.

Subd. 3. **Services.** The program must be designed not to duplicate existing programs, but to enable schools to collaborate with county social service agencies and county health boards and with local public and private providers to assure that at-risk children and youth receive health care, mental health services, family drug and alcohol counseling, and needed social services. Screenings and referrals under this program shall not duplicate screenings under section 123.702.

Subd. 4. **Funding.** The program must be designed to take advantage of available federal funding, including the following:

(1) child welfare funds under United States Code, title 42, sections 620-628 (1988) and United States Code, title 42, sections 651-669 (1988);

(2) funds available for health care and health care screening under medical assistance, United States Code, title 42, section 1396 (1988);

(3) social services funds available under United States Code, title 42, section 1397 (1988);

(4) children's day care funds available under federal transition year child care, the Family Support Act, Public Law Number 100-485; federal at-risk child care program, Public Law Number 101-5081; and federal child care and development block grant, Public Law Number 101-5082; and

(5) funds available for fighting drug abuse and chemical dependency in children and youth, including the following:

(i) funds received by the office of drug policy under the federal Anti-Drug Abuse Act and other federal programs;

(ii) funds received by the commissioner of human services under the federal alcohol, drug abuse, and mental health block grant; and

(iii) funds received by the commissioner of human services under the drug-free schools and communities act.

Subd. 5. **Waivers.** The commissioner of human services shall collaborate with the commissioners of education, health, and public safety to seek the federal waivers necessary to secure federal funds for implementing the statewide school-based program mandated by this section. Each commissioner shall amend the state plans for programs specified in subdivision 3, to the extent necessary to ensure the availability of federal funds for the school-based program.

Subd. 6. **Pilot projects.** Within 90 days of receiving the necessary federal waivers, the commissioners of human services and education shall implement at least two pilot programs that link health and social services in the schools. One program shall be located in a school district in the seven-county metropolitan area. The other program shall be located in a greater Minnesota school district. The commissioner of human services, in collaboration with the commissioner of education, shall select the pilot programs on a request for proposal basis. The commissioners shall give priority to school districts with some expertise in collocating services for at-risk children and youth. Programs funded under this subdivision must:

(1) involve a plan for collaboration between a school district and at least two local social service or health care agencies to provide services for which federal funds are available to at-risk children or youth;

(2) include parents or guardians in program planning and implementation;

(3) contain a community outreach component; and

(4) include protocol for evaluating the program.

Subd. 7. **Report.** The commissioners of human services and education shall report to the legislature by January 15, 1993, on the design and status of the statewide program for school-linked services. The report shall include the following:

(1) a complete program design for assuring the implementation of health and human services for children within school districts statewide;

(2) a statewide funding plan based on the use of federal funds, including federal funds available only through waiver;

(3) copies of the waiver requests and information on the status of requests for federal approval;

(4) status of the pilot program development; and

(5) recommendations for statewide implementation of the school-linked services program.

History: *1992 c 571 art 10 s 18*