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;

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

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

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

(3) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child–caring and child–placing agen-

cies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the state board of control.

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

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

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

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

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

(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 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.

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

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

(14) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children, Minnesota family investment program–statewide, 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, MFIP–S, 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, MFIP–S, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(21) Have the authority to administer a drug rebate program for drugs purchased pursuant to the senior citizen drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the basic rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r–8(c)(1). This basic rebate shall be applied to single–source and multiple–source drugs. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

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. 4a. **Technical assistance for immunization reminders.** The state agency shall provide appropriate technical assistance to county agencies to develop methods to have county financial workers remind and encourage recipients of aid to families with dependent children, Minnesota family investment program–statewide, the Minnesota family investment plan, medical assistance, family general assistance, or food stamps whose assistance unit includes at least one child under the age of five to have each young child immunized against childhood diseases. The state agency must examine the feasibility of utilizing the capacity of a statewide computer system to assist county agency financial workers in performing this function at appropriate intervals.

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 ser-

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

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

(c) If the commissioner of human services has reason to believe that a child's death was caused by maltreatment or that maltreatment was a contributing cause, the commissioner has access to not public data under chapter 13 maintained by state agencies, statewide systems, or political subdivisions that are related to the child's death or circumstances surrounding the

care of the child. The commissioner shall also have access to records of private hospitals as necessary to carry out the duties prescribed by this section. Access to data under this paragraph is limited to police investigative data; autopsy records and coroner or medical examiner investigative data; hospital, public health, or other medical records of the child; hospital and other medical records of the child's parent that relate to prenatal care; and records created by social service agencies that provided services to the child or family within three years preceding the child's death. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner. Not public data may be shared with members of the state or local child mortality review panel in connection with an individual case.

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

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

Subd. 13. **Pilot project; protocols for persons lacking proficiency in English.** The commissioner of human services shall establish pilot projects in Hennepin and Ramsey counties to provide language assistance to clients applying for or receiving aid through the county social service agency. The projects shall be designed to provide translation, in the five foreign languages that are most common to applicants and recipients in the pilot counties, to individuals lacking proficiency in English, who are applying for or receiving assistance under any program supervised by the commissioner of human services. As part of the project, the commissioner shall ensure that the Combined Application Form (CAF) is available in these five languages. The projects shall also provide language assistance to individuals applying for or receiving aid under programs which the department of human services operates jointly with other executive branch agencies, including all work and training programs operated under this chapter and chapter 256D. The purpose of the pilot projects is to ensure that information regarding a program is presented in translation to applicants for and recipients of assistance who lack proficiency in English. In preparing the protocols to be used in the pilot programs, the commissioner shall seek input from the following groups: advocacy organizations that represent non–English–speaking clients, county social service agencies, legal advocacy groups, employment and training providers, and other affected groups. The commissioner shall develop the protocols by October 1, 1995, and shall implement them as soon as feasible in the pilot counties. The commissioner shall report to the legislature by February 1, 1996, on the protocols developed, on the status of their implementation in the pilot counties, and shall include recommendations for statewide implementation.

Subd. 14. **Child welfare reform pilots.** The commissioner of human services shall encourage local reforms in the delivery of child welfare services and is authorized to approve local pilot programs which focus on reforming the child protection and child welfare systems in Minnesota. Authority to approve pilots includes authority to waive existing state rules as

needed to accomplish reform efforts. Notwithstanding section 626.556, subdivision 10, 10b, or 10d, the commissioner may authorize programs to use alternative methods of investigating and assessing reports of child maltreatment, provided that the programs comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. Pilot programs must be required to address responsibility for safety and protection of children, be time limited, and include evaluation of the pilot program.

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

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

(c) A citizen review panel has access to the following data for specific case review under this paragraph: police investigative data; autopsy records and coroner or medical examiner investigative data; hospital, public health, or other medical records of the child; hospital and other medical records of the child's parent that relate to prenatal care; records created by social service agencies that provided services to the child or family; and personnel data related to an employee's performance in discharging child protection responsibilities. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner. Not public data may be shared with members of the state or local citizen review panel in connection with an individual case.

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

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

Subd. 16. **Information for persons with limited English–language proficiency.** By July 1, 1998, the commissioner shall implement a procedure for public assistance applicants

and recipients to identify a language preference other than English in order to receive information pertaining to the public assistance programs in that preferred language.

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

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, including the electronic distribution of benefits;

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

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

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.

The commissioner may enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to participate in state–operated computer systems related to the management and administration of the food stamp, income maintenance, child support enforcement, and medical assistance and general assistance medical care programs to the extent necessary for the tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner.

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

Subd. 3. **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; 1995 c 207 art 2 s 21; 1998 c 407 art 6 s 8*

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

Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the agency shall have a lien for the cost of the care and payments on any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury which accrue to the person to whom the care or payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments. For purposes of this section, "state agency" includes authorized agents of the state agency.

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

addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries.

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

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

Subd. 3. **Prosecutor.** The attorney general, 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 party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

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

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

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

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

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

Subd. 7. **Cooperation 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. Upon the request of the department of human services or county child support or human service agencies, any employer or third party payer shall cooperate in furnishing information about group health insurance plans or medical benefit plans available to its employees. The department of human services and county agencies shall limit its use of information gained from agencies, third party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

History: *1987 c 370 art 2 s 3; 1988 c 689 art 2 s 122; 1990 c 568 art 4 s 84; 1Sp1993 c 1 art 5 s 9; 1995 c 207 art 6 s 9–11; 1997 c 217 art 2 s 2–4*

256.016 PLAIN LANGUAGE IN WRITTEN MATERIALS.

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

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

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

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

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

256.017 COMPLIANCE SYSTEM.

Subdivision 1. **Authority and purpose.** The commissioner shall administer a compliance system for aid to families with dependent children, Minnesota family investment program–statewide, the food stamp program, emergency assistance, general assistance, 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 purposes of this section.

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

(b) "Quality control case penalty" means an adjustment against the county agency's federal administrative reimbursement and state and federal benefit reimbursement when the commissioner determines through a quality control review that the county agency has made incorrect payments, terminations, or denials of benefits as determined by state quality control procedures for the aid to families with dependent children, Minnesota family investment program–statewide, 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/quality assurance" means a review system of a statewide random sample of cases, designed to provide data on program outcomes and the accuracy with which state and federal policies are being applied in issuing benefits and as a fiscal audit to ensure the accuracy of expenditures. The quality control/quality assurance system is administered by the department. For the aid to families with dependent children, Minnesota family investment program–statewide, food stamp, and medical assistance programs, the quality control system is that required by federal regulation, or those developed by the commissioner.

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

Subd. 4. **Determining the amount of the quality control case penalty.** (a) The amount of the quality control case penalty is limited to the amount of the dollar error for the quality control sample month in a reviewed case as determined by the state quality control review procedures for the aid to families with dependent children, Minnesota family investment program–statewide 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; 1997 c 85 art 4 s 9,10; art 5 s 3*

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, MFIP–S, general assistance medical care, emergency assistance, general assistance, and Minnesota supplemental aid, the county may keep one–half of recovery made by the county agency using any method other than recoupment. For medical assistance, if the recovery is made by a county agency using any method other than recoupment, the county may keep one–half of the nonfederal share of the recovery. This does not apply to recoveries from medical providers or to recoveries begun by the department of human services' surveillance and utilization review division, state hospital collections unit, and the benefit recoveries division or, by the attorney general's office, or child support collections. In the food stamp program, the nonfederal share of recoveries in the federal tax refund offset program (FTROP) only will be divided equally between the state agency and the involved county agency.

History: *1988 c 719 art 8 s 29; 1993 c 306 s 2; 1997 c 85 art 5 s 4*

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, excluding county optional costs which are not reimbursable with state funds. 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 2002 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, for assistance costs incurred prior to July 1, 1997;

(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, for assistance costs incurred prior to July 1, 1997;

(4) general assistance under section 256D.03, subdivision 2, for assistance costs incurred prior to July 1, 1997;

(5) work readiness under section 256D.03, subdivision 2, for assistance costs incurred prior to July 1, 1995;

(6) emergency assistance under section 256.871, subdivision 6, for assistance costs incurred prior to July 1, 1997;

(7) Minnesota supplemental aid under section 256D.36, subdivision 1, for assistance costs incurred prior to July 1, 1997;

(8) preadmission screening and alternative care grants for assistance costs incurred prior to July 1, 1997;

(9) work readiness services under section 256D.051 for employment and training services costs incurred prior to July 1, 1995;

(10) case management services under section 256.736, subdivision 13, for case management service costs incurred prior to July 1, 1995;

(11) general assistance claims processing, medical transportation and related costs for costs incurred prior to July 1, 1997;

(12) medical transportation and related costs for transportation and related costs incurred prior to July 1, 1997; and

(13) group residential housing under section 256I.05, subdivision 8, transferred from programs in clauses (4) and (7), for assistance costs incurred prior to July 1, 1997.

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. Reimbursement may take the form of offsets to billings of a county, if the county agrees to the offset process.

(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 March 1998 shall be made on or before the third of each month through 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 April 1999 shall be made on or before the third of each month through April

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 May 2000 shall be made on or before the third of each month through May 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) Effective January 1, 2001, 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; 1995 c 207 art 2 s 22–24; 1997 c 203 art 11 s 1,2*

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

256.027 USE OF VANS PERMITTED.

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

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

256.03 [Repealed, 1961 c 561 s 17]

MINNESOTA FAMILY INVESTMENT PLAN

256.031 MINNESOTA FAMILY INVESTMENT PLAN.

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

Subd. 1a. **Use of federal authority.** Federal authority as cited in sections 256.031 to 256.0361 and 256.047 is reference to United States Code, title 42, chapter 7, subchapter II, section 402, and subchapter IV, sections 601 and 602, and Code of Federal Regulations, title 45, as constructed on the day prior to their federal repeal.

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

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

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

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

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

NOTE: Subdivision 6 was also amended by Laws 1998, chapter 407, article 6, section 9, to read as follows:

"Subd. 6. **End of field trials.** (a) Upon agreement with the federal government, the field trials of the Minnesota family investment plan will end June 30, 1998.

(b) Families in the comparison group under subdivision 3, paragraph (d), clause (i), receiving aid to families with dependent children under sections 256.72 to 256.87, and STRIDE services under section 256.736 will continue in those programs until June 30, 1998. After June 30, 1998, families who cease receiving assistance under the Minnesota family investment plan and comparison group families who cease receiving assistance under AFDC and STRIDE who are eligible for the Minnesota family investment program–statewide (MFIP–S), medical assistance, general assistance medical care, or the food stamp program shall be placed with their consent on the programs for which they are eligible.

(c) Families who cease receiving assistance under the MFIP and comparison families who cease receiving assistance under AFDC and STRIDE who are ineligible for MFIP–S due to increased income from employment, or increased child or spousal support or a combination of employment income and child or spousal support, shall be eligible for transition year child care under section 119B.05, and extended medical assistance under section 256B.0635. For the purpose of assistance for transition year child care and determining receipt of extended medical assistance, receipt of AFDC and MFIP shall be considered to be the same as receipt of MFIP–S."

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; 1994 c 483 s 1; 1995 c 212 art 3 s 59; 1Sp1995 c 3 art 16 s 13; 1996 c 465 art 3 s 2; 1997 c 85 art 3 s 1; art 4 s 11*

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

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

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

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

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

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

256.04 [Temporary]

256.045 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, 3b, 4a, and 5. Human services referees designated pursuant to this section may administer oaths and shall be under the control and supervision of the commissioner of human services and shall not be a part of the office of administrative hearings established pursuant to sections 14.48 to 14.56.

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

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; or (8) an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30–day time limit.

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

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

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

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

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

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

Subd. 3a. **Prepaid health plan appeals.** (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). 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, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to au-

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

Subd. 3b. **Standard of evidence for maltreatment hearings.** The state human services referee shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557.

The state human services referee shall recommend an order to the commissioner of health or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. In any licensing appeal under chapter 245A and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive.

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

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

Subd. 4a. **Case management appeals.** Any recipient of case management services pursuant to section 256B.092, who contests the county agency's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a

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

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

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

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

A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services 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, unless assisting a recipient as provided in subdivision 4. A prepaid health

plan is a party to an appeal under subdivision 3a, but cannot seek judicial review of an order issued under this section.

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

(b) Any party to a hearing held pursuant to subdivision 3, 3a, 3b, or 4a may request that the commissioner issue a subpoena to compel the attendance of witnesses 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.** Except for a prepaid health plan, any party who is aggrieved by an order of the commissioner of human services, or the commissioner of health in appeals within the commissioner's jurisdiction under subdivision 3b, may appeal the order to the district court of the county responsible for furnishing assistance, or, in appeals under subdivision 3b, the county where the maltreatment occurred, by serving a written copy of a notice of appeal upon the commissioner and any adverse party of record within 30 days after the date the commissioner issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with the court administrator of the district court. Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision, with the exception of appeals taken under subdivision 3b. The commissioner may elect to become a party to the proceedings in the district court. Except for appeals under subdivision 3b, any party may demand that the commissioner furnish all parties to the proceedings with a copy of the decision, and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the human services referee, by serving a written demand upon the commissioner within 30 days after service of the notice of appeal. Any party aggrieved by the failure of an adverse party to obey an order issued by the commissioner under subdivision 5 may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

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

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

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

ent 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. Provision of a health care service by the state agency under medical assistance, general assistance medical care, or MinnesotaCare pending appeal shall not render moot the state agency's position in a court of law.

History: *1976 c 131 s 1; 1978 c 560 s 7; 1982 c 424 s 130; 1983 c 247 s 108,109; 1983 c 312 art 5 s 4; 1984 c 534 s 14–18; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 148 s 1–8; 1987 c 403 art 2 s 61; 1989 c 282 art 5 s 12–20; 1990 c 568 art 4 s 84; 1991 c 94 s 11; 1991 c 292 art 4 s 16; art 6 s 58 subd 2; 1993 c 247 art 4 s 1; 1993 c 339 s 9; 1994 c 625 art 8 s 72; 1995 c 207 art 2 s 27–29; art 11 s 5; 1995 c 229 art 3 s 6–14; 1996 c 408 art 10 s 6; 1996 c 416 s 1; 1996 c 451 art 5 s 9; 1997 c 85 art 5 s 5; 1997 c 203 art 4 s 11; art 5 s 6–10; art 9 s 5; 1997 c 225 art 2 s 55*

256.046 ADMINISTRATIVE FRAUD DISQUALIFICATION HEARINGS.

Subdivision 1. **Hearing authority.** A local agency shall initiate an administrative fraud disqualification hearing for individuals accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the aid to families with dependent children, MFIP–S, child care, general assistance, family general assistance, Minnesota supplemental aid, medical care, 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, as of September 30, 1995, for the cash grant and medical care programs.

Subd. 2. **Combined hearing.** The referee may combine a fair hearing and administrative fraud disqualification hearing into a single hearing if the factual issues arise out of the same, or related, circumstances and the individual receives prior notice that the hearings will be combined. If the administrative fraud disqualification hearing and fair hearing are combined, the time frames for administrative fraud disqualification hearings specified in Code of Federal Regulations, title 7, section 273.16, and title 45, section 235.112, as of September 30, 1995, apply. If the individual accused of wrongfully obtaining assistance is charged under section 256.98 for the same act or acts which are the subject of the hearing, the individual may request that the hearing be delayed until the criminal charge is decided by the court or withdrawn.

History: *1992 c 513 art 8 s 10; 1997 c 85 art 4 s 12; art 5 s 6; 1Sp1997 c 5 s 13*

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

256.0471 OVERPAYMENTS BECOME JUDGMENTS BY OPERATION OF LAW.

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under sections 119B.05, 256.031 to 256.0361, and 256.72 to 256.871; chapters 256B, 256D, 256I, 256J, and 256K; and the food stamp program, except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1997 c 85 art 5 s 7*

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

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

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

256.05 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 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1973 c 717 s 33]
Subd. 3. [Repealed, 1973 c 717 s 33]
Subd. 4. [Repealed, 1973 c 717 s 33]
Subd. 5. [Repealed, 1973 c 717 s 33]
Subd. 6. [Repealed, 1973 c 717 s 33]
Subd. 7. [Repealed, 1973 c 717 s 33]
Subd. 8. [Repealed, 1973 c 717 s 33]
Subd. 9. [Repealed, 1997 c 85 art 1 s 74]
Subd. 10. [Repealed, 1997 c 85 art 1 s 74]
Subd. 11. [Repealed, 1973 c 717 s 33]
Subd. 12. [Repealed, 1973 c 717 s 33]
Subd. 13. [Repealed, 1973 c 717 s 33]
Subd. 14. [Repealed, 1997 c 85 art 1 s 74]
Subd. 15. [Repealed, 1997 c 85 art 1 s 74]
Subd. 16. [Repealed, 1973 c 717 s 33]
Subd. 17. [Repealed, 1973 c 717 s 33]
Subd. 18. [Repealed, 1969 c 329 s 1]
Subd. 19. [Repealed, 1997 c 85 art 1 s 74]
Subd. 20. [Repealed, 1997 c 85 art 1 s 74]
Subd. 21. [Repealed, 1997 c 85 art 1 s 74]
Subd. 22. [Repealed, 1997 c 85 art 1 s 74]
Subd. 23. [Repealed, 1997 c 85 art 1 s 74]

256.13 [Repealed, 1973 c 717 s 33]

256.14 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1959 c 622 s 7]

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

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

256.151 [Repealed, 1951 c 92 s 2]

256.16 [Repealed, 1973 c 717 s 33]

256.17 [Repealed, 1973 c 717 s 33]

256.18 [Repealed, 1973 c 717 s 33]

256.183 [Expired]

256.184 [Expired]

256.185 [Expired]

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

256.20 [Repealed, 1973 c 717 s 33]

256.21 [Repealed, 1973 c 717 s 33]

256.22 [Repealed, 1973 c 717 s 33]

256.23 [Repealed, 1973 c 717 s 33]

256.24 [Repealed, Ex1971 c 16 s 6]

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

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

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

256.26 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1973 c 717 s 33]
Subd. 3. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 4. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 5. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 6. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 7. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 8. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 9. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 10. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]
Subd. 11. [Repealed, 1973 c 78 s 2; 1973 c 717 s 33]

256.263 LAND ACQUIRED BY STATE UNDER OLD AGE ASSISTANCE LIENS.

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

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

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

256.27 [Repealed, 1973 c 717 s 33]

256.28 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1967 c 89 s 2; 1967 c 885 s 6]

256.29 [Repealed, 1973 c 717 s 33]

256.30 [Repealed, 1973 c 717 s 33]

256.31 [Repealed, 1971 c 550 s 2]

256.32 [Repealed, 1973 c 717 s 33]

256.33 [Repealed, 1973 c 717 s 33]

256.34 [Repealed, 1973 c 717 s 33]

256.35 [Repealed, 1973 c 717 s 33]

256.36 [Repealed, 1973 c 717 s 33]

256.362 REPORTS AND IMPLEMENTATION.

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

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

Subd. 3. **Coordination of medical assistance and the MinnesotaCare program.** 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 [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]

256.476 CONSUMER SUPPORT PROGRAM.

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program to assist individuals with functional limitations and their families in purchasing and securing supports which the individuals need to live as independently and productively in the community as possible. The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability. The program shall:

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

(2) provide consumers more control, flexibility, and responsibility over the needed supports;

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

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

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

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

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

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

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

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

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

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board to carry out the provisions of this section.

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

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

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

(i) "Supports" means services, care, aids, home modifications, or assistance purchased by the person or the person's family. Examples of supports include respite care, assistance with daily living, and adaptive aids. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

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

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

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person is eligible for and has been approved to receive services under alternative care services as determined under section 256B.0913 or the person has been approved to receive a grant under the developmental disability family support program under section 252.32;

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

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

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

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

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

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

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program. A person or person's family is not eligible for a consumer support grant if their income is at a level where they are required to pay a parental fee under sections 252.27, 256B.055, subdivision 12, and 256B.14 and rules adopted under those sections for medical assistance services to a disabled child living with at least one parent.

(d) The commissioner may limit the participation of nursing facility residents, residents of intermediate care facilities for persons with mental retardation, and the recipients of services from federal waiver programs in the consumer support grant program if the participation of these individuals will result in an increase in the cost to the state.

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

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county board chooses to participate in the program, the local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time–limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 5, paragraph (f).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars expended on those individuals for those programs and services or, in situations where an individual is unable to obtain the support needed from the program of origination due to the unavailability of service providers at the time or the location where the supports are needed, the allocation will be based on the county's best estimate of the nonfederal dollars that would have been expended if the services had been available; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service

openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

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

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

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

(f) Except as provided in this paragraph, the county allocation for each individual or individual's family cannot exceed 80 percent of the total nonfederal dollars expended on the individual by the program of origination except for the developmental disabilities family support grant program which can be approved up to 100 percent of the nonfederal dollars and in situations as described in paragraph (b), clause (3). In situations where exceptional need exists or the individual's need for support increases, up to 100 percent of the nonfederal dollars expended may be allocated to the county. Allocations that exceed 80 percent of the nonfederal dollars expended on the individual by the program of origination must be approved by the commissioner. The remainder of the amount expended on the individual by the program of origination will be used in the following proportions: half will be made available to the consumer support grant program and participating counties for consumer training, resource development, and other costs, and half will be returned to the state general fund.

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

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

Subd. 7. **Federal funds.** The commissioner and the counties shall make reasonable efforts to maximize the use of federal funds including funds available through grants and federal waivers. If federal funds are made available to the consumer support grant program, the money shall be allocated to the responsible county agency's consumer support grant fund.

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

(1) transfer and allocate funds pursuant to this section;

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

(3) monitor and oversee overall program spending;

(4) evaluate the effectiveness of the program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) arrange and pay for supports; and

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

History: *1995 c 207 art 3 s 15; 1997 c 203 art 4 s 12–15*

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 children, families, and learning, 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 children, families, and learning, 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.

Subd. 8. **Sunset.** Notwithstanding section 15.059, subdivision 5, the council on disability shall not sunset until June 30, 2001.

History: *1973 c 254 s 3; 1973 c 757 s 2; 1975 c 61 s 1; 1975 c 271 s 6; 1975 c 315 s 18; 1975 c 359 s 23; 1977 c 177 s 2; 1977 c 305 s 45; 1977 c 430 s 14; 1983 c 216 art 2 s 5; 1983 c 260 s 56; 1983 c 277 s 2; 1983 c 299 s 25; 1984 c 654 art 5 s 58; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 354 s 6; 1988 c 629 s 50; 1989 c 335 art 1 s 185,186; art 4 s 67; 1991 c 292 art 3 s 7; 1994 c 483 s 1; 1Sp1995 c 3 art 16 s 13; 1996 c 451 art 6 s 7*

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, children, families, and learning, 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; 1Sp1995 c 3 art 16 s 13*

256.49 Subdivision 1. [Repealed, 1973 c 717 s 33]
Subd. 2. [Repealed, 1955 c 711 s 3]

256.50 [Repealed, 1973 c 717 s 33]

256.51 [Repealed, 1973 c 717 s 33]

256.515 [Repealed, 1973 c 717 s 33]

256.52 [Repealed, 1973 c 717 s 33]

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

256.54 [Repealed, 1973 c 717 s 33]

256.55 [Repealed, 1973 c 717 s 33]

256.56 [Repealed, 1973 c 717 s 33]

256.57 [Repealed, 1973 c 717 s 33]

256.58 [Repealed, 1973 c 717 s 33]

256.59 [Repealed, 1973 c 717 s 33]

256.60 [Repealed, 1973 c 717 s 33]

256.61 [Repealed, 1973 c 717 s 33]

256.62 [Repealed, 1973 c 717 s 33]

256.63 [Repealed, 1973 c 717 s 33]

256.64 [Repealed, 1973 c 717 s 33]

256.65 [Repealed, 1973 c 574 s 2]

256.66 [Repealed, 1973 c 717 s 33]

256.67 [Repealed, 1973 c 717 s 33]

256.68 [Repealed, 1971 c 550 s 2]

256.69 [Repealed, 1973 c 717 s 33]

256.70 [Repealed, 1973 c 717 s 33]

256.71 [Repealed, 1973 c 717 s 33]

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

256.73 Subdivision 1. [Repealed, 1997 c 85 art 1 s 74; 1Sp1997 c 5 s 12]
Subd. 1a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 1b. [Repealed, 1997 c 85 art 1 s 74; 1Sp1997 c 5 s 12]
Subd. 2. [Repealed, 1997 c 85 art 1 s 74]
Subd. 3. [Repealed, 1973 c 717 s 33]
Subd. 3a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 3b. [Repealed, 1997 c 85 art 1 s 74]
Subd. 4. [Repealed, 1987 c 363 s 14]
Subd. 5. [Repealed, 1997 c 85 art 1 s 74]
Subd. 5a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 6. [Repealed, 1997 c 85 art 1 s 74]
Subd. 7. [Repealed, 1989 c 343 s 7]
Subd. 8. [Repealed, 1997 c 85 art 1 s 74]
Subd. 8a. [Repealed, 1997 c 85 art 1 s 74]
Subd. 9. [Repealed, 1997 c 85 art 1 s 74]
Subd. 10. [Repealed, 1997 c 85 art 1 s 74]
Subd. 11. [Repealed, 1997 c 85 art 1 s 74]

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

TEMPORARY PUBLIC OR COMMUNITY SERVICE JOBS

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

256.735 [Repealed, 1969 c 334 s 2]

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

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

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

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

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

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

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

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

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

256.736 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" or "two–parent family" 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) "Case manager" means the county agency's employment and training service provider who provides the services identified in sections 256.736 to 256.739 according to subdivision 12.

(e) "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 and vocational education 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.

(f) "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.

(g) "Minor parent" means a person who is under age 18 who is either the birth parent of a minor child or children in the assistance unit and who is under the age of 18 or is eligible for AFDC as a pregnant woman.

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

(i) "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.

(j) "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;

(8) employed at least 30 hours per week; or

(9) an individual added to an assistance unit as an essential person under section 256.74, subdivision 1, who does not meet the definition of a "caretaker" as defined in subdivision 1a, paragraph (c).

(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) 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; and

(3) after the county agency assures the availability of employment and training services for recipients identified under clauses (1) and (2), and to the extent of available resources, any other AFDC recipient.

(b) Participants who are eligible and enroll in the STRIDE program under one of the categories of this subdivision are required to cooperate with the assessment and employabil-

ity plan development and to meet the terms of their employability plan. Failure to comply, without good cause, shall result in the imposition of sanctions as specified in subdivision 4, clause (6).

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 124D.09, 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.

(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 124D.331.

(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 provided, 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 the project STRIDE program for completion of an employability plan and mandatory participation in employment and training services. If the custodial parent fails to participate or cooperate with employment and training 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) in consultation with the commissioner of children, families, and learning, arrange for or provide any caretaker or child who participates 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, to comply with the recipient's employability development plan, 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 comply with the recipient's employability development plan, 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 a two–parent family, cash payments may continue to the caretaker in the assistance unit who remains eligible for AFDC, 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 parent in a two–parent family and the other parent is not participating in an approved employment and training service, the needs of both parents 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, conciliation, 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 the date the notice was mailed or hand delivered, a conciliation conference. The employment and training service provider or the county agency must conduct a conciliation conference within five days of a timely request. 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, the employment and training service provider shall notify the county board of a caretaker's failure without good cause to cooperate or accept employment. Unless the county agency has evidence to the contrary, the county agency shall implement the sanction provisions of subdivision 4. Any determination, action, or inaction on the part of the county board relating to a caretaker's participation under this section 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 and the commissioner of trade and economic development to extend the availability of training and employment opportunities on a statewide basis and to assist local employment advisory groups convened under this subdivision. The county welfare agency may convene an employment advisory group which shall include but not be limited to representatives from the local chamber of commerce, from major area employers, from private and public collective bargaining units who shall be represented by their exclusive representatives, from secondary and post–secondary educational institutions in the community, and from job services offices operated by the commissioner of economic security under chapter 268. The county welfare agency shall work with the local employment advisory group to maximize the job opportunities for welfare clients. In a county where a private industry council has been established, the county welfare agency may work with the council to maximize job opportunities in lieu of or in addition to convening an employment advisory group.

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 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, if any, and whether the person's participation is mandatory or voluntary;

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

(4) work with the employment and training service provider to encourage participation in employment and training services;

(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 caretakers to develop a plan to obtain self–sufficiency;

(8) notify the commissioner of the caretakers who 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 the required services of orientation, services to custodial parents under the age of 20 who have not completed high school or an equivalent program, job search, educational activities, and work experience for two–parent families are made available to appropriate caretakers under this section, and that services are provided to volunteer caretakers to the extent resources permit;

(12) explain in its local service unit plan under section 268.88 how it will ensure that 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 60 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 121A, 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) reflects the effort to arrange mandatory activities so that the activities do not interfere with access to available English as a second language classes and to the extent possible, reflects the preferences of the participant;

(viii) includes a written agreement between the county agency and the caretaker that outlines a reasonable schedule for completing the plan, including specific completion deadlines, and confirms that

(A) there is a market for full–time employees with this education or training where the caretaker will or is willing to reside upon completion of the program;

(B) the average wage level for employees with this education or training is greater than the caretaker can earn without this education or training;

(C) the caretaker has the academic ability to successfully complete the program; and

(D) there is a reasonable expectation that the caretaker will complete the training program based on such factors as the caretaker's previous education, training, work history, current motivation, and changes in previous circumstances; and

(ix) specifies the recipient's long–term employment goal which shall lead to self–sufficiency. Caretakers shall be counseled to set realistic attainable goals, taking into account the long–term needs of the caretaker and the caretaker's family;

(16) provide written notification to and obtain the written concurrence of the appropriate exclusive bargaining representatives with respect to job duties covered under collective bargaining agreements and assure that no work assignment under this section or sections 256.737, 256.738, and 256.739, or the Minnesota parent's fair share mandatory community work experience program 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. If an exclusive bargaining representative and a county or public service employer disagree regarding whether job duties are covered under a collective bargaining agreement, the exclusive bargaining representative or the county or public service employer may petition the bureau of mediation services, and the bureau shall determine if the job duties are covered by a collective bargaining agreement;

(17) assess each caretaker in a two–parent 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; and

(18) provide counseling and other personal follow–up support as needed for up to six months after the participant loses AFDC eligibility to assist the person to maintain employment or to secure new employment.

(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 written employability development plan approved by the county human service agency, or its employment and training service provider, the county that approved the plan is responsible for the costs of services required to carry out the plan. 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 119B. A county human service agency may pay for the costs of 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 who are permitted to volunteer for services under subdivision 3a; or

(2) within 30 days of being determined eligible for AFDC for caretakers who are required to participate in services under subdivision 3a.

(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, including the requirement that volunteer participants comply with their employability development plan;

(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 121A;

(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;

(12) the availability of the federal earned income tax credits and the state working family tax credits; and

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

(d) All orientation programs should provide information to caretakers on parenting, nutrition, household management, food preparation, and other subjects relevant to promoting family integration and self–sufficiency and provide detailed information on community resources available for training sessions on these topics.

(e) 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.

(f) 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 (13), 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.

(g) 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.

(h) 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.

(i) 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. [Repealed, 1996 c 465 art 3 s 45]

Subd. 11. [Repealed, 1996 c 465 art 3 s 45]

Subd. 12. **Employment and training service provision.** (a) Counties may directly employ case managers to provide the employment and training services in this section if the county is certified as an employment and training service provider under section 268.0122, or may contract for services with a certified employment and training service provider. Uncertified counties and contracting agencies may provide services only if they demonstrate the ability to coordinate employment, training, education, and support services. The com-

missioner 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 this section. Counties that contract with another agency for 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 employability development plans.

Subd. 13. [Repealed, 1996 c 465 art 3 s 45]

Subd. 14. **Job search.** (a) Each county agency must establish and operate a job search program as provided under this section. Unless all caretakers in the household are exempt, one nonexempt caretaker in each two–parent AFDC household must be referred to and begin participation in the job search program within 30 days of being determined eligible for AFDC. If the assistance unit contains more than one nonexempt caretaker, the caretakers may determine which caretaker shall participate. The designation may be changed only once annually at the annual redetermination of eligibility. If no designation is made or if the caretakers cannot agree, the county agency shall designate the caretaker having earned the greater of the incomes, including in–kind income, during the 24–month period immediately preceding the month of application for AFDC benefits as the caretaker that must participate. When no designation is made or the caretakers cannot agree and neither caretaker had earnings or the earnings were identical for each caretaker, then the county agency shall designate the caretaker who must participate. A caretaker is exempt from job search participation if:

(1) the caretaker is exempt from registration under subdivision 3, except that the second caretaker cannot be exempt to provide child care or care to an ill or incapacitated household member if the first caretaker is sanctioned for failure to comply or is exempt under any other exemption category, provided the first caretaker is capable of providing the needed care; 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. A person for whom lack of proficiency in English, as determined by an appropriate evaluation, is a barrier to employment, can choose to attend an available intensive, functional work literacy program for a minimum of 20 hours in place of the 20 hours of job search activities. The caretaker's employability development plan must include the length of time needed in the program, specific outcomes, attendance requirements, completion dates, and employment goals as they pertain to the intensive literacy program.

(c) The job search program may provide services to caretakers who are not in two–parent families.

(d) After completion of job search requirements in this section, if the caretaker is not employed, 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. When a nonexempt caretaker fails to cooperate with the job search program, the work experience program, the on–the–job training program, or the community work experience program and is subject to the sanction provisions of subdivision 4, the second caretaker in the assistance unit, unless exempt, must also be removed from the grant unless that second caretaker has been referred to and has started participating in the

job search program and subsequently in the work experience program, the on–the–job training program, or the community work experience program prior to the date the sanction begins for the first caretaker. The second caretaker is ineligible for AFDC until the first caretaker's sanction ends or the second caretaker cooperates with the requirements.

(e) The commissioner may require that, to the extent of available resources and provided the second caretaker is proficient in English, both caretakers in a two–parent AFDC family where all children are over age six and are not in kindergarten participate in job search and work experience. A caretaker shall be determined proficient in English if the county agency, or its employment and training service provider, determines that the person has sufficient English language capabilities to become suitably employed.

If, as of July 1, 1996, the second caretaker is enrolled in a post–secondary education or training program that is limited to one year and can reasonably be expected to lead to employment, the second caretaker is exempt from job search and work experience for a period of one year or until the caretaker stops attending the post–secondary program, whichever is shorter.

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

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

Subd. 18. [Repealed, 1997 c 85 art 1 s 74]

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 119B 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.

Subd. 20. **Special provisions for persons participating in educational programs.** The provisions of this subdivision are applicable to all STRIDE participants, including those subject to subdivision 3b and section 256.737.

(a) For recipients eligible to participate under subdivision 3b who are enrolled in a high school equivalency program on a full–time basis, there is no work requirement. Individuals who are enrolled part time in a high school equivalency program must take classroom instruction for at least six hours per week, meet the attendance and satisfactory progress requirements as defined by the employment and training service provider in consultation with the provider of the high school equivalency program, and concurrently work a monthly average of not less than 64 hours in employment paying at least minimum wage or in documented volunteer work. Hours spent assisting at a licensed day care center shall count toward the weekly hours needed to fulfill the employment or volunteer requirement. "Volunteer work" shall include attendance at parenting skill classes. Failure to comply, without good cause, with this requirement shall result in the imposition of sanctions as specified in subdivision 4, clause (6).

(b) Concurrent with participation in post–secondary education or training approved in an employability development plan under subdivision 10, paragraph (a), clause (15), the participant must work at a minimum the number of hours per month prescribed by this subdivision in employment paying at least minimum wage or in documented volunteer work for a public or nonprofit agency and agree to search for and accept any offer of suitable employment upon completion of the education or training. For individuals who are participating in an educational program under this paragraph on a full–time basis as determined by the insti-

tution, there is no work requirement. For individuals participating in an educational program on a part-time basis as determined by the institution, the number of hours that a participant must work shall be increased or decreased in inverse proportion to the number of credit hours being taken, with a maximum of eight hours weekly of work. Hours spent assisting at a licensed day care center shall count towards the weekly hours needed to fulfill the employment or volunteer requirement. "Volunteer work" shall include attendance at parenting skill classes.

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; 1995 c 178 art 2 s 8–15; 1995 c 207 art 5 s 4,5; 1996 c 465 art 3 s 16–23; 1997 c 7 art 2 s 42; art 5 s 28; 1997 c 85 art 3 s 4; 1998 c 397 art 11 s 3*

NOTE: Subdivision 11 was also amended by Laws 1996, chapter 412, article 4, section 25, to read as follows:

"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 assistance 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 119B.01 to 119B.16;

(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 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."

256.7365 Subdivision 1. [Repealed, 1997 c 85 art 1 s 74]

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

Subd. 3. [Repealed, 1997 c 85 art 1 s 74]

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

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

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

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

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

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

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

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

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

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

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

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

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

256.74 ASSISTANCE.

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

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

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

Subd. 1c. **MFIP and MFIP–R comparison group families.** Notwithstanding subdivision 1, the limitations of this subdivision apply to MFIP and MFIP–R comparison group families under sections 256.031 to 256.0361. The disregard of $30 plus one–third of earned income in this subdivision 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 subdivision 1, paragraph (4), clauses (a) to (c), 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 subdivision, the individual must not be a recipient of and 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.

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

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

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

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

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

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

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; 1995 c 178 art 2 s 19; 1995 c 207 art 5 s 6; art 10 s 5; 1997 c 85 art 3 s 5,6*

256.741 CHILD SUPPORT AND MAINTENANCE.

Subdivision 1. **Public assistance.** (a) The term "public assistance" as used in this chapter and chapters 257, 518, and 518C, includes any form of assistance provided under AFDC, MFIP, and MFIP–R under chapter 256, MFIP–S under chapter 256J, and work first under chapter 256K; child care assistance provided through the child care fund according to chapter 119B; any form of medical assistance under chapter 256B; MinnesotaCare under chapter 256L; and foster care as provided under title IV–E of the Social Security Act.

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

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

Subd. 2. **Assignment of support and maintenance rights.** (a) An individual receiving public assistance in the form of assistance under AFDC, MFIP–S, MFIP–R, MFIP, and work first is considered to have assigned to the state at the time of application all rights to child support and maintenance from any other person the applicant or recipient may have in the individual's own behalf or in the behalf of any other family member for whom application for public assistance is made. An assistance unit is ineligible for aid to families with dependent children or its successor program unless the caregiver assigns all rights to child support and spousal maintenance benefits according to this section.

(1) An assignment made according to this section is effective as to:

(i) any current child support and current spousal maintenance; and

(ii) any accrued child support and spousal maintenance arrears.

(2) An assignment made after September 30, 1997, is effective as to:

(i) any current child support and current spousal maintenance;

(ii) any accrued child support and spousal maintenance arrears collected before October 1, 2000, or the date the individual terminates assistance, whichever is later; and

(iii) any accrued child support and spousal maintenance arrears collected under federal tax intercept.

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

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

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

An assignment made according to this paragraph is effective as to:

(1) any current child care support and any child care support arrears assigned and accruing after July 1, 1997, that are collected before October 1, 2000; and

(2) any accrued child care support arrears collected under federal tax intercept.

Subd. 2a. **Families–first distribution of child support arrearages.** When the public authority collects support arrearages on behalf of an individual who is receiving assistance provided under MFIP or MFIP–R under this chapter, MFIP–S under chapter 256J, or work first under chapter 256K, and the public authority has the option of applying the collection to arrears permanently assigned to the state or to arrears temporarily assigned to the state, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

Subd. 3. **Existing assignments.** Assignments based on the receipt of public assistance in existence prior to July 1, 1997, are permanently assigned to the state.

Subd. 4. **Effect of assignment.** Assignments in this section take effect upon a determination that the applicant is eligible for public assistance. The amount of support assigned

under this subdivision may not exceed the total amount of public assistance issued or the total support obligation, whichever is less. Child care support collections made according to an assignment under subdivision 2, paragraph (c), must be transferred, subject to any limitations of federal law, from the commissioner of human services to the commissioner of children, families, and learning and dedicated to the child care fund under chapter 119B. These collections are in addition to state and federal funds appropriated to the child care fund.

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

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

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

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

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

The caregiver of a minor child must cooperate with the efforts of the public authority to collect support according to this subdivision. A caregiver must forward to the public authority all support the caregiver receives during the period the assignment of support required under subdivision 2 is in effect. Support received by a caregiver and not forwarded to the public authority must be repaid to the child support enforcement unit for any month following the date on which initial eligibility is determined, except as provided under subdivision 8, paragraph (b), clause (4).

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

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

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

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

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

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

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

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

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

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

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

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

(4) direct support retained by a caregiver must be counted as unearned income when determining the amount of the assistance payment.

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

Subd. 10. **Good cause exemption.** (a) Cooperation with the child support agency under subdivision 5 is not necessary if the individual asserts, and both the child support agency and the public assistance agency find, good cause exists under this subdivision for failing to cooperate. An individual may request a good cause exemption by filing a written claim with the public assistance agency on a form provided by the commissioner of human services. Upon notification of a claim for good cause exemption, the child support agency shall cease all child support enforcement efforts until the claim for good cause exemption is reviewed and the validity of the claim is determined. Designated representatives from public assistance agencies and at least one representative from the child support enforcement agency shall review each claim for a good cause exemption and determine its validity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1997 c 203 art 6 s 5; 1997 c 245 art 3 s 5; 1998 c 382 art 1 s 1; 1998 c 407 art 6 s 10*

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

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

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

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

256.77 [Repealed, 1976 c 131 s 2]

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

256.79 [Repealed, 1987 c 363 s 14]

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

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

256.82 PAYMENTS BY STATE.

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

Subd. 2. **Foster care maintenance payments.** 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. Beginning July 1, 1997, for the purposes of determining a child's eligibility under title IV–E of the Social Security Act, the placing agency shall use AFDC requirements in effect on July 16, 1996.

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

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

Subd. 5. **Difficulty of care assessment pilot project.** Notwithstanding any law to the contrary, the commissioner of human services shall conduct a two–year statewide pilot project beginning July 1, 1997, to conduct a difficulty of care assessment process which both assesses an individual child's current functioning and identifies needs in a variety of life situations. The pilot project must take into consideration existing difficulty of care payments so that, to the extent possible, no child for whom a difficulty of care rate is currently established will be adversely affected. The pilot project must include an evaluation and an interim report to the legislature by January 15, 1999.

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

NOTE: Subdivision 1 was also amended by Laws 1997, chapter 203, article 11, section 3, to read as follows:

"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 100 percent. 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."

256.83 [Repealed, 1971 c 550 s 2]

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

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

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

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

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

256.87 CONTRIBUTION BY PARENTS.

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

the child, which the parent has had the ability to pay. Ability to pay must be determined according to chapter 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 or in the name of the state agency against the parent for the recovery of the amount of assistance granted, together with the costs and disbursements of the action.

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

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

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

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

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

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

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

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

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

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

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

Subd. 9. **Arrears for parent who reunites with family.** (a) A parent liable for assistance under this section may seek a suspension of collection efforts under Title IV–D of the Social Security Act or a payment agreement based on ability to pay if the parent has reunited

with that parent's family and lives in the same household as the child on whose behalf the assistance was furnished.

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

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

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

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

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

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

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

256.872 [Repealed, 1983 c 308 s 32]

256.873 [Repealed, 1983 c 308 s 32]

256.874 [Repealed, 1982 c 488 s 8]

256.875 [Repealed, 1982 c 488 s 8]

256.876 [Repealed, 1983 c 308 s 32]

256.877 [Repealed, 1982 c 488 s 8]

256.878 [Repealed, 1982 c 488 s 8]

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

256.8799 FOOD STAMP OUTREACH PROGRAM.

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

Subd. 2. **Administration of the program.** A community association representing community action agencies under section 119A.375, in consultation with the commissioner shall administer the outreach program, issue the request for proposals, and review and approve the potential grantee's plan. Grantees shall comply with the monitoring and reporting requirements as developed by the commissioner in accordance with subdivision 4, and must also participate in the evaluation process as directed by the commissioner. Grantees must successfully complete one year of outreach and demonstrate compliance with all monitoring and reporting requirements in order to be eligible for additional funding.

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

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

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

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

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

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

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

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

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

(1) develop the reporting requirements for the program;

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

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

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

History: *1995 c 178 art 2 s 21; 1Sp1995 c 3 art 16 s 13*

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

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

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

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 district court having jurisdiction thereof.

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

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 court having jurisdiction of the estate may on such notice as the court may direct, authorize the commissioner to take possession of the personal property in the estate, liquidate it, and hold the proceeds in trust for the ward, to be invested, expended and accounted for as provided by sections 256.88 to 256.92.

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

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

256.935 FUNERAL EXPENSES, PAYMENT BY COUNTY AGENCY.

Subdivision 1. On the death of any person receiving public assistance through aid to dependent children or MFIP–S, 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 shall pay the entire amount of county agency expenditures. Benefits shall be issued to recipients by the state or county subject to provisions of section 256.017.

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

History: *Ex1971 c 16 s 4,5; 1973 c 717 s 15; 1976 c 239 s 81; 1986 c 444; 1988 c 719 art 8 s 9; 1989 c 89 s 9; 1Sp1989 c 1 art 16 s 5; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 25; 1992 c 513 art 8 s 13; 1997 c 85 art 4 s 13; 1997 c 203 art 11 s 5*

MINNESOTA CARE PROGRAM

256.9351 [Renumbered 256L.01]

256.9352 Subdivision 1. [Renumbered 256L.02, subd. 1]
Subd. 2. [Renumbered 256L.02, subd. 2]
Subd. 3. [Renumbered 256L.02, subd. 3]
Subd. 4. [Deleted, 1995 c 233 art 2 s 56]
Subd. 4. [Deleted, 1995 c 233 art 2 s 56]

256.9353 Subdivision 1. [Renumbered 256L.03, subd. 1]
Subd. 2. [Renumbered 256L.03, subd. 2]
Subd. 3. [Renumbered 256L.03, subd. 3]
Subd. 4. [Repealed, 1995 c 234 art 6 s 46]
Subd. 5. [Repealed, 1995 c 234 art 6 s 46]
Subd. 6. [Renumbered 256L.03, subd. 4]
Subd. 7. [Renumbered 256L.03, subd. 5]
Subd. 8. [Renumbered 256L.03, subd. 6]

256.9354 Subdivision 1. [Renumbered 256L.04, subd. 1]
Subd. 1a. [Renumbered 256L.04, subd. 2]
Subd. 2. [Renumbered 256L.04, subd. 3]
Subd. 3. [Renumbered 256L.04, subd. 4]
Subd. 4. [Renumbered 256L.04, subd. 5]
Subd. 4a. [Renumbered 256L.04, subd. 6]
Subd. 5. [Renumbered 256L.04, subd. 7]
Subd. 6. [Renumbered 256L.04, subd. 8]
Subd. 7. [Renumbered 256L.04, subd. 9]

256.9355 [Renumbered 256L.05]

256.9356 [Renumbered 256L.06]

256.9357 [Renumbered 256L.07]

256.9358 [Renumbered 256L.08]

256.9359 [Renumbered 256L.09]

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

256.9361 [Renumbered 256L.10]

256.9362 [Renumbered 256L.11]

256.9363 [Renumbered 256L.12]

256.9364 POST-KIDNEY TRANSPLANT DRUG PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services shall establish and administer a program to pay for costs of drugs prescribed exclusively for post-kidney transplant maintenance when those costs are not otherwise reimbursed by a third-party payer. The commissioner may contract with a nonprofit entity to administer this program.

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

(1) the applicant's family gross income must not exceed 275 percent of the federal poverty level; and

(2) the applicant must be a Minnesota resident who has resided in Minnesota for at least 12 months.

An applicant shall not be excluded because the applicant received the transplant outside the state of Minnesota, so long as the other requirements are met.

Subd. 3. **Payment amounts.** (a) The amount of the payments made for each eligible recipient shall be based on the following:

(1) available funds; and

(2) the cost of the post-kidney transplant maintenance drugs.

(b) The payment rate under this program must be no greater than the medical assistance reimbursement rate for the prescribed drug.

(c) Payments shall be made to or on behalf of an eligible recipient for the cost of the post-kidney transplant maintenance drugs that is not covered, reimbursed, or eligible for reimbursement by any other third party or government entity, including, but not limited to, private or group health insurance, medical assistance, Medicare, the Veterans Administration, the senior citizen drug program established under section 256.955, or under any waiver arrangement received by the state to provide a prescription drug benefit for qualified Medicare beneficiaries or service-limited Medicare beneficiaries.

(d) The commissioner may restrict or categorize payments to meet the appropriation allocated for this program.

(e) Any cost of the post-kidney transplant maintenance drugs that is not reimbursed under this program is the responsibility of the program recipient.

Subd. 4. **Drug formulary.** The commissioner shall maintain a drug formulary that includes all drugs eligible for reimbursement by the program. The commissioner may use the drug formulary established under section 256B.0625, subdivision 13. The commissioner shall establish an internal review procedure for updating the formulary that allows for the addition and deletion of drugs to the formulary. The drug formulary must be reviewed at least quarterly per fiscal year.

Subd. 5. **Private donations.** The commissioner may accept funding from other public or private sources.

Subd. 6. **Sunset.** This program expires on July 1, 2000.

History: *1998 c 407 art 4 s 6*

256.9365 PURCHASE OF CONTINUATION COVERAGE FOR AIDS PATIENTS.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents.

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

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

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

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

(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan.

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under subdivision 2, clause (5), must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance or general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

History: *1990 c 568 art 3 s 15; 1991 c 292 art 4 s 18,19; 1995 c 207 art 6 s 13*

ELIGIBILITY FOR MINNESOTACARE FOR FAMILIES UNDER HEALTH CARE REFORM WAIVER

256.9366 [Renumbered 256L.13]

256.9367 [Renumbered 256L.14]

256.9368 [Renumbered 256L.15]

256.9369 [Renumbered 256L.16]

256.94 CONFERENCES OF VARIOUS OFFICIALS.

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

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

256.95 EXPENSE OF ATTENDANCE AT CONFERENCE.

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

History: *(4469) 1917 c 224 s 2; 1921 c 403 s 2; 1995 c 189 s 8; 1996 c 277 s 1*

256.955 SENIOR CITIZEN DRUG PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services shall establish and administer a senior citizen drug program. Qualified senior citizens shall be eligible for prescription drug coverage under the program beginning no later than January 1, 1999.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning provided in section 62Q.01, subdivision 3.

(c) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(d) "Qualified senior citizen" means an individual age 65 or older who:

(1) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a, or is eligible under section 256B.057, subdivision 3 or 3a, and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5. Persons who are determined eligible for medical assistance according to section 256B.0575, who are eligible for medical assistance or general assistance medical care without a spenddown, or who are enrolled in MinnesotaCare, are not eligible for this program;

(2) is not enrolled in prescription drug coverage under a health plan;

(3) is not enrolled in prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(4) has not had coverage described in clauses (2) and (3) for at least four months prior to application for the program; and

(5) is a permanent resident of Minnesota as defined in section 256L.09.

Subd. 3. **Prescription drug coverage.** Coverage under the program is limited to prescription drugs covered under the medical assistance program as described in section 256B.0625, subdivision 13, subject to a maximum deductible of $300 annually, except drugs cleared by the FDA shall be available to qualified senior citizens enrolled in the program without restriction when prescribed for medically accepted indication as defined in the federal rebate program under section 1927 of title XIX of the federal Social Security Act.

Subd. 4. **Application procedures and coordination with medical assistance.** Applications and information on the program must be made available at county social service agencies, health care provider offices, and agencies and organizations serving senior citizens. Senior citizens shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the county social service agencies:

(1) beginning January 1, 1999, the county social service agency shall determine medical assistance spenddown eligibility of individuals who qualify for the senior citizen drug program of individuals; and

(2) program payments will be used to reduce the spenddown obligations of individuals who are determined to be eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5.

Seniors who are eligible for medical assistance with a spenddown shall be financially responsible for the deductible amount up to the satisfaction of the spenddown. No deductible applies once the spenddown has been met. Payments to providers for prescription drugs for persons eligible under this subdivision shall be reduced by the deductible.

County social service agencies shall determine an applicant's eligibility for the program within 30 days from the date the application is received.

Subd. 5. **Drug utilization review program.** The commissioner shall utilize the drug utilization review program as described in section 256B.0625, subdivision 13a.

Subd. 6. **Pharmacy reimbursement.** The commissioner shall reimburse participating pharmacies for drug and dispensing costs at the medical assistance reimbursement level, minus the deductible required under subdivision 7.

Subd. 7. **Cost sharing.** (a) Enrollees shall pay an annual premium of $120.

(b) Program enrollees must satisfy a $300 annual deductible, based upon expenditures for prescription drugs, to be paid as follows:

(1) $25 monthly deductible for persons with a monthly spenddown; or

(2) $150 biannual deductible for persons with a six–month spenddown.

Subd. 8. **Report.** The commissioner shall annually report to the legislature on the senior citizen drug program. The report must include demographic information on enrollees, per–prescription expenditures, total program expenditures, hospital and nursing home costs avoided by enrollees, any savings to medical assistance and Medicare resulting from the provision of prescription drug coverage under Medicare by health maintenance organizations, other public and private options for drug assistance to the senior population, any hardships caused by the annual premium and deductible, and any recommendations for changes in the senior drug program.

Subd. 9. **Program limitation.** This section shall be repealed upon federal approval of the waiver to allow the commissioner to provide prescription drug coverage for qualified Medicare beneficiaries whose income is less than 150 percent of the federal poverty guidelines.

History: *1997 c 225 art 4 s 2; 1997 c 251 s 30*

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 MinnesotaCare programs. At a minimum, the commissioner shall:

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

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

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

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

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

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

History: *1988 c 689 art 2 s 138; 1992 c 513 art 7 s 14; 1995 c 234 art 8 s 56*

256.9656 DEPOSITS INTO THE GENERAL FUND.

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

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

256.9657 PROVIDER SURCHARGES.

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

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

Subd. 1a. **Waiver request.** The commissioner shall request a waiver from the secretary of health and human services to: (1) exclude from the surcharge under subdivision 1 a nursing home that provides all services free of charge; (2) make a pro rata reduction in the surcharge paid by a nursing home that provides a portion of its services free of charge; and (3) limit the hospital surcharge to acute care hospitals only. If a waiver is approved under this subdivision, the commissioner shall adjust the nursing home surcharge accordingly. Any waivers granted by the federal government shall be effective on or after October 1, 1992.

Subd. 1b. [Repealed, 1998 c 254 art 1 s 68]

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

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

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

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

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

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

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

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

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

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

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

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

(e) Whenever the commissioner determines that the number of physicians likely to be excused from the surcharge under subdivision 1b may cause the physician surcharge to violate the requirements of Public Law 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; community 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 community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six–tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

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

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

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

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the health care financing administration of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 4001 and 4002 of Public Law Number 105–33 received by a health maintenance organization or community integrated service network through risk sharing or Medicare Choice Plus contracts; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge

under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Subd. 4. **Payments into the account.** (a) Payments to the commissioner under subdivisions 1 to 3 must be paid in monthly installments due on the 15th of the month beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. Payments to the commissioner under subdivisions 2 and 3 for fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues earned in the second previous calendar year.

(b) Effective October 1, 1995, and each October 1 thereafter, the payments in subdivisions 2 and 3 must be based on revenues earned in the previous calendar year.

(c) If the commissioner of health does not provide by August 15 of any year data needed to update the base year for the hospital and health maintenance organization surcharges, the commissioner of human services may estimate base year revenue and use that estimate for the purposes of this section until actual data is provided by the commissioner of health.

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. The commissioner of human services shall impose civil penalties for violation of this section as provided in section 289A.60, and the tax and penalties are subject to interest at the rate provided in section 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.

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; 1995 c 207 art 6 s 14,15; 1997 c 225 art 2 s 57; 1998 c 254 art 1 s 67,69; 1998 c 407 art 4 s 7*

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. Services must meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), to be eligible for payment.

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.

Subd. 1c. **Judicial review.** A hospital or physician aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician or hospital is located by:

(1) serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order; and

(2) filing the original notice of appeal and proof of service with the court administrator of the district court. The appeal shall be treated as a dispositive motion under the Minnesota General Rules of Practice, rule 115. The district court scope of review shall be as set forth in section 14.69.

Subd. 1d. **Transmittal of record.** Within 30 days after being served with the notice of appeal, the commissioner shall transmit to the district court the original or certified copy of the entire record considered by the commissioner in making the final agency decision. The district court shall not consider evidence that was not included in the record before the commissioner.

Subd. 2. **Federal requirements.** If it is determined that a provision of this section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare limitations.

History: *1989 c 282 art 3 s 36; 1991 c 292 art 4 s 22; 1992 c 513 art 7 s 22; 1Sp1993 c 1 art 5 s 17; 1995 c 207 art 6 s 16–18; 1997 c 187 art 1 s 19; 1998 c 407 art 4 s 8*

256.9686 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this section and sections 256.969 and 256.9695, the following terms and phrases have the meanings given.

Subd. 2. **Base year.** "Base year" means a hospital's fiscal year that is recognized by the Medicare program or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information by the Medicare program from which cost and statistical data are used to establish medical assistance and general assistance medical care payment rates.

Subd. 3. **Case mix index.** "Case mix index" means a hospital's distribution of relative values among the diagnostic categories.

Subd. 4. **Charges.** "Charges" means the usual and customary payment requested of the general public.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Hospital.** "Hospital" means a facility defined in section 144.696, subdivision 3, and licensed under sections 144.50 to 144.58, an out–of–state facility licensed to provide acute care under the requirements of that state in which it is located, or an Indian health service facility designated to provide acute care by the federal government.

Subd. 7. **Medical assistance.** "Medical assistance" means the program established under chapter 256B and Title XIX of the Social Security Act. Medical assistance includes general assistance medical care established under chapter 256D, unless otherwise specifically stated.

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.

Subd. 9. **Relative value.** "Relative value" means the average allowable cost of inpatient services provided within a diagnostic category divided by the average allowable cost of inpatient services provided in all diagnostic categories.

History: *1989 c 282 art 3 s 37; 1991 c 292 art 4 s 23,24; 1993 c 339 s 10*

256.969 PAYMENT RATES.

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Consumer Price Index–All Items (United States city average) (CPI–U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care, except that the inflation

adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply through calendar year 1999. 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. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997. 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. 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 recipient 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. 8a. **Unusual short length of stay.** Except as provided in subdivision 13, for admissions occurring on or after July 1, 1995, payment shall be determined as follows and shall be included in the base year for rate setting purposes.

(1) For an admission that is categorized to a neonatal diagnostic related group in which the length of stay is less than 50 percent of the average length of stay for the category in the base year and the patient at admission is equal to or greater than the age of one, payments shall be established according to the methods of subdivision 14.

(2) For an admission that is categorized to a diagnostic category that includes neonatal respiratory distress syndrome, the hospital must have a level II or level III nursery and the patient must receive treatment in that unit or payment will be made without regard to the syndrome condition.

Subd. 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 adjust-

ment 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 had medical assistance fee–for–service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee–for–service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee–for–service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee–for–service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995.

(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 even–numbered years to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services.

For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.

Subd. 11. **Special rates.** The commissioner may establish special rate–setting methodologies, including a per day operating and property payment system, for hospice, ventilator dependent, and other services on a hospital and recipient specific basis taking into consideration such variables as federal designation, program size, and admission from a medical assistance waiver or home care program. The data and rate calculation method shall conform to the requirements of subdivision 13, except that rates shall not be standardized by the case mix index or adjusted by relative values and hospice rates shall not exceed the amount allowed under federal law. Rates and payments established under this subdivision must meet the requirements of section 256.9685, subdivisions 1 and 2. The cost and charges used to establish rates shall only reflect inpatient medical assistance covered services. Hospital and claims data that are used to establish rates under this subdivision shall not be used to establish payments or relative values under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 12. **Rehabilitation distinct parts.** Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating and property payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services. The commissioner may establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

Subd. 13. **Neonatal transfers.** For admissions occurring on or after July 1, 1989, neonatal diagnostic category transfers shall have operating and property payment rates established at receiving hospitals which have neonatal intensive care units on a per day payment system that is based on the cost finding methods and allowable costs of the Medicare program during the base year. Other neonatal diagnostic category transfers shall have rates established according to subdivision 14. The rate per day for the neonatal service setting within the hospital shall be determined by dividing base year neonatal allowable costs by neonatal patient days. The operating payment rate portion of the rate shall be adjusted by the hospital

cost index and the disproportionate population adjustment. For admissions occurring after the transition period specified in section 256.9695, subdivision 3, the operating payment rate portion of the rate shall be standardized by the case mix index and adjusted by relative values. The cost and charges used to establish rates shall only reflect inpatient services covered by medical assistance. Hospital and claims data used to establish rates under this subdivision shall not be used to establish rates under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 14. **Transfers.** Except as provided in subdivisions 11 and 13, operating and property payment rates for admissions that result in transfers and transfers shall be established on a per day payment system. The per day payment rate shall be the sum of the adjusted operating and property payment rates determined under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 12, divided by the arithmetic mean length of stay for the diagnostic category. Each admission that results in a transfer and each transfer is considered a separate admission to each hospital, and the total of the admission and transfer payments to each hospital must not exceed the total per admission payment that would otherwise be made to each hospital under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 13.

Subd. 15. **Routine service cost limitation; applicability.** The computation of each hospital's payment rate and the relative values of the diagnostic categories are not subject to the routine service cost limitation imposed under the Medicare program.

Subd. 16. **Indian health service facilities.** Facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by title III of the Indian Self–Determination and Education Assistance Act, Public Law Number 93–638, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are exempt from the rate establishment methods required by this section and shall be paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

Subd. 17. **Out–of–state hospitals in local trade areas.** Out–of–state hospitals that are located within a Minnesota local trade area and that have more than 20 admissions in the base year shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by rule. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Subd. 18. **Out–of–state hospitals outside local trade areas.** Hospitals that are not located within Minnesota or a Minnesota local trade area shall have operating and property rates established at the average of statewide and local trade area rates or, at the commissioner's discretion, at an amount negotiated by the commissioner. Relative values shall not include data from hospitals that have rates established under this subdivision. Payments, including third party and recipient liability, established under this subdivision may not exceed the charges on a claim specific basis for inpatient services that are covered by medical assistance.

Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical assistance inpatient payment rates must include the cost incurred by hospitals to pay the department of health for metabolic disorder testing of newborns who are medical assistance recipients, if the cost is not recognized by another payment source.

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had 100 or fewer Minnesota medical assistance annu-

alized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

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

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under 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. [Repealed, 1995 c 207 art 6 s 124]

Subd. 25. **Long–term hospital rates.** For admissions occurring on or after April 1, 1995, a long–term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate–setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long–term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

History: *1983 c 312 art 5 s 9; 1984 c 534 s 20,21; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1Sp1985 c 9 art 2 s 34–36; 1986 c 420 s 6; 1Sp1986 c 3 art 2 s 51; 1987 c 403 art 2 s 64,65; 1988 c 435 s 1; 1988 c 689 art 2 s 139,140; 1989 c 282 art 3 s 38; 1990 c 568 art 3 s 16,17; 1991 c 292 art 4 s 25–29; 1992 c 464 art 1 s 27,28; 1992 c 513 art 7 s 23–27; 1992 c 603 s 34,35; 1993 c 20 s 1–5; 1Sp1993 c 1 art 5 s 18–25; 1Sp1993 c 6 s 7,8; 1995 c 207 art 6 s 19–25; 1996 c 395 s 11; 1996 c 451 art 2 s 5; art 5 s 11–13; 1997 c 187 art 1 s 20; 1997 c 203 art 4 s 16; 1998 c 407 art 4 s 9,10*

256.9691 TECHNOLOGY ASSISTANCE REVIEW PANEL.

Subdivision 1. **Establishment.** The commissioner of health shall establish a technology assistance review panel to resolve disputes over the provision of health care benefits for technology–assisted persons who receive benefits under a policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under chapter 62A, a subscriber contract of a nonprofit health service plan corporation regulated under chapter 62C, or a certificate of coverage of a health maintenance organization regulated under chapter 62D.

Subd. 2. **Definition.** For purposes of this section, "technology–assisted person" means a person who:

(1) has a chronic health condition;

(2) requires the routine use of a medical device to compensate for the loss of a life–sustaining body function; and

(3) requires ongoing care or monitoring by trained personnel on a daily basis.

Subd. 3. **Steering committee.** The commissioner shall appoint a seven–member steering committee to appoint the review panel members, develop policies and procedures for the review process, including the replacement of review panel members, serve as a liaison between the regulatory agencies and the review panel, and provide the review panel with technical assistance. The steering committee shall consist of representatives of the departments of health, human services, and commerce; a health maintenance organization regulated under chapter 62D; an insurer regulated under chapter 62A or a health service plan corporation regulated under chapter 62C; an advocacy organization representing persons who are technology assisted; and a tertiary care center that serves technology–assisted persons. The steering committee shall not be reimbursed for any expenses as defined under section 15.0575, subdivision 3. The steering committee shall dissolve no later than June 30, 1992.

Subd. 4. **Composition of review panel.** (a) The review panel shall be appointed by the members of the steering committee that do not represent state agencies and must include:

(1) a medical director from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(2) a contract benefits analyst from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(3) a consumer board member of an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(4) a physician with expertise in providing care for technology–assisted persons in a nonhospital setting;

(5) a registered nurse with expertise in providing care for technology–assisted persons in a nonhospital setting; and

(6) a consumer of health care benefits regulated under chapter 62A, 62C, or 62D who is a technology–assisted person or the parent or guardian of a technology–assisted person.

(b) The term of service for review panel members is three years except that, for the initial appointment, the steering committee shall establish procedures to assure that the terms of the members are staggered. Members are eligible to serve two consecutive terms.

Subd. 5. **Authority.** The review panel may review cases involving disputes over the provision of contract benefits regarding discharge planning, home health care benefits eligibility and coverage, or changes in the level of home health care services for technology–assisted persons. The review may be requested by a third–party payor, a health or social service professional, or a parent or guardian of a technology–assisted child or a technology–assisted adult. For the case to be eligible for review by the panel, the parent or guardian of a technology–assisted child or technology–assisted adult must consent to the review. The review panel may not review cases involving discharge to a long–term care facility or cases involving coverage by title 18 or 19 of the Social Security Act or other public funding sources. The review panel may seek advice from experts outside the membership of the panel as necessary. The internal grievance process within an insurer, health service plan corporation, or health maintenance organization, except binding arbitration, must be exhausted before requesting a review by the review panel. The recommendations of the review panel are not binding. If, following a review by the review panel, a complaint is filed with the appropriate state agency regarding the same subject matter, the findings of the review panel must be made available to the agency upon request and with the consent of the parent or guardian of a technology–assisted child or technology–assisted adult. The information must be maintained by the agency as nonpublic information under chapter 13. The steering committee may establish policies

for reimbursement of expenses for review panel members consistent with the provisions of section 15.0575, subdivision 3.

Subd. 6. **Confidentiality.** All proceedings of the review organization are nonpublic under chapter 13. All data, information, and findings acquired and developed by the review panel in the exercise of its duties or functions must be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review panel or as described in subdivision 5, and are not subject to subpoena or discovery. Members of the review panel may not disclose what transpired at a meeting of the review panel except to the extent necessary to carry out one or more of the purposes of the review panel. The proceedings and record of the review panel are not subject to discovery or introduction into evidence in any civil action against a health care professional or insurer, health service plan corporation, or health maintenance organization, arising out of the matter or matters that are the subject of consideration by the review panel.

Subd. 7. **Limitation on liability for members of steering committee and review panel.** A person who is a member of, or who acts in an advisory capacity to or who gives counsel or services to, the steering committee or review panel is not liable for damages or other relief in any action brought by a person or persons whose case has been reviewed by the panel, by reason of the performance of any duty, function, or activity of the review panel, unless the performance of the duty, function, or activity was motivated by malice toward the person affected. A member is not liable for damages or other relief in any action by reason of the performance of the member of any duty, function, or activity as a member of the steering committee or review panel or by reason of any recommendation or action of the review committee when the member acts in the reasonable belief that the action or recommendation is warranted by the facts known to the member or review panel after reasonable efforts to ascertain the facts.

History: *1990 c 534 s 1*

256.9692 EFFECT OF INTEGRATION AGREEMENT ON DIVISION OF COST.

Beginning in the first calendar month after there is a definitive integration agreement affecting the University of Minnesota hospital and clinics and Fairview hospital and health care services, Fairview hospital and health care services shall pay the University of Minnesota $505,000 on the 15th of each month, after receiving the state payment, provided that the University of Minnesota has fulfilled the requirements of section 256B.19, subdivision 1c.

History: *1996 c 395 s 12; 1996 c 451 art 2 s 6*

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

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

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

(b) To appeal a payment rate or payment change that results from a difference in case mix between the base year and a rate year, the procedures and requirements of paragraph (a) apply. However, the appeal must be filed with the commissioner within 120 days after the end of a rate year. A case mix appeal must apply to the cost of services to all medical assistance patients that received inpatient services from the hospital during the rate year appealed. For case mix appeals filed after January 1, 1997, the difference in case mix and the corresponding payment adjustment must exceed a threshold of five percent.

Subd. 2. **Prohibited practices.** (a) Hospitals that have a provider agreement with the department may not limit medical assistance admissions to percentages of certified capacity or to quotas unless patients from all payors are limited in the same manner. This requirement does not apply to certified capacity that is unavailable due to contracts with payors for specific occupancy levels.

(b) Hospitals may not transfer medical assistance patients to or cause medical assistance patients to be admitted to other hospitals without the explicit consent of the receiving hospital when service needs of the patient are available and within the scope of the transferring hospital. The transferring hospital is liable to the receiving hospital for patient charges and ambulance services without regard to medical assistance payments plus the receiving hospital's reasonable attorney fees if found in violation of this prohibition.

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

During the transition period:

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

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

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

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

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

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

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for

admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Subd. 4. **Study.** The commissioner shall contract for an evaluation of the inpatient and outpatient hospital payment systems. The study shall include recommendations concerning:

(1) more effective methods of assigning operating and property payment rates to specific services or diagnoses;

(2) effective methods of cost control and containment;

(3) fiscal impacts of alternative payment systems;

(4) the relationships of the use of and payment for inpatient and outpatient hospital services;

(5) methods to relate reimbursement levels to the efficient provision of services; and

(6) methods to adjust reimbursement levels to reflect cost differences between geographic areas.

The commissioner shall report the findings to the legislature by January 15, 1991, along with recommendations for implementation.

Subd. 5. **Rules.** The commissioner of human services shall adopt permanent rules to implement this section and sections 256.9685, 256.9686, and 256.969 under chapter 14, the Administrative Procedure Act.

History: *1989 c 282 art 3 s 39; 1990 c 568 art 3 s 18,19; 1991 c 292 art 4 s 30,78; 1992 c 513 art 7 s 28; 1993 c 339 s 11,12; 1Sp1993 c 1 art 5 s 26; 1994 c 465 art 3 s 571; 1997 c 203 art 4 s 17*

256.97 [Repealed, 1957 c 737 s 2]

256.971 SERVICES FOR DEAF.

The commissioner of human services shall provide such services for the deaf and hard of hearing in the state as will best promote their personal, economic and social well being. The commissioner shall maintain a register of all such persons, with such information as the commissioner deems necessary to improve services for them. The commissioner shall gather and disseminate information relating to the causes of deafness , collect statistics on the deaf and ascertain what trades or occupations are most suitable for them, and use best efforts to aid them in securing vocational rehabilitation and employment, through cooperation with other agencies, both public and private.

History: *1957 c 737 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

256.973 HOUSING FOR PERSONS WHO ARE ELDERLY, PERSONS WITH PHYSICAL OR DEVELOPMENTAL DISABILITIES, AND SINGLE-PARENT FAMILIES.

Subdivision 1. **Home sharing.** The home-sharing grant program authorized by section 462A.05, subdivision 24, is transferred from the Minnesota housing finance agency to the department of human services. The housing finance agency shall administer the current grants that terminate on August 30, 1995. The department of human services shall administer grants funded after August 30, 1995. The department of human services may engage in housing programs, as defined by the agency, to provide grants to housing sponsors who will provide a home-sharing program for low- and moderate-income elderly, persons with physical or developmental disabilities, or single-parent families in urban and rural areas.

Subd. 2. **Matching owners and tenants.** Housing sponsors of home-sharing programs, as defined by the agency, shall match existing homeowners with prospective tenants who will contribute either rent or services to the homeowner, where either the homeowner or the prospective tenant is elderly, a person with physical or developmental disabilities, or the head of a single-parent family. Home-sharing projects will coordinate efforts with appropriate public and private agencies and organizations in their area.

Subd. 3. **Information for participants.** Housing sponsors who receive funding through these programs shall provide homeowners and tenants participating in a home–sharing program with information regarding their rights and obligations as they relate to federal and state tax law including, but not limited to, taxable rental income, homestead credit under chapter 273, and the Property Tax Refund Act under chapter 290A.

Subd. 4. **Technical assistance.** The department of human services may provide technical assistance to sponsors of home–sharing programs or may contract or delegate the provision of technical assistance.

Subd. 5. **Using outside agencies.** The department of human services may delegate, use, or employ any federal, state, regional, or local public or private agency or organization, including organizations of physically handicapped persons, upon terms it deems necessary or desirable, to assist in the exercise of any of the powers granted in this section.

History: *1995 c 207 art 3 s 16*

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's program shall:

(1) gather information and evaluate any act, practice, policy, procedure, or administrative action of a long–term care facility, acute care facility, home care service provider, or government agency that may adversely affect the health, safety, welfare, or rights of any client;

(2) mediate or advocate on behalf of clients;

(3) monitor the development and implementation of federal, state, or local laws, rules, regulations, and policies affecting the rights and benefits of clients;

(4) comment on and recommend to public and private agencies regarding laws, rules, regulations, and policies affecting clients;

(5) inform public agencies about the problems of clients;

(6) provide for training of volunteers and promote the development of citizen participation in the work of the office;

(7) conduct public forums to obtain information about and publicize issues affecting clients;

(8) provide public education regarding the health, safety, welfare, and rights of clients; and

(9) collect and analyze data relating to complaints, conditions, and services.

Subd. 1a. **Designation; local ombudsman staff and volunteers.** (a) In designating an individual to perform duties under this section, the ombudsman must determine that the individual is qualified to perform the duties required by this section.

(b) An individual designated as ombudsman staff under this section must successfully complete an orientation training conducted under the direction of the ombudsman or approved by the ombudsman. Orientation training shall be at least 20 hours and will consist of training in: investigation, dispute resolution, health care regulation, confidentiality, resident and patients' rights, and health care reimbursement.

(c) The ombudsman shall develop and implement a continuing education program for individuals designated as ombudsman staff under this section. The continuing education program shall be at least 60 hours annually.

(d) An individual designated as an ombudsman volunteer under this section must successfully complete an approved orientation training course with a minimum curriculum including federal and state bills of rights for long-term care residents, acute hospital patients and home care clients, the Vulnerable Adults Act, confidentiality, and the role of the ombudsman.

(e) The ombudsman shall develop and implement a continuing education program for ombudsman volunteers which will provide a minimum of 12 hours of continuing education per year.

(f) The ombudsman may withdraw an individual's designation if the individual fails to perform duties of this section or meet continuing education requirements. The individual may request a reconsideration of such action by the board on aging whose decision shall be final.

Subd. 2. **Immunity from liability.** The ombudsman or designee including staff and volunteers under this section is immune from civil liability that otherwise might result from the person's actions or omissions if the person's actions are in good faith, are within the scope of the person's responsibilities as an ombudsman or designee, and do not constitute willful or reckless misconduct.

Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a conspicuous place the address and telephone number of the office. A home care service provider shall provide all recipients, including those in elderly housing with services under chapter 144D, with the address and telephone number of the office. Counties shall provide clients receiving a consumer support grant or a service allowance with the name, address, and telephone number of the office. The posting or notice is subject to approval by the ombudsman.

Subd. 4. **Access to long-term care and acute care facilities and clients.** The ombudsman or designee may:

(1) enter any long-term care facility without notice at any time;

(2) enter any acute care facility without notice during normal business hours;

(3) enter any acute care facility without notice at any time to interview a patient or observe services being provided to the patient as part of an investigation of a matter that is within the scope of the ombudsman's authority, but only if the ombudsman's or designee's pres-

ence 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, as long as the ombudsman has the client's consent for such communication;

(5) inspect records of a long-term care facility, home care service provider, or acute care facility that pertain to the care of the client according to sections 144.335 and 144.651; and

(6) with the consent of a client or client's legal guardian, the ombudsman or designated staff shall have access to review records pertaining to the care of the client according to sections 144.335 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, excluding volunteers, has access to data of a state agency necessary for the discharge of the ombudsman's duties, including records classified confidential or private under chapter 13, or any other law. The data requested must be related to a specific case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the ombudsman or designee shall first obtain the individual's consent. If the individual cannot consent and has no legal guardian, then access to the data is authorized by this section.

Each state agency responsible for licensing, regulating, and enforcing state and federal laws and regulations concerning long-term care, home care service providers, and acute care facilities shall forward to the ombudsman on a quarterly basis, copies of all correction orders, penalty assessments, and complaint investigation reports, for all long-term care facilities, acute care facilities, and home care service providers.

Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a patient, resident, or guardian or family member of a patient, resident, or guardian for filing in good faith a complaint with or providing information to the ombudsman or designee including volunteers. A person who violates this subdivision or who aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

(b) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose of this clause, the term "adverse action" refers to action taken by the entity involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from a facility;

(2) termination of service;

(3) restriction or prohibition of access to the facility or its residents;

(4) discharge from or termination of employment;

(5) demotion or reduction in remuneration for services; and

(6) any restriction of rights set forth in section 144.651 or 144A.44.

History: *1987 c 403 art 2 s 68; 1989 c 282 art 2 s 119; 1997 c 7 art 2 s 44; 1997 c 203 art 9 s 6*

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, a client receiving home–care services, or a resident of a long–term facility may be released at the discretion of the ombudsman responsible for maintaining the data. Data relating to the identity of a complainant, a client receiving home–care services, or a resident of a long–term facility may be released only with the consent of the complainant, the client or resident or by court order.

History: *1987 c 403 art 2 s 70; 1989 c 282 art 2 s 120; 1997 c 203 art 9 s 7*

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.

Subd. 6. **Indian elders position.** The Minnesota board on aging shall create an Indian elders coordinator position, and shall hire staff as appropriations permit for the purposes of coordinating efforts with the National Indian Council on Aging and developing a comprehensive statewide service system for Indian elders. An Indian elder is defined for purposes of this subdivision as an Indian enrolled in a band or tribe who is 55 years or older. The statewide service system must include the following components:

(1) an assessment of the program eligibility, examining the need to change the age–based eligibility criteria to need–based eligibility criteria;

(2) a planning system that would grant or make recommendations for granting federal and state funding for services;

(3) a plan for service focal points, senior centers, or community centers for socialization and service accessibility for Indian elders;

(4) a plan to develop and implement education and public awareness campaigns including awareness programs, sensitivity cultural training, and public education on Indian elder needs;

(5) a plan for information and referral services including trained advocates and an Indian elder newsletter;

(6) a plan for a coordinated health care system including health promotion/prevention, in–home service, long–term care service, and health care services;

(7) a plan for ongoing research involving Indian elders including needs assessment and needs analysis;

(8) information and referral services for legal advice or legal counsel; and

(9) a plan to coordinate services with existing organizations including the council of Indian affairs, the Minnesota Indian council of elders, the Minnesota board on aging, and tribal governments.

History: *1961 c 466 s 1,2; 1974 c 536 s 1; 1975 c 271 s 6; 1976 c 134 s 59,60; 1976 c 275 s 1; 1986 c 404 s 10; 1986 c 444; 1989 c 282 art 2 s 121; 1989 c 294 s 1; 1995 c 207 art 3 s 17*

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*

256.9752 SENIOR NUTRITION PROGRAMS.

Subdivision 1. **Program goals.** It is the goal of all agencies on aging and senior nutrition programs to support the physical and mental health of seniors living in the community by:

(1) promoting nutrition programs that serve senior citizens in their homes and communities; and

(2) providing, within the limit of funds available, the support services that will enable the senior citizen to access nutrition programs in the most cost–effective and efficient manner.

Subd. 2. **Authority.** The Minnesota board on aging shall allocate to area agencies on aging the federal funds which are received for the senior nutrition programs of congregate dining and home–delivered meals in a manner consistent with federal requirements.

Subd. 3. **Nutrition support services.** (a) Funds allocated to an area agency on aging for nutrition support services may be used for the following:

(1) transportation of home–delivered meals and purchased food and medications to the residence of a senior citizen;

(2) expansion of home–delivered meals into unserved and underserved areas;

(3) transportation to supermarkets or delivery of groceries from supermarkets to homes;

(4) vouchers for food purchases at selected restaurants in isolated rural areas;

(5) food stamp outreach;

(6) transportation of seniors to congregate dining sites;

(7) nutrition screening assessments and counseling as needed by individuals with special dietary needs, performed by a licensed dietitian or nutritionist; and

(8) other appropriate services which support senior nutrition programs, including new service delivery models.

(b) An area agency on aging may transfer unused funding for nutrition support services to fund congregate dining services and home–delivered meals.

History: *1996 c 451 art 6 s 10*

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 citizenship and 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; 1996 c 305 art 1 s 57*

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*

256.9772 HEALTH CARE CONSUMER ASSISTANCE GRANT PROGRAM.

The board on aging shall award grants to area agencies on aging to develop projects to provide information about health coverage and to provide assistance to individuals in obtaining public and private health care benefits. Projects must:

(1) train and support staff and volunteers to work in partnership to provide one–on–one information and assistance services;

(2) provide individual consumers with assistance in understanding the terms of a certificate, contract, or policy of health coverage, including, but not limited to, terms relating to covered services, limitations on services, limitations on access to providers, and enrollee complaint and appeal procedures;

(3) assist individuals to understand medical bills and to process health care claims and appeals to obtain health care benefits;

(4) coordinate with existing health insurance counseling programs serving Medicare eligible individuals or establish programs to serve all consumers;

(5) target those individuals determined to be in greatest social and economic need for counseling services; and

(6) operate according to United States Code, title 42, section 1395b–4, if serving Medicare beneficiaries.

History: *1997 c 203 art 9 s 8*

256.978 LOCATION OF PARENTS, ACCESS TO RECORDS.

Subdivision 1. **Request for information.** (a) The public authority responsible for child support in this state or any other state, in order to locate a person to establish paternity and child support or to modify or enforce child support, 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 268.19 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 or electronic request by an agency responsible for child support enforcement regarding individuals owing or allegedly owing a duty to support within 30 days of service of the request made by the public authority. Information requested and used or transmitted by the commissioner according to the authority conferred by this section may be made available to other agencies, statewide systems, and political subdivisions of this state, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program.

(b) For purposes of this section, "state" includes the District of Columbia, Puerto Rico, the United States Virgin Islands, and any territory or insular possession subject to the jurisdiction of the United States.

Subd. 2. **Access to information.** (a) A request for information by the public authority responsible for child support of this state or any other state may be made to:

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

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

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

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

(5) financial institutions when there is reasonable cause to believe that the subject of the inquiry has or has had accounts, stocks, loans, certificates of deposits, treasury bills, life insurance policies, or other forms of financial dealings with the institution. Information to be released by the financial institution is limited to place of residence, home telephone, work telephone, identifying information on the type of financial relationships, social security number, current value of financial relationships, and current indebtedness of the subject with the financial institution.

(b) For purposes of this subdivision, utility companies include telephone companies, radio common carriers, and telecommunications carriers as defined in section 237.01, and companies that provide electrical, telephone, natural gas, propane gas, oil, coal, or cable television services to retail customers. The term financial institution includes banks, savings and loans, credit unions, brokerage firms, mortgage companies, insurance companies, benefit associations, safe deposit companies, money market mutual funds, or similar entities authorized to do business in the state.

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

History: *1963 c 401 s 1; 1982 c 488 s 1; 1984 c 654 art 5 s 58; 1988 c 668 s 3; 1989 c 184 art 2 s 10; 1993 c 340 s 7; 1995 c 257 art 3 s 1; 1997 c 66 s 79; 1997 c 203 art 6 s 11,12; 1997 c 245 art 3 s 6*

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

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

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

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

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

(b) Only one county agency may receive a bonus per paternity establishment or child support order establishment or modification for each case. The county agency completing the action or procedure needed to establish paternity or a child support order or modify an order is the county agency entitled to claim the bonus incentive.

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

(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.

(e) Payment of bonus incentives is limited by the amount of the appropriation for this purpose. If the appropriation is insufficient to cover all claims, the commissioner of human services may prorate payments among the county agencies.

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.

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

Subd. 9. [Repealed, 1997 c 203 art 6 s 93]

Subd. 10. **Transferability between bonus incentive accounts and grants to county agencies.** The commissioner of human services may transfer money appropriated for child support enforcement county performance incentives under this section and section 256.9791 among county performance incentive accounts. Incentive funds to counties transferred un-

der this section must be reinvested in the child support enforcement program and may not be used to supplant money now spent by counties for child support enforcement.

History: *1987 c 403 art 3 s 25; 1993 c 340 s 8–11; 1994 c 529 s 8; 1995 c 178 art 2 s 22; 1997 c 245 art 1 s 4–8*

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.

(c) 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.

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; 1997 c 245 art 1 s 9*

256.9792 ARREARAGE COLLECTION PROJECTS.

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

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

(b) "Public assistance arrearage case" means a case where current support may be due, no payment, with the exception of tax offset, has been made within the last 90 days, and the arrearages are assigned to the public agency according to section 256.741.

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

(d) "Nonpublic assistance arrearage case" means a support case where arrearages have accrued that have not been assigned according to section 256.741.

Subd. 3. **Agency participation.** (a) The collection remedy under this section is in addition to and not in substitution for any other remedy available by law to the public authority. The public authority remains responsible for the case even after collection efforts are referred to the department of revenue, a private agency, or other collection entity.

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

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

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

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

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

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

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

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

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

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

Subd. 8. **Remedies.** (a) The commissioner of revenue is authorized to use the tax collection remedies in sections 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; 1997 c 203 art 6 s 13,14*

256.98 WRONGFULLY OBTAINING ASSISTANCE; THEFT.

Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, 256.12, 256.031 to 256.361, 256.72 to 256.871, 256.9365, 256.94 to 256.966, child care, MFIP–S, chapter 256B, 256D, 256J, 256K, or 256L, or all of these sections, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care or vouchers produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.16, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency.

The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Subd. 2. **Joint trials.** When two or more defendants are jointly charged with the same offense under subdivision 1, or are jointly charged with different offenses under subdivision 1 arising from the same course of conduct, they shall be tried jointly; however, if it appears to the court that a defendant or the state is substantially prejudiced by the joinder for trial, the court may order an election or separate trial of counts, grant a severance of defendants, or provide other relief.

Subd. 3. **Amount of assistance incorrectly paid.** The amount of the assistance incorrectly paid under this section is 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 oc-

curred. 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:

(1) the recipient or the recipient's estate by the county or the state as a debt due the county or the state or both; and

(2) any person found to have taken independent action to establish eligibility for, conspired with, or aided and abetted, any recipient of public assistance found to have been incorrectly paid.

The obligations established under this subdivision shall be joint and several and shall extend to all cases involving client error as well as cases involving wrongfully obtained assistance.

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, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the aid to families with dependent children program, the Minnesota family assistance program-statewide, the food stamp program, the Minnesota family investment plan, child care program, the general assistance or family general assistance program, or the Minnesota supplemental aid 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 one year after the first offense;

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

(3) permanently after the third or subsequent offense.

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

Subd. 9. **Welfare reform coverage.** All references to MFIP-S or Minnesota family investment program-statewide contained in sections 256.017, 256.019, 256.045, 256.046, and 256.98 to 256.9866 shall be construed to include all variations of the Minnesota family in-

vestment program including, but not limited to, chapter 256J, MFIP–S, MFIP–R, and chapter 256K.

History: *1971 c 550 s 1; 1973 c 348 s 1; 1973 c 717 s 16; 1975 c 437 art 2 s 2; 1977 c 225 s 1; 1986 c 444; 1987 c 254 s 6; 1987 c 403 art 2 s 72; 1988 c 712 s 2; 1990 c 566 s 6; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 26; 1992 c 513 art 8 s 14; 1995 c 207 art 2 s 30,31; 1997 c 85 art 5 s 8–10; 1Sp1997 c 5 s 14,15*

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 and Minnesota family investment program–statewide program issues, other income maintenance program changes, recovery issues, alternative sentencing methods, use of technical aids for interviews and interrogations, and other matters affecting prosecution of welfare fraud cases.

History: *1987 c 403 art 2 s 154; 1997 c 85 art 4 s 14*

256.982 TRAINING OF WELFARE FRAUD INVESTIGATORS.

The commissioner of human services shall, to the extent an appropriation is provided for this purpose, establish a pilot project for further education and training of welfare fraud investigators. The commissioner may enter into contractual agreements with other state, federal, or county agencies as part of cooperative projects employing experienced investigators to provide on–the–job training to county investigators.

History: *1987 c 403 art 2 s 155*

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioner of human services shall require the maintenance of budget neutral fraud prevention investigation programs in the counties participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties provided the expansion is budget neutral to the state.

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.** (a) County agency reimbursement shall be made through the settlement provisions applicable to the aid to families with dependent children program, food stamp program, Minnesota family investment program–statewide, and medical assistance program and other federal and state–funded programs.

(b) The commissioner will maintain program compliance if for any three consecutive month period, a county agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost–effectiveness standards developed by the commissioner.

This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county agency for fraud prevention investigation (FPI) service provided by the commissioner, or reallocation of program grant funds, or investigative resources, or both, to other counties. The denial of funding shall apply to the general settlement received by the county agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

History: *1989 c 282 art 5 s 41; 1991 c 292 art 5 s 27; 1Sp1993 c 1 art 6 s 24; 1995 c 178 art 2 s 23; 1995 c 207 art 2 s 32; 1997 c 85 art 5 s 11,12*

256.9831 BENEFITS; GAMBLING ESTABLISHMENTS.

Subdivision 1. **Definition.** For purposes of this section, "gambling establishment" means a bingo hall licensed under section 349.164, a racetrack licensed under section 240.06 or 240.09, a casino operated under a tribal–state compact under section 3.9221, or any other establishment that receives at least 50 percent of its gross revenue from the conduct of gambling.

Subd. 2. **Financial transaction cards.** The commissioner shall take all actions necessary to ensure that no person may obtain benefits under chapter 256 or 256D through the use of a financial transaction card, as defined in section 609.821, subdivision 1, paragraph (a), at a terminal located in or attached to a gambling establishment.

Subd. 3. **Warrants.** The commissioner shall take all actions necessary to ensure that warrants issued to pay benefits under chapter 256 or 256D bear a restrictive endorsement that prevents their being cashed in a gambling establishment.

History: *1996 c 465 art 3 s 27*

256.984 DECLARATION AND PENALTY.

Subdivision 1. **Declaration.** Every application for public assistance under this chapter and/or chapters 256B, 256D, 256K, MFIP–S program, and 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; 1997 c 85 art 5 s 13*

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

256.9850 IDENTITY VERIFICATION.

The commissioner of human services shall seek from the Secretary of Health and Human Services all necessary waivers of the requirements of the program of AFDC, to enable the commissioner to establish a statewide program to test the effectiveness of identity verification systems in the electronic benefit transfer systems in the state AFDC program. Identity verification provisions shall be added to the statewide requests for proposal on the expansion of electronic benefit transfer systems in the AFDC program.

History: *1995 c 178 art 2 s 24*

256.986 COUNTY COORDINATION OF FRAUD CONTROL ACTIVITIES.

(a) The county agency shall prepare and submit to the commissioner of human services by April 30 of each state fiscal year a plan to coordinate county duties related to the preven-

tion, investigation, and prosecution of fraud in public assistance programs. Each county must submit its first annual plan prior to April 30, 1998.

(b) Within the limits of appropriations specifically made available for this purpose, the commissioner may make grants to counties submitting plans under paragraph (a) to implement coordination activities.

History: *1995 c 178 art 2 s 25; 1997 c 85 art 5 s 14*

256.9861 FRAUD CONTROL; PROGRAM INTEGRITY REINVESTMENT PROJECT.

Subdivision 1. **Program established.** Within the limits of available state and federal appropriations, the commissioner of human services shall make funding available to county agencies for fraud control efforts and require the maintenance of county efforts and financial contributions that were in place during fiscal year 1996.

Subd. 2. **County proposals.** Each included county shall develop and submit annual funding, staffing, and operating grant proposals to the commissioner no later than April 30 of each year for the purpose of allocating federal and state funding and appropriations. Each proposal shall provide information on:

(1) the staffing and funding of the fraud investigation and prosecution operations;

(2) job descriptions for agency fraud control staff;

(3) contracts covering outside investigative agencies;

(4) operational methods to integrate the use of fraud prevention investigation techniques; and

(5) implementation and utilization of administrative disqualification hearings and diversions by the existing county fraud control and prosecution procedures.

Subd. 3. **Department responsibilities.** The commissioner shall provide written instructions outlining the contents of the proposals to be submitted under this section. Instructions shall be made available 30 days prior to the date by which proposals under subdivision 2 must be submitted. The commissioner shall establish training programs which shall be attended by fraud control staff of all involved counties. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms which shall be used by the involved counties.

Subd. 4. **Standards.** The commissioner shall, after consultation with the involved counties, establish standards governing the performance levels of county investigative units based on grant agreements with the county agencies. The standards shall take into consideration and may include investigative caseloads, grant savings levels, the comparison of fraud prevention and prosecution directed investigations, utilization levels of administrative disqualification hearings, the timely reporting and implementation of disqualifications, and the timeliness of the submission of statistical reports.

Subd. 5. **Funding.** (a) State funding shall be made available contingent on counties submitting a plan that is approved by the department of human services. Failure or delay in obtaining that approval shall not, however, eliminate the obligation to maintain fraud control efforts at the June 30, 1996, level. County agency reimbursement shall be made through the settlement provisions applicable to the AFDC, MFIP–S, food stamp, and medical assistance programs.

(b) Should a county agency fail to comply with the standards set, or fail to meet cost–effectiveness standards developed by the commissioner for any three–month period, the commissioner shall deny reimbursement or administrative costs, after allowing an opportunity to establish compliance.

(c) Any denial of reimbursement under paragraph (b) is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent months of noncompliance. The county agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or continued deviation from standards of more than ten percent after submission of corrective action plan, will result in denial of funding for each such month during the grant year, or billing of the county agency

for program integrity reinvestment project services provided by the commissioner or reallocation of grant funds to other counties. The denial of funding shall apply to the general settlement received by the county agency on a quarterly basis and shall not reduce the grant amount applicable to the program integrity reinvestment project.

History: *1995 c 207 art 2 s 33; 1997 c 85 art 5 s 15–18*

256.9862 ASSISTANCE TRANSACTION CARD FEE.

Subdivision 1. **Replacement card.** The commissioner of human services may charge a cardholder, defined as a person in whose name the transaction card was issued, a $2 fee to replace an assistance transaction card. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

Subd. 2. **Transaction fee.** The commissioner may charge transaction fees in accordance with this subdivision up to a maximum of $10 in transaction fees per cardholder per month. In a given month, the first four cash withdrawals made by an individual cardholder are free. For subsequent cash withdrawals, $1 may be charged. No transaction fee can be charged if the card is used to purchase goods or services on a point of sale basis. A transaction fee subsequently set by the federal government may supersede a fee established under this subdivision. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

History: *1995 c 207 art 2 s 34*

256.9863 ASSISTANCE TRANSACTION CARD; PRESUMPTION OF RECEIPT OF BENEFITS.

Any person in whose name an assistance transaction card has been issued shall be presumed to have received the benefit of all transactions involving that card. This presumption applies in all situations unless the card in question has been reported lost or stolen by the cardholder. This presumption may be overcome by a preponderance of evidence indicating that the card was neither used by nor with the consent of the cardholder. Overcoming this presumption does not create any new or additional payment obligation not otherwise established in law, rule, or regulation.

History: *1997 c 85 art 5 s 19*

256.9864 REPORTS BY RECIPIENT.

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

(b) An assistance unit required to submit a report on the form designated by the commissioner and within ten days of the due date or the date of the significant change, whichever is later, or otherwise report significant changes which would affect eligibility or assistance amounts, is considered to have continued its application for assistance effective the date the required report is received by the county agency, if a complete report is received within a calendar month in which assistance was received.

History: *1997 c 85 art 5 s 20; 1998 c 407 art 6 s 11*

256.9865 RECOVERY OF OVERPAYMENTS AND ATM ERRORS.

Subdivision 1. **Obligation to recover.** If an amount of MFIP–S assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. This recovery authority also extends to preexisting claims or newly discovered claims established under the AFDC program in effect on January 1, 1997. The agency shall give written notice to the recipient of its intention to recover the overpayment. County agency efforts and financial contributions shall be maintained at the level in place during fiscal year 1996.

Subd. 2. **Recoupment.** When an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member for one or more monthly assistance payments

until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred. For recipients receiving benefits via electronic benefits transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error. In cases where there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

Subd. 3. **Voluntary repayments.** Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions in subdivision 2, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

Subd. 4. **Closed case recoveries.** The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance according to standards adopted by rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance unless the individual has been convicted of fraud under section 256.98.

History: *1997 c 85 art 5 s 21*

256.9866 COMMUNITY SERVICE AS A COUNTY OBLIGATION.

Community service shall be an acceptable sentencing option but shall not reduce the state or federal share of any amount to be repaid or any subsequent recovery. Any reduction or offset of any such amount ordered by a court shall be treated as follows:

(1) any reduction in an overpayment amount, to include the amount ordered as restitution, shall not reduce the underlying amount established as an overpayment by the state or county agency;

(2) total overpayments shall continue as a debt owed and may be recovered by any civil or administrative means otherwise available to the state or county agency; and

(3) any amount ordered to be offset against any overpayment shall be deducted from the county share only of any recovery and shall be based on the prevailing state minimum wage. To the extent that any deduction is in fact made against any state or county share, it shall be reimbursed from the county share of payments to be made under section 256.025.

History: *1997 c 85 art 5 s 22*

256.99 REVERSE MORTGAGE PROCEEDS DISREGARDED.

All reverse mortgage loan proceeds received, including interest or earnings thereon, shall be disregarded and shall not be considered available to the borrower for purposes of determining initial or continuing eligibility for, or amount of, medical assistance, Minnesota supplemental assistance, general assistance, general assistance medical care, or a federal or state low interest loan or grant. This section applies regardless of the time elapsed since the loan was made or the disposition of the proceeds.

For purposes of medical assistance eligibility provided under sections 256B.055, 256B.056, and 256B.06, proceeds from a reverse mortgage must be disregarded as income in the month of receipt but are a resource if retained after the month of receipt.

History: *1979 c 265 s 2; 3Sp1981 c 3 s 16; 1985 c 252 s 18; 1988 c 689 art 2 s 268; 1996 c 414 art 1 s 35*

256.991 RULES.

The commissioner of human services may promulgate rules as necessary to implement sections 256.01, subdivision 2; 256.82, subdivision 3; 256.966, subdivision 1; 256D.03, subdivisions 3, 4, 6, and 7; and 261.23. The commissioner shall promulgate rules to establish standards and criteria for deciding which medical assistance services require prior authorization and for deciding whether a second medical opinion is required for an elective surgery. The commissioner shall promulgate rules as necessary to establish the methods and standards for determining inappropriate utilization of medical assistance services.

History: *1983 c 312 art 5 s 38; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1987 c 384 art 2 s 1; 1988 c 719 art 8 s 10; 1989 c 209 art 2 s 28; 1996 c 305 art 2 s 47*

256.995 SCHOOL–LINKED SERVICES FOR AT–RISK CHILDREN AND YOUTH.

Subdivision 1. **Program established.** In order to enhance the delivery of needed services to at–risk children and youth and maximize federal funds available for that purpose, the commissioners of human services and children, families, and learning 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 children, families, and learning in designing the program.

Subd. 2. **At–risk children and youth.** The program shall target at–risk children and youth, defined as individuals, whether or not enrolled in school, who are under 21 years of age and who:

(1) are school dropouts;

(2) have failed in school;

(3) have become pregnant;

(4) are economically disadvantaged;

(5) are children of drug or alcohol abusers;

(6) are victims of physical, sexual, or psychological abuse;

(7) have committed a violent or delinquent act;

(8) have experienced mental health problems;

(9) have attempted suicide;

(10) have experienced long–term physical pain due to injury;

(11) are at risk of becoming or have become drug or alcohol abusers or chemically dependent;

(12) have experienced homelessness;

(13) have been excluded or expelled from school under sections 121A.40 to 121A.56; or

(14) have been adjudicated children in need of protection or services.

Subd. 3. **Services.** The program must be designed not to duplicate existing programs, but to enable schools to collaborate with county social service agencies and county health boards and with local public and private providers to assure that at–risk children and youth receive health care, mental health services, family drug and alcohol counseling, and needed social services. Screenings and referrals under this program shall not duplicate screenings under section 121A.17.

Subd. 4. **Funding.** The program must be designed to take advantage of available federal funding, including the following:

(1) child welfare funds under United States Code, title 42, sections 620–628 (1988) and United States Code, title 42, sections 651–669 (1988);

(2) funds available for health care and health care screening under medical assistance, United States Code, title 42, section 1396 (1988);

(3) social services funds available under United States Code, title 42, section 1397 (1988);

(4) children's day care funds available under federal transition year child care, the Family Support Act, Public Law 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 children, families, and learning, 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 children, families, and learning 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 children, families, and learning, 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; 1Sp1995 c 3 art 16 s 13; 1998 c 397 art 11 s 3*

256.996 [Repealed, 1997 c 245 art 2 s 12]

256.997 CHILD SUPPORT OBLIGOR COMMUNITY SERVICE WORK EXPERIENCE PROGRAM.

Subdivision 1. **Authorization.** The commissioner of human services may contract with a county that operates a community work experience program or a judicial district department of corrections that operates a community work experience program to include child support obligors who are physically able to work and fail to pay child support as participants in the community work experience program.

Subd. 2. **Limitations.** (a) Except as provided in paragraph (f), a person ordered to participate in a work program under section 518.617 shall do so if services are available.

(b) A person may not be required to participate for more than 32 hours per week in the program under this section.

(c) A person may not be required to participate for more than six weeks for each finding of contempt.

(d) If a person is required by a governmental entity to participate in another work or training program, the person may not be required to participate in a program under this section in a week for more than 32 hours minus the number of hours the person is required to participate in the other work or training program in that week.

(e) If a person is employed, the person may not be required to participate in a program under this section in a week for more than 80 percent of the difference between 40 hours and

the number of hours actually worked in the unsubsidized job during that week, to a maximum of 32 hours.

(f) A person who works an average of 32 hours or more per week in an unsubsidized job is not required to participate in a program under this section.

Subd. 3. **Notice to court.** If a person does not complete six weeks of participation in a program under this section, the county operating the program shall inform the court administrator, by affidavit, of that noncompletion.

Subd. 4. **Injury protection for work experience participants.** (a) This subdivision applies to payment of any claims resulting from an alleged injury or death of a child support obligor participating in a community work experience program established and operated by a county or a judicial district department of corrections under this section.

(b) Claims that are subject to this section must be investigated by the county agency responsible for supervising the work to determine whether the claimed injury occurred, whether the claimed medical expenses are reasonable, and whether the loss is covered by the claimant's insurance. If insurance coverage is established, the county agency shall submit the claim to the appropriate insurance entity for payment. The investigating county agency shall submit all valid claims, in the amount net of any insurance payments, to the commissioner of human services.

(c) The commissioner of human services shall submit all claims for impairment compensation to the commissioner of labor and industry. The commissioner of labor and industry shall review all submitted claims and recommend to the commissioner of human services an amount of compensation comparable to what would be provided under the impairment compensation schedule of section 176.101, subdivision 3b.

(d) The commissioner of human services shall approve a claim of $1,000 or less for payment if appropriated funds are available, if the county agency responsible for supervising the work has made the determinations required by this section, and if the work program was operated in compliance with the safety provisions of this section. The commissioner shall pay the portion of an approved claim of $1,000 or less that is not covered by the claimant's insurance within three months of the date of submission. On or before February 1 of each year, the commissioner shall submit to the appropriate committees of the senate and the house of representatives a list of claims of $1,000 or less paid during the preceding calendar year and shall be reimbursed by legislative appropriation for any claims that exceed the original appropriation provided to the commissioner to operate this program. Unspent money from this appropriation carries over to the second year of the biennium, and any unspent money remaining at the end of the second year must be returned to the general fund. On or before February 1 of each year, the commissioner shall submit to the appropriate committees of the senate and the house of representatives a list of claims in excess of $1,000 and a list of claims of $1,000 or less that were submitted to but not paid by the commissioner of human services, together with any recommendations of appropriate compensation. These claims shall be heard and determined by the appropriate committees of the senate and house of representatives and, if approved, paid under the legislative claims procedure.

(e) Compensation paid under this section is limited to reimbursement for reasonable medical expenses and impairment compensation for disability in like amounts as allowed in section 176.101, subdivision 3b. Compensation for injuries resulting in death shall include reasonable medical expenses and burial expenses in addition to payment to the participant's estate in an amount not to exceed the limits set forth in section 466.04. Compensation may not be paid under this section for pain and suffering, lost wages, or other benefits provided in chapter 176. Payments made under this section must be reduced by any proceeds received by the claimant from any insurance policy covering the loss. For the purposes of this section, "insurance policy" does not include the medical assistance program authorized under chapter 256B or the general assistance medical care program authorized under chapter 256D.

(f) The procedure established by this section is exclusive of all other legal, equitable, and statutory remedies against the state, its political subdivisions, or employees of the state or its political subdivisions. The claimant may not seek damages from any state or county insurance policy or self–insurance program.

(g) A claim is not valid for purposes of this subdivision if the local agency responsible for supervising the work cannot verify to the commissioner of human services:

(1) that appropriate safety training and information is provided to all persons being supervised by the agency under this subdivision; and

(2) that all programs involving work by those persons comply with federal Occupational Safety and Health Administration and state department of labor and industry safety standards.

A claim that is not valid because of failure to verify safety training or compliance with safety standards may not be paid by the commissioner of human services or through the legislative claims process and must be heard, decided, and paid, if appropriate, by the local government unit responsible for supervising the work of the claimant.

Subd. 5. **Transportation expenses.** A county shall reimburse a person for reasonable transportation costs incurred because of participation in a program under this section, up to a maximum of $25 per month.

Subd. 6. **Payment to county.** The commissioner shall pay a county $200 for each person who participates in the program under this section in that county. The county is responsible for any additional costs of the program.

History: *1995 c 257 art 1 s 15*

256.998 WORK REPORTING SYSTEM.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Date of hiring" means the earlier of: (1) the first day for which an employee is owed compensation by an employer; or (2) the first day that an employee reports to work or performs labor or services for an employer.

(c) "Earnings" means payment owed by an employer for labor or services rendered by an employee.

(d) "Employee" means a person who resides or works in Minnesota, performs services for compensation, in whatever form, for an employer and satisfies the criteria of an employee under chapter 24 of the Internal Revenue Code. Employee does not include:

(1) persons hired for domestic service in the private home of the employer, as defined in the Federal Tax Code; or

(2) an employee of the federal or state agency performing intelligence or counterintelligence functions, if the head of such agency has determined that reporting according to this law would endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(e) "Employer" means a person or entity located or doing business in this state that employs one or more employees for payment, and satisfies the criteria of an employer under chapter 24 of the Internal Revenue Code. Employer includes a labor organization as defined in paragraph (g). Employer also includes the state, political or other governmental subdivisions of the state, and the federal government.

(f) "Hiring" means engaging a person to perform services for compensation and includes the reemploying or return to work of any previous employee who was laid off, furloughed, separated, granted a leave without pay, or terminated from employment when a period of 90 days elapses from the date of layoff, furlough, separation, leave, or termination to the date of the person's return to work.

(g) "Labor organization" means entities located or doing business in this state that meet the criteria of labor organization under section 2(5) of the National Labor Relations Act. This includes any entity, that may also be known as a hiring hall, used to carry out requirements described in chapter 7 of the National Labor Relations Act.

(h) "Payor" means a person or entity located or doing business in Minnesota who pays money to an independent contractor according to an agreement for the performance of services.

Subd. 2. **Work reporting system established.** The commissioner of human services shall establish a centralized work reporting system for the purpose of receiving and maintain-

ing information from employers on newly hired or rehired employees. The commissioner of human services shall take reasonable steps to inform the state's employers of the requirements of this section and the acceptable processes by which employers can comply with the requirements of this section.

Subd. 3. **Duty to report.** Employers doing business in this state shall report to the commissioner of human services the hiring of any employee who resides or works in this state to whom the employer anticipates paying earnings. Employers shall submit reports required under this subdivision within 20 calendar days of the date of hiring of the employee.

Employers are not required to report the hiring of any person who will be employed for less than two months' duration; and will have gross earnings less than $250 per month.

Subd. 4. **Means to report.** Employers may report by delivering, mailing, or telefaxing a copy of the employee's federal W–4 form or W–9 form or any other document that contains the required information, submitting electronic media in a compatible format, toll–free telecommunication, or other means authorized by the commissioner of human services that will result in timely reporting.

Subd. 5. **Report contents.** Reports required under this section must contain:

(1) the employee's name, address, social security number, and date of birth when available, which can be handwritten or otherwise added to the W–4 form, W–9 form, or other document submitted; and

(2) the employer's name, address, and federal identification number.

Subd. 6. **Sanctions.** If an employer fails to report under this section, the commissioner of human services, by certified mail, shall send the employer a written notice of noncompliance requesting that the employer comply with the reporting requirements of this section. The notice of noncompliance must explain the reporting procedure under this section and advise the employer of the penalty for noncompliance. An employer who has received a notice of noncompliance and later incurs a second violation is subject to a civil penalty of $25 for each intentionally unreported employee. An employer who has received a notice of noncompliance is subject to a civil penalty of $500 for each intentionally unreported employee, if noncompliance is the result of a conspiracy between an employer and an employee not to supply the required report or to supply a false or incomplete report. These penalties may be imposed and collected by the commissioner of human services. An employer who has been served with a notice of noncompliance and incurs a second or subsequent violation resulting in a civil penalty, has the right to a contested case hearing under chapter 14. An employer has 20 days from the date of service of the notice, to file a request for a contested case hearing with the commissioner. The order of the administrative law judge constitutes the final decision in the case.

Subd. 7. **Access to data.** The commissioner of human services shall retain the information reported to the work reporting system for a period of six months. Data in the work reporting system may be disclosed to the public authority responsible for child support enforcement, federal agencies, state and local agencies of other states for the purposes of enforcing state and federal laws governing child support, and agencies responsible for the administration of programs under title IV–A of the Social Security Act, the department of economic security, and the department of labor and industry.

Subd. 8. **Authority to contract.** The commissioner may contract for services to carry out this section.

Subd. 9. **Independent contractors.** The state and all political subdivisions of the state, when acting in the capacity of an employer, shall report the hiring of any person as an independent contractor to the centralized work reporting system in the same manner as the hiring of an employee is reported.

Other payors may report independent contractors to whom they make payments that require the filing of a 1099–MISC report. Payors reporting independent contractors shall report by use of the same means and provide the same information required under subdivisions 4 and 5. The commissioner of human services shall establish procedures for payors reporting under this section.

Subd. 10. **Use of work reporting system information in determining eligibility for public assistance programs.** The commissioner of human services is authorized to use in-

formation from the work reporting system to determine eligibility for applicants and recipients of public assistance programs administered by the department of human services. Data including names, dates of birth, and social security numbers of people applying for or receiving public assistance benefits will be compared to the work reporting system information to determine if applicants or recipients of public assistance are employed. County agencies will be notified of discrepancies in information obtained from the work reporting system.

Subd. 11. **Action on information.** Upon receipt of the discrepant information, county agencies will notify clients of the information and request verification of employment status and earnings. County agencies must attempt to resolve the discrepancy within 45 days of receipt of the information.

Subd. 12. **Client notification.** Persons applying for public assistance programs administered by the department of human services will be notified at the time of application that data including their name, date of birth, and social security number will be shared with the work reporting system to determine possible employment. All current public assistance recipients will be notified of this provision prior to its implementation.

History: *1995 c 257 art 1 s 16; 1997 c 203 art 6 s 15–20; 1997 c 245 art 1 s 10; art 3 s 7*