

CHAPTER 256

HUMAN SERVICES

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256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

[For text of subd 1, see M.S.2004]

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

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

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

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

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

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

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

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

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

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

(c) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and

children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the State Board of Control.

(d) 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.

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

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

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

(h) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as 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 or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs, 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. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

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

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

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

(l) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a

project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(1) the secretary of health and human services of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity; and

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

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

(n) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the following manner:

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

(2) notwithstanding the provisions of clause (1), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in clause (1), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to clause (1).

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

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

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

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

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

(3) if the required reports are not received by the deadlines established in clause (2), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received;

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

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

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

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

(r) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample 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.

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

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

(u) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined

in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(v) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

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

(x) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(y) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(z) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers

shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

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

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

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

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

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

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

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

Subd. 2a. Authorization for test sites for health care programs. In coordination with the development and implementation of HealthMatch, an automated eligibility system for medical assistance, general assistance medical care, and MinnesotaCare, the commissioner, in cooperation with county agencies, is authorized to test and compare a variety of administrative models to demonstrate and evaluate outcomes of integrating health care program business processes and points of access. The models will be evaluated for ease of enrollment for health care program applicants and recipients and administrative efficiencies. Test sites will combine the administration of all three programs and will include both local county and centralized statewide customer assistance. The duration of each approved test site shall be no more than one year. Based on the evaluation, the commissioner shall recommend the most efficient and effective administrative model for statewide implementation.

[For text of subds 3 to 14a, see M.S.2004]

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

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

(b) For the purposes of this section, "American Indian child" means a person under 18 years of age who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

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

- (1) be one of the existing tribes with reservation land in Minnesota;
 - (2) have a tribal court with jurisdiction over child custody proceedings;
 - (3) have a substantial number of children for whom determinations of maltreatment have occurred;
 - (4) have capacity to respond to reports of abuse and neglect under section 626.556;
 - (5) provide a wide range of services to families in need of child welfare services;
- and

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

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

- (1) assessment and prevention of child abuse and neglect;
- (2) family preservation;
- (3) facilitative, supportive, and reunification services;
- (4) out-of-home placement for children removed from the home for child protective purposes; and
- (5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

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

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

[For text of subds 15 to 22, see M.S.2004]

History: *1Sp2005 c 4 art 3 s 8; art 5 s 12; art 8 s 5,6*

256.014 STATE AND COUNTY SYSTEMS.

[For text of subds 1 and 2, see M.S.2004]

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

[For text of subd 4, see M.S.2004]

256.019 RECOVERY OF MONEY; APPORTIONMENT.

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

This does not apply to recoveries from medical providers or to recoveries begun by the Department of Human Services' Surveillance and Utilization Review Division, State Hospital Collections Unit, and the Benefit Recoveries Division or, by the attorney general's office, or child support collections. In the food stamp or food support program, the nonfederal share of recoveries in the federal tax offset program only will be divided equally between the state agency and the involved county agency.

[For text of subd 2, see M.S.2004]

History: 1Sp2005 c 4 art 8 s 7

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICE MATTERS.

[For text of subd 1, see M.S.2004]

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245C, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; (8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a; (9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; or (10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The

failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4), (9), or (10) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under 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 (9) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (9) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

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 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 prescribed under chapter 256M or other social services the person is eligible for under state law.

(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). Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

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

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

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

[For text of subd 3b, see M.S.2004]

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

[For text of subds 4 to 5, see M.S.2004]

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

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

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

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

notice of appeal. Any party aggrieved by the failure of an adverse party to obey an order issued by the commissioner under subdivision 5 may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

[For text of subds 8 to 10, see M.S.2004]

History: 2005 c 98 art 1 s 9,10; art 3 s 18; 1Sp2005 c 4 art 8 s 8,9

256.046 ADMINISTRATIVE FRAUD DISQUALIFICATION HEARINGS.

Subdivision 1. **Hearing authority.** A local agency must initiate an administrative fraud disqualification hearing for individuals, including child care providers caring for children receiving child care assistance, accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, MFIP, the diversionary work program, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, food stamp programs, general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare except for children through age 18. The Department of Human Services, in lieu of a local agency, may initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration of the health care program for which benefits were wrongfully obtained. The hearing is subject to the requirements of section 256.045 and the requirements in Code of Federal Regulations, title 7, section 273.16, for the food stamp program and title 45, section 235.112, as of September 30, 1995, for the cash grant, medical care programs, and child care assistance under chapter 119B.

[For text of subd 2, see M.S.2004]

History: 1Sp2005 c 4 art 8 s 10

256.476 CONSUMER SUPPORT PROGRAM.

[For text of subds 1 to 10, see M.S.2004]

Subd. 11. **Consumer support grant program after July 1, 2001.** (a) Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly grant levels are calculated by:

(i) determining the nonfederal share of the average service authorization for each home care rating;

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

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

(iv) adjusting the result for any authorized rate increases provided by the legislature; and

(v) adjusting the result for the average monthly utilization per recipient.

(2) The commissioner may review and evaluate the methodology to reflect changes in the home care program's overall ratio of actual payments to service authorizations.

(b) Effective January 1, 2004, persons previously receiving exception grants will have their grants calculated using the methodology in paragraph (a), clause (1). If a person currently receiving an exception grant wishes to have their home care rating

reevaluated, they may request an assessment as defined in section 256B.0651, subdivision 1, paragraph (b).

256.741 CHILD SUPPORT AND MAINTENANCE.

[For text of subs 1 to 3, see M.S.2004]

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

[For text of subs 5 to 15, see M.S.2004]

History: 1Sp2005 c 4 art 5 s 13

256.8799 FOOD STAMP OR FOOD SUPPORT OUTREACH PROGRAM.

[For text of subd 1, see M.S.2004]

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

[For text of subs 3 and 4, see M.S.2004]

History: 2005 c 98 art 1 s 24

256.93 COMMISSIONER OF HUMAN SERVICES, POSSESSION OF ESTATES.

Subdivision 1. **Limitations.** In any case where the guardianship 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 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.

[For text of subd 2, see M.S.2004]

History: 2005 c 10 art 4 s 13

256.955 [Repealed, 1Sp2005 c 4 art 8 s 88]

256.9657 PROVIDER SURCHARGES.

[For text of subs 1 to 2, see M.S.2004]

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of

the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

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

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

(2) premiums from Medicare 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 Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

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

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

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

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

[For text of subds 3a to 6, see M.S.2004]

Subd. 7. Collection; civil penalties. The provisions of sections 270C.31, except subdivisions 5 and 7; 270C.32, except subdivisions 6 and 10; 270C.33; 270C.61, subdivision 2; and 289A.35 to 289A.50 relating to the authority to audit, assess, collect, and pay refunds of other state taxes may be implemented by the commissioner of human services with respect to the tax, penalty, and interest imposed by this section. The commissioner of human services shall impose civil penalties for violation of this section as provided in section 289A.60, and the tax and penalties are subject to interest at the rate provided in section 270C.40. The commissioner of human services shall have the power to abate penalties and interest when discrepancies occur resulting from, but not limited to, circumstances of error and mail delivery. The commissioner of human services shall bring appropriate civil actions to collect provider payments due under this section.

Subd. 7a. Withholding. If any provider obligated to pay an annual surcharge under this section is more than two months delinquent in the timely payment of a monthly surcharge installment payment, the provisions in paragraphs (a) to (f) apply.

(a) The department may withhold some or all of the amount of the delinquent surcharge, together with any interest and penalties due and owing on those amounts, from any money the department owes to the provider. The department may, at its discretion, also withhold future surcharge installment payments from any money the department owes the provider as those installments become due and owing. The department may continue this withholding until the department determines there is no longer any need to do so.

(b) The department shall give prior notice of the department's intention to withhold by mailing a written notice to the provider at the address to which remittance advices are mailed or faxing a copy of the notice to the provider at least ten business days before the date of the first payment period for which the withholding begins. The notice may be sent by ordinary or certified mail, or facsimile, and shall be deemed received as of the date of mailing or receipt of the facsimile. The notice shall:

(i) state the amount of the delinquent surcharge;

(ii) state the amount of the withholding per payment period;

(iii) state the date on which the withholding is to begin;

(iv) state whether the department intends to withhold future installments of the provider's surcharge payments;

(v) inform the provider of their rights to informally object to the proposed withholding and to appeal the withholding as provided for in this subdivision;

(vi) state that the provider may prevent the withholding during the pendency of their appeal by posting a bond; and

(vii) state other contents as the department deems appropriate.

(c) The provider may informally object to the withholding in writing anytime before the withholding begins. An informal objection shall not stay or delay the commencement of the withholding. The department may postpone the commencement of the withholding as deemed appropriate and shall not be required to give another notice at the end of the postponement and before commencing the withholding. The provider shall have the right to appeal any withholding from remittances by filing an appeal with Ramsey County District Court and serving notice of the appeal on the department within 30 days of the date of the written notice of the withholding. Notice shall be given and the appeal shall be heard no later than 45 days after the appeal is filed. In a hearing of the appeal, the department's action shall be sustained if the department proves the amount of the delinquent surcharges or overpayment the provider owes, plus any accrued interest and penalties, has not been repaid. The department may continue withholding for delinquent and current surcharge installment payments during the pendency of an appeal unless the provider posts a bond from a surety company licensed to do business in Minnesota in favor of the department in an

amount equal to two times the provider's total annual surcharge payment for the fiscal year in which the appeal is filed with the department.

(d) The department shall refund any amounts due to the provider under any final administrative or judicial order or decree which fully and finally resolves the appeal together with interest on those amounts at the rate of three percent per annum simple interest computed from the date of each withholding, as soon as practical after entry of the order or decree.

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

(f) Notwithstanding any law to the contrary, all unpaid surcharges, plus any accrued interest and penalties, shall be overpayments for purposes of section 256B.0641.

[For text of subd 8, see M.S.2004]

History: 2005 c 17 art 3 s 3; 2005 c 151 art 2 s 4; 1Sp2005 c 4 art 8 s 11

256.9658 TOBACCO HEALTH IMPACT FEE.

Subdivision 1. **Purpose.** A tobacco use health impact fee is imposed on and collected from cigarette distributors and tobacco products distributors to recover for the state health costs related to or caused by tobacco use and to reduce tobacco use, particularly by youths.

Subd. 2. **Definitions.** The definitions under section 297F.01 apply to this section.

Subd. 3. **Fee imposed.** (a) A fee is imposed upon the sale of cigarettes in this state, upon having cigarettes in possession in this state with intent to sell, upon any person engaged in business as a distributor, and upon the use or storage by consumers of cigarettes. The fee is imposed at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, 37.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, 75 mills on each cigarette.

(b) A fee is imposed upon all tobacco products in this state and upon any person engaged in business as a distributor in an amount equal to the liability for tax under section 297F.05, subdivision 3, or on a consumer of tobacco products equal to the tax under section 297F.05, subdivision 4. Liability for the fee is in addition to the tax under section 297F.05, subdivision 3 or 4.

Subd. 4. **Payment.** A distributor must pay the fee at the same time and in the same manner as provided for payment of tax under chapter 297F.

Subd. 5. **Fee on use of unstamped cigarettes.** Any person, other than a distributor, that purchases or possesses cigarettes that have not been stamped and on which the fee imposed under this section has not been paid is liable for the fee under this section on the possession or use of those cigarettes.

Subd. 6. **Administration.** The audit, assessment, interest, appeal, refund, penalty, enforcement, administrative, and collection provisions of chapters 270C and 297F apply to the fee imposed under this section.

Subd. 7. **Cigarette stamp.** (a) The stamp in section 297F.08 must be affixed to each package and is prima facie evidence that the fee imposed by this section has been paid.

(b) Notwithstanding any other provisions of this section, the fee due on the return is based upon actual stamps purchased during the reporting period.

Subd. 8. **License revocation.** The commissioner of revenue may revoke or suspend the license of a distributor for failure to pay the fee or otherwise comply with the requirements under this section. The provisions and procedures under section 297F.04 apply to a suspension or revocation under this subdivision.

Subd. 9. **Deposit of revenues.** The commissioner of revenue shall deposit the revenues from the fee under this section in the state treasury and credit them to the health impact fund.

History: *1Sp2005 c 4 art 4 s 2*

256.969 PAYMENT RATES.

[For text of subds 1 to 2c, see M.S.2004]

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to

managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

[For text of subs 4a to 8b, see M.S.2004]

Subd. 9. Disproportionate numbers of low-income patients served. (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

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

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

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

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

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

(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this

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

(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.

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

(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

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

(f) For hospital services occurring on or after July 1, 2005, to June 30, 2007, general assistance medical care expenditures made by the department and by prepaid health plans participating in general assistance medical care shall be considered Medicaid disproportionate share hospital payments, except as limited below:

(1) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used for general assistance medical care expenditures;

(2) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;

(3) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(4) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

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

[For text of subs 9a to 25, see M.S.2004]

Subd. 26. Greater Minnesota payment adjustment after June 30, 2001. (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

- (1) 370 cesarean section with complicating diagnosis;
- (2) 371 cesarean section without complicating diagnosis;
- (3) 372 vaginal delivery with complicating diagnosis;
- (4) 373 vaginal delivery without complicating diagnosis;
- (5) 386 extreme immaturity and respiratory distress syndrome, neonate;
- (6) 388 full-term neonates with other problems;
- (7) 390 prematurity without major problems;
- (8) 391 normal newborn;
- (9) 385 neonate, died or transferred to another acute care facility;
- (10) 425 acute adjustment reaction and psychosocial dysfunction;
- (11) 430 psychoses;
- (12) 431 childhood mental disorders; and
- (13) 164-167 appendectomy.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena; and

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse nonstate expenditures reported under section 256B.199. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services.

(c) The payments under paragraph (a) shall be paid quarterly beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision.

(f) By January 15 of each year, beginning January 15, 2006, the commissioner shall report to the chairs of the house and senate finance committees and divisions with jurisdiction over funding for the Department of Human Services the following estimates for the current and upcoming federal and state fiscal years:

(1) the difference between the Medicare upper payment limit and actual or anticipated medical assistance payments for hospital services;

(2) the amount of federal disproportionate share hospital funding available to Minnesota and the amount expected to be claimed by the state; and

(3) the methodology used to calculate the results reported for clauses (1) and (2).

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

(h) This section sunsets on June 30, 2009. The commissioner shall report to the legislature by December 15, 2008, with recommendations for maximizing federal disproportionate share hospital payments after June 30, 2009.

History: *1Sp2005 c 4 art 8 s 12-15*

256.9693 INPATIENT TREATMENT FOR MENTAL ILLNESS.

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. The commissioner may authorize additional days beyond 45 based on an individual review of medical necessity. Persons with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

History: *2005 c 165 art 1 s 2*

256.975 MINNESOTA BOARD ON AGING.

[For text of subds 1 to 8, see M.S.2004]

Subd. 9. **Prescription drug assistance.** The Minnesota Board on Aging shall establish and administer a prescription drug assistance program to assist individuals in accessing programs offered by pharmaceutical manufacturers that provide free or discounted prescription drugs or provide coverage for prescription drugs. The board shall use computer software programs to:

(1) list eligibility requirements for pharmaceutical assistance programs offered by manufacturers;

(2) list drugs that are included in a supplemental rebate contract between the commissioner and a pharmaceutical manufacturer under section 256.01, subdivision 2, clause (23); and

(3) link individuals with the pharmaceutical assistance programs most appropriate for the individual. The board shall make information on the prescription drug assistance program available to interested individuals and health care providers and shall coordinate the program with the statewide information and assistance service provided through the Senior LinkAge Line under subdivision 7.

History: *1Sp2005 c 4 art 8 s 16*

256.978 LOCATION OF PARENTS, ACCESS TO RECORDS.

[For text of subd 1, see M.S.2004]

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.

(c) For purposes of this section, the public authority may request or obtain information from any person or entity enumerated in this section, or from any third party who contracts with any such person or entity to obtain or retain information that may be requested by the public authority.

[For text of subd 3, see M.S.2004]

History: 2005 c 159 art 4 s 1

256.9792 ARREARAGE COLLECTION PROJECTS.

[For text of subds 1 to 7, see M.S.2004]

Subd. 8. Remedies. (a) The commissioner of revenue is authorized to use the tax collection remedies in sections 270C.32, subdivision 1, 270C.63, 270C.67, 270C.68, 270C.69, 270C.70 to 270C.72, and 270C.728, and tax return information to collect arrearages.

(b) Liens arising under paragraph (a) shall be perfected under the provisions of section 270C.63. The lien may be filed as long as the time period allowed by law for collecting the arrearages has not expired. The lien shall attach to all property of the debtor within the state, both real and personal under the provisions of section 270C.63. The lien shall be enforced under the provisions in section 270C.63 relating to state tax liens.

History: 2005 c 151 art 2 s 5