

CHAPTER 256D

GENERAL ASSISTANCE

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256D.02 DEFINITIONS.

[For text of subds 1 to 16, see M.S.2004]

Subd. 17. **Professional certification.** "Professional certification" means a statement about a person's illness, injury, or incapacity that is signed by a "qualified professional" as defined in section 256J.08, subdivision 73a.

[For text of subds 18 and 19, see M.S.2004]

History: 2005 c 159 art 5 s 3

256D.024 PERSONS PROHIBITED FROM RECEIVING GENERAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, MINNESOTA SUPPLEMENTAL AID.

Subdivision 1. **Person convicted of drug offenses.** (a) If an applicant or recipient has been convicted of a drug offense after July 1, 1997, the assistance unit is ineligible for benefits under this chapter until five years after the applicant has completed terms of the court-ordered sentence, unless the person is participating in a drug treatment program, has successfully completed a drug treatment program, or has been assessed by the county and determined not to be in need of a drug treatment program. Persons subject to the limitations of this subdivision who become eligible for assistance under this chapter shall be subject to random drug testing as a condition of continued eligibility and shall lose eligibility for benefits for five years beginning the month following:

- (1) any positive test result for an illegal controlled substance; or
- (2) discharge of sentence after conviction for another drug felony.

(b) For the purposes of this subdivision, "drug offense" means a conviction that occurred after July 1, 1997, of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the offense occurred after July 1, 1997, and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

[For text of subds 2 to 4, see M.S.2004]

History: 2005 c 136 art 7 s 21

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

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

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of \$1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum;

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month eligibility period, until their six-month renewal.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.

(e) Applicants and recipients eligible under paragraph (a), clause (1), or who have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration, or who fail to meet the requirements of section 256L.09, subdivision 2, are exempt from the MinnesotaCare enrollment requirements of this subdivision.

(f) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(g) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

(h) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name,

address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

(i) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(k) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(l) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(n) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(p) Effective July 1, 2003, general assistance medical care emergency services end.

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

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare certified rehabilitation agencies;
- (4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations provided by a physician or optometrist;
- (7) hearing aids;
- (8) prosthetic devices;
- (9) laboratory and X-ray services;
- (10) physician's services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services as covered under the medical assistance program;
- (15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;
- (16) day treatment services for mental illness provided under contract with the county board;
- (17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;
- (18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;
- (19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;
- (20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;
- (21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;
- (22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b; and
- (23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) \$25 for eyeglasses;

(2) \$25 for nonemergency visits to a hospital-based emergency room;

(3) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the \$12 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(k) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

(l) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(m) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(n) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(o) Fee-for-service payments for nonpreventive visits shall be reduced by \$3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(p) Payments to managed care plans shall not be increased as a result of the removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

[For text of subs 5 to 9, see M.S.2004]

History: 2005 c 98 art 2 s 14; 1Sp2005 c 4 art 2 s 15; art 8 s 52,53

NOTE: The amendment to subdivision 3 by Laws 2005, First Special Session chapter 4, article 8, section 52, is effective September 1, 2006. Laws 2005, First Special Session chapter 4, article 8, section 52, the effective date.

256D.045 SOCIAL SECURITY NUMBER REQUIRED.

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

History: 1Sp2005 c 4 art 8 s 54

NOTE: The amendment to this section by Laws 2005, First Special Session chapter 4, article 8, section 54, is effective August 1, 2007, or upon HealthMatch implementation, whichever is later. Laws 2005, First Special Session chapter 4, article 8, section 54, the effective date.

256D.051 FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM.

[For text of subs 1 to 6b, see M.S.2004]

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of food stamp employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's food stamp employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of food stamp cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September

30, and December 31 of the previous calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

[For text of subs 7 to 18, see M.S.2004]

History: 2005 c 159 art 5 s 4

256D.06 AMOUNT OF ASSISTANCE.

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

Subd. 5. Eligibility; requirements. (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (1) make application for those benefits within 30 days of the general assistance application; and (2) execute an interim assistance agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(d) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled.

(e) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

Subd. 7. SSI conversions and back claims. (a) **SSI conversions.** The commissioner of human services shall contract with agencies or organizations capable of ensuring that clients who are presently receiving assistance under sections 256D.01 to 256D.21, and who may be eligible for benefits under the federal Supplemental Security Income program, apply and, when eligible, are converted to the federal income assistance program and made eligible for health care benefits under the medical assistance program. The commissioner shall ensure that money owing to the state under interim assistance agreements is collected.

(b) **Back claims for federal health care benefits.** The commissioner shall also directly or through contract implement procedures for collecting federal Medicare and medical assistance funds for which clients converted to SSI are retroactively eligible.

(c) **Additional requirements.** The commissioner shall contract with agencies to ensure implementation of this section. County contracts with providers for residential services shall include the requirement that providers screen residents who may be eligible for federal benefits and provide that information to the local agency. The commissioner shall modify the MAXIS computer system to provide information on clients who have been on general assistance for two years or longer. The list of clients shall be provided to local services for screening under this section.

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

History: 1Sp2005 c 4 art 3 s 11,12

256D.44 STANDARDS OF ASSISTANCE.

[For text of subs 1 to 4, see M.S.2004]

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

- (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
- (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;
- (3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;
- (4) low cholesterol diet, 25 percent of thrifty food plan;
- (5) high residue diet, 20 percent of thrifty food plan;
- (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
- (7) gluten-free diet, 25 percent of thrifty food plan;
- (8) lactose-free diet, 25 percent of thrifty food plan;
- (9) antidumping diet, 15 percent of thrifty food plan;
- (10) hypoglycemic diet, 15 percent of thrifty food plan; or
- (11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution, or an adult mental health residential treatment program under section 256B.0622, and who are shelter needy. An

eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

“Shelter needy” means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit’s gross income before the application of this special needs standard. “Gross income” for the purposes of this section is the applicant’s or recipient’s income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

[For text of subd 6, see M.S.2004]

History: 1Sp2005 c 4 art 2 s 16

256D.54 APPLICATION FOR OTHER BENEFITS.

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

Subd. 3. [Repealed, 1Sp2005 c 4 art 3 s 20]