

A bill for an act

relating to human services; amending health care services provisions; making changes to general assistance medical care, medical assistance, and MinnesotaCare; modifying claims, liens, and treatment of assets; establishing a statewide information exchange; amending Minnesota Statutes 2006, sections 256B.056, subdivisions 2, 4a, 11, by adding a subdivision; 256B.057, subdivision 1; 256B.0571, subdivisions 8, 9, 15, by adding a subdivision; 256B.058; 256B.059, subdivisions 1, 1a; 256B.0594; 256B.0595, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.0625, subdivision 13g; 256B.075, subdivision 2; 256B.15, subdivision 4; 256B.69, subdivisions 6, 27; 524.3-803; Minnesota Statutes 2007 Supplement, sections 256B.055, subdivision 14; 256B.0625, subdivision 49; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 256B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2007 Supplement, section 256B.055, subdivision 14, is amended to read:

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section ~~435.1009~~ 435.1010, is not eligible for medical assistance.

Sec. 2. Minnesota Statutes 2006, section 256B.056, subdivision 2, is amended to read:

Subd. 2. **Homestead exclusion and homestead equity limit for institutionalized persons residing in a long-term care facility.** ~~(a)~~ The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

- (1) the spouse;
- (2) a child under age 21;
- (3) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;
- (4) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or
- (5) a child of any age, ~~or, subject to federal approval,~~ a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

~~(b) Effective for applications filed on or after July 1, 2006, and for renewals after July 1, 2006, for persons who first applied for payment of long-term care services on or after January 2, 2006, the equity interest in the homestead of an individual whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed \$500,000, unless it is the lawful residence of the individual's spouse or child who is under age 21, blind, or disabled. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000. This provision may be waived in the case of demonstrated hardship by a process to be determined by the secretary of health and human services pursuant to section 6014 of the Deficit Reduction Act of 2005, Public Law 109-171.~~

Sec. 3. Minnesota Statutes 2006, section 256B.056, is amended by adding a subdivision to read:

Subd. 2a. **Home equity limit for medical assistance payment of long-term care services.** (a) Effective for requests of medical assistance payment of long-term care services filed on or after July 1, 2006, and for renewals on or after July 1, 2006, for persons who received payment of long-term care services under a request filed on or after January 1, 2006, the equity interest in the home of a person whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed \$500,000, unless it is the lawful residence of the person's spouse or child who is under age 21, or a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

(b) For purposes of this subdivision, a "home" means any real or personal property interest, including an interest in an agricultural homestead as defined under section 273.124, subdivision 1, that, at the time of the request for medical assistance payment of long-term care services, is the primary dwelling of the person or was the primary dwelling of the person before receipt of long-term care services began outside of the home.

(c) A person denied or terminated from medical assistance payment of long-term care services because the person's home equity exceeds the home equity limit may seek a waiver based upon a hardship by filing a written request with the county agency. Hardship is an imminent threat to the person's health and well-being that is demonstrated by documentation of no alternatives for payment of long-term care services. The county agency shall make a decision regarding the written request to waive the home equity limit within 30 days if all necessary information has been provided. The county agency shall send the person and the person's representative a written notice of decision on the request for a demonstrated hardship waiver that also advises the person of appeal rights under the fair hearing process of section 256.045.

Sec. 4. Minnesota Statutes 2006, section 256B.056, subdivision 4a, is amended to read:

Subd. 4a. **Asset verification.** For purposes of verification, the value of an individual is not required to make a good faith effort to sell a life estate that is not excluded under subdivision 2 and the life estate shall be considered deemed not salable unless the owner of the remainder interest intends to purchase the life estate, or the owner of the life estate and the owner of the remainder sell the entire property. This subdivision applies only for

the purpose of determining eligibility for medical assistance, and does not apply to the valuation of assets owned by either the institutional spouse or the community spouse under section 256B.059, subdivision 2.

Sec. 5. Minnesota Statutes 2006, section 256B.056, subdivision 11, is amended to read:

Subd. 11. **Treatment of annuities.** (a) Any ~~individual applying for or seeking recertification of eligibility for~~ person requesting medical assistance payment of long-term care services shall provide a complete description of any interest either the individual person or the individual's person's spouse has in annuities on a form designated by the department. The form shall include a statement that the state becomes a preferred remainder beneficiary of annuities or similar financial instruments by virtue of the receipt of medical assistance payment of long-term care services. The individual person and the individual's person's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents ~~for review as part of the application process on disclosure forms provided by the department as part of their application~~ and complete the form designating the state as the preferred remainder beneficiary for each annuity in which the person or the person's spouse has an interest.

(b) ~~The disclosure form shall include a statement that the department becomes the remainder beneficiary under the annuity or similar financial instrument by virtue of the receipt of medical assistance. The disclosure form~~ department shall ~~include a~~ provide notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the individual person or the individual's person's spouse, and ~~require the issuer to provide confirmation that a remainder beneficiary designation has been made and to notify the county agency when there is a change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure required under this section. The individual and the individual's spouse shall execute separate disclosure forms for each annuity or similar financial instrument that they are required to disclose under this section and in which they have an interest.~~ provide notice of the issuer's responsibilities as provided in paragraph (c).

(c) An issuer of an annuity or similar financial instrument who receives notice ~~on a disclosure form of the state's right to be named a preferred remainder beneficiary~~ as described in paragraph (b) shall provide confirmation to the requesting agency that ~~a remainder beneficiary designating the state has been made and a preferred remainder beneficiary.~~ The issuer shall also notify the county agency when there is a change in the amount of income or principal being withdrawn from the annuity or other similar financial

instrument or a change in the state's preferred remainder beneficiary designation under the annuity or other similar financial instrument occurs. The county agency shall provide the issuer with the name, address, and telephone number of a unit within the department that the issuer can contact to comply with this paragraph.

(d) "Preferred remainder beneficiary" for purposes of this subdivision and sections 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position in an amount equal to the amount of medical assistance paid on behalf of the institutionalized person, or is a remainder beneficiary in the second position if the institutionalized person designates and is survived by a remainder beneficiary who is (1) a spouse who does not reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. Notwithstanding this paragraph, the state is the remainder beneficiary in the first position if the spouse or child disposes of the remainder for less than fair market value.

(e) For purposes of this subdivision, "institutionalized person" and "long-term care services" have the meanings given in section 256B.0595, subdivision 1, paragraph (h).

(f) For purposes of this subdivision, "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital.

Sec. 6. Minnesota Statutes 2006, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a)(1) An infant less than one year of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. ~~A pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 200 percent of the federal poverty guideline for the same family size.~~ For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, except for the earned income disregard and employment deductions.

(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for

any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after July 1, 2003. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions allowed under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(c) Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.

(d) An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

Sec. 7. Minnesota Statutes 2006, section 256B.0571, subdivision 8, is amended to read:

Subd. 8. Program established. (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident at the time coverage first became effective under the partnership policy;

(2) be a beneficiary of a partnership policy that (i) is issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota,

or (ii) qualifies as a partnership policy under the provisions of subdivision 8a, or (iii) if permitted under subdivision 17, qualifies for a partnership program established by another state under United States Code, title 42, section 1396p(b)(1)(C), and is either issued on or after the effective date of the state plan amendment implementing the partnership program in the state of issuance or qualifies for an exchange under the requirements of the partnership program in that state; and

(3) have exhausted all of the benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Sec. 8. Minnesota Statutes 2006, section 256B.0571, subdivision 9, is amended to read:

Subd. 9. **Medical assistance eligibility.** (a) Upon ~~application~~ request for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) to (i).

(b) After determining assets subject to the asset limit under section 256B.056, subdivision 3 or 3c, or 256B.057, subdivision 9 or 10, the commissioner shall allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 up to the dollar amount of the benefits utilized under the partnership policy. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services.

(c) The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of initial application for medical assistance. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone

with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services, the individual may designate additional assets that become available during the individual's lifetime for protection under this section. The individual must make the designation in writing ~~to the county agency no later than the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program~~ ten days from the date the designation is requested by the county agency. Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15 or 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Sec. 9. Minnesota Statutes 2006, section 256B.0571, subdivision 15, is amended to read:

Subd. 15. **Limitation on liens.** (a) An individual's interest in real property shall not be subject to a medical assistance lien under sections 514.980 to 514.985 or a ~~notice of potential claim~~ lien arising under section 256B.15 while and to the extent it is protected under subdivision 9. An individual's interest in real property that exceeds the value protected under subdivision 9 is subject to a lien for recovery.

(b) Medical assistance liens under sections 514.980 to 514.985 or liens arising ~~under notices of potential claims~~ section 256B.15 against an individual's interests in real property in the individual's estate that are designated as protected under subdivision 13, paragraph (b), shall be released to the extent of the dollar value of the protection applied to the interest.

(c) If an interest in real property is protected from a lien for recovery of medical assistance paid on behalf of the individual under paragraph (a) or (b), no lien for recovery of medical assistance paid on behalf of that individual shall be filed against the protected interest in real property after it is distributed to the individual's heirs or devisees.

Sec. 10. Minnesota Statutes 2006, section 256B.0571, is amended by adding a subdivision to read:

Subd. 17. **Reciprocal agreements.** The commissioner may enter into an agreement with any other state with a partnership program under United States Code, title 42, section 1396p(b)(1)(C), for reciprocal recognition of qualified long-term care insurance policies purchased under each state's partnership program. The commissioner shall notify the secretary of the United States Department of Health and Human Services if the commissioner declines to enter into a national reciprocal agreement.

Sec. 11. Minnesota Statutes 2006, section 256B.058, is amended to read:

256B.058 TREATMENT OF INCOME OF INSTITUTIONALIZED SPOUSE.

Subdivision 1. **Income not available.** The income described in subdivisions 2 and 3 shall be deducted from an institutionalized spouse's monthly income and is not considered available for payment of the monthly costs of an institutionalized ~~person~~ spouse in the institution after ~~the person has been~~ determined eligible for medical assistance.

Subd. 2. **Monthly income allowance for community spouse.** (a) For an institutionalized spouse ~~with a spouse residing in the community~~, monthly income may be allocated to the community spouse as a monthly income allowance for the community spouse. Beginning with the first full calendar month the institutionalized spouse is in the institution, the monthly income allowance is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution as long as the income is made available to the community spouse.

(b) The monthly income allowance is the amount by which the community spouse's monthly maintenance needs allowance under paragraphs (c) and (d) exceeds the amount of monthly income otherwise available to the community spouse.

(c) The community spouse's monthly maintenance needs allowance is the lesser of \$1,500 or 122 percent of the monthly federal poverty guideline for a family of two plus an excess shelter allowance. The excess shelter allowance is for the amount of shelter expenses that exceed 30 percent of 122 percent of the federal poverty guideline line for a family of two. Shelter expenses are the community spouse's expenses for rent, mortgage payments including principal and interest, taxes, insurance, required maintenance charges for a cooperative or condominium that is the community spouse's principal residence, and the standard utility allowance under section 5(e) of the federal Food Stamp Act of 1977. If the community spouse has a required maintenance charge for a cooperative or condominium, the standard utility allowance must be reduced by the amount of utility expenses included in the required maintenance charge.

If the community or institutionalized spouse establishes that the community spouse needs income greater than the monthly maintenance needs allowance determined in this paragraph due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance may be increased to an amount that provides needed additional income.

(d) The percentage of the federal poverty guideline used to determine the monthly maintenance needs allowance in paragraph (c) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes. The \$1,500 maximum must be adjusted January 1, 1990, and every January 1 after that by the same percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) between the two previous Septembers.

(e) If a court has entered an order against an institutionalized spouse for monthly income for support of the community spouse, the community spouse's monthly income allowance under this subdivision shall not be less than the amount of the monthly income ordered.

Subd. 3. Family allowance. (a) A family allowance determined under paragraph (b) is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution.

(b) The family allowance is equal to one-third of the amount by which 122 percent of the monthly federal poverty guideline for a family of two exceeds the monthly income for that family member.

(c) For purposes of this subdivision, the term family member only includes a minor or dependent child as defined in the Internal Revenue Code, dependent parent, or

11.1 dependent sibling of the institutionalized or community spouse if the sibling resides with
11.2 the community spouse.

11.3 (d) The percentage of the federal poverty guideline used to determine the family
11.4 allowance in paragraph (b) is increased to 133 percent on July 1, 1991, and to 150 percent
11.5 on July 1, 1992. Adjustments in the income limits due to annual changes in the federal
11.6 poverty guidelines shall be implemented the first day of July following publication of
11.7 the annual changes.

11.8 Subd. 4. **Treatment of income.** (a) No income of the community spouse will
11.9 be considered available to an eligible institutionalized spouse, beginning the first full
11.10 calendar month of institutionalization, except as provided in this subdivision.

11.11 (b) In determining the income of an institutionalized spouse or community spouse,
11.12 after the institutionalized spouse has been determined eligible for medical assistance,
11.13 the following rules apply.

11.14 (1) For income that is not from a trust, availability is determined according to items
11.15 (i) to (v), unless the instrument providing the income otherwise specifically provides:

11.16 (i) if payment is made solely in the name of one spouse, the income is considered
11.17 available only to that spouse;

11.18 (ii) if payment is made in the names of both spouses, one-half of the income is
11.19 considered available to each;

11.20 (iii) if payment is made in the names of one or both spouses together with one or
11.21 more other persons, the income is considered available to each spouse according to the
11.22 spouse's interest, or one-half of the joint interest is considered available to each spouse
11.23 if each spouse's interest is not specified;

11.24 (iv) if there is no instrument that establishes ownership, one-half of the income is
11.25 considered available to each spouse; and

11.26 (v) either spouse may rebut the determination of availability of income by showing
11.27 by a preponderance of the evidence that ownership interests are different than provided
11.28 above.

11.29 (2) For income from a trust, income is considered available to each spouse as
11.30 provided in the trust. If the trust does not specify an amount available to either or both
11.31 spouses, availability will be determined according to items (i) to (iii):

11.32 (i) if payment of income is made only to one spouse, the income is considered
11.33 available only to that spouse;

11.34 (ii) if payment of income is made to both spouses, one-half is considered available to
11.35 each; and

12.1 (iii) if payment is made to either or both spouses and one or more other persons,
12.2 the income is considered available to each spouse in proportion to each spouse's interest,
12.3 or if no such interest is specified, one-half of the joint interest is considered available
12.4 to each spouse.

12.5 Sec. 12. Minnesota Statutes 2006, section 256B.059, subdivision 1, is amended to read:

12.6 Subdivision 1. **Definitions.** (a) For purposes of this section and ~~section~~ sections
12.7 256B.058 and 256B.0595, the terms defined in this subdivision have the meanings given
12.8 them.

12.9 (b) "Community spouse" means the spouse of an institutionalized spouse.

12.10 (c) "Spousal share" means one-half of the total value of all assets, to the extent that
12.11 either the institutionalized spouse or the community spouse had an ownership interest at
12.12 the time of the first continuous period of institutionalization.

12.13 (d) "Assets otherwise available to the community spouse" means assets individually
12.14 or jointly owned by the community spouse, other than assets excluded by subdivision 5,
12.15 paragraph (c).

12.16 (e) "Community spouse asset allowance" is the value of assets that can be transferred
12.17 under subdivision 3.

12.18 (f) "Institutionalized spouse" means a person who is:

12.19 (1) in a hospital, nursing facility, or intermediate care facility for persons with
12.20 developmental disabilities, or receiving home and community-based services under
12.21 section 256B.0915 ~~or 256B.49~~, and is expected to remain in the facility or institution or
12.22 receive the home and community-based services for at least 30 consecutive days; and

12.23 (2) married to a person who is not in a hospital, nursing facility, or intermediate
12.24 care facility for persons with developmental disabilities, and is not receiving home and
12.25 community-based services under section 256B.0915 or 256B.49.

12.26 (g) "For the sole benefit of" means no other individual or entity can benefit in any
12.27 way from the assets or income at the time of a transfer or at any time in the future.

12.28 (h) "Continuous period of institutionalization" means a 30-consecutive-day period
12.29 of time in which a person is expected to stay in a medical or long-term care facility,
12.30 or receive home and community-based services that would qualify for coverage under
12.31 the elderly waiver (EW) or alternative care (AC) programs. For a stay in a facility, the
12.32 30-consecutive-day period begins on the date of entry into a medical or long-term care
12.33 facility. For receipt of home and community-based services, the 30-consecutive-day
12.34 period begins on the date that the following conditions are met:

- 13.1 (1) the person is receiving services that meet the nursing facility level of care
13.2 determined by a long-term care consultation;
- 13.3 (2) the person has received the long-term care consultation within the past 60 days;
- 13.4 (3) the services are paid by the EW program under section 256B.0915 or the AC
13.5 program under section 256B.0913 or would qualify for payment under the EW or AC
13.6 programs if the person were otherwise eligible for either program, and but for the receipt
13.7 of such services the person would have resided in a nursing facility; and
- 13.8 (4) the services are provided by a licensed provider qualified to provide home and
13.9 community-based services.

13.10 Sec. 13. Minnesota Statutes 2006, section 256B.059, subdivision 1a, is amended to
13.11 read:

13.12 Subd. 1a. **Institutionalized spouse.** The provisions of this section apply only
13.13 when a spouse ~~is institutionalized for a~~ begins the first continuous period ~~beginning of~~
13.14 institutionalization on or after October 1, 1989.

13.15 Sec. 14. Minnesota Statutes 2006, section 256B.0594, is amended to read:

13.16 **256B.0594 PAYMENT OF BENEFITS FROM AN ANNUITY.**

13.17 When payment becomes due under an annuity that names the department a
13.18 remainder beneficiary ~~as described in section 256B.056, subdivision 11,~~ the issuer shall
13.19 request and the department shall, within 45 days after receipt of the request, provide
13.20 a written statement of the total amount of the medical assistance paid or confirmation
13.21 that any family member designated as a remainder beneficiary meets requirements for
13.22 qualification as a beneficiary in the first position. Upon timely receipt of the written
13.23 statement of the amount of medical assistance paid, the issuer shall pay the department an
13.24 amount equal to the lesser of the amount due the department under the annuity or the total
13.25 amount of medical assistance paid on behalf of the individual or the individual's spouse.
13.26 Any amounts remaining after the issuer's payment to the department shall be payable
13.27 according to the terms of the annuity or similar financial instrument. The county agency
13.28 or the department shall provide the issuer with the name, address, and telephone number
13.29 of a unit within the department the issuer can contact to comply with this section. The
13.30 requirements of section 72A.201, subdivision 4, clause (3), shall not apply to payments
13.31 made under this section until the issuer has received final payment information from the
13.32 department, if the issuer has notified the beneficiary of the requirements of this section at
13.33 the time it initially requests payment information from the department.

Sec. 15. Minnesota Statutes 2006, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before August 10, 1993, if ~~a~~ an institutionalized person or the institutionalized person's spouse has given away, sold, or disposed of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security program, within 30 months before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made after August 10, 1993, ~~a~~ an institutionalized person, ~~a~~ an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or institutionalized person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person ~~applies for~~ requests medical assistance payment of long-term care services, or 36 months before or any time after a medical assistance recipient becomes an institutionalized person, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the institutionalized person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the institutionalized person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time after an institutionalized person ~~applies for~~ requests medical assistance payment of long-term care services and within 60 months before or any time after a medical assistance recipient becomes an institutionalized person, may be considered.

15.1 (c) This section applies to transfers, for less than fair market value, of income
15.2 or assets, including assets that are considered income in the month received, such as
15.3 inheritances, court settlements, and retroactive benefit payments or income to which the
15.4 institutionalized person or the institutionalized person's spouse is entitled but does not
15.5 receive due to action by the institutionalized person, the institutionalized person's spouse,
15.6 or any person, court, or administrative body with legal authority to act in place of, on
15.7 behalf of, at the direction of, or upon the request of the institutionalized person or the
15.8 institutionalized person's spouse.

15.9 (d) This section applies to payments for care or personal services provided by a
15.10 relative, unless the compensation was stipulated in a notarized, written agreement which
15.11 was in existence when the service was performed, the care or services directly benefited
15.12 the person, and the payments made represented reasonable compensation for the care
15.13 or services provided. A notarized written agreement is not required if payment for the
15.14 services was made within 60 days after the service was provided.

15.15 (e) This section applies to the portion of any asset or interest that ~~a~~ an institutionalized
15.16 person, ~~a~~ an institutionalized person's spouse, or any person, court, or administrative body
15.17 with legal authority to act in place of, on behalf of, at the direction of, or upon the request
15.18 of the institutionalized person or the institutionalized person's spouse, transfers to any
15.19 annuity that exceeds the value of the benefit likely to be returned to the institutionalized
15.20 person or institutionalized person's spouse while alive, based on estimated life expectancy
15.21 ~~using the life expectancy tables employed by the supplemental security income program~~
15.22 ~~to determine the value of an agreement for services for life~~ as determined according to the
15.23 current actuarial tables published by the Office of the Chief Actuary of the Social Security
15.24 Administration. The commissioner may adopt rules reducing life expectancies based on
15.25 the need for long-term care. This section applies to an annuity ~~described in this paragraph~~
15.26 purchased on or after March 1, 2002, that:

15.27 (1) is not purchased from an insurance company or financial institution that is
15.28 subject to licensing or regulation by the Minnesota Department of Commerce or a similar
15.29 regulatory agency of another state;

15.30 (2) does not pay out principal and interest in equal monthly installments; or

15.31 (3) does not begin payment at the earliest possible date after annuitization.

15.32 (f) Effective for transactions, including the purchase of an annuity, occurring on
15.33 or after February 8, 2006, ~~the purchase of an annuity~~ by or on behalf of an ~~individual~~
15.34 institutionalized person who has applied for or is receiving long-term care services or the
15.35 ~~individual's~~ institutionalized person's spouse shall be treated as the disposal of an asset for
15.36 less than fair market value unless the department is named ~~as the~~ a preferred remainder

beneficiary ~~in first position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse; or the department is named as the remainder beneficiary in second position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse after the individual's community spouse or minor or disabled child and is named as the remainder beneficiary in the first position if the community spouse or a representative of the minor or disabled child disposes of the remainder for less than fair market value~~ as described in section 256B.056, subdivision 11. Any subsequent change to the designation of the department as a preferred remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the individual institutionalized person or the individual's institutionalized person's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the individual institutionalized person or the individual's institutionalized person's spouse demonstrates that the transaction was for fair market value. In the event a distribution of income or principal has been improperly distributed or disbursed from an annuity or other retirement planning instrument of an institutionalized person or the institutionalized person's spouse, a cause of action exists against the individual receiving the improper distribution for the cost of medical assistance services provided or the amount of the improper distribution, whichever is less.

(g) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, ~~the purchase of an annuity~~ by or on behalf of an ~~individual~~ institutionalized person applying for or receiving long-term care services shall be treated as a disposal of assets for less than fair market value unless it is:

(i) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(ii) purchased with proceeds from:

(A) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code;

(B) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code; or

(C) a Roth IRA described in section 408A of the Internal Revenue Code; or

(iii) an annuity that is irrevocable and nonassignable; is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of

the Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(h) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with developmental disabilities, and home and community-based services provided pursuant to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with developmental disabilities or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

(i) This section applies to funds used to purchase a promissory note, loan, or mortgage unless the note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not meet an exception in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the ~~individual's application~~ institutionalized person's request for medical assistance payment of long-term care services.

(j) This section applies to the purchase of a life estate interest in another ~~individual's~~ person's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

Sec. 16. Minnesota Statutes 2006, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. Period of ineligibility. (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of

ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. ~~The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G.~~ The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee ~~for the cost of medical assistance~~ that portion of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. ~~The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G.~~

The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility:

(1) for uncompensated transfers by or on behalf of individuals receiving medical assistance payment of long-term care services, begins on the first day of the month in which following advance notice can be given following of the penalty period, but no later than the first day of the month in which assets have been transferred for less than fair market value, that follows three full calendar months from the date of the report or discovery of the transfer; or

(2) for uncompensated transfers by individuals requesting medical assistance payment of long-term care services, begins the date on which the individual is eligible for medical assistance under the Medicaid state plan and would otherwise be receiving long-term care services based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur

(3) cannot begin during any other period of ineligibility.

(d) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction.

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

Sec. 17. Minnesota Statutes 2006, section 256B.0595, subdivision 3, is amended to read:

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's:

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the supplemental security income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility the

20.1 individual became an institutionalized person, and who provided care to the individual
20.2 that, as certified by the individual's attending physician, permitted the individual to reside
20.3 at home rather than receive care in an institution or facility;

20.4 (2) a satisfactory showing is made that the individual intended to dispose of the
20.5 homestead at fair market value or for other valuable consideration; or

20.6 (3) the local agency grants a waiver of a penalty resulting from a transfer for less
20.7 than fair market value because denial of eligibility would cause undue hardship for the
20.8 individual, based on imminent threat to the individual's health and well-being. Whenever
20.9 an applicant or recipient is denied eligibility because of a transfer for less than fair market
20.10 value, the local agency shall notify the applicant or recipient that the applicant or recipient
20.11 may request a waiver of the penalty if the denial of eligibility will cause undue hardship.
20.12 With the written consent of the individual or the personal representative of the individual,
20.13 a long-term care facility in which an individual is residing may file an undue hardship
20.14 waiver request, on behalf of the individual who is denied eligibility for long-term care
20.15 services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on
20.16 or after February 8, 2006. In evaluating a waiver, the local agency shall take into account
20.17 whether the individual was the victim of financial exploitation, whether the individual has
20.18 made reasonable efforts to recover the transferred property or resource, and other factors
20.19 relevant to a determination of hardship. If the local agency does not approve a hardship
20.20 waiver, the local agency shall issue a written notice to the individual stating the reasons
20.21 for the denial and the process for appealing the local agency's decision.

20.22 (b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists
20.23 against the person to whom the homestead was transferred for that portion of long-term
20.24 care services ~~granted~~ provided within:

20.25 (1) 30 months of a transfer made on or before August 10, 1993;

20.26 (2) 60 months if the homestead was transferred after August 10, 1993, to a trust or
20.27 portion of a trust that is considered a transfer of assets under federal law;

20.28 (3) 36 months if transferred in any other manner after August 10, 1993, but prior
20.29 to February 8, 2006; or

20.30 (4) 60 months if the homestead was transferred on or after February 8, 2006,

20.31 or the amount of the uncompensated transfer, whichever is less, together with the
20.32 costs incurred due to the action. ~~The action shall be brought by the state unless the~~
20.33 ~~state delegates this responsibility to the local agency responsible for providing medical~~
20.34 ~~assistance under chapter 256G.~~

21.1 Sec. 18. Minnesota Statutes 2006, section 256B.0595, subdivision 4, is amended to
21.2 read:

21.3 Subd. 4. **Other exceptions to transfer prohibition.** An institutionalized person
21.4 who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not
21.5 ineligible for long-term care services if one of the following conditions applies:

21.6 (1) the assets were transferred to the individual's spouse or to another for the sole
21.7 benefit of the spouse; or

21.8 (2) the institutionalized spouse, prior to being institutionalized, transferred assets
21.9 to a spouse, provided that the spouse to whom the assets were transferred does not then
21.10 transfer those assets to another person for less than fair market value. (At the time when
21.11 one spouse is institutionalized, assets must be allocated between the spouses as provided
21.12 under section 256B.059); or

21.13 (3) the assets were transferred to the individual's child who is blind or permanently
21.14 and totally disabled as determined in the supplemental security income program; or

21.15 (4) a satisfactory showing is made that the individual intended to dispose of the
21.16 assets either at fair market value or for other valuable consideration; or

21.17 (5) the local agency determines that denial of eligibility for long-term care services
21.18 would work an undue hardship and grants a waiver of a penalty resulting from a transfer
21.19 for less than fair market value based on an imminent threat to the individual's health
21.20 and well-being. Whenever an applicant or recipient is denied eligibility because of a
21.21 transfer for less than fair market value, the local agency shall notify the applicant or
21.22 recipient that the applicant or recipient may request a waiver of the penalty if the denial of
21.23 eligibility will cause undue hardship. With the written consent of the individual or the
21.24 personal representative of the individual, a long-term care facility in which an individual
21.25 is residing may file an undue hardship waiver request, on behalf of the individual who
21.26 is denied eligibility for long-term care services on or after July 1, 2006, due to a period
21.27 of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a
21.28 waiver, the local agency shall take into account whether the individual was the victim of
21.29 financial exploitation, whether the individual has made reasonable efforts to recover the
21.30 transferred property or resource, whether the individual has taken any action to prevent
21.31 the designation of the department as a remainder beneficiary on an annuity as described
21.32 in section 256B.056, subdivision 11, and other factors relevant to a determination of
21.33 hardship. The local agency shall make a determination within 30 days of the receipt of all
21.34 necessary information needed to make such a determination. If the local agency does not
21.35 approve a hardship waiver, the local agency shall issue a written notice to the individual
21.36 stating the reasons for the denial and the process for appealing the local agency's decision.

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22.1 When a waiver is granted, a cause of action exists against the person to whom the assets
22.2 were transferred for that portion of long-term care services ~~granted~~ provided within:

22.3 (i) 30 months of a transfer made on or before August 10, 1993;

22.4 (ii) 60 months of a transfer if the assets were transferred after August 30, 1993, to a
22.5 trust or portion of a trust that is considered a transfer of assets under federal law;

22.6 (iii) 36 months of a transfer if transferred in any other manner after August 10, 1993,
22.7 but prior to February 8, 2006; or

22.8 (iv) 60 months of any transfer made on or after February 8, 2006,

22.9 or the amount of the uncompensated transfer, whichever is less, together with the
22.10 costs incurred due to the action. ~~The action shall be brought by the state unless the~~

22.11 ~~state delegates this responsibility to the local agency responsible for providing medical~~
22.12 ~~assistance under this chapter; or~~

22.13 (6) for transfers occurring after August 10, 1993, the assets were transferred by
22.14 the person or person's spouse: (i) into a trust established for the sole benefit of a son or
22.15 daughter of any age who is blind or disabled as defined by the Supplemental Security
22.16 Income program; or (ii) into a trust established for the sole benefit of an individual who is
22.17 under 65 years of age who is disabled as defined by the Supplemental Security Income
22.18 program.

22.19 "For the sole benefit of" has the meaning found in section 256B.059, subdivision 1.

22.20 Sec. 19. Minnesota Statutes 2006, section 256B.0595, is amended by adding a
22.21 subdivision to read:

22.22 Subd. 8. Cause of action; transfer prior to death. (a) A cause of action exists
22.23 against a transferee who receives assets for less than fair market value, either:

22.24 (1) from a person who was a recipient of medical assistance and who made an
22.25 uncompensated transfer that was known to the county agency but a penalty period could
22.26 not be implemented under this section due to the death of the person; or

22.27 (2) from a person who was a recipient of medical assistance who made an
22.28 uncompensated transfer that was not known to the county agency and the transfer was
22.29 made with the intent to hinder, delay, or defraud the state or local agency from recovering
22.30 as allowed under section 256B.15. In determining intent under this clause consideration
22.31 may be given, among other factors, to whether:

22.32 (i) the transfer was to a family member;

22.33 (ii) the transferor retained possession or control of the property after the transfer;

22.34 (iii) the transfer was concealed;

22.35 (iv) the transfer included the majority of the transferor's assets;

23.1 (v) the value of the consideration received was not reasonably equivalent to the fair
23.2 market value of the property; and

23.3 (vi) the transfer occurred shortly before the death of the transferor.

23.4 (b) No cause of action exists under this subdivision unless:

23.5 (1) the transferee knew or should have known that the transfer was being made by a
23.6 person who was receiving medical assistance as described in section 256B.15, subdivision
23.7 1, paragraph (b); and

23.8 (2) the transferee received the asset without providing a reasonable equivalent fair
23.9 market value in exchange for the transfer.

23.10 (c) The cause of action is for the uncompensated amount of the transfer or the
23.11 amount of medical assistance paid on behalf of the person, whichever is less. The
23.12 uncompensated transfer amount is the fair market value of the asset at the time it was
23.13 given away, sold, or disposed of, less the amount of the compensation received.

23.14 Sec. 20. Minnesota Statutes 2006, section 256B.0595, is amended by adding a
23.15 subdivision to read:

23.16 Subd. 9. **Filing cause of action; limitation.** (a) The county of financial
23.17 responsibility under chapter 256G may bring a cause of action under any or all of the
23.18 following:

23.19 (1) subdivision 1, paragraph (f);

23.20 (2) subdivision 2, paragraphs (a) and (b);

23.21 (3) subdivision 3, paragraph (b);

23.22 (4) subdivision 4, clause (5); and

23.23 (5) subdivision 8

23.24 on behalf of the claimant who must be the commissioner.

23.25 (b) Notwithstanding any other law to the contrary, a cause of action under
23.26 subdivision 2, paragraph (a) or (b) or subdivision 8, must be commenced within six years
23.27 of the date the local agency determines that a transfer was made for less than fair market
23.28 value. Notwithstanding any other law to the contrary, a cause of action under subdivision
23.29 3, paragraph (b), or subdivision 4, clause (5), must be commenced within six years of the
23.30 date of approval of a waiver of the penalty period for a transfer for less than fair market
23.31 value based on undue hardship.

23.32 Sec. 21. Minnesota Statutes 2006, section 256B.0625, subdivision 13g, is amended to
23.33 read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor ~~or one or more states~~ for the purpose of participating in a ~~multistate~~ preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization, unless the drug manufacturer signs a supplemental rebate contract.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Sec. 22. Minnesota Statutes 2007 Supplement, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, or advanced practice registered nurse, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, or advanced practice registered nurse, or

25.1 work under the supervision of a certified public health nurse operating under the direct
25.2 authority of an enrolled unit of government.

25.3 Sec. 23. Minnesota Statutes 2006, section 256B.075, subdivision 2, is amended to read:

25.4 Subd. 2. **Fee-for-service.** (a) The commissioner shall develop and implement
25.5 a disease management program for medical assistance and general assistance medical
25.6 care recipients who are not enrolled in the prepaid medical assistance or prepaid general
25.7 assistance medical care programs and who are receiving services on a fee-for-service basis.
25.8 The commissioner may contract with an outside organization to provide these services.

25.9 (b) The commissioner shall seek any federal approval necessary to implement this
25.10 section and to obtain federal matching funds.

25.11 (c) The commissioner shall develop and implement a pilot intensive care
25.12 management program for medical assistance children with complex and chronic medical
25.13 issues ~~who are not able to participate in the metro-based U Special Kids program due~~
25.14 ~~to geographic distance.~~

25.15 Sec. 24. **[256B.0948] STATEWIDE HEALTH INFORMATION EXCHANGE.**

25.16 Subdivision 1. **Commissioner's authority to join and participate.** The
25.17 commissioner of human services has the authority to join and participate as a member
25.18 in a legal entity developing and operating a statewide health information exchange that
25.19 shall meet the following criteria:

25.20 (1) the legal entity must meet all constitutional and statutory requirements to allow
25.21 the commissioner to participate including, without limitation, the Minnesota Constitution,
25.22 article X, section 1; and

25.23 (2) the commissioner or the commissioner's designated representative must have
25.24 the right to participate in the governance of the legal entity under the same terms and
25.25 conditions and subject to the same requirements as any other member in the legal entity
25.26 and in that role shall act to advance state interests and lessen the burdens of government.

25.27 Subd. 2. **Development expenses.** Notwithstanding chapter 16C, the commissioner
25.28 may pay the state's prorated share of development-related expenses of the legal entity
25.29 retroactively from October 29, 2007, regardless of the date the commissioner joins the
25.30 legal entity as a member.

25.31 Sec. 25. Minnesota Statutes 2006, section 256B.15, subdivision 4, is amended to read:

25.32 Subd. 4. **Other survivors.** (a) If the decedent who was single or the surviving
25.33 spouse of a married couple is survived by one of the following persons, a claim exists

against the estate payable first from the value of the nonhomestead property included in the estate and the personal representative shall make, execute, and deliver to the county agency a lien against the homestead property in the estate for any unpaid balance of the claim to the claimant as provided under this section:

~~(a)~~ (1) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

~~(b)~~ (2) a son or daughter or a grandchild who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's or grandparent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent or grandparent to reside at home rather than in an institution.

(b) For purposes of this subdivision, "institutionalization" means receiving care:
(1) in a nursing facility or swing bed, or intermediate care facility for persons with
developmental disabilities; or (2) through home and community-based services under
section 256B.0915, 256B.092, or 256B.49.

Sec. 26. Minnesota Statutes 2006, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees, notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

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

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

27.1 (b) Demonstration providers must comply with the standards for claims settlement
27.2 under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health
27.3 care and social service practitioners to provide services to enrollees. A demonstration
27.4 provider must pay a clean claim, as defined in Code of Federal Regulations, title 42,
27.5 section 447.45(b), within 30 business days of the date of acceptance of the claim.

27.6 Sec. 27. Minnesota Statutes 2006, section 256B.69, subdivision 27, is amended to read:

27.7 Subd. 27. **Information for persons with limited English-language proficiency.**
27.8 Managed care contracts entered into under this section and sections 256D.03, subdivision
27.9 4, paragraph (c), and 256L.12 must require demonstration providers to ~~inform enrollees~~
27.10 ~~that upon request the enrollee can obtain a certificate of coverage in the following~~
27.11 ~~languages: Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, or Cambodian.~~
27.12 ~~Upon request, the demonstration provider must provide the enrollee with a certificate of~~
27.13 ~~coverage in the specified language of preference~~ provide language assistance to enrollees
27.14 that ensures meaningful access to its programs and services according to Title VI of the
27.15 Civil Rights Act and federal regulations adopted under that law or any guidance from the
27.16 United States Department of Health and Human Services.

27.17 Sec. 28. Minnesota Statutes 2007 Supplement, section 256D.03, subdivision 3, is
27.18 amended to read:

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

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

27.27 (2) who is a resident of Minnesota; and

27.28 (i) who has gross countable income not in excess of 75 percent of the federal poverty
27.29 guidelines for the family size, using a six-month budget period and whose equity in assets
27.30 is not in excess of \$1,000 per assistance unit. General assistance medical care is not
27.31 available for applicants or enrollees who are otherwise eligible for medical assistance but
27.32 fail to verify their assets. Enrollees who become eligible for medical assistance shall be
27.33 terminated and transferred to medical assistance. Exempt assets, the reduction of excess
27.34 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 general assistance medical care 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), ~~who are~~ exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) 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; ~~who~~

(2) fail to meet the requirements of section 256L.09, subdivision 2; ~~who~~

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

~~who~~

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

~~who~~

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9; ~~who~~

(6) are eligible under paragraph (j); ~~or who~~

(7) receive treatment funded pursuant to section 254B.02 ~~are exempt from the MinnesotaCare enrollment requirements of this subdivision; or~~

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(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 United States Citizenship and Immigration Services.

(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.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 29. Minnesota Statutes 2006, section 524.3-803, is amended to read:

524.3-803 LIMITATIONS ON PRESENTATION OF CLAIMS.

(a) All claims as defined in section 524.1-201(6), against a decedent's estate which arose before the death of the decedent, including claims of the state and any subdivision thereof, whether due or to become due, absolute or contingent, liquidated or unliquidated, if not barred earlier by other statute of limitations, are barred against the estate, the personal representative, and the heirs and devisees of the decedent, unless presented as follows:

(1) in the case of a creditor who is only entitled, under the United States Constitution and under the Minnesota Constitution, to notice by publication under section 524.3-801, within four months after the date of the court administrator's notice to creditors which is subsequently published pursuant to section 524.3-801;

(2) in the case of a creditor who was served with notice under section 524.3-801(c), within the later to expire of four months after the date of the first publication of notice to creditors or one month after the service;

(3) within the later to expire of one year after the decedent's death, or one year after June 16, 1989, whether or not notice to creditors has been published or served under section 524.3-801, provided, however, that in the case of a decedent who died before June 16, 1989, no claim which was then barred by any provision of law may be deemed to have been revived by the amendment of this section. Claims authorized by section 246.53, 256B.15, or 256D.16 must not be barred after one year as provided in this clause.

(b) All claims against a decedent's estate which arise at or after the death of the decedent, including claims of the state and any subdivision thereof, whether due or to become due, absolute or contingent, liquidated or unliquidated, are barred against the estate, the personal representative, and the heirs and devisees of the decedent, unless presented as follows:

- 32.1 (1) a claim based on a contract with the personal representative, within four months
32.2 after performance by the personal representative is due;
- 32.3 (2) any other claim, within four months after it arises.
- 32.4 (c) Nothing in this section affects or prevents:
- 32.5 (1) any proceeding to enforce any mortgage, pledge, or other lien upon property
32.6 of the estate;
- 32.7 (2) any proceeding to establish liability of the decedent or the personal representative
32.8 for which there is protection by liability insurance, to the limits of the insurance protection
32.9 only;
- 32.10 (3) the presentment and payment at any time within one year after the decedent's
32.11 death of any claim arising before the death of the decedent that is referred to in section
32.12 524.3-715, clause (18), although the same may be otherwise barred under this section; or
- 32.13 (4) the presentment and payment at any time before a petition is filed in compliance
32.14 with section 524.3-1001 or 524.3-1002 or a closing statement is filed under section
32.15 524.3-1003, of:
- 32.16 (i) any claim arising after the death of the decedent that is referred to in section
32.17 524.3-715, clause (18), although the same may be otherwise barred hereunder;
- 32.18 (ii) any other claim, including claims subject to clause (3), which would otherwise be
32.19 barred hereunder, upon allowance by the court upon petition of the personal representative
32.20 or the claimant for cause shown on notice and hearing as the court may direct.