CHAPTER 326–H.F.No. 3222

An act relating to human services; amending health care services provisions; making changes to a managed care contract provision; increasing a HMO renewal fee; changing provisions relating to sex offender program; changing a work activity provision under MFIP; requiring a report; appropriating money; amending Minnesota Statutes 2006, sections 13.851, by adding a subdivision; 125A.02, subdivision 1; 144A.45, subdivision 1, by adding a subdivision; 150A.06, by adding a subdivision; 214.40, by adding a subdivision; 246B.02; 253B.045, subdivisions 1, 2, by adding a subdivision; 253B.18, subdivisions 4c, 5, 5a; 253B.185, subdivision 5, by adding a subdivision; 253B.19, subdivisions 2, 3; 256.01, by adding a subdivision; 256B.056, subdivisions 2, 4a, 11, by adding a subdivision; 256B.057, subdivision 1; 256B.0571, subdivisions 6, 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, subdivisions 3c, 13g, 13h; 256B.075, subdivision 2; 256B.15, subdivision 4; 256B.69, subdivisions 3a, 6, 27, 28; 256B.692, subdivision 7; 524.3-803; 626.5572, subdivision 21; Minnesota Statutes 2007 Supplement, sections 253B.185, subdivision 1b; 256B.055, subdivision 14; 256B.0625, subdivision 49; 256D.03, subdivision 3; 256J.49, subdivision 13; Laws 2005, First Special Session chapter 4, article 8, section 84, as amended; proposing coding for new law in Minnesota Statutes, chapters 145; 246B; repealing Minnesota Statutes 2006, section 256B.0571, subdivision 8a; Laws 2003, First Special Session chapter 5, section 11.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2006, section 125A.02, subdivision 1, is amended to read:

Subdivision 1. **Child with a disability.** Every child who has a hearing impairment, blindness, visual disability, speech or language impairment, physical disability, other health impairment, mental disability, emotional/behavioral disorder, specific learning disability, autism, traumatic brain injury, multiple disabilities, or deaf/blind disability and needs special instruction and services, as determined by the standards of the commissioner, is a child with a disability. A licensed physician, an advanced practice nurse, or a licensed psychologist is qualified to make a diagnosis and determination of attention deficit disorder or attention deficit hyperactivity disorder for purposes of identifying a child with a disability. In addition, every child under age three, and at local district discretion from age three to age seven, who needs special instruction and services, as determined by the standards of the commissioner, because the child has a substantial delay or has

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an identifiable physical or mental condition known to hinder normal development is a child with a disability.

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

Sec. 2. Minnesota Statutes 2006, section 144A.45, subdivision 1, is amended to read:

Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of home care providers pursuant to sections 144A.43 to 144A.47. The rules shall include the following:

~~(a)~~ (1) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services;

~~(b)~~ (2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.47;

~~(c)~~ (3) standards of training of home care provider personnel, which may vary according to the nature of the services provided or the health status of the consumer;

~~(d)~~ (4) standards for medication management which may vary according to the nature of the services provided, the setting in which the services are provided, or the status of the consumer. Medication management includes the central storage, handling, distribution, and administration of medications;

~~(e)~~ (5) standards for supervision of home care services requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that, notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 5, item B, supervision of a person performing home care aide tasks for a class B licensee providing paraprofessional services must occur only every 180 days, or more frequently if indicated by a clinical assessment;

~~(f)~~ (6) standards for client evaluation or assessment which may vary according to the nature of the services provided or the status of the consumer;

~~(g)~~ (7) requirements for the involvement of a consumer's physician, the documentation of physicians' orders, if required, and the consumer's treatment plan, and the maintenance of accurate, current clinical records;

~~(h)~~ (8) the establishment of different classes of licenses for different types of providers and different standards and requirements for different kinds of home care services; and

~~(i)~~ (9) operating procedures required to implement the home care bill of rights.

Sec. 3. Minnesota Statutes 2006, section 144A.45, is amended by adding a subdivision to read:

Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting toileting, transfers, and ambulation if the client is ambulatory and if the client has no serious acute illness or infectious disease.

Sec. 4. **[145.1622] POLICY FOR NOTIFICATION OF DISPOSITION OPTIONS.**

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Hospitals, clinics, and medical facilities must have in place by January 15, 2009, a policy for informing a woman of available options for fetal disposition when the woman experiences a miscarriage or is expected to experience a miscarriage.

Sec. 5. Minnesota Statutes 2006, section 150A.06, is amended by adding a subdivision to read:

Subd. 9. **Graduates of nonaccredited dental programs.** A graduate of a nonaccredited dental program who successfully completes the clinical licensure examination, and meets all other applicant requirements of the board shall be licensed to practice dentistry and granted a limited general dentist license by the board. The board shall place limitations on the licensee's authority to practice by requiring the licensee to practice under the general supervision of a Minnesota-licensed dentist approved by the board. A person licensed under this subdivision must practice for three consecutive years in Minnesota pursuant to a written agreement, approved by the board, between the licensee and a Minnesota-licensed dentist who may limit the types of services authorized. At the conclusion of the three-year period, the board shall grant an unlimited license without further restrictions if all supervising dentists who had entered into written agreements with the licensee during any part of the three-year period recommend unlimited licensure, and if no corrective action or disciplinary action has been taken by the board against the licensee.

Sec. 6. Minnesota Statutes 2006, section 214.40, is amended by adding a subdivision to read:

Subd. 8. **Fee adjustment.** The administrative services unit shall apportion between the Board of Medical Practice, the Board of Dentistry, and the Board of Nursing an amount to be raised through fees by the respective board. The amount apportioned to each board shall be the total amount expended on medical professional liability insurance coverage purchased for the providers regulated by the respective board. The respective board may adjust the fees which the board is required to collect to compensate for the amount apportioned to the board by the administrative services unit.

Sec. 7. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 28. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

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

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

Sec. 8. Minnesota Statutes 2007 Supplement, section 256B.055, subdivision 14, is amended to read:

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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. 9. 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),~~

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~~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. 10. 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. 11. 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. 12. Minnesota Statutes 2006, section 256B.056, subdivision 11, is amended to read:

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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).

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(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. 13. 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.

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Sec. 14. Minnesota Statutes 2006, section 256B.0571, subdivision 6, is amended to read:

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 and was issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota. Policies that are exchanged or that have riders or endorsements added on or after the effective date of the state plan amendment as authorized by the commissioner of commerce qualify as a partnership policy.

Sec. 15. 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) meet one of the following criteria:

(i) be a beneficiary of, and a Minnesota resident at the time coverage first became effective under ~~the~~ a partnership policy~~,~~

~~(2) be a beneficiary of a partnership policy~~ that ~~(i)~~ either 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~~ as authorized by the commissioner of commerce under subdivision 6; ~~and~~ or

(ii) be a beneficiary of a policy recognized under subdivision 17; and

~~(3)~~ (2) 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. 16. 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

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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. 17. 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.

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(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. 18. 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. 19. 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 in the institution~~ spouse after ~~the person has been~~ the institutionalized spouse 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

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

(d) The percentage of the federal poverty guideline used to determine the family allowance in paragraph (b) 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.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2006, section 256B.059, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, and is not receiving home and community-based services under section 256B.0915, 256B.092, or 256B.49.

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

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

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

(3) the services are paid by the EW program under section 256B.0915 or the AC program under section 256B.0913 or would qualify for payment under the EW or AC programs if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

Sec. 21. Minnesota Statutes 2006, section 256B.059, subdivision 1a, is amended to read:

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

Sec. 22. Minnesota Statutes 2006, section 256B.0594, is amended to read:

256B.0594 PAYMENT OF BENEFITS FROM AN ANNUITY.

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

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department, if the issuer has notified the beneficiary of the requirements of this section at the time it initially requests payment information from the department.

Sec. 23. 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.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the institutionalized person or the institutionalized person's spouse is entitled but does not receive due to action by the institutionalized person, the 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 the institutionalized person's spouse.

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

(e) This section applies to the portion of any asset or interest that ~~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 the institutionalized person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the institutionalized person or institutionalized person's spouse while alive, based on estimated life expectancy ~~using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life~~ as determined according to the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity ~~described in this paragraph~~ purchased on or after March 1, 2002, that:

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

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

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

(f) 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 who has applied for or is receiving long-term care services or the ~~individual's~~ institutionalized person's spouse shall be treated as the disposal of an asset for 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

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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.

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Sec. 24. 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.

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

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

(3) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2006, section 256B.0595, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 27. Minnesota Statutes 2006, section 256B.0595, is amended by adding a subdivision to read:

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

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

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

(i) the transfer was to a family member;

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

(iii) the transfer was concealed;

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

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

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

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

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

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

(c) The cause of action is for the uncompensated amount of the transfer or the amount of medical assistance paid on behalf of the person, whichever is less. 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 the compensation received.

Sec. 28. Minnesota Statutes 2006, section 256B.0595, is amended by adding a subdivision to read:

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

(1) subdivision 1, paragraph (f);

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

(3) subdivision 3, paragraph (b);

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

(5) subdivision 8

on behalf of the claimant who must be the commissioner.

(b) Notwithstanding any other law to the contrary, a cause of action under subdivision 2, paragraph (a) or (b), or 8, must be commenced within six years of the date the local agency determines that a transfer was made for less than fair market value. Notwithstanding any other law to the contrary, a cause of action under subdivision 3,

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paragraph (b), or 4, clause (5), must be commenced within six years of the date of approval of a waiver of the penalty period for a transfer for less than fair market value based on undue hardship.

Sec. 29. Minnesota Statutes 2006, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services Policy Committee.** The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance, general assistance medical care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

Sec. 30. Minnesota Statutes 2006, section 256B.0625, subdivision 13g, is amended to 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. 31. Minnesota Statutes 2006, section 256B.0625, subdivision 13h, is amended to read:

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Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, excluding long-term care and group homes, if the service is ordered by the provider-directed care coordination team; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact

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requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups, shall convene an 11-member Medication Therapy Management Advisory Committee to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; two health plan company representatives; and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee expires on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance and general assistance medical care programs that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

Sec. 32. 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 dentist, 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 dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 33. Minnesota Statutes 2006, section 256B.075, subdivision 2, is amended to read:

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

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

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

Sec. 34. Minnesota Statutes 2006, section 256B.15, subdivision 4, is amended to read:

Subd. 4. **Other survivors.** (a) If the decedent who was single or the surviving 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. 35. Minnesota Statutes 2006, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to

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the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. ~~The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county-based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.~~

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one

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designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one ~~designee of the commissioner of health~~ person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

~~(f) Notwithstanding the requirement in this subdivision that a county must agree to initial enrollment on or before January 1, 1999, the commissioner shall grant a delay in the implementation of the county-based purchasing authorized in section 256B.692 until federal waiver authority and approval has been granted, if the county or group of counties has submitted a preliminary proposal for county-based purchasing by September 1, 1997, has not already implemented the prepaid medical assistance program before January 1, 1998, and has submitted a written request for the delay to the commissioner by July 1, 1998. In order for the delay to be continued, the county or group of counties must also submit to the commissioner the following information by December 1, 1998. The information must:~~

~~(1) identify the proposed date of implementation, as determined under section 256B.692, subdivision 5;~~

~~(2) include copies of the county board resolutions which demonstrate the continued commitment to the implementation of county-based purchasing by the proposed date. County board authorization may remain contingent on the submission of a final proposal which meets the requirements of section 256B.692, subdivision 5, paragraph (b);~~

~~(3) demonstrate actions taken for the establishment of a governance structure between the participating counties and describe how the fiduciary responsibilities of county-based purchasing will be allocated between the counties, if more than one county is involved in the proposal;~~

~~(4) describe how the risk of a deficit will be managed in the event expenditures are greater than total capitation payments. This description must identify how any of the following strategies will be used:~~

~~(i) risk contracts with licensed health plans;~~

~~(ii) risk arrangements with providers who are not licensed health plans;~~

~~(iii) risk arrangements with other licensed insurance entities; and~~

~~(iv) funding from other county resources;~~

~~(5) include, if county-based purchasing will not contract with licensed health plans or provider networks, letters of interest from local providers in at least the categories of hospital, physician, mental health, and pharmacy which express interest in contracting for services. These letters must recognize any risk transfer identified in clause (4), item (ii), and~~

~~(6) describe the options being considered to obtain the administrative services required in section 256B.692, subdivision 3, clauses (3) and (5).~~

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~~(g) For counties which receive a delay under this subdivision, the final proposals required under section 256B.692, subdivision 5, paragraph (b), must be submitted at least six months prior to the requested implementation date. Authority to implement county-based purchasing remains contingent on approval of the final proposal as required under section 256B.692.~~

~~(h) If the commissioner is unable to provide county-specific, individual-level fee-for-service claims to counties by June 4, 1998, the commissioner shall grant a delay under paragraph (f) of up to 12 months in the implementation of county-based purchasing, and shall require implementation not later than January 1, 2000. In order to receive an extension of the proposed date of implementation under this paragraph, a county or group of counties must submit a written request for the extension to the commissioner by August 1, 1998, must submit the information required under paragraph (f) by December 1, 1998, and must submit a final proposal as provided under paragraph (g).~~

~~(i) Notwithstanding other requirements of this subdivision, the commissioner shall not require the implementation of the county-based purchasing authorized in section 256B.692 until six months after federal waiver approval has been obtained for county-based purchasing, if the county or counties have submitted the final plan as required in section 256B.692, subdivision 5. The commissioner shall allow the county or counties which submitted information under section 256B.692, subdivision 5, to submit supplemental or additional information which was not possible to submit by April 1, 1999. A county or counties shall continue to submit the required information and substantive detail necessary to obtain a prompt response and waiver approval. If amendments to the final plan are necessary due to the terms and conditions of the waiver approval, the commissioner shall allow the county or group of counties 60 days to make the necessary amendments to the final plan and shall not require implementation of the county-based purchasing until six months after the revised final plan has been submitted.~~

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

Sec. 36. 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,

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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.

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

Sec. 37. Minnesota Statutes 2006, section 256B.69, subdivision 27, is amended to read:

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

Sec. 38. Minnesota Statutes 2006, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

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The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner may mail marketing materials to potential enrollees on behalf of health plans, in which case the health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 39. Minnesota Statutes 2006, section 256B.692, subdivision 7, is amended to read:

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the recommendation of a three-person mediation panel. The commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner

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of human services, and one ~~designee of the commissioner of health~~ person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

Sec. 40. Minnesota Statutes 2007 Supplement, section 256D.03, subdivision 3, is amended to read:

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. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. 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,

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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

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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.

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(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. 41. 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:

(1) a claim based on a contract with the personal representative, within four months after performance by the personal representative is due;

(2) any other claim, within four months after it arises.

(c) Nothing in this section affects or prevents:

(1) any proceeding to enforce any mortgage, pledge, or other lien upon property of the estate;

(2) any proceeding to establish liability of the decedent or the personal representative for which there is protection by liability insurance, to the limits of the insurance protection only;

(3) the presentment and payment at any time within one year after the decedent's death of any claim arising before the death of the decedent that is referred to in section 524.3-715, clause (18), although the same may be otherwise barred under this section; or

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(4) the presentment and payment at any time before a petition is filed in compliance with section 524.3-1001 or 524.3-1002 or a closing statement is filed under section 524.3-1003, of:

(i) any claim arising after the death of the decedent that is referred to in section 524.3-715, clause (18), although the same may be otherwise barred hereunder;

(ii) any other claim, including claims subject to clause (3), which would otherwise be barred hereunder, upon allowance by the court upon petition of the personal representative or the claimant for cause shown on notice and hearing as the court may direct.

Sec. 42. **NURSING FACILITY PENSION COSTS.**

The commissioner of human services shall evaluate the extent to which the alternative payment system reimbursement methodology for pension costs leads to funding shortfalls for nursing facilities that convert from public to private ownership. The commissioner shall report to the legislature by January 15, 2009, recommendations for any changes to the alternative payment system reimbursement methodology for pension costs necessary to ensure the financial viability of nursing facilities. The commissioner shall pay for any costs related to this study using existing resources.

Sec. 43. **NURSING FACILITY RATE DISPARITY REPORT.**

The commissioner of human services shall study and make a report to the legislature by January 15, 2009, with recommendations to reduce rate disparities between nursing facilities in various regions of the state. The recommendations shall include cost estimates and may include a phase-in schedule. The study shall be accomplished using existing resources.

Sec. 44. **HOME MODIFICATIONS.**

Effective upon federal approval, the costs associated with home modifications that add to the square footage of an unlicensed private residence when necessary to complete a modification to configure a bathroom to accommodate a wheelchair may be allowed expenses for home and community-based waiver services provided under Minnesota Statutes, sections 256B.0916 and 256B.49, for persons with disabilities when the following conditions are met:

(1) the annual cost of the care and modifications for the waiver recipient does not exceed the cost of care that would otherwise be incurred for the recipient without the modification, as determined by the local lead agency;

(2) the modification is based on the assessed needs, goals, and best interest of the recipient as identified in the plan of care;

(3) the modification has been found to be the least costly appropriate alternative after other alternatives have been explored through an evaluation by the local lead agency; and

(4) the modification is reasonable given the value and size of the home.

Sec. 45. **WAIVER AMENDMENT.**

The commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services consistent with section 44 by October 1, 2008.

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

Sec. 46. **APPROPRIATION.**

$65,000 is appropriated in the fiscal year beginning July 1, 2008, from the state government special revenue fund to the administrative services unit to pay for medical professional liability insurance coverage required under Minnesota Statutes, section 214.40. This appropriation shall become part of the base appropriation for the administrative services unit and shall be annually adjusted based on the cost of the coverage purchased to comply with Minnesota Statutes, section 214.40.

Sec. 47. **REPEALER.**

(a) Minnesota Statutes 2006, section 256B.0571, subdivision 8a, is repealed.

(b) Laws 2003, First Special Session chapter 5, section 11, is repealed.

ARTICLE 2

SEX OFFENDER PROGRAM

Section 1. Minnesota Statutes 2006, section 13.851, is amended by adding a subdivision to read:

Subd. 9. **Civil commitment of sexual offenders.** Data relating to the preparation of a petition to commit an individual as a sexual psychopathic personality or sexually dangerous person is governed by section 253B.185, subdivision 1b.

Sec. 2. Minnesota Statutes 2006, section 246B.02, is amended to read:

246B.02 ESTABLISHMENT OF MINNESOTA SEX OFFENDER PROGRAM.

The commissioner of human services shall establish and maintain a secure facility located in Moose Lake. The facility shall be operated by the Minnesota sex offender program. The program shall provide care and treatment in secure treatment facilities to persons on a court-hold order and residing in a secure treatment facility or program pending commitment or committed by the courts as sexual psychopathic personalities or sexually dangerous persons~~; or persons admitted there with the consent of the commissioner of human services~~.

Sec. 3. **[246B.06] ESTABLISHMENT OF MINNESOTA STATE INDUSTRIES.**

Subdivision 1. **Establishment; purpose.** (a) The commissioner of human services may establish, equip, maintain, and operate the Minnesota State Industries at any Minnesota sex offender program facility under this chapter. The commissioner may establish industrial and commercial activities for sex offender treatment patients as the commissioner deems necessary and suitable to the profitable employment, educational training, and development of proper work habits of patients consistent with the requirements in section 246B.05. The industrial and commercial activities authorized by this section are designated Minnesota State Industries and must be for the primary purpose of sustaining and ensuring Minnesota State Industries' self-sufficiency, providing educational training, meaningful employment, and the teaching of proper work habits to

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the patients of the Minnesota sex offender program under this chapter, and not solely as competitive business ventures.

(b) The net profits from Minnesota State Industries must be used for the benefit of the patients as it relates to building education and self-sufficiency skills. Prior to the establishment of any industrial and commercial activity, the commissioner of human services shall consult with stakeholders including representatives of business, industry, organized labor, the commissioner of education, the state Apprenticeship Council, the commissioner of labor and industry, the commissioner of employment and economic development, the commissioner of administration, and other stakeholders the commissioner deems qualified. The purpose of the stakeholder consultation is to determine the quantity and nature of the goods, wares, merchandise, and services to be made or provided, and the types of processes to be used in their manufacture, processing, repair, and production consistent with the greatest opportunity for the reform and educational training of the patients, and with the best interests of the state, business, industry, and labor.

(c) The commissioner of human services shall, at all times in the conduct of any industrial or commercial activity authorized by this section, utilize patient labor to the greatest extent feasible, provided that the commissioner may employ all administrative, supervisory, and other skilled workers necessary to the proper instruction of the patients and the profitable and efficient operation of the industrial and commercial activities authorized by this section.

(d) The commissioner of human services may authorize the director of any Minnesota sex offender treatment facility under the commissioner's control to accept work projects from outside sources for processing, fabrication, or repair, provided that preference is given to the performance of work projects for state departments and agencies.

Subd. 2. **Revolving fund.** As described in section 246B.05, subdivision 2, there is established a Minnesota State Industries revolving fund under the control of the commissioner of human services. The revolving fund must be used for Minnesota State Industries authorized under this section, including, but not limited to, the purchase of equipment and raw materials, the payment of salaries and wages, and other necessary expenses as determined by the commissioner of human services. The purchase of services, materials, and commodities used in and held for resale are not subject to the competitive bidding procedures of section 16C.06, but are subject to all other provisions of chapters 16B and 16C. When practical, purchases must be made from small targeted group businesses designated under section 16C.16. Additionally, the expenses of patient educational training and self-sufficiency skills may be financed from the revolving fund in an amount to be determined by the commissioner or designee. The proceeds and income from all Minnesota State Industries conducted at the Minnesota sex offender treatment facilities must be deposited in the revolving fund subject to disbursement under subdivision 3. The commissioner of human services may request that money in the fund be invested pursuant to section 11A.25. Proceeds from the investment not currently needed must be accounted for separately and credited to the revolving fund.

Subd. 3. **Disbursement from fund.** The Minnesota State Industries revolving fund must be deposited in the state treasury and paid out only on proper vouchers as authorized and approved by the commissioner of human services, and in the same manner and under the same restrictions as are now provided by law for the disbursement of funds by the commissioner. An amount deposited in the state treasury equal to six months of net operating cash as determined by the prior 12 months of revenue and cash flow

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statements must be restricted for use only by Minnesota State Industries as described under subdivision 2. For purposes of this subdivision, "net operating cash" means net income, minus sales, plus cost of goods sold. Cost of goods sold include all direct costs of industry products attributable to the goods' production.

Subd. 4. **Revolving fund; borrowing.** The commissioner of human services is authorized to borrow sums of money as the commissioner deems necessary to meet current demands on the Minnesota State Industries revolving fund. The sums borrowed must not exceed, in any calendar year, six months of net operating cash as determined by the previous 12 months of the industries' revenue and cash flow statements. If the commissioner of human services determines that borrowing of funds is necessary, the commissioner of human services shall certify this need to the commissioner of finance. Funds may be borrowed from general fund appropriations to the Minnesota sex offender program with the authorization of the commissioner of finance. Upon authorization of the commissioner of finance, the transfer must be made and credited to the Minnesota State Industries revolving fund. The sum transferred to the Minnesota State Industries revolving fund must be repaid by the commissioner of human services from the revolving fund to the fund from which it was transferred in a time period specified by the commissioner of finance, but by no later than the end of the biennium, as defined in section 16A.011, in which the loan is made. When any transfer is made to the Minnesota State Industries revolving fund, the commissioner of finance shall notify the commissioner of human services of the amount transferred to the fund and the date the transfer is to be repaid.

Subd. 5. **Federal grant fund transfers.** Grants received by the commissioner of human services from the federal government for any vocational training program or for administration by the commissioner of human services must (1) be credited to a federal grant fund and then (2) be transferred from the federal grant fund to the credit of the commissioner of human services in the appropriate account upon certification by the commissioner of human services that the amounts requested to be transferred have been earned or are required for the purposes of this section. Funds received by the federal grant fund need not be budgeted as such, provided transfers from the fund are budgeted for allotment purposes in the appropriate appropriation.

Subd. 6. **Wages.** Notwithstanding section 177.24 or any other law to the contrary, wages paid to patients working within this program are at the discretion of the commissioner of human services.

Sec. 4. Minnesota Statutes 2006, section 253B.045, subdivision 1, is amended to read:

Subdivision 1. **Restriction.** Except when ordered by the court pursuant to a finding of necessity to protect the life of the proposed patient or others, or as provided under subdivision 1a, no person subject to the provisions of this chapter shall be confined in a jail or correctional institution, except pursuant to chapter 242 or 244.

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

Sec. 5. Minnesota Statutes 2006, section 253B.045, is amended by adding a subdivision to read:

Subd. 1a. **Exception.** A person who is being petitioned for commitment under section 253B.185 and who is placed under a judicial hold order under section 253B.07, subdivision 2b or 7, may be confined at a Department of Corrections or a

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county correctional or detention facility, rather than a secure treatment facility, until a determination of the commitment petition as specified in this subdivision.

(a) A court may order that a person who is being petitioned for commitment under section 253B.185 be confined in a Department of Corrections facility pursuant to the judicial hold order under the following circumstances and conditions:

(1) The person is currently serving a sentence in a Department of Corrections facility and the court determines that the person has made a knowing and voluntary (i) waiver of the right to be held in a secure treatment facility and (ii) election to be held in a Department of Corrections facility. The order confining the person in the Department of Corrections facility shall remain in effect until the court vacates the order or the person's criminal sentence and conditional release term expire.

In no case may the person be held in a Department of Corrections facility pursuant only to this subdivision, and not pursuant to any separate correctional authority, for more than 210 days.

(2) A person who has elected to be confined in a Department of Corrections facility under this subdivision may revoke the election by filing a written notice of intent to revoke the election with the court and serving the notice upon the Department of Corrections and the county attorney. The court shall order the person transferred to a secure treatment facility within 15 days of the date that the notice of revocation was filed with the court, except that, if the person has additional time to serve in prison at the end of the 15-day period, the person shall not be transferred to a secure treatment facility until the person's prison term expires. After a person has revoked an election to remain in a Department of Corrections facility under this subdivision, the court may not adopt another election to remain in a Department of Corrections facility without the agreement of both parties and the Department of Corrections.

(3) Upon petition by the commissioner of corrections, after notice to the parties and opportunity for hearing and for good cause shown, the court may order that the person's place of confinement be changed from the Department of Corrections to a secure treatment facility.

(4) While at a Department of Corrections facility pursuant to this subdivision, the person shall remain subject to all rules and practices applicable to correctional inmates in the facility in which the person is placed including, but not limited to, the powers and duties of the commissioner of corrections under section 241.01, powers relating to use of force under section 243.52, and the right of the commissioner of corrections to determine the place of confinement in a prison, reformatory, or other facility.

(5) A person may not be confined in a Department of Corrections facility under this provision beyond the end of the person's executed sentence or the end of any applicable conditional release period, whichever is later. If a person confined in a Department of Corrections facility pursuant to this provision reaches the person's supervised release date and is subject to a period of conditional release, the period of conditional release shall commence on the supervised release date even though the person remains in the Department of Corrections facility pursuant to this provision. At the end of the later of the executed sentence or any applicable conditional release period, the person shall be transferred to a secure treatment facility.

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(6) Nothing in this section may be construed to establish a right of an inmate in a state correctional facility to participate in sex offender treatment. This section must be construed in a manner consistent with the provisions of section 244.03.

(b) The committing county may offer a person who is being petitioned for commitment under section 253B.185 and who is placed under a judicial hold order under section 253B.07, subdivision 2b or 7, the option to be held in a county correctional or detention facility rather than a secure treatment facility, under such terms as may be agreed to by the county, the commitment petitioner, and the commitment respondent. If a person makes such an election under this paragraph, the court hold order shall specify the terms of the agreement, including the conditions for revoking the election.

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

Sec. 6. Minnesota Statutes 2006, section 253B.045, subdivision 2, is amended to read:

Subd. 2. **Facilities.** Each county or a group of counties shall maintain or provide by contract a facility for confinement of persons held temporarily for observation, evaluation, diagnosis, treatment, and care. When the temporary confinement is provided at a regional treatment center, the commissioner shall charge the county of financial responsibility for the costs of confinement of persons hospitalized under section 253B.05, subdivisions 1 and 2, and section 253B.07, subdivision 2b, except that the commissioner shall bill the responsible health plan first. If the person has health plan coverage, but the hospitalization does not meet the criteria in subdivision 6 or section 62M.07, 62Q.53, or 62Q.535, the county is responsible. When a person is temporarily confined in a Department of Corrections facility solely under subdivision 1a, and not based on any separate correctional authority:

(1) the commissioner of corrections may charge the county of financial responsibility for the costs of confinement; and

(2) the Department of Human Services shall use existing appropriations to fund all remaining nonconfinement costs. The funds received by the commissioner for the confinement and nonconfinement costs are appropriated to the department for these purposes.

"County of financial responsibility" means the county in which the person resides at the time of confinement or, if the person has no residence in this state, the county which initiated the confinement. The charge for confinement in a facility operated by the commissioner of human services shall be based on the commissioner's determination of the cost of care pursuant to section 246.50, subdivision 5. When there is a dispute as to which county is the county of financial responsibility, the county charged for the costs of confinement shall pay for them pending final determination of the dispute over financial responsibility. Disputes about the county of financial responsibility shall be submitted to the commissioner to be settled in the manner prescribed in section 256G.09.

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

Sec. 7. Minnesota Statutes 2006, section 253B.18, subdivision 4c, is amended to read:

Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more panels of a special review board ~~for persons committed as mentally ill and dangerous to the public~~. The board shall consist of three members experienced in the field of mental

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illness. One member of each special review board panel shall be a psychiatrist and one member shall be an attorney. No member shall be affiliated with the Department of Human Services. The special review board shall meet at least every six months and at the call of the commissioner. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. A "reduction in custody" means transfer from a secure treatment facility~~; all petitions for~~, discharge, and provisional discharge~~, and revocation of provisional discharge; and make recommendations to the commissioner concerning them~~. Patients may be transferred by the commissioner between secure treatment facilities without a special review board hearing.

~~(b)~~ Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner.

(b) A petition filed by a person committed as mentally ill and dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under section 253B.185, or committed as both mentally ill and dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253B.185, subdivision 9.

Sec. 8. Minnesota Statutes 2006, section 253B.18, subdivision 5, is amended to read:

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for ~~an order of transfer, discharge, provisional discharge,~~ a reduction in custody or revocation of provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the treatment facility. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The medical director may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing. The board shall provide the commissioner with written findings of fact and recommendations within 21 days of the hearing. The commissioner shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be ~~sent by certified mail~~ mailed to every person entitled to statutory notice of the hearing within five days after it is signed. No order by the commissioner shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the commissioner agree that it may become effective sooner.

(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the commissioner. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the commissioner.

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(d) Prior to the final decision by the commissioner, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and commissioner must consider any statements received from victims under subdivision 5a.

Sec. 9. Minnesota Statutes 2006, section 253B.18, subdivision 5a, is amended to read:

Subd. 5a. **Victim notification of petition and release; right to submit statement.** (a) As used in this subdivision:

(1) "crime" has the meaning given to "violent crime" in section 609.1095, and includes criminal sexual conduct in the fifth degree and offenses within the definition of "crime against the person" in section 253B.02, subdivision 4a, and also includes offenses listed in section 253B.02, subdivision 7a, paragraph (b), regardless of whether they are sexually motivated;

(2) "victim" means a person who has incurred loss or harm as a result of a crime the behavior for which forms the basis for a commitment under this section or section 253B.185; and

(3) "convicted" and "conviction" have the meanings given in section 609.02, subdivision 5, and also include juvenile court adjudications, findings under Minnesota Rules of Criminal Procedure, Rule 20.02, that the elements of a crime have been proved, and findings in commitment cases under this section or section 253B.185 that an act or acts constituting a crime occurred.

(b) A county attorney who files a petition to commit a person under this section or section 253B.185 shall make a reasonable effort to provide prompt notice of filing the petition to any victim of a crime for which the person was convicted. In addition, the county attorney shall make a reasonable effort to promptly notify the victim of the resolution of the petition.

(c) Before provisionally discharging, discharging, granting pass-eligible status, approving a pass plan, or otherwise permanently or temporarily releasing a person committed under this section or section 253B.185 from a treatment facility, the head of the treatment facility shall make a reasonable effort to notify any victim of a crime for which the person was convicted that the person may be discharged or released and that the victim has a right to submit a written statement regarding decisions of the medical director, special review board, or commissioner with respect to the person. To the extent possible, the notice must be provided at least 14 days before any special review board hearing or before a determination on a pass plan. Notwithstanding section 611A.06, subdivision 4, the commissioner shall provide the judicial appeal panel with victim information in order to comply with the provisions of this section. The judicial appeal panel shall ensure that the data on victims remains private as provided for in section 611A.06, subdivision 4.

(d) This subdivision applies only to victims who have requested notification by contacting, in writing, the county attorney in the county where the conviction for the crime occurred. A county attorney who receives a request for notification under this paragraph shall promptly forward the request to the commissioner of human services.

(e) The rights under this subdivision are in addition to rights available to a victim under chapter 611A. This provision does not give a victim all the rights of a "notified person" or a person "entitled to statutory notice" under subdivision 4a, 4b, or 5.

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Sec. 10. Minnesota Statutes 2007 Supplement, section 253B.185, subdivision 1b, is amended to read:

Subd. 1b. **County attorney access to data.** Notwithstanding sections 144.291 to 144.298; 245.467, subdivision 6; 245.4876, subdivision 7; 260B.171; 260B.235, subdivision 8; 260C.171; and 609.749, subdivision 6, or any provision of chapter 13 or other state law, prior to filing a petition for commitment as a sexual psychopathic personality or as a sexually dangerous person, and upon notice to the proposed patient, the county attorney or the county attorney's designee may move the court for an order granting access to any records or data, to the extent it relates to the proposed patient, for the purpose of determining whether good cause exists to file a petition and, if a petition is filed, to support the allegations set forth in the petition.

The court may grant the motion if: (1) the Department of Corrections refers the case for commitment as a sexual psychopathic personality or a sexually dangerous person; or (2) upon a showing that the requested category of data or records may be relevant to the determination by the county attorney or designee. The court shall decide a motion under this subdivision within 48 hours after a hearing on the motion. Notice to the proposed patient need not be given upon a showing that such notice may result in harm or harassment of interested persons or potential witnesses.

Notwithstanding any provision of chapter 13 or other state law, a county attorney considering the civil commitment of a person under this section may obtain records and data from the Department of Corrections or any probation or parole agency in this state upon request, without a court order, for the purpose of determining whether good cause exists to file a petition and, if a petition is filed, to support the allegations set forth in the petition. At the time of the request for the records, the county attorney shall provide notice of the request to the person who is the subject of the records.

Data collected pursuant to this subdivision shall retain their original status and, if not public, are inadmissible in any court proceeding unrelated to civil commitment, unless otherwise permitted.

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

Sec. 11. Minnesota Statutes 2006, section 253B.185, subdivision 5, is amended to read:

Subd. 5. **Financial responsibility.** (a) For purposes of this subdivision, "state facility" has the meaning given in section 246.50 and also includes a Department of Corrections facility when the proposed patient is confined in such a facility pursuant to section 253B.045, subdivision 1a.

(b) Notwithstanding sections 246.54, 253B.045, and any other law to the contrary, when a petition is filed for commitment under this section pursuant to the notice required in section 244.05, subdivision 7, the state and county are each responsible for 50 percent of the cost of the person's confinement at a state facility or county jail, prior to commitment.

(c) The county shall submit an invoice to the state court administrator for reimbursement of the state's share of the cost of confinement.

(d) Notwithstanding paragraph (b), the state's responsibility for reimbursement is limited to the amount appropriated for this purpose.

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

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Sec. 12. Minnesota Statutes 2006, section 253B.185, is amended by adding a subdivision to read:

Subd. 9. **Petition for reduction in custody.** (a) This subdivision applies only to committed persons as defined in paragraph (b). The procedures in section 253B.18, subdivision 5a, for victim notification and right to submit a statement under section 253B.18 apply to petitions filed and reductions in custody recommended under this subdivision.

(b) As used in this subdivision:

(1) "committed person" means an individual committed under this section, or under this section and under section 253B.18, as mentally ill and dangerous. It does not include persons committed only as mentally ill and dangerous under section 253B.18; and

(2) "reduction in custody" means transfer out of a secure treatment facility, a provisional discharge, or a discharge from commitment. A reduction in custody is considered to be a commitment proceeding under section 8.01.

(c) A petition for a reduction in custody or an appeal of a revocation of provisional discharge may be filed by either the committed person or by the head of the treatment facility and must be filed with and considered by the special review board. A committed person may not petition the special review board any sooner than six months following either:

(1) the entry of judgment in the district court of the order for commitment issued under section 253B.18, subdivision 3, or upon the exhaustion of all related appeal rights in state court relating to that order, whichever is later; or

(2) any recommendation of the special review board or order of the judicial appeal panel, or upon the exhaustion of all appeal rights in state court, whichever is later. The medical director may petition at any time. The special review board proceedings are not contested cases as defined in chapter 14.

(d) The special review board shall hold a hearing on each petition before issuing a recommendation under paragraph (f). Fourteen days before the hearing, the committing court, the county attorney of the county of commitment, the designated agency, an interested person, the petitioner and the petitioner's counsel, and the committed person and the committed person's counsel must be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing.

(e) A person or agency receiving notice that submits documentary evidence to the special review board before the hearing must also provide copies to the committed person, the committed person's counsel, the county attorney of the county of commitment, the case manager, and the commissioner. The special review board must consider any statements received from victims under section 253B.18, subdivision 5a.

(f) Within 30 days of the hearing, the special review board shall issue written findings of fact and shall recommend denial or approval of the petition to the judicial appeal panel established under section 253B.19. The commissioner shall forward the recommendation of the special review board to the judicial appeal panel and to every person entitled to statutory notice. No reduction in custody or reversal of a revocation

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of provisional discharge recommended by the special review board is effective until it has been reviewed by the judicial appeal panel and until 15 days after an order from the judicial appeal panel affirming, modifying, or denying the recommendation.

Sec. 13. Minnesota Statutes 2006, section 253B.19, subdivision 2, is amended to read:

Subd. 2. **Petition; hearing.** ~~The committed person or the county attorney of the county from which a patient was committed as a person who is mentally ill and dangerous to the public, or as a sexual psychopathic personality or as a sexually dangerous person may petition the appeal panel for a rehearing and reconsideration of a decision by the commissioner. The petition shall be filed with the Supreme Court within 30 days after the decision of the commissioner is signed. The Supreme Court shall refer the petition to the chief judge of the appeal panel.~~ (a) A person committed as mentally ill and dangerous to the public under section 253B.18, or the county attorney of the county from which the person was committed or the county of financial responsibility, may petition the judicial appeal panel for a rehearing and reconsideration of a decision by the commissioner under section 253B.18, subdivision 5. The judicial appeal panel must not consider petitions for relief other than those considered by the commissioner from which the appeal is taken. The petition must be filed with the Supreme Court within 30 days after the decision of the commissioner is signed. The hearing must be held within 45 days of the filing of the petition unless an extension is granted for good cause.

(b) A person committed as a sexual psychopathic personality or as a sexually dangerous person under section 253B.185, or committed as both mentally ill and dangerous to the public under section 253B.18 and as a sexual psychopathic personality or as a sexually dangerous person under section 253B.185; the county attorney of the county from which the person was committed or the county of financial responsibility; or the commissioner may petition the judicial appeal panel for a rehearing and reconsideration of a decision of the special review board under section 253B.185, subdivision 9. The petition must be filed with the Supreme Court within 30 days after the decision is mailed by the commissioner as required in section 253B.185, subdivision 9, paragraph (f). The hearing must be held within 180 days of the filing of the petition unless an extension is granted for good cause. If no party petitions the judicial appeal panel for a rehearing or reconsideration within 30 days, the judicial appeal panel shall either issue an order adopting the recommendations of the special review board or set the matter on for a hearing pursuant to this paragraph.

(c) For an appeal under paragraph (a) or (b), the Supreme Court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the commissioner, the head of the treatment facility, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing. ~~The hearing shall be within 45 days of the filing of the petition unless an extension is granted for good cause.~~

(d) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the commissioner shall participate as parties to the proceeding pending before the judicial appeal panel and shall, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position. The judicial appeal panel may appoint examiners and may adjourn the hearing from time to time. It shall hear

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and receive all relevant testimony and evidence and make a record of all proceedings. The patient, the patient's counsel, and the county attorney of the committing county ~~may~~ or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party bears the burden of going forward with the evidence. The party opposing discharge bears the burden of proof by clear and convincing evidence that the respondent is in need of commitment.

Sec. 14. Minnesota Statutes 2006, section 253B.19, subdivision 3, is amended to read:

Subd. 3. **Decision.** A majority of the judicial appeal panel shall rule upon the petition. The panel shall consider the petition de novo. The order of the judicial appeal panel shall supersede ~~the~~ an order of the commissioner ~~in the cases~~ under section 253B.18, subdivision 5. No order of the judicial appeal panel granting a transfer, discharge or provisional discharge shall be made effective sooner than 15 days after it is issued. The panel may not consider petitions for relief other than those considered by the commissioner or special review board from which the appeal is taken. The judicial appeal panel may not grant a transfer or provisional discharge on terms or conditions that were not presented to the commissioner or the special review board.

Sec. 15. Minnesota Statutes 2006, section 626.5572, subdivision 21, is amended to read:

Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, and 256B.0653 to 256B.0656; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

Sec. 16. **MINNESOTA SEX OFFENDER PROGRAM; OPERATING STANDARDS.**

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The commissioner of human services shall convene a working group of interested parties to develop standards and guidelines for the operations of the Minnesota sex offender program. The standards and guidelines shall include, but not be limited to:

(1) criteria to establish a sex offender treatment advisory board;

(2) criteria to ensure the necessary provision of health and dental care for patients;

(3) criteria to ensure the necessary provision of mental health care; and

(4) fire and safety criteria.

The standards and guidelines shall be developed by the commissioner in consultation with the working group members by February 1, 2009, and presented to the chairs of the policy and finance committees having jurisdiction over the Minnesota sex offender program for review.

ARTICLE 3

MFIP

Section 1. Minnesota Statutes 2007 Supplement, section 256J.49, subdivision 13, is amended to read:

Subd. 13. **Work activity.** "Work activity" means any activity in a participant's approved employment plan that leads to employment. For purposes of the MFIP program, this includes activities that meet the definition of work activity under the participation requirements of TANF. Work activity includes:

(1) unsubsidized employment, including work study and paid apprenticeships or internships;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69, on-the-job training as specified in section 256J.66, ~~the self-employment investment demonstration program (SEID) as specified in section 256J.65,~~ paid work experience, and supported work when a wage subsidy is provided;

(3) unpaid work experience, including community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided. Unpaid work experience is only an option if the participant has been unable to obtain or maintain paid employment in the competitive labor market, and no paid work experience programs are available to the participant. Prior to placing a participant in unpaid work, the county must inform the participant that the participant will be notified if a paid work experience or supported work position becomes available. Unless a participant consents in writing to ~~participating~~ participate in unpaid work experience, the participant's employment plan may only include unpaid work experience if including the unpaid work experience in the plan will meet the following criteria:

(i) the unpaid work experience will provide the participant specific skills or experience that cannot be obtained through other work activity options where the participant resides or is willing to reside; and

(ii) the skills or experience gained through the unpaid work experience will result in higher wages for the participant than the participant could earn without the unpaid work experience;

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(4) job search including job readiness assistance, job clubs, job placement, job-related counseling, and job retention services;

(5) job readiness education, including English as a second language (ESL) or functional work literacy classes as limited by the provisions of section 256J.531, subdivision 2, general educational development (GED) course work, high school completion, and adult basic education as limited by the provisions of section 256J.531, subdivision 1;

(6) job skills training directly related to employment, including education and training that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;

(7) providing child care services to a participant who is working in a community service program;

(8) activities included in the employment plan that is developed under section 256J.521, subdivision 3; and

(9) preemployment activities including chemical and mental health assessments, treatment, and services; learning disabilities services; child protective services; family stabilization services; or other programs designed to enhance employability.

ARTICLE 4

MANAGED CARE CONTRACT

Section 1. Laws 2005, First Special Session chapter 4, article 8, section 84, as amended by Laws 2006, chapter 264, section 15, is amended to read:

Sec. 84. **SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.**

(a) Notwithstanding Minnesota Statutes, section 256B.692, subdivision 6, clause (1), paragraph (c), the commissioner of human services shall approve a county-based purchasing health plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, that requires county-based purchasing on a single-plan basis contract if the implementation of the single-plan purchasing proposal does not limit an enrollee's provider choice or access to services and all other requirements applicable to health plan purchasing are satisfied. ~~The commissioner shall continue single health plan purchasing arrangements with county-based purchasing entities in the service areas in existence on May 1, 2006, including arrangements for which a proposal was submitted by May 1, 2006, on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, in response to a request for proposals issued by the commissioner.~~ The commissioner shall continue to use single-health plan, county-based purchasing arrangements for medical assistance and general assistance medical care programs and products for the counties that were in single-health plan, county-based purchasing arrangements on March 1, 2008. This paragraph does not require the commissioner to terminate an existing contract with a noncounty-based purchasing plan that had enrollment in a medical assistance program or product in these counties on March 1, 2008. This paragraph expires on December 31, 2010, or the effective date of a new contract for medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's next scheduled reprocurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

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(b) The commissioner shall consider, and may approve, contracting on a single-health plan basis with other county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons with a disability who voluntarily enroll, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in Minnesota Statutes, section 256B.69, subdivision 23, are satisfied. ~~By January 15, 2007, the commissioner shall report to the chairs of the appropriate legislative committees in the house and senate an analysis of the advantages and disadvantages of using single-health plan purchasing to serve persons with a disability who are eligible for health care programs. The report shall include consideration of the impact of federal health care programs and policies for persons who are eligible for both federal and state health care programs and shall consider strategies to improve coordination between federal and state health care programs for those persons.~~ Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).

Presented to the governor May 12, 2008

Signed by the governor May 15, 2008, 6:25 p.m.

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