CHAPTER 203—S.F.No. 1407

An act relating to human services; modifying provisions in health care access programs; amending Minnesota Statutes 2000, sections 245B.02, by adding a subdivision; 245B.03, subdivision 1; 252.28, subdivisions 3a and 3b; 256B.056, subdivisions 1a and 5a; 256B.0595, subdivisions 1 and 2; 256B.0625, subdivision 9; 256B.071, subdivision 2; 256B.094, subdivisions 6 and 8; 256B.5013, subdivision 1; 256B.69, subdivision 3a; 256D.03, subdivision 3; and 256L.15, subdivision 1a; Laws 1996, chapter 451, article 2, sections 61 and 62; repealing Minnesota Statutes 2000, section 256B.071, subdivision 5; Laws 1995, chapter 178, article 2, section 46, subdivision 10; Laws 1996, chapter 451, article 2, sections 12, 14, 16, 18, 29, and 30.

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

Section 1. Minnesota Statutes 2000, section 245B.02, is amended by adding a subdivision to read:

Subd. 23a. **SUPPORTED EMPLOYMENT.** "Supported employment" services include individualized counseling, individualized job development and placement that produce an appropriate job match for the individual and the employer, on-the-job training in work and related work skills required for job performance, ongoing supervision and monitoring of the person's performance, long-term support services to assure job retention, training in related skills essential to obtaining and retaining employment such as the effective use of community resources, use of break and lunch areas, transportation and mobility training, and transportation between the individual's place of residence and the work place when other forms of transportation are unavailable or inaccessible.

Sec. 2. Minnesota Statutes 2000, section 245B.03, subdivision 1, is amended to read:

Subdivision 1. **APPLICABILITY.** The standards in this chapter govern services to persons with mental retardation or related conditions receiving services from license holders providing residential-based habilitation; day training and habilitation services for adults; supported employment; semi-independent living services; residential programs that serve more than four consumers, including intermediate care facilities for persons with mental retardation; and respite care provided outside the consumer's home for more than four consumers at the same time at a single site.

Sec. 3. Minnesota Statutes 2000, section 252.28, subdivision 3a, is amended to read:

Subd. 3a. **LICENSING EXCEPTION.** (a) Notwithstanding the provisions of subdivision 3, the commissioner may license service sites, each accommodating up to six residents moving from a 48-bed intermediate care facility for persons with mental retardation or related conditions located in Dakota county that is closing under section 252.292.

(b) Notwithstanding the provisions of any other state law or administrative rule, the rate provisions of section 256I.05, subdivision 1, apply to the exception in this subdivision.

(c) If a service site is licensed for six persons according to this subdivision, the capacity of the license may remain at six persons.

Sec. 4. Minnesota Statutes 2000, section 252.28, subdivision 3b, is amended to read:

Subd. 3b. **OLMSTED COUNTY LICENSING EXEMPTION.** (a) Notwithstanding subdivision 3, the commissioner may license service sites each accommodating up to five residents moving from a 43-bed intermediate care facility for persons with mental retardation or related conditions located in Olmsted county that is closing under section 252.292.

(b) Notwithstanding the provisions of any other state law or administrative rule, the rate provisions of section 256I.05, subdivision 1, apply to the exception in this subdivision.

(c) If a service site is licensed for five persons according to this subdivision, the capacity of the license may remain at five persons.

Sec. 5. Minnesota Statutes 2000, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **INCOME AND ASSETS GENERALLY.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, shall be used. ~~Effective upon federal approval, in kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient.~~ For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 6. Minnesota Statutes 2000, section 256B.056, subdivision 5a, is amended to read:

Subd. 5a. **INDIVIDUALS ON FIXED OR EXCLUDED INCOME.** Recipients of medical assistance who receive only fixed unearned or excluded income, ~~where such~~ when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.

Sec. 7. Minnesota Statutes 2000, 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 person or the 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 person, a 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 person or 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. 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 medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, 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 person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the 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. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, 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 person or the person's spouse is entitled but does not receive due to action by the person, the 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 person or the person's spouse.

(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 person, a 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 person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to

be returned to the person or 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. The commissioner may adopt rules reducing life expectancies based on the need for long-term care.

(f) 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 mental retardation, 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 mental retardation or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

~~(g) Effective for transfers made on or after July 1, 1995, or upon federal approval, whichever is later, a person, a 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 person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long-term care services, any transfer of such assets within 60 months before, or any time after, an institutionalized person applies for medical assistance, or 60 months before, or any time after, a medical assistance recipient becomes institutionalized, 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 person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the 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.~~

Sec. 8. Minnesota Statutes 2000, 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 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 in the month the first uncompensated transfer was made. If the transfer was not reported to the local agency at the time of application, and the applicant 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 services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

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

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

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

(c) 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, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $500, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

Sec. 9. Minnesota Statutes 2000, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **DENTAL SERVICES.** Medical assistance covers dental services. Dental services include, with prior authorization, fixed ~~cast metal restorations~~ bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

Sec. 10. Minnesota Statutes 2000, section 256B.071, subdivision 2, is amended to read:

Subd. 2. **TECHNICAL ASSISTANCE TO PROVIDERS.** (a) The commissioner shall establish a technical assistance program to require providers of services and equipment under this section to maximize collections from the federal Medicare program. The technical assistance may include the provision of materials to help providers determine those services and equipment likely to be reimbursed by Medicare. ~~The technical assistance may also include the provision of computer software to providers to assist in this process. The commissioner may expand the technical assistance program to include providers of other services under this chapter.~~

(b) Any provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical assistance waiver programs, is required to use the method developed and supplied by the department of human services for determining Medicare coverage for home care equipment and services provided to dual entitlees to ensure appropriate billing of Medicare. ~~The method will be developed in two phases; the first phase is a manual system effective July 1, 1996, and the second phase will automate the manual procedure by expanding the current Medicaid Management Information System (MMIS) effective January 1, 1997. Both methods will determine Medicare coverage for the dates of service and Medicare coverage for home care services, and create an audit trail including reports. Both methods will be linked to prior authorization, therefore, either method must be used before home care services are authorized and when there is a change of condition affecting medical assistance authorization. The department will conduct periodic reviews of participant performance with the method and upon demonstrating appropriate referral and billing of Medicare, participants may be determined exempt from regular performance audits.~~

Sec. 11. Minnesota Statutes 2000, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **MEDICAL ASSISTANCE REIMBURSEMENT OF CASE MANAGEMENT SERVICES.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, section 260.851, and the placement in either case is more than

60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8.

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 12. Minnesota Statutes 2000, section 256B.094, subdivision 8, is amended to read:

Subd. 8. **PAYMENT LIMITATION.** Services that are not eligible for payment as a child welfare targeted case management service include, but are not limited to:

(1) assessments prior to opening a case;

(2) therapy and treatment services;

(3) legal services, including legal advocacy, for the client;

(4) information and referral services that are part of a county's community social services plan, that are not provided to an eligible recipient;

(5) outreach services including outreach services provided through the community support services program;

(6) services that are not documented as required under subdivision 7 and Minnesota Rules, parts ~~9505.1800 to 9505.1880~~ 9505.2165 and 9505.2175;

(7) services that are otherwise eligible for payment on a separate schedule under rules of the department of human services;

(8) services to a client that duplicate the same case management service from another case manager;

(9) case management services provided to patients or residents in a medical assistance facility except as described under subdivision 2, clause (9); and

(10) for children in foster care, group homes, or residential care, payment for case management services is limited to case management services that focus on permanency planning or return to the family home and that do not duplicate the facility's discharge planning services.

Sec. 13. Minnesota Statutes 2000, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **VARIABLE RATE ADJUSTMENTS.** For rate years beginning on or after October 1, 2000, when there is a documented increase in the resource needs of a current ICF/MR recipient or recipients, or a person is admitted to a facility who requires additional resources, the county of financial responsibility may recommend approval of a variable rate to enable the facility to meet the individual's increased needs ~~based on the recipient's screening~~. Variable rate adjustments made under this subdivision replace payments for persons with special needs under section 256B.501, subdivision 8, and payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. Resource needs directly attributable to an individual that may be considered under the variable rate adjustment include increased direct staff hours ~~and~~, other specialized services, and equipment~~, and human resources~~. The guidelines in paragraphs (a) to (d) apply for the payment rate adjustments under this section.

(a) All persons must be screened according to section 256B.092, subdivisions 7 and 8, prior to implementation of the new payment system, and annually thereafter, and when a variable rate is being requested due to changes in the needs of the recipient. ~~Screening data shall be analyzed to develop broad profiles of the functional characteristics of recipients.~~ Screening data shall be used to monitor changes as follows:

~~Criteria to be used to develop these profiles shall include, but not be limited to:~~

(1) the functional ability of a recipient to care for and maintain the recipient's own basic needs;

(2) the intensity of any aggressive or destructive behavior; and

(3) any history of obstructive behavior in combination with a diagnosis of psychosis or neurosis~~;~~.

(b) A variable rate may be recommended for increased service needs such as:

~~(4)~~ (1) a need for resources due to a change in resident day program participation because the resident: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the ~~developmental disabilities~~ mental retardation and related conditions screening process under section 256B.092; and

~~(5)~~ (2) a need for additional resources for intensive short-term ~~training~~ programming which is necessary prior to a recipient's discharge to a less restrictive, more integrated setting.

~~The recipients' screenings~~ Recommendations for a variable rate shall be used to link resource needs to funding. ~~The resource profile shall determine the level of funding.~~ The variable rate must be applied to expenses related to increased direct staff hours ~~and~~, other specialized services, and equipment~~, and human resources~~.

~~(b)~~ (c) A recipient must be screened by the county of financial responsibility using the developmental disabilities screening document completed immediately prior to approval of a variable rate by the county. A comparison of the updated screening and the previous screening must demonstrate an increase in resource needs.

~~(c)~~ (d) Rate adjustments projected to exceed the authorized funding level associated with the person's profile must be submitted to the commissioner.

~~(d)~~ (e) The county of financial responsibility must indicate the projected length of time that the additional funding may be needed for the individual. The need to continue an individual variable rate must be reviewed at the end of the anticipated duration of need but at least annually through the completion of the developmental disabilities screening document.

Sec. 14. Minnesota Statutes 2000, 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 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) ~~The commissioner shall seek a federal waiver to allow a fee-for-service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256L.06 up to 20 percent of the premium fees for the enrollees who elect the fee-for-service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.~~

~~(c)~~ 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.

~~(d)~~ (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.

~~(e)~~ (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 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.

~~(f)~~ (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.

~~(g)~~ (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).

~~(h)~~ (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.

~~(i)~~ (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 ~~(g)~~ (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 ~~(g)~~ (f) by December 1, 1998, and must submit a final proposal as provided under paragraph ~~(h)~~ (g).

~~(j)~~ (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.

Sec. 15. Minnesota Statutes 2000, 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-statewide (MFIP-S), who is having a payment made on the person's behalf under sections 256I.01 to 256I.06, or who resides in group residential housing as defined in chapter 256I and can meet a spenddown using the cost of remedial services received through group residential housing; or

(2)(i) who is a resident of Minnesota; and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in chapter 256B, 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; and

(ii) who has countable income not in excess of the assistance standards established in section 256B.056, subdivision 4, or whose excess income is spent down according to section 256B.056, subdivision 5, using a six-month budget period. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall follow section 256B.056, subdivision 1a. However, if a disregard of $30 and one-third of the remainder has been applied to the wage earner's income, the disregard shall not be applied again until the wage earner's income has not been considered in an eligibility determination for general assistance, general assistance medical care, medical assistance, or MFIP-S for 12 consecutive months. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first $50 of earned income is not allowed;

(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal Health Care Financing

Administration to be an institution for mental diseases; or

(4) who is ineligible for medical assistance under chapter 256B or general assistance medical care under any other provision of this section, and is receiving care and rehabilitation services from a nonprofit center established to serve victims of torture. These individuals are eligible for general assistance medical care only for the period during which they are receiving services from the center. During this period of eligibility, individuals eligible under this clause shall not be required to participate in prepaid general assistance medical care.

(b) Beginning January 1, 2000, applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are:

(i) adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines; or

(ii) adults without children with earned income and whose family gross income is between 75 percent of the federal poverty guidelines and the amount set by section 256L.04, subdivision 7, shall be terminated from general assistance medical care upon enrollment in MinnesotaCare. Earned income is deemed available to family members as defined in section 256D.02, subdivision 8.

(c) For services rendered on or after July 1, 1997, eligibility is limited to one month prior to application if the person is determined eligible in the prior month. A redetermination of eligibility must occur every 12 months. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the department of human services or sent directly to the department of human services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are 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 paragraph (e).

(d) 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 an initial application when health care is delivered due to a medical condition or disability, a health care provider may act on the person's behalf to complete the initial application. 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. On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) has gross income less than 90 percent of the applicable income standard;

(2) has liquid assets that total within $300 of the asset standard;

(3) does not reside in a long-term care facility; and

(4) meets all other eligibility requirements.

The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.

(e) 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.

(f) 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.

(g) 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. General assistance medical care is limited to payment of emergency services only for applicants or recipients as described in paragraph (b), whose MinnesotaCare coverage is denied or terminated for nonpayment of premiums as required by sections 256L.06 and 256L.07.

(h) In determining the amount of assets of an individual, 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.

(i) 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 Number 104-193, sections 421 and 422, and subsequently set out in federal rules.

(j)(1) An undocumented noncitizen or a nonimmigrant is ineligible for general assistance medical care other than emergency services. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(2) This paragraph does not apply to a child under age 18, to a Cuban or Haitian entrant as defined in Public Law Number 96-422, section 501(e)(1) or (2)(a), or to a noncitizen who is aged, blind, or disabled as defined in Code of Federal Regulations, title 42, sections 435.520, 435.530, 435.531, 435.540, and 435.541, or effective October 1, 1998, to an individual eligible for general assistance medical care under paragraph (a), clause (4), who cooperates with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify the individual for medical assistance with federal financial participation.

(k) For purposes of paragraphs (g) and (j), "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.

(l) 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.

Sec. 16. Minnesota Statutes 2000, section 256L.15, subdivision 1a, is amended to read:

Subd. 1a. **PAYMENT OPTIONS.** The commissioner may offer the following payment options to an enrollee:

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by one-time electronic transfer of funds;

(5) payment by wage withholding with the consent of the employer and the employee; or

(6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's ~~state income tax~~ refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation ~~for the forthcoming year~~. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

Sec. 17. Laws 1996, chapter 451, article 2, section 61, is amended to read:

Sec. 61. **REPEALER.**

Minnesota Statutes 1995 Supplement, sections ~~256B.15, subdivision 5;~~ 256G.05, subdivision 1; and 256G.07, subdivision 3a, are repealed.

Sec. 18. Laws 1996, chapter 451, article 2, section 62, is amended to read:

Sec. 62. **EFFECTIVE DATE; APPLICATION.**

(a) ~~Sections 12, 14, 16, 18, 29, 30, and the portion of section 61 that repeals section 256B.15, subdivision 5, are effective the day following final enactment to the extent permitted by federal law. If any provisions of these sections are prohibited by federal law, the provisions shall become effective when federal law is changed to permit their application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.~~

~~(b) If, by July 1, 1996, any provisions of the sections mentioned in paragraph (a) are not effective because of prohibitions in federal law, the commissioner shall apply to the federal government for a waiver of those prohibitions, and those provisions shall become effective upon receipt of a federal waiver, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. If the commissioner applies for a waiver of the lookback period, the commissioner shall seek the longest lookback period the health care financing administration will approve, not to exceed 72 months.~~

~~(c)~~ Section 54 applies to estates of decedents dying on or after its effective date. Section 55 applies to estates where the notice under Minnesota Statutes, section 524.3-801, paragraph (a), was first published on or after its effective date. Section 55 does not affect any right or duty to provide notice to known creditors, including a local agency, before its effective date.

~~(d)~~ (b) Sections 7, 13, 15, 17, 33, 34, 35, 38, and 60 are effective the day following final enactment.

~~(e)~~ (c) Section 11 is effective retroactive to October 1, 1993.

~~(f)~~ (d) Sections 8, 22, subdivision 3, and 34 are effective upon federal approval.

New language is indicated by underline, deletions by ~~strikeout.~~

~~(g)~~ (e) Sections 10 and 31 are effective upon receipt of federal approval, retroactive to January 1, 1996.

Sec. 19. **REPEALER.**

(a) Laws 1995, chapter 178, article 2, section 46, subdivision 10; and Laws 1996, chapter 451, article 2, sections 12, 14, 16, 18, 29, and 30, are repealed.

(b) Minnesota Statutes 2000, section 256B.071, subdivision 5, is repealed.

Presented to the governor May 25, 2001

Signed by the governor May 29, 2001, 11:23 a.m.

CHAPTER 204—S.F.No. 103

An act relating to civil actions; changing civil penalties for issuing checks that are dishonored; providing civil remedies for receiving motor fuel from a motor fuel retail business without paying for it; amending Minnesota Statutes 2000, section 332.50; proposing coding for new law in Minnesota Statutes, chapter 332.

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

Section 1. Minnesota Statutes 2000, section 332.50, is amended to read:

332.50 ~~CIVIL LIABILITY FOR~~ **ISSUANCE OF WORTHLESS CHECK.**

Subdivision 1. **DEFINITIONS.** (a) The definitions provided in this subdivision apply to this section.

(b) "Check" means a check, draft, order of withdrawal, or similar negotiable or nonnegotiable instrument.

(c) "Credit" means an arrangement or understanding with the drawee for the payment of the check.

(d) "Dishonor" has the meaning given in section 336.3-502, but does not include dishonor due to a stop payment order requested by an issuer who has a good faith defense to payment on the check. "Dishonor" does include a stop payment order requested by an issuer if the account did not have sufficient funds for payment of the check at the time of presentment, except for stop payment orders on a check found to be stolen.

(e) "Payee" or "holder" includes an agent of the payee or holder.

Subd. 2. **ACTS CONSTITUTING.** Whoever issues any check that is dishonored is liable for the following penalties:

(a) A service charge ~~of up to $20, or actual costs of collection,~~ not to exceed $30, may be imposed immediately on any dishonored check by the payee or holder of the check, regardless of mailing a notice of dishonor, if notice of the service charge was