CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

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256B.02 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1980]

Subd. 8. "Medical assistance" or "medical care" means payment of part or all of the cost of the following care and services for eligible individuals whose income and resources are insufficient to meet all of such cost:

(1) Inpatient hospital services.

(2) Skilled nursing home services and services of intermediate care facilities.

(3) Physicians' services.

(4) Outpatient hospital or clinic services.

(5) Home health care services.

(6) Private duty nursing services.

(7) Physical therapy and related services.

(8) Dental services, excluding cast metal restorations.

(9) Laboratory and x-ray services.

(10) The following if prescribed by a licensed practitioner: drugs, eyeglasses, dentures, and prosthetic devices. The commissioner shall designate a formulary committee which shall advise the commissioner on the names of drugs for which payment shall not be made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of public welfare, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of public welfare, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve two year terms and shall serve without compensation. Promulgation of the formulary shall be consistent with the requirements of section 15.0412, subdivision 5. Payment to drug vendors shall not be modified before the formulary is promulgated. The commissioner may promulgate conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(11) Diagnostic, screening, and preventive services.

(12) Health care pre-payment plan premiums and insurance premiums if paid directly to a vendor and supplementary medical insurance benefits under Title XVIII of the Social Security Act.

(13) Abortion services, but only if one of the following conditions is met:

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(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, clauses (c), (d), (e)(i), and (f), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.

(14) Transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by non-ambulatory persons in obtaining emergency or non-emergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this clause, a person who is incapable of transport by taxicab or bus shall be considered to be non-ambulatory.

(15) To the extent authorized by rule of the state agency, costs of bus or taxicab transportation incurred by any ambulatory eligible person for obtaining non-emergency medical care.

(16) Any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law.

[For text of subds 9 and 10, see M.S.1980]

History: *1981 c 360 art 2 s 26; 1Sp1981 c 2 s 12*

NOTE: The amendments to subdivision 8 by Laws 1981, Chapter 360, Article 2, Section 26 are repealed by Laws 1981, Chapter 360, Article 2, Section 54, as amended by First Special Session Laws 1981, Chapter 4, Article 4, Section 22, effective June 30, 1983.

256B.03 PAYMENTS TO VENDORS.

Subdivision 1. **General limit.** All payments for medical assistance hereunder must be made to the vendor.

Subd. 2. **Limit on annual increase to long-term care providers.** Notwithstanding the provisions of sections 256B.42 to 256B.48, Laws 1981, Chapter 360, Article II, Section 2, or any other provision of chapter 360, and rules promulgated under those sections, rates paid to a skilled nursing facility or an intermediate care facility, including boarding care facilities and supervised living facilities, except state owned and operated facilities, for rate years beginning during the biennium ending June 30, 1983, shall not exceed by more than ten percent the final rate allowed to the facility for the preceding rate year.

Notwithstanding provisions of section 256B.45, subdivision 1, the commissioner shall not increase the percentage for investment allowances.

History: *1981 c 360 art 2 s 27; 1Sp1981 c 2 s 13*

NOTE: The amendment to this section by Laws 1981, Chapter 360, Article 2, Section 27 is repealed by Laws 1981, Chapter 360, Article 2, Section 54, as amended by First Special Session Laws 1981, Chapter 4, Article 4, Section 22 effective June 30, 1983.

256B.06 ELIGIBILITY REQUIREMENTS.

Subdivision 1. Medical assistance may be paid for any person:

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(1) Who is eligible for or receiving public assistance under the aid to families with dependent children program; or

(2) Who is eligible for or receiving supplemental security income for the aged, blind and disabled; or

(3) Who except for the amount of income or resources would qualify for supplemental security income for the aged, blind and disabled, or aid to families with dependent children and is in need of medical assistance; or

(4) Who is under 21 years of age and in need of medical care that neither he nor his relatives responsible under sections 256B.01 to 256B.26 are financially able to provide; or

(5) Who is residing in a hospital for treatment of mental disease or tuberculosis and is 65 years of age or older and without means sufficient to pay the per capita hospital charge; and

(6) Who resides in Minnesota, or, if absent from the state, is deemed to be a resident of Minnesota in accordance with the regulations of the state agency; and

(7) Who alone, or together with his spouse, does not own real property other than the homestead. For the purposes of this section, "homestead" means the house owned and occupied by the applicant as his dwelling place, together with the land upon which it is situated and an area no greater than two contiguous lots in a platted or laid out city or town or the smallest parcel allowed under applicable zoning regulations in unplatted land. Real estate not used as a home may not be retained unless it produces net income applicable to the family's needs or the family is making a continuing effort to sell it at a fair and reasonable price or unless sale of the real estate would net an insignificant amount of income applicable to the family's needs, or unless the commissioner determines that sale of the real estate would cause undue hardship; and

(8) Who individually does not own more than $2,000 in cash or liquid assets, or if a member of a household with two family members (husband and wife, or parent and child), does not own more than $4,000 in cash or liquid assets, plus $200 for each additional legal dependent. When only one spouse resides, or will reside after applying for medical assistance, in a nursing home, or is receiving or will receive alternative care under the alternative care grants program in a county with preadmission screening under section 256B.091, the cash or liquid asset amount for two family members is $10,000. The value of the following shall not be included:

(a) the homestead, and (b) one motor vehicle licensed pursuant to chapter 168 and defined as: (1) passenger automobile, (2) station wagon, (3) motorcycle, (4) motorized bicycle or (5) truck of the weight found in categories A to E, of section 168.013, subdivision 1e; and

(9) Who has or anticipates receiving an annual income not in excess of $2,600 for a single person, or $3,250 for two family members (husband and wife, parent and child, or two siblings), plus $625 for each additional legal dependent, or who has income in excess of these maxima and in the month of application, or during the three months prior to the month of application, incurs expenses for medical care that total more than one-half of the annual excess income in accordance with the regulations of the state agency. In computing income to determine eligibility of persons who are not residents of long term care facilities, the commissioner shall disregard increases in income of social security or supplementary security income recipients due solely to increases required by sections 215(i) and 1617 of the social security act, and shall disregard income of disabled persons that is also disregard-

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ed in determining eligibility for supplemental aid under section 256D.37, subdivision 1, unless prohibited by federal law or regulation. If prohibited, the commissioner shall first seek a waiver. In excess income cases, eligibility shall be limited to a period of six months beginning with the first of the month in which these medical obligations are first incurred; and

(10) Who has continuing monthly expenses for medical care that are more than the amount of his excess income, computed on a monthly basis, in which case eligibility may be established before the total income obligation referred to in the preceding paragraph is incurred, and medical assistance payments may be made to cover the monthly unmet medical need. In licensed nursing home and state hospital cases, income over and above that required for justified needs, determined pursuant to a schedule of contributions established by the commissioner of public welfare, is to be applied to the cost of institutional care. The commissioner of public welfare may establish a schedule of contributions to be made by the spouse of a nursing home resident to the cost of care and shall seek a waiver from federal regulations which establish the amount required to be contributed by either spouse when one spouse is a nursing home resident; and

(11) Who has applied or agrees to apply all proceeds received or receivable by him or his spouse from automobile accident coverage and private health care coverage to the costs of medical care for himself, his spouse, and children. The state agency may require from any applicant or recipient of medical assistance the assignment of any rights accruing under private health care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to receipt of the assignment by the person or organization providing the benefits.

[For text of subd 3, see M.S.1980]

History: *1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14*

256B.062 CONTINUED ELIGIBILITY.

Any family which was eligible for aid to families with dependent children in at least three of the six months immediately preceding the month in which the family became ineligible for aid to families with dependent children because of increased income from employment shall, while a member of the family is employed, remain eligible for medical assistance for four calendar months following the month in which the family would otherwise be determined to be ineligible due to the income and resources limitations of this chapter.

History: *1981 c 231 s 1*

256B.08 APPLICATION.

An applicant for medical assistance hereunder, or a person acting in his behalf, shall file his application with a county agency in such manner and form as shall be prescribed by the state agency. When a married applicant resides in a nursing home or applies for medical assistance for nursing home services, the county agency shall consider an application on behalf of the applicant's spouse only upon specific request of the applicant or upon specific request of the spouse and separate filing of an application.

History: *1Sp1981 c 2 s 15*

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256B.091 NURSING HOME PRE-ADMISSION SCREENING PROGRAM.

[For text of subds 1 to 7, see M.S.1980]

Subd. 8. **Alternative care grants.** The commissioner shall provide grants to counties participating in the program to pay costs of providing alternative care to individuals screened under subdivision 4. Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home admission if alternative care were not available; (2) who are receiving medical assistance or who would be eligible for medical assistance within 90 days of admission to a nursing home; and (3) who need services that are not available at that time in the county through other public assistance.

Grants may be used for payment of costs of providing services such as, but not limited to, foster care for elderly persons, day care whether or not offered through a nursing home, nutritional counseling, or medical social services, which services are provided by a licensed health care provider, a home health service eligible for reimbursement under Titles XVIII and XIX of the federal Social Security Act, or by persons employed by or contracted with by the county board or the local welfare agency. The county agency shall ensure that a plan of care is established for each individual in accordance with subdivision 3, clause (e)(2). The plan shall include any services prescribed by the individual's attending physician as necessary and follow up services as necessary. The county agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program. Grants to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.

The commissioner shall apply for a waiver for federal financial participation to expand the availability of services under this subdivision. The commissioner shall provide grants to counties from the non-federal share, unless the commissioner obtains a federal waiver for medical assistance payments, of medical assistance appropriations. The state expenditures for this section shall not exceed $1,800,000 for the biennium ending June 30, 1983. A county agency may use grant money to supplement but not supplant services available through other public assistance or service programs and shall not use grant money to establish new programs for which public money is available through sources other than grants provided under this subdivision. Total payment of the costs of providing care under this subdivision shall not exceed 75 percent of the per diem payment for which each individual served would have been eligible if the individual had been admitted to a nursing home. The non-federal share may be used to pay up to 90 percent of the start-up and service delivery costs of providing care under this subdivision. Each county agency that receives a grant shall pay 10 percent of the costs.

The commissioner shall promulgate temporary rules in accordance with section 15.0412, subdivision 5, to establish required documentation and reporting of care delivered.

History: *1981 c 360 art 2 s 29*

256B.15 CLAIMS AGAINST ESTATES.

If a person receives any medical assistance hereunder, on his death, if he is single, or on the death of the person and his surviving spouse, if he is married, and only at a time when he has no surviving child who is under 21 or is blind or totally disabled, the total amount paid for medical assistance rendered for the person, after age 65, without interest, shall be filed as a claim against the estate of the

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person in the court having jurisdiction to probate the estate. The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Counties may retain one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort.

History: *1981 c 360 art 1 s 22; 1Sp1981 c 4 art 1 s 126*

256B.17 TRANSFERS OF PROPERTY.

Subdivision 1. **Transfers for less than market value.** In determining the resources of an individual and an eligible spouse, there shall be included any resource or interest therein which was given away or sold for less than fair market value within the 24 months preceding application for medical assistance or during the period of eligibility.

Subd. 2. **Presumption of purpose.** Any transaction described in subdivision 1 shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this chapter unless the individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for another purpose.

Subd. 3. **Resource value.** For purposes of subdivision 1, the value of the resource or interest shall be the fair market value at the time it was sold or given away, less the amount of compensation received.

Subd. 4. **Period of ineligibility.** In any case where the uncompensated value of transferred resources exceeds $12,000, the commissioner shall require a period of ineligibility which exceeds 24 months, provided that the period of ineligibility bears a reasonable relationship to the excess uncompensated value of the transferred asset.

History: *1981 c 360 art 2 s 30*

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