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256B.056, Minnesota Statutes 2006

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256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

Subdivision 1. **Residency.** To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

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. Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section [256B.055, subdivision 12](#), or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income. 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 104-193, shall be used, except that effective October 1, 2003, the earned income disregards and deductions are limited to those in subdivision 1c. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Subd. 1b. **Aged, blind, and disabled income methodology.** The \$20 general income disregard allowed under the supplemental security income program is included in the standard and shall not be allowed as a deduction from income for a person eligible under section 256B.055, subdivisions 7, 7a, and 12 .

Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003 c 14 art 12 s 17]

(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 July 1, 2003, 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.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2 , the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: \$90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall

in section ~~256B.056, subdivision 1~~, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) 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.

Subd. 2. Homestead exclusion and homestead equity limit for institutionalized persons.

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

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

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

Subd. 3. Asset limitations for individuals and families. To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of

those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

- (a) Household goods and personal effects are not considered.
- (b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.
- (c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.
- (d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses.
- (e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

Subd. 3a.[Repealed, 1992 c 513 art 7 s 135]

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in *Sullivan v. Zebley*, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103-66.

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than \$20,000 in total net assets, and a household of one person must not own more than \$10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

- (1) household goods and personal effects are not considered;
- (2) capital and operating assets of a trade or business up to \$200,000 are not considered;
- (3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;
- (4) one burial plot and all other burial expenses equal to the supplemental security income

- program asset limit are not considered for each individual;
- (5) court-ordered settlements up to \$10,000 are not considered;
- (6) individual retirement accounts and funds are not considered; and
- (7) assets owned by children are not considered.

Subd. 3d. **Reduction of excess assets.** Assets in excess of the limits in subdivisions 3 to 3c may be reduced to allowable limits as follows:

- (a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by:
- (1) designating burial funds up to \$1,500 for each applicant, spouse, and MA-eligible dependent child; and
- (2) paying health service bills incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.
- (b) Assets may be reduced beginning the month of application by:
- (1) paying bills for health services that would otherwise be paid by medical assistance; and
- (2) using any means other than a transfer of assets for less than fair market value as defined in section 256B.0595, subdivision 1, paragraph (b).

Subd. 3e. **Continuing care retirement and life care community entrance fees.** An entrance fee paid by an individual to a continuing care retirement or life care community shall be treated as an available asset to the extent that:

- (1) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care;
- (2) the individual is eligible for a refund of any remaining entrance fees when the individual dies or terminates the continuing care retirement or life care community contract and leaves the community; and
- (3) the entrance fee does not confer an ownership interest in the continuing care retirement or life care community.

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, subdivision 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) In computing income to determine eligibility of persons under paragraphs (a) to (c) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Subd. 4a. **Asset verification.** For purposes of verification, the value of a life estate shall be considered not saleable unless the owner of the remainder interest intends to purchase the life

CONSIDERED 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.

Subd. 4b. Income verification. The local agency shall not require a monthly income verification form for a recipient who is a resident of a long-term care facility and who has monthly earned income of \$80 or less. The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification.

Subd. 5. Excess income. A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the last business day of the month in order to be eligible for this option in the following month.

Subd. 5a. Individuals on fixed or excluded income. Recipients of medical assistance who receive only fixed unearned or excluded income, 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 every 12 months. The 12-month period begins with the month of application.

Subd. 5b. Individuals with low income. Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income every six months. The six-month period begins the month of application.

Subd. 5c. Excess income standard. (a) The excess income standard for families with children is the standard specified in subdivision 4.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines.

Subd. 6. Assignment of benefits. To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By accepting medical assistance, a person assigns to the Department of Human Services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon

the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. For the purposes of this section, "the Department of Human Services or the state" includes prepaid health plans under contract with the commissioner according to sections 256B.031, 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and the county-based purchasing entities under section 256B.692.

Subd. 7. Period of eligibility. Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

Subd. 8. Cooperation. To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost-effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B.19.

Subd. 9. Notice. The state agency must be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care when the state agency has paid or becomes liable for the cost of that care. Notice must be given according to paragraphs (a) to (d).

(a) An applicant for medical assistance shall notify the state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim that may be assigned to the state agency under this section shall notify the state agency of its potential assignment claim in writing at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(d) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the

claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to the claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual assignment claim.

Subd. 10. Eligibility verification. (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall modify the application for Minnesota health care programs to require more detailed information related to verification of assets and income, and shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall require Minnesota health care program recipients to report new or an increase in earned income within ten days of the change, and to verify new or an increase in earned income that affects eligibility within ten days of notification by the agency that the new or increased earned income affects eligibility. Recipients who fail to verify new or an increase in earned income that affects eligibility shall be disenrolled.

Subd. 11. Treatment of annuities. (a) Any individual applying for or seeking recertification of eligibility for medical assistance payment of long-term care services shall provide a complete description of any interest either the individual or the individual's spouse has in annuities. The individual and the individual'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.

(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 shall include a 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 or the individual'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.

(c) An issuer of an annuity or similar financial instrument who receives notice on a disclosure form as described in paragraph (b) shall provide confirmation to the requesting agency that a remainder beneficiary designating the state has been made and shall 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. 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.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1989 c 282 art 3 s 45-47; 1989 c 332 s 1; 1990 c 568 art 3 s 28-32; 1992 c 513 art 7 s 34-38; 1993 c 339 s 13; 1Sp1993 c 1 art 5 s 31; art 6 s 25; 1995 c 207 art 6 s 28,29; 1995 c 248 art 17 s 1-4; 1996 c 451 art 2 s 8,9; 1997 c 85 art 3 s 13-15; 1997 c 203 art 4 s 20,21; 1997 c 225 art 6 s 4; 1998 c 407 art 4 s 15,16; 1999 c 245 art 4 s 32; art 10 s 10; 2001 c 203 s 5,6; 1Sp2001 c 9 art 2 s 16-24; 2002 c 220 art 15 s 6; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 16; art 12 s 16-18; 2004 c 228 art 1 s 75; 2005 c 56 s 1; 2005 c 98 art 2 s 2; 1Sp2005 c 4 art 8 s 20-26; 2006 c 282 art 17 s 25-27*

NOTE: The amendments to subdivisions 5, 5a, 5b, and 7, by Laws 2005, First Special Session chapter 4, article 8, sections 21 to 24, are effective August 1, 2007, or upon HealthMatch implementation, whichever is later. Laws 2005, First Special Session chapter 4, article 8, sections 21 to 24, the effective dates.

1.1 A bill for an act

1.2 relating to human services; modifying treatment of assets for medical assistance
1.3 eligibility; amending Minnesota Statutes 2006, section 256B.059, subdivision 5.

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

1.5 Section 1. Minnesota Statutes 2006, section 256B.059, subdivision 5, is amended to
1.6 read:

1.7 Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for
1.8 medical assistance benefits following the first continuous period of institutionalization on
1.9 or after October 1, 1989, assets considered available to the institutionalized spouse shall
1.10 be the total value of all assets in which either spouse has an ownership interest, reduced by
1.11 the following amount for the community spouse:

1.12 (1) prior to July 1, 1994, the greater of:

1.13 (i) \$14,148;

1.14 (ii) the lesser of the spousal share or \$70,740; or

1.15 (iii) the amount required by court order to be paid to the community spouse;

1.16 (2) for persons whose date of initial determination of eligibility for medical
1.17 assistance following their first continuous period of institutionalization occurs on or after
1.18 July 1, 1994, the greater of:

1.19 (i) \$20,000;

1.20 (ii) the lesser of the spousal share or \$70,740; or

1.21 (iii) the amount required by court order to be paid to the community spouse.

1.22 The value of assets transferred for the sole benefit of the community spouse under section
1.23 256B.0595, subdivision 4, in combination with other assets available to the community
1.24 spouse under this section, cannot exceed the limit for the community spouse asset

S.F. No. 2214, as introduced - 85th Legislative Session (2007-2008)

2.1 allowance determined under subdivision 3 or 4. ~~Assets that exceed this allowance shall be~~
2.2 ~~considered available to the institutionalized spouse whether or not converted to income.~~ If
2.3 the community spouse asset allowance has been increased under subdivision 4, then the
2.4 assets considered available to the institutionalized spouse under this subdivision shall be
2.5 further reduced by the value of additional amounts allowed under subdivision 4.

2.6 (b) An institutionalized spouse may be found eligible for medical assistance even
2.7 though assets in excess of the allowable amount are found to be available under paragraph
2.8 (a) if the assets are owned jointly or individually by the community spouse, and the
2.9 institutionalized spouse cannot use those assets to pay for the cost of care without the
2.10 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the
2.11 commissioner the right to support from the community spouse under section 256B.14,
2.12 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment
2.13 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an
2.14 imminent threat to the institutionalized spouse's health and well-being.

2.15 (c) After the month in which the institutionalized spouse is determined eligible for
2.16 medical assistance, during the continuous period of institutionalization, no assets of the
2.17 community spouse are considered available to the institutionalized spouse, unless the
2.18 institutionalized spouse has been found eligible under paragraph (b).

2.19 (d) Assets determined to be available to the institutionalized spouse under this
2.20 section must be used for the health care or personal needs of the institutionalized spouse.

2.21 (e) For purposes of this section, assets do not include assets excluded under the
2.22 supplemental security income program.

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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. 1719

March 5, 2007

Authored by Huntley, Otremba and Murphy, E.

The bill was read for the first time and referred to the Committee on Health and Human Services

March 27, 2007

Committee Recommendation and Adoption of Report:

To Pass as Amended and re-referred to the Committee on Finance

1.1 A bill for an act
1.2 relating to human services; modifying treatment of assets for medical assistance
1.3 eligibility; amending Minnesota Statutes 2006, section 256B.059, subdivision 5.

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

1.5 Section 1. Minnesota Statutes 2006, section 256B.059, subdivision 5, is amended to
1.6 read:

1.7 Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for
1.8 medical assistance benefits following the first continuous period of institutionalization on
1.9 or after October 1, 1989, assets considered available to the institutionalized spouse shall
1.10 be the total value of all assets in which either spouse has an ownership interest, reduced by
1.11 the following amount for the community spouse:

1.12 (1) prior to July 1, 1994, the greater of:

1.13 (i) \$14,148;

1.14 (ii) the lesser of the spousal share or \$70,740; or

1.15 (iii) the amount required by court order to be paid to the community spouse;

1.16 (2) for persons whose date of initial determination of eligibility for medical

1.17 assistance following their first continuous period of institutionalization occurs on or after

1.18 July 1, 1994, the greater of:

1.19 (i) \$20,000;

1.20 (ii) the lesser of the spousal share or \$70,740; or

1.21 (iii) the amount required by court order to be paid to the community spouse.

1.22 The value of assets transferred for the sole benefit of the community spouse under section
1.23 256B.0595, subdivision 4, in combination with other assets available to the community
1.24 spouse under this section, cannot exceed the limit for the community spouse asset

2.1 allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be
2.2 considered available to the institutionalized spouse ~~whether or not converted to income~~. If
2.3 the community spouse asset allowance has been increased under subdivision 4, then the
2.4 assets considered available to the institutionalized spouse under this subdivision shall be
2.5 further reduced by the value of additional amounts allowed under subdivision 4.

2.6 (b) An institutionalized spouse may be found eligible for medical assistance even
2.7 though assets in excess of the allowable amount are found to be available under paragraph

2.8 (a) if the assets are owned jointly or individually by the community spouse, and the
2.9 institutionalized spouse cannot use those assets to pay for the cost of care without the
2.10 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the
2.11 commissioner the right to support from the community spouse under section 256B.14,
2.12 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment
2.13 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an
2.14 imminent threat to the institutionalized spouse's health and well-being.

2.15 (c) After the month in which the institutionalized spouse is determined eligible for
2.16 medical assistance, during the continuous period of institutionalization, no assets of the
2.17 community spouse are considered available to the institutionalized spouse, unless the
2.18 institutionalized spouse has been found eligible under paragraph (b).

2.19 (d) Assets determined to be available to the institutionalized spouse under this
2.20 section must be used for the health care or personal needs of the institutionalized spouse.

2.21 (e) For purposes of this section, assets do not include assets excluded under the
2.22 supplemental security income program.

1.1 A bill for an act

1.2 relating to human services; increasing the medical assistance asset limit
1.3 and excess income standard for aged, blind, or disabled persons; modifying
1.4 a Minnesota disabilities health options program provision; modifying the
1.5 medical assistance employed persons with disabilities program; directing the
1.6 commissioner of human services to seek federal approval; amending Minnesota
1.7 Statutes 2006, sections 256B.056, subdivisions 1a, 3, 5c; 256B.69, subdivision
1.8 23.

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

1.10 Section 1. Minnesota Statutes 2006, section 256B.056, subdivision 1a, is amended to
1.11 read:

1.12 Subd. 1a. **Income and assets generally.** Unless specifically required by state law or
1.13 rule or federal law or regulation, the methodologies used in counting income and assets
1.14 to determine eligibility for medical assistance for persons whose eligibility category is
1.15 based on blindness, disability, or age of 65 or more years, the methodologies for the
1.16 supplemental security income program shall be used, except as provided under subdivision
1.17 3, paragraph (f). Increases in benefits under title II of the Social Security Act shall not be
1.18 counted as income for purposes of this subdivision until July 1 of each year. Effective
1.19 upon federal approval, for children eligible under section 256B.055, subdivision 12, or
1.20 for home and community-based waiver services whose eligibility for medical assistance
1.21 is determined without regard to parental income, child support payments, including any
1.22 payments made by an obligor in satisfaction of or in addition to a temporary or permanent
1.23 order for child support, and Social Security payments are not counted as income. For
1.24 families and children, which includes all other eligibility categories, the methodologies
1.25 under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal
1.26 Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public

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2.1 Law 104-193, shall be used, except that effective October 1, 2003, the earned income
2.2 disregards and deductions are limited to those in subdivision 1c. For these purposes, a
2.3 "methodology" does not include an asset or income standard, or accounting method,
2.4 or method of determining effective dates.

2.5 Sec. 2. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to read:

2.6 Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.**

2.7 To be eligible for medical assistance, a person whose eligibility is based on blindness,
2.8 disability, or age of 65 or more years must not individually own more than ~~\$3,000~~ \$6,000
2.9 in assets, or if a member of a household with two family members, husband and wife, or
2.10 parent and child, the household must not own more than ~~\$6,000~~ \$12,000 in assets, plus
2.11 ~~\$200~~ \$400 for each additional legal dependent. In addition to these maximum amounts,
2.12 an eligible individual or family may accrue interest on these amounts, but they must be
2.13 reduced to the maximum at the time of an eligibility redetermination. The accumulation
2.14 of the clothing and personal needs allowance according to section 256B.35 must also be
2.15 reduced to the maximum at the time of the eligibility redetermination. The value of assets
2.16 that are not considered in determining eligibility for medical assistance is the value of
2.17 those assets excluded under the supplemental security income program for aged, blind,
2.18 and disabled persons, with the following exceptions:

2.19 (a) Household goods and personal effects are not considered.

2.20 (b) Capital and operating assets of a trade or business that the local agency
2.21 determines are necessary to the person's ability to earn an income are not considered.

2.22 (c) Motor vehicles are excluded to the same extent excluded by the supplemental
2.23 security income program.

2.24 (d) Assets designated as burial expenses are excluded to the same extent excluded by
2.25 the supplemental security income program. Burial expenses funded by annuity contracts
2.26 or life insurance policies must irrevocably designate the individual's estate as contingent
2.27 beneficiary to the extent proceeds are not used for payment of selected burial expenses.

2.28 (e) Effective upon federal approval, for a person who no longer qualifies as an
2.29 employed person with a disability due to loss of earnings, assets allowed while eligible
2.30 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
2.31 months, beginning with the first month of ineligibility as an employed person with a
2.32 disability, to the extent that the person's total assets remain within the allowed limits of
2.33 section 256B.057, subdivision 9, paragraph (b).

2.34 (f) When a person enrolled in medical assistance under section 256B.057,
2.35 subdivision 9, reaches age 65 and has been enrolled during each of the 24 consecutive

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3.1 months before the person's 65th birthday, the assets owned by the person and the person's
3.2 spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph
3.3 (b), when determining eligibility for medical assistance under section 256B.055,
3.4 subdivision 7. The income of a spouse of a person enrolled in medical assistance under
3.5 section 256B.057, subdivision 9, during each of the 24 consecutive months before the
3.6 person's 65th birthday must be disregarded when determining eligibility for medical
3.7 assistance under section 256B.055, subdivision 7, when the person reaches age 65. This
3.8 paragraph does not apply at the time the person or the person's spouse requests medical
3.9 assistance payment for long-term care services.

3.10 **EFFECTIVE DATE.** This section is effective July 1, 2007.

3.11 Sec. 3. Minnesota Statutes 2006, section 256B.056, subdivision 5c, is amended to read:

3.12 Subd. 5c. **Excess income standard.** (a) The excess income standard for families
3.13 with children is the standard specified in subdivision 4.

3.14 (b) The excess income standard for a person whose eligibility is based on blindness,
3.15 disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the
3.16 family size. Effective July 1, 2002, the excess income standard for this paragraph shall
3.17 equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess
3.18 income standard for this paragraph shall equal 85 percent of the federal poverty guidelines.
3.19 The excess income standard for this paragraph shall be increased by five percentage points
3.20 on July 1 of each of the next three years, so that the excess income standard shall equal
3.21 100 percent of the federal poverty guidelines effective July 1, 2010.

3.22 **EFFECTIVE DATE.** This section is effective July 1, 2007.

3.23 Sec. 4. Minnesota Statutes 2006, section 256B.69, subdivision 23, is amended to read:

3.24 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
3.25 commissioner may implement demonstration projects to create alternative integrated
3.26 delivery systems for acute and long-term care services to elderly persons and persons
3.27 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
3.28 coordination, improve access to quality services, and mitigate future cost increases.
3.29 The commissioner may seek federal authority to combine Medicare and Medicaid
3.30 capitation payments for the purpose of such demonstrations and may contract with
3.31 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
3.32 services shall be administered according to the terms and conditions of the federal contract
3.33 and demonstration provisions. For the purpose of administering medical assistance funds,

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4.1 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
4.2 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
4.3 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
4.4 items B and C, which do not apply to persons enrolling in demonstrations under this
4.5 section. An initial open enrollment period may be provided. Persons who disenroll from
4.6 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
4.7 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
4.8 the health plan's participation is subsequently terminated for any reason, the person shall
4.9 be provided an opportunity to select a new health plan and shall have the right to change
4.10 health plans within the first 60 days of enrollment in the second health plan. Persons
4.11 required to participate in health plans under this section who fail to make a choice of
4.12 health plan shall not be randomly assigned to health plans under these demonstrations.
4.13 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
4.14 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
4.15 the commissioner may contract with managed care organizations, including counties, to
4.16 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
4.17 disabled persons only. For persons with a primary diagnosis of developmental disability,
4.18 serious and persistent mental illness, or serious emotional disturbance, the commissioner
4.19 must ensure that the county authority has approved the demonstration and contracting
4.20 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
4.21 commissioner shall not implement any demonstration project under this subdivision for
4.22 persons with a primary diagnosis of developmental disabilities, serious and persistent
4.23 mental illness, or serious emotional disturbance, without approval of the county board of
4.24 the county in which the demonstration is being implemented.

4.25 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
4.26 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
4.27 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
4.28 under this section projects for persons with developmental disabilities. The commissioner
4.29 may capitate payments for ICF/MR services, waived services for developmental
4.30 disabilities, including case management services, day training and habilitation and
4.31 alternative active treatment services, and other services as approved by the state and by the
4.32 federal government. Case management and active treatment must be individualized and
4.33 developed in accordance with a person-centered plan. Costs under these projects may not
4.34 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
4.35 and until two years after the pilot project implementation date, subcontractor participation
4.36 in the long-term care developmental disability pilot is limited to a nonprofit long-term

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5.1 care system providing ICF/MR services, home and community-based waiver services,
5.2 and in-home services to no more than 120 consumers with developmental disabilities in
5.3 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
5.4 prior to expansion of the developmental disability pilot project. This paragraph expires
5.5 two years after the implementation date of the pilot project.

5.6 (c) Before implementation of a demonstration project for disabled persons, the
5.7 commissioner must provide information to appropriate committees of the house of
5.8 representatives and senate and must involve representatives of affected disability groups
5.9 in the design of the demonstration projects.

5.10 (d) A nursing facility reimbursed under the alternative reimbursement methodology
5.11 in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity
5.12 provide services under paragraph (a). The commissioner shall amend the state plan and
5.13 seek any federal waivers necessary to implement this paragraph.

5.14 (e) The commissioner, in consultation with the commissioners of commerce and
5.15 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
5.16 according to federal laws and regulations governing that program and state laws or rules
5.17 applicable to participating providers. The process for approval of these programs shall
5.18 begin only after the commissioner receives grant money in an amount sufficient to cover
5.19 the state share of the administrative and actuarial costs to implement the programs during
5.20 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
5.21 account in the special revenue fund and are appropriated to the commissioner to be used
5.22 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
5.23 not required to be licensed or certified as a health plan company as defined in section
5.24 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
5.25 and found to be eligible for services under the elderly waiver or community alternatives
5.26 for disabled individuals or who are already eligible for Medicaid but meet level of
5.27 care criteria for receipt of waiver services may choose to enroll in the PACE program.
5.28 Medicare and Medicaid services will be provided according to this subdivision and
5.29 federal Medicare and Medicaid requirements governing PACE providers and programs.
5.30 PACE enrollees will receive Medicaid home and community-based services through the
5.31 PACE provider as an alternative to services for which they would otherwise be eligible
5.32 through home and community-based waiver programs and Medicaid State Plan Services.
5.33 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
5.34 costs that would have been incurred under fee-for-service or other relevant managed care
5.35 programs operated by the state.

6.1 (f) The commissioner shall seek federal approval to expand the Minnesota disability
6.2 health options (MnDHO) program established under this subdivision in stages, first to
6.3 regional population centers outside the seven-county metro area and then to all areas
6.4 of the state. ~~Until January 1, 2008~~ July 1, 2009, expansion for MnDHO projects that
6.5 include home and community-based services is limited to the two projects and service
6.6 areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that
6.7 include home and community-based services shall remain voluntary. Costs for home
6.8 and community-based services included under MnDHO must not exceed costs that
6.9 would have been incurred under the fee-for-service program. In developing program
6.10 specifications for expansion of integrated programs, the commissioner shall involve and
6.11 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
6.12 including consultation on whether and how to include home and community-based waiver
6.13 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
6.14 of the house and senate committees with jurisdiction over health and human services
6.15 policy and finance by February 1, 2007.

6.16 (g) Notwithstanding section 256B.0261, health plans providing services under this
6.17 section are responsible for home care targeted case management and relocation targeted
6.18 case management. Services must be provided according to the terms of the waivers and
6.19 contracts approved by the federal government.

6.20 **Sec. 5. COMMISSIONER REQUIRED TO SEEK FEDERAL APPROVAL.**

6.21 By October 1, 2007, the commissioner shall seek federal approval to allow persons
6.22 who have been eligible for medical assistance for employed persons with disabilities
6.23 (MA-EPD) under Minnesota Statutes, section 256B.057, subdivision 9, for each of the 24
6.24 consecutive months prior to becoming age 65 to continue using the MA-EPD eligibility
6.25 rules as long as they qualify.

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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. 784

February 8, 2007

Authored by Murphy, E.; Huntley; Abeler and Hosch

The bill was read for the first time and referred to the Committee on Finance

February 12, 2007

By motion, recalled and re-referred to the Committee on Health and Human Services

February 15, 2007

Committee Recommendation and Adoption of Report:

To Pass and re-referred to the Committee on Finance

1.1 A bill for an act
1.2 relating to human services; increasing the medical assistance asset limit and
1.3 excess income standard for aged, blind, or disabled persons; amending Minnesota
1.4 Statutes 2006, section 256B.056, subdivisions 3, 5c.

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

1.6 Section 1. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to
1.7 read:

1.8 Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.**

1.9 To be eligible for medical assistance, a person whose eligibility is based on blindness,
1.10 disability, or age of 65 or more years must not individually own more than ~~\$3,000~~ \$6,000
1.11 in assets, or if a member of a household with two family members, husband and wife, or
1.12 parent and child, the household must not own more than ~~\$6,000~~ \$12,000 in assets, plus
1.13 ~~\$200~~ \$400 for each additional legal dependent. In addition to these maximum amounts,
1.14 an eligible individual or family may accrue interest on these amounts, but they must be
1.15 reduced to the maximum at the time of an eligibility redetermination. The accumulation
1.16 of the clothing and personal needs allowance according to section 256B.35 must also be
1.17 reduced to the maximum at the time of the eligibility redetermination. The value of assets
1.18 that are not considered in determining eligibility for medical assistance is the value of
1.19 those assets excluded under the supplemental security income program for aged, blind,
1.20 and disabled persons, with the following exceptions:

1.21 (a) Household goods and personal effects are not considered.

1.22 (b) Capital and operating assets of a trade or business that the local agency
1.23 determines are necessary to the person's ability to earn an income are not considered.

2.1 (c) Motor vehicles are excluded to the same extent excluded by the supplemental
2.2 security income program.

2.3 (d) Assets designated as burial expenses are excluded to the same extent excluded by
2.4 the supplemental security income program. Burial expenses funded by annuity contracts
2.5 or life insurance policies must irrevocably designate the individual's estate as contingent
2.6 beneficiary to the extent proceeds are not used for payment of selected burial expenses.

2.7 (e) Effective upon federal approval, for a person who no longer qualifies as an
2.8 employed person with a disability due to loss of earnings, assets allowed while eligible
2.9 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
2.10 months, beginning with the first month of ineligibility as an employed person with a
2.11 disability, to the extent that the person's total assets remain within the allowed limits of
2.12 section 256B.057, subdivision 9, paragraph (b).

2.13 **EFFECTIVE DATE.** This section is effective July 1, 2007.

2.14 Sec. 2. Minnesota Statutes 2006, section 256B.056, subdivision 5c, is amended to read:

2.15 Subd. 5c. **Excess income standard.** (a) The excess income standard for families
2.16 with children is the standard specified in subdivision 4.

2.17 (b) The excess income standard for a person whose eligibility is based on blindness,
2.18 disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the
2.19 family size. Effective July 1, 2002, the excess income standard for this paragraph shall
2.20 equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess
2.21 income standard for this paragraph shall equal 85 percent of the federal poverty guidelines.
2.22 The excess income standard for this paragraph shall be increased by five percentage points
2.23 on July 1 of each of the next three years, so that the excess income standard shall equal
2.24 100 percent of the federal poverty guidelines effective July 1, 2010.

2.25 **EFFECTIVE DATE.** This section is effective July 1, 2007.