TITLE 56
PUBLIC ASSISTANCE AND WELFARE

CHAPTER 2
PUBLIC ASSISTANCE LAW

56-201. DEFINITIONS. As used in this act:

(a) "State department" means the state department of health and welfare;

(b) "Director" means the director of the department of health and welfare;

(c) "Public welfare" means public assistance and social services;

(d) "Social services" means activities of the department in efforts to bring about economic, social and vocational adjustment of families and persons;

(e) "Public assistance" includes general assistance, old-age assistance, aid to the blind, assistance to families with children, aid to the disabled, and medical assistance;

(f) "General assistance" means direct assistance in cash, direct assistance in kind, and supplementary assistance;

(g) "Direct assistance in cash" means money payments to eligible people not classified as old-age assistance, or aid to the blind, or assistance to families with children, or aid to the disabled, or medical assistance;

(h) "Direct assistance in kind" means payments to others on behalf of a person or family for food, rent, clothing, and other normal subsistence needs;

(i) "Supplementary assistance" means payments to others on behalf of a person or family for transportation and costs incidental to vocational adjustment or employment;

(j) "Old-age assistance" means money payments to or on behalf of needy aged people;

(k) "Aid to the blind" means money payments to or on behalf of blind people who are needy;

(l) "Assistance to families with children" means money payments, direct assistance in kind, supplementary assistance, and social services targeted toward self-sufficiency with respect to or on behalf of eligible families with children;

(m) "Aged" means any person sixty-five (65) years or older;

(n) "Aid to the disabled" means money payments to or on behalf of needy individuals who are disabled, and whose disability prevents self-support through employment for a period of at least one (1) year from the date of onset of the disability;

(o) "Medical assistance" means payments for part or all of the cost of such care and services allowable within the scope of title XIX of the federal social security act as amended as may be designated by department rule;

(p) "Provider" means any individual, partnership, association, corporation or organization, public or private, who provides residential or assisted living services, certified family home services, nursing facility services, services offered pursuant to the medicaid program, or services offered pursuant to titles IV or XX of the social security act;

(q) "Needy" means the condition where a person or family does not have income and available resources in accordance with the provisions of section 56-210, Idaho Code.

[56-201, added 1941, ch. 181, sec. 1, p. 379; am. 1945, ch. 109, sec. 1, p. 165; am. 1957, ch. 323, sec. 1, p. 379; am. 1961, ch. 217, sec. 1, p. 346; am. 1966 (2nd E.S.), ch. 11, sec. 1, p. 28; am. 1967, ch. 373, sec. 13, p. 1071; am. 1967 (1st E.S.), ch. 5, sec. 1, p. 23; am. 1972, ch. 44, sec. 5, p. 67; am. 1972, ch. 196, sec. 8, p. 483; am. 1974, ch. 23, sec. 162, p. 633; am. 1974, ch. 233, sec. 1, p. 1590; am. 1977, ch. 226, sec. 1, p. 673; am. 1978, ch. 246, sec. 1, p. 537; am. 1981, ch. 179, sec. 1, p. 313; am. 1982, ch. 59, sec. 5, p. 94; am. 1989, ch. 193, sec. 15, p. 486; am. 1996, ch. 50, sec. 1, p. 147; am. 2000, ch. 274, sec. 148, p. 882.]

56-202. DUTIES OF DIRECTOR OF STATE DEPARTMENT OF HEALTH AND WELFARE. The director of the state department of health and welfare shall:

(a) Administer public assistance and social services to eligible people;

(b) Promulgate, adopt and enforce such rules and such methods of administration as may be necessary or proper to carry out the provisions of title 56, Idaho Code, except as provided in section 56-203A, Idaho Code;

(c) Conduct research and compile statistics relating to public welfare;

(d) Prepare for the governor and legislature an annual report of activities and expenditures; make such reports in such form and containing such information as the federal government may from time to time require; and comply with such provisions as the federal government may from time to time find necessary to assure the correctness and verification of such reports;

(e) Cooperate with the federal government through its appropriate agency or instrumentality in establishing, extending, and strengthening services for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent; and to undertake other services for children authorized by law;

(f) Cooperate with the federal government through its appropriate agency or instrumentality in establishing and maintaining a comprehensive system of in-home services as defined in section 67-5006, Idaho Code, designed to assist older persons, as defined in section 67-5006, Idaho Code, of Idaho to continue living in an independent and dignified home environment and to undertake other services for older persons as authorized by law;

(g) Exercise the opt out provision in section 115 of the personal responsibility and work opportunity reconciliation act of 1996, P.L. 104-193. Consistent with this, the department may provide food stamps and services funded under title 4A (including cash assistance, TANF supportive services and at risk payments) to a person who has been convicted of a felony involving a controlled substance as defined in chapter 27, title 37, Idaho Code, if they comply with the terms of a withheld judgment, probation or parole.

[56-202, added 1941, ch. 181, sec. 2, p. 379; am. 1945, ch. 109, sec. 2, p. 165; am. 1967, ch. 373, sec. 14, p. 1071; am. 1976, ch. 9, sec. 6, p. 28; am. 1980, ch. 325, sec. 10, p. 832; am. 1982, ch. 155, sec. 1, p. 421; am. 1996, ch. 50, sec. 2, p. 148; am. 2000, ch. 198, sec. 1, p. 489; am. 2004, ch. 257, sec. 1, p. 732.]

56-203. POWERS OF STATE DEPARTMENT. The state department shall have the power to:

(1) Enter into contracts and agreements with the federal government through its appropriate agency or instrumentality whereby the state of Idaho shall receive federal grants-in-aid or other benefits for public assistance

or public welfare purposes under any act or acts of congress heretofore or hereafter enacted;

(2) Cooperate with the federal government in carrying out the purposes of any federal acts pertaining to public assistance or welfare services, and in other matters of mutual concern;

(3) Cooperate with county governments and other branches of government and other agencies, public or private, in administering and furnishing public welfare services;

(4) Enter into reciprocal agreements with other states relative to the provisions of public assistance and welfare services to residents and nonresidents;

(5) Initiate and administer public assistance and social services for persons with physical or mental disabilities;

(6) Establish such requirements of residence for public assistance under this chapter as may be deemed advisable, subject to any limitations imposed in this chapter;

(7) Define persons entitled to medical assistance in such terms as will meet requirements for federal financial participation in medical assistance payments;

(8) Accept the legal custody of children committed to it by district courts of this state under the child protective act, to provide protective supervision as defined therein, to place children for adoption when such children are in the legal custody of the state department and are legally available for adoption, and to exercise consent to adoption when the authority to do so is vested in the department by court order or legally authorized parental relinquishment;

(9) Determine the amount, duration and scope of care and services to be purchased as medical assistance on behalf of needy eligible individuals;

(10) Manage and operate the southwest Idaho treatment center at Nampa, Idaho; and

(11) Manage and operate state hospital north at Orofino, Idaho; state hospital south at Blackfoot, Idaho; and state hospital west at Nampa, Idaho.

[56-203, added 1941, ch. 181, sec. 3, p. 379; am. 1945, ch. 109, sec. 3, p. 165; am. 1959, ch. 241, sec. 1, p. 523; am. 1961, ch. 217, sec. 2, p. 346; am. 1963, ch. 325, sec. 1, p. 936; am. 1966 (2nd E.S.), ch. 11, sec. 2, p. 28; am. 1967, ch. 373, sec. 15, p. 1071; am. 1967 (1st E.S.), ch. 5, sec. 2, p. 23; am. 1972, ch. 44, sec. 6, p. 67; am. 1973, ch. 161, sec. 1, p. 306; am. 2010, ch. 235, sec. 44, p. 583; am. 2011, ch. 102, sec. 2, p. 261; am. 2022, ch. 60, sec. 2, p. 184.]

56-203A. AUTHORITY OF DEPARTMENT TO ENFORCE CHILD SUPPORT -- SUPPORT ENFORCEMENT SERVICES. Whenever the department receives an application for public assistance on behalf of a child and it shall appear to the satisfaction of the department that said child has been abandoned by its parents, or that the child and one (1) parent have been abandoned by the other parent, or that the parent or other person who has a responsibility for the care, support or maintenance of such child has failed or neglected to give proper care or support to such child, the department shall take appropriate action under the provisions of this chapter, the abandonment or nonsupport statutes, or other appropriate statutes of this state to ensure that such parent or other person responsible shall pay for the care, support or maintenance of said dependent child.

The department may accept applications for support enforcement services on behalf of persons who are not recipients of public assistance and may take action as it deems appropriate to establish, modify or enforce support obligations against persons owing a duty to pay support. Action to establish support obligations may be taken under the abandonment or nonsupport statutes or other appropriate statutes of this state.

The department may charge fees to compensate it for services rendered in establishment of or enforcement of support obligations. The director shall, by rule, establish reasonable fees for support enforcement services, and said schedules of fees shall be made available to all applicants for support enforcement services. The department may, on showing of necessity, waive or defer any such fee.

Effective October 1, 1998, the department shall maintain a state case registry that contains records of each case in which enforcement services are being provided under this section and each child support order established or modified in the state from and after that date. Effective the same date, the department shall collect and disburse payments for all support orders related to cases for which services are provided under this section and each child support order established or modified after January 1, 1994, that is subject to income withholding orders. For child support orders established prior to January 1, 1994, at the option of each county and upon payment of the cost of the service, the department shall collect and disburse payments.

[56-203A, as added by 1975, ch. 264, sec. 2, p. 712; am. 1990, ch. 327, sec. 1, p. 898; am. 1998, ch. 249, sec. 1, p. 814.]

56-203B. PAYMENT OF PUBLIC ASSISTANCE FOR CHILD CONSTITUTES DEBT TO DEPARTMENT BY PARENTS -- LIMITATIONS -- DEPARTMENT SUBROGATED TO RIGHTS. Any payment of public assistance money made to or for the benefit of any dependent child or children creates a debt due or owing to the department by the parent or others who are responsible for support of such children in an amount equal to the support obligation as is subsequently determined by court order pursuant to the Idaho child support guidelines which debt arises at the end of the first month for which the payment of public assistance commences. If a judgment entered by the court under the Idaho child support guidelines is more than the public assistance expended, the amount in excess of the public assistance expended shall be payable to the custodial parent or caretaker. Provided, that where there has been a district court order, the debt shall be limited to the amount provided for by said order. The department shall have the right to petition the appropriate district court for modification of a district court order on the same grounds as a party to said cause. Where a child has been placed in foster care, and a written agreement for payment of support has been entered into by the responsible parent or parents and the department, the debt shall be limited to the amount provided for in said agreement. Provided, that if a court order for support is or has been entered, the provisions of said order shall prevail over the agreement.

The department shall be subrogated to the right of said child or children or person having the care, custody and control of said child or children to prosecute or maintain any support action existing under the laws of the state of Idaho to obtain reimbursement of moneys thus expended. If a district court order enters judgment for an amount of support to be paid by an obligor parent, the department shall be subrogated to the debt created

by such order, and said money judgment shall be deemed to be in favor of the department. This subrogation shall specifically be applicable to temporary spouse support orders, family maintenance orders and alimony orders up to the amount paid by the department in public assistance moneys to or for the benefit of a dependent child or children but allocated to the benefit of said children on the basis of providing necessities for the caretaker of said children.

Debt under this section shall not be incurred by, nor at any time be collected from a parent or other person who would be or is eligible for or who is the recipient of public assistance moneys for the benefit of minor dependent children for the period such person or persons are in such status and the collection of the debt from such person would not be in the fiscal interest of the state or would not be in the best interest of the child(ren) for whom such person owes support.

[56-203B, as added by 1975, ch. 264, sec. 3, p. 712; am. 1994, ch. 289, sec. 1, p. 909; am. 1998, ch. 208, sec. 1, p. 736.]

56-203C. POWERS OF DEPARTMENT. (1) In order to carry out its responsibilities imposed under this chapter and title IV-D of the social security act, the state department of health and welfare, through the attorney general or the respective county prosecuting attorney, or through private counsel is hereby authorized to take the following action:

(a) Petition to establish an order for support including medical support and support for a period during which a child received public assistance;

(b) Petition to establish paternity and order genetic testing of any individual involved in the paternity action;

(c) Petition to modify an order for support in accordance with the Idaho child support guidelines at the request of an obligor, obligee or state agency providing services under title IV-D of the social security act;

(d) Petition to enforce an order for support of a child or a spouse or former spouse who is living with a child for whom the individual also owes support; and

(e) Intervene in a divorce or separate maintenance action or proceedings supplemental thereto, for the purpose of advising the court regarding support of a child or advising the court as to the financial interest of the state of Idaho therein without necessity of further leave of the court.

(f) Other services as required by title IV-D of the social security act.

(2) The department of health and welfare is not authorized to provide services regarding visitation or custody of a child unless so authorized by title IV-D of the social security act.

(3) In any action taken under this section, the prevailing party may, at the discretion of the court, be allowed reasonable attorney's fees and costs to be set by the court.

[56-203C, as added by 1975, ch. 264, sec. 4, p. 712; am. 1979, ch. 201, sec. 1, p. 581; am. 1986, ch. 222, sec. 3, p. 603; am. 1990, ch. 361, sec. 6, p. 978; am. 1996, ch. 221, sec. 1, p. 725; am. 1997, ch. 195, sec. 2, p. 553.]

56-203D. SET-OFF PROCEDURE FOR CHILD SUPPORT DEBT. (1) The state tax commission shall withhold and set-off any income tax or tax credit refund

of any taxpayer upon notification from the department of health and welfare to collect any unpaid child support, including a judgment for reimbursement of public assistance, or unpaid spousal support. The state tax commission shall also withhold and set-off any income tax or tax credit refund of any taxpayer upon notification from the department of health and welfare to collect any payment received from a third party for the costs of health services to a child by a person who is required by court or administrative order to provide the costs of health services to a child and such payment has not been used to reimburse either the other parent or guardian of such child, the provider of such services, or the state agency, to the extent necessary to reimburse the other parent, guardian, provider or state agency for such costs. Any claims for current or past-due child support shall take priority over any such claims for the costs of such health services. The set-off or withholding of a refund due a taxpayer shall be completed only after the following conditions have been met:

(a) A delinquency exists, which shall be defined as any unpaid child or spousal support including public assistance, pursuant to a court order from this state or a court or administrative order of another state.

(b) All outstanding tax liabilities collectible by the state tax commission are satisfied.

(c) The department of health and welfare, bureau of child support enforcement, shall forward to the state tax commission the full name and social security number of the taxpayer. The tax commission shall notify the department of health and welfare of the amount of refund due the taxpayer and the taxpayer's address on the income tax return.

(d) Notice of the proposed set-off shall be sent by registered or certified mail to the taxpayer at the address listed on the income tax return. Within fourteen (14) days after such notice has been mailed (not counting Saturday, Sunday or state holidays as the 14th day) the taxpayer may file a protest in writing requesting a hearing before the department of health and welfare. The hearing shall be held within thirty-five (35) days from the date of the mailing of the original notice. No issues at that hearing may be considered that have been litigated previously. The department of health and welfare shall issue its findings and decision either at the hearing or by mail to the taxpayer within ten (10) days of the hearing.

(e) When set-off is attempted on a joint return under the provisions of this section the taxpayer not specified to be the obligor in the claim may protest under the provisions of subsection (1)(d) of this section, and the set-off will be limited to one-half (1/2) of the joint refund.

(f) After the decision of the department of health and welfare is issued, or if the taxpayer has failed to file a timely protest of the claim, the set-off procedure shall become final.

(2) The proceeds from the set-off shall be credited to an account designated by the department of health and welfare, and notice shall be given to the appropriate clerk of the district court.

(3) This procedure for set-off shall not be subject to section 67-1021, Idaho Code.

(4) Any information furnished by the state tax commission, its employees or agents, under this section shall not be subject to the restrictions and penalties enumerated in section 63-3076, Idaho Code.

(5) Upon request, the department of health and welfare, bureau of child support enforcement, shall make the procedures established in this section

for collecting child support arrears available to county prosecuting attorneys. The provisions of this subsection apply only if appropriate arrangements have been made for reimbursement by the requesting prosecuting attorney for the administrative costs incurred by the bureau which are attributable to the request.

[56-203D, added 1981, ch. 167, sec. 1, p. 293; am. 1985, ch. 159, sec. 2, p. 421; am. 1990, ch. 91, sec. 1, p. 191; am. 1994, ch. 308, sec. 8, p. 974.]

56-203E. LOTTERY PRIZE SET-OFF PROCEDURE FOR SUPPORT DEBT. (1) The Idaho state lottery shall immediately withhold, set-off and transfer prize moneys of a lottery prize winner to the department of health and welfare upon notification and verification from the department of health and welfare to collect a support delinquency. The set-off or withholding of a prize shall be final only after the following conditions have been met:

(a) A delinquency exists, which shall be defined as any unpaid child or spousal support including public assistance, pursuant to a court order from this state or a court or administrative order of another state.

(b) The department of health and welfare, bureau of child support enforcement, shall forward to the Idaho state lottery the full name and social security number of the obligor and the amount of the delinquent child support. The Idaho state lottery shall notify the department of health and welfare of the amount of the prize withheld to satisfy the child support delinquency and the prize winner's address.

(c) The department of health and welfare shall provide notice of the proposed set-off by registered or certified mail to the prize winner at the address provided to the Idaho state lottery. Within fourteen (14) days after such notice has been mailed (not counting Saturday, Sunday or state holidays as the 14th day) the prize winner may file a protest in writing requesting a hearing before the department of health and welfare. The hearing shall be held within thirty-five (35) days from the date of the mailing of the original notice. No issues at that hearing may be considered that have been litigated previously. The department of health and welfare shall issue its findings and decision either at the hearing or by mail to the prize winner within ten (10) days of the hearing.

(d) After the decision of the department of health and welfare is issued, or if the prize winner has failed to file a timely protest of the claim, the set-off procedure shall become final.

(2) The proceeds from the set-off shall be credited to an account designated by the department of health and welfare, and notice shall be given to the appropriate clerk of the district court.

[56-203E, added 1990, ch. 153, sec. 2, p. 338; am. 2013, ch. 250, sec. 1, p. 608.]

56-203F. REGISTRATION OF FOREIGN SUPPORT ORDERS. Notwithstanding any other provision of law, the state department of health and welfare shall register a family support order or family support agreement originating in a foreign country prior to taking enforcement action on the resulting family support obligation. A foreign support order or foreign support agreement shall be registered pursuant to the provisions of chapter 10, title 7, Idaho Code.

[56-203F, added 2015, 1st E.S., ch. 1, sec. 66, p. 32.]

56-204A. SERVICES FOR CHILDREN. The state department is hereby authorized and directed to maintain, by the adoption of appropriate rules and regulations, activities which, through social casework and the use of other appropriate and available resources, shall embrace:

(a) Protective services on behalf of children whose opportunities for normal physical, social and emotional growth and development are endangered for any reason;

(b) Services for unmarried parents, which may be necessary to assure or provide adequate care, and to safeguard the rights and promote the well-being of such parents and their infants;

(c) Services on behalf of children in their own homes to help overcome problems that may result in dependency, neglect or delinquency, and to strengthen parental care and supervision; and

(d) Undertaking care of, and planning for children including those committed to the state department by the courts.

Such rules and regulations shall provide for:

(1) Receiving from any source and investigating all reasonable reports or complaints of neglect, abuse, exploitation or cruel treatment of children;

(2) Initiation of appropriate services and action where indicated with parents or other persons for the protection of children exposed to neglect, abuse, exploitation or cruel treatment;

(3) Filing pleadings with appropriate courts in cases requiring court action;

(4) Arrangements for prenatal care of unmarried expectant mothers and payment for such care when necessary for the well-being of the parents and infant;

(5) Counseling with unmarried parents in relation to their plans for their children, including assisting parents to reach a decision concerning relinquishment through an understanding of what would be best for the child and themselves;

(6) Services and assistance for minor unmarried parents;

(7) Services on behalf of children in their own homes to strengthen parental care and supervision;

(8) Specifying the conditions under which payment shall be made for the purchase of services and care for children, such as medical, psychiatric or psychological services and foster family or institutional care, group care, homemaker service, or day care;

(9) Procedures to be observed in planning and caring for or placing for adoption a child committed to the state department following the termination of his parent-child relationship;

(10) The establishment of appropriate administrative procedures for the conduct of administrative reviews and hearings as required by federal statute for all children committed to the department and placed in out of home care.

[56-204A, added 1963, ch. 325, sec. 2, p. 936; am. 1989, ch. 217, sec. 1, p. 526; am. 1989, ch. 218, sec. 6, p. 531; am. 1992, ch. 341, sec. 5, p. 1036.]

56-204B. TEMPORARY SHELTER CARE. The state department shall provide places of shelter as authorized by law for the placement of children for

temporary care who have been brought into the custody of the magistrate courts or who have been taken into custody for their protection by peace officers. Such places of shelter may be maintained by the state department or may be licensed foster family homes or licensed foster institutional facilities employed or retained for shelter care by the state department.

[56-204B, added 1963, ch. 325, sec. 3, p. 936; am. 1974, ch. 233, sec. 2, p. 1590; am. 2001, ch. 107, sec. 20, p. 370.]

56-205. ISSUANCE OF SNAP BENEFITS. (1) In each month that the state department or its authorized agent issues benefits under the supplemental nutrition assistance program (SNAP) to eligible persons, such benefits shall be issued over the course of not less than ten (10) consecutive days within the month.

(2) To reduce the burden on state general funds, any implementation costs incurred by the department under subsection (1) of this section shall be paid using SNAP performance bonus money if such money is received from the United States department of agriculture. If the department does not receive sufficient SNAP performance bonus money, state general funds shall be requested to implement the provisions of this act. This act is dependent upon ongoing operating and personnel appropriations.

(3) Unless expressly required by federal law, the department of health and welfare shall obtain specific authorization from the legislature before seeking, applying for, accepting, or renewing any waiver of work requirements established by the supplemental nutrition assistance program under 7 U.S.C. 2015(o).

(4) The department of health and welfare may not exercise the state's option to provide any exemptions from the work requirement under 7 U.S.C. 2015(o)(6)(E).

(5)(a) Under the authority given to a state agency to operate the general work requirement pursuant to 7 U.S.C. 2015(d), the department of health and welfare shall assign all individuals who are over the age of seventeen (17) years and under the age of sixty (60) years to an employment and training program as defined in 7 U.S.C. 2015(d)(4), unless the individual is:

(i) Currently subject to and complying with a work registration requirement under title IV of the social security act, as amended, or the federal-state unemployment insurance system, in which case, failure by such person to comply with any work requirement to which such person is subject shall be the same as failure to comply with the general work requirement;

(ii) A parent or other member of a household with responsibility for the care of a dependent child under the age of six (6) years or of an incapacitated person;

(iii) A bona fide student enrolled at least half-time in any recognized school, training program, or institution of higher education, except any such person enrolled in an institution of higher education who is ineligible to participate under 7 U.S.C. 2015(d);

(iv) A regular participant in a drug addiction or alcoholic treatment and rehabilitation program;

(v) Employed a minimum of thirty (30) hours per week or receiving weekly earnings that equal the minimum hourly rate under the fair labor standards act of 1938, as amended, multiplied by thirty (30) hours; or

(vi) A person between the ages of sixteen (16) and eighteen (18) years who is not a head of a household or who is attending school, or enrolled in an employment training program, on at least a half-time basis.

(b) The department of health and welfare may develop a list of additional state-specific exemptions from participation, such as but not necessarily including exemptions for lack of transportation or pregnancy, but may not, in any fiscal year, provide exemptions to a number of individuals equal to or greater than twenty percent (20%) of the total number of work registrants enrolled the previous fiscal year without first obtaining specific authorization from the legislature to do so.

(c) In the event that the director of the department of health and welfare finds that employment and training assignments cannot be funded or provided to all individuals subject to such assignment under this section, the director shall:

(i) Submit a report within fourteen (14) days of first failing to make a required assignment to all members of the legislature and the governor containing:

1. An attestation that the department has expended the state's biennial employment and training grant from the federal government;

2. An attestation that the department has received and expended its able-bodied adults without dependents pledge funding from the federal government;

3. A detailed explanation of the cost-saving measures considered and taken to increase the number of assignments, including online training, work experience components, or work partnerships, and why additional assignments cannot be made within existing funding streams despite those measures;

4. Recommendations for additional funding sources related to workforce training that would be more effectively used to increase workforce participation by directing funds toward employment and training assignments or an explanation for why such redirection from other funding sources would not be more effective to that end;

5. The percentage of work registrants assigned to an employment and training program in the previous month, to be updated and resubmitted monthly to all members of the legislature and the governor; and

6. A plan for how the department plans to restart assignments for all individuals subject to assignment within six (6) months without additional funding using more scalable and affordable employment and training assignments, such as participation in online training, work experience components, or work partnerships;

(ii) Provide updates to all members of the legislature and the governor every thirty (30) days as to the metrics and plans submitted in the first report for as long as the department is failing to make all such required assignments; and

(iii) Continue to assign as many individuals subject to the requirement as possible, prioritizing adults without dependents who have been enrolled for more than one (1) year.

(d) The department may not stop making assignments or decline to assign any individual to an employment and training program because the work requirement for able-bodied adults without dependents under 7 U.S.C. 2015(o) has been suspended or waived partially or wholly by the department, state, or federal government.

[56-205, added 2014, ch. 322, sec. 1, p. 800; am. 2023, ch. 227, sec. 1, p. 699.]

56-206. GENERAL ASSISTANCE. Public assistance awarded under the terms of this act which is not classified as old-age assistance, or aid to the blind, or assistance to families with children, or aid to the disabled, or medical assistance, shall be designated as general assistance.

[56-206, added 1941, ch. 181, sec. 6, p. 379; am. 1966 (2nd E.S.), ch. 11, sec. 3, p. 28; am. 1996, ch. 50, sec. 4, p. 149.]

56-207. OLD-AGE ASSISTANCE. Old-age assistance shall be awarded to needy people who have attained the age of sixty-five (65) years, are residents of the state, and who are not inmates of public institutions at the time of receiving assistance except as patients in public medical institutions and who are not patients in any institution for tuberculosis or for mental diseases or who are not patients in any medical institution as a result of having been diagnosed as having tuberculosis or psychosis.

[56-207, added 1941, ch. 181, sec. 7, p. 379; am. 1951, ch. 246, sec. 1, p. 520; am. 1974, ch. 233, sec. 4, p. 1590.]

56-208. AID TO THE BLIND. Aid to the blind shall be awarded to needy people who have no vision, or whose vision is so defective as to prevent the performance of ordinary activities for which eyesight is essential, who are not receiving old-age assistance, and who are not inmates of public institutions at the time of receiving assistance.

[56-208, added 1941, ch. 181, sec. 8, p. 379; am. 1974, ch. 233, sec. 5, p. 1590.]

56-209. ASSISTANCE TO FAMILIES WITH CHILDREN. The director of the department is authorized to promulgate rules establishing assistance programs for eligible families, including temporary cash assistance, which will promote personal responsibility and self-sufficiency. The department shall define eligibility and other requirements of participation, and may establish time limitations, in conformity with federal law and regulation. The amount and duration of assistance shall be based on available funding.

[56-209, added 1996, ch. 50, sec. 6, p. 149.]

56-209a. AID TO THE DISABLED. Aid to the disabled shall be awarded to needy persons who are disabled and whose disability prevents self-support through employment for a period of at least one (1) year from the date of onset of the disability, but who are not inmates of public institutions (except

as patients in medical institutions) and who are not patients in an institution for tuberculosis or mental diseases or who are not patients in any medical institution as a result of having been diagnosed as having tuberculosis or psychosis.

[56-209a, as added by 1961, ch. 217, sec. 3, p. 346; am. 1974, ch. 233, sec. 7, p. 1590; am. 1978, ch. 246, sec. 3, p. 539.]

56-209b. MEDICAL ASSISTANCE -- MEDICAL ASSISTANCE ACCOUNT. (1) Medical assistance shall be awarded to persons as mandated by federal law; and medical assistance may be awarded to such other persons not required to be awarded medical assistance as mandated by federal law when such award is to the fiscal advantage of the state of Idaho.

(2) There is hereby created in the dedicated fund the medical assistance account. The medical assistance account shall be an entity primarily designed to receive moneys from the families and relatives of patients receiving medical assistance under the state plan for medicaid, and to provide a source of moneys to pay for the state's share of medical assistance expenses. Moneys in the medical assistance account may not be commingled with moneys in the cooperative welfare account. Moneys in the medical assistance account must be appropriated in order to be expended to pay for the state's share of medical assistance expenses.

(3) In all cases where the department of health and welfare through the medical assistance program has or will be required to pay medical expenses for a recipient and that recipient is entitled to recover any or all such medical expenses from any third party or entity, the department of health and welfare will be subrogated to the rights of the recipient to the extent of the amount of medical assistance benefits paid by the department as the result of the occurrence giving rise to the claim against the third party or entity.

(4) If a recipient of medical assistance pursues a claim against a third party or entity through litigation or a settlement, the recipient will so notify the department. If a recipient fails to notify the department of such claim, the department may recover the amount of any public assistance obtained by the recipient while the recipient pursued such claim. In addition, if the recipient recovers funds, either by settlement or judgment, from such a third party or entity, the recipient shall reimburse the department to the extent of the funds received in settlement minus attorney's fees and costs, the amount of the medical assistance benefits paid by the department on his behalf as a result of the occurrence giving rise to the need for medical assistance. The department shall be entitled to all the legal rights and powers of a creditor against a debtor in enforcing the recipient's reimbursement obligation.

(5) The department shall have priority to any amount received from a third party or entity which can reasonably be construed to compensate the recipient for the occurrence giving rise to the need for medical assistance, whether the settlement or judgment is obtained through the subrogation right of the department or through recovery by the recipient, and whether or not the recipient is made whole by the amount recovered. The department will be entitled to reimbursement of medical assistance benefits paid on behalf of the recipient arising from the incident or occurrence prior to any amount being distributed to the recipient. The department may notify such third party or entity of the department's entitlement to receive the reimbursement prior to any amount being distributed to the recipient. Furthermore, the department may instruct the third party or entity to make such payment directly to

the department prior to any amount being distributed to the recipient. Any third party or entity who distributed funds in violation of such a notice shall be liable to the department for the amount of the reimbursement.

(6) In the event a recipient of assistance through the medical assistance program incurs the obligation to pay attorney's fees and costs for the purpose of enforcing a monetary claim to which the department has a right under this section, the amount which the department is entitled to recover, or any lesser amount which the department may agree to accept in compromise of its claim, shall be reduced by an amount which bears the same relation to the total amount of attorney's fees and costs actually paid by the recipient as the amount actually recovered for medical expenses paid by the department, exclusive of the reduction for attorney's fees and costs, bears to the total amount paid by the third party or entity to the recipient. If a settlement or judgment is received by the recipient without delineating what portion of the settlement or judgment is in payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the recipient in an amount equal to the expenditure for medical assistance benefits paid by the department as a result of the occurrence giving rise to the payment or payments to the recipient.

[56-209b, added 1961, ch. 217, sec. 3, p. 346; am. 1966 (2nd E.S.), ch. 11, sec. 4, p. 28; am. 1973, ch. 161, sec. 2, p. 306; am. 1978, ch. 246, sec. 4, p. 539; am. 1981, ch. 201, sec. 1, p. 354; am. 1982, ch. 180, sec. 1, p. 468; am. 1996, ch. 196, sec. 1, p. 614; am. 2002, ch. 369, sec. 1, p. 1038.]

56-209c. DENIAL OF PAYMENT FOR ABORTIONS UNDER CERTAIN CONDITIONS. No funds available to the department of health and welfare, by appropriation or otherwise, shall be used to pay for abortions, unless it is the recommendation of one (1) consulting physician that an abortion is necessary to save the life of the mother, or unless the pregnancy is a result of rape, as defined in section 18-6101, Idaho Code, or incest as determined by the courts.

[56-209c, added 1977, ch. 321, sec. 1, p. 898; am. 2001, ch. 273, sec. 3, p. 997.; am. 2011, ch. 152, sec. 2, p. 437.]

56-209d. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED -- EXPERIMENTAL SERVICES OR PROCEDURES EXCLUDED. Notwithstanding any other provision of this chapter, medical assistance shall increase:

(1) Payment as determined under rules established by the director from forty (40) days per fiscal year to unlimited days of inpatient hospital care per state fiscal year.

(2) Payment as determined under rules established by the director from thirty dollars ($30.00) per month to an unlimited amount of prescribed drugs for each recipient.

(3) Provision of eligibility for medical assistance for residents of skilled and intermediate care facilities who meet the medical criteria for medical assistance, from those with countable income of two hundred one and two-tenths percent (201.2%) to those with countable income of three hundred percent (300%) of the SSI standard.

(4) Payment, as authorized by title XIX of the social security act, as amended, and as determined under rules established by the director for:

(a) Durable medical equipment.

(b) Soft organ transplants.

(c) Adult dental services.
(d) Adult vision services.
(e) Adult hearing services.
(f) Prosthetics.
(g) Assistive and augmentative communication devices.

(5) Payment for breast and cervical cancer-related treatment services for persons who are eligible for screening for these cancers under the federal centers for disease control and prevention's national breast and cervical cancer early detection program, and are eligible for medical assistance pursuant to the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000" (Pub. L. 106-354).

(6) The cost of physician, hospital or other services deemed experimental are excluded from coverage. The director may allow coverage of procedures or services deemed investigational if the procedures or services are as cost effective as traditional, standard treatments.

[56-209d, added 1987, ch. 170, sec. 2, p. 336; am. 1991, ch. 233, sec. 15, p. 561, sec. 18, p. 563; am. 1995, ch. 41, sec. 1, p. 62; am. 1999, ch. 132, sec. 1, p. 378; am. 2001, ch. 205, sec. 1, p. 698; am. 2005, ch. 294, sec. 1, p. 933.]

56-209e ELIGIBILITY OF MARRIED COUPLES FOR MEDICAL ASSISTANCE UNDER THE MEDICAID PROGRAM. (1) It is the intent of the legislature in enacting this section to reduce the number of situations in which medicaid regulations as they apply to long term care costs, cause either the destitution of the entire family, or a dissolution of marriage carried out to prevent destitution. It is further the intent of this section to protect the community and separate property rights, insofar as such rights are not specifically preempted by federal law, of a married person whose spouse applies for medical assistance regardless of whether they are living together.

(2) (a) In determining the eligibility of an aged, blind or disabled married individual or of a couple for medical assistance under title XIX of the social security act, the amount of income and resources to be counted as available to such individual or couple shall be calculated in accordance with the community property provisions of chapter 9, title 32, Idaho Code, or should it be to the advantage of such individual or couple, in accordance with the methods utilized by the federal supplemental security income program under title XVI of the social security act.

(b) Where both spouses are applying or are covered by medical assistance, the same method of counting income and resources shall be applied to both spouses and utilized to determine the liability of each for the cost of medical care; however, for any month for which either spouse receives a supplemental security income payment or a state supplement under section 56-207, 56-208or 56-209a Idaho Code, or for which an application is filed and subsequently approved, the methodology of the supplemental security income program shall be applied.

(c) The presumption of the availability of income under either the community property or supplemental security income method may be rebutted by either spouse.

(d) The department of health and welfare shall furnish to each married medical assistance applicant who is aged, blind or disabled, a clear and simple statement in writing advising them of the provisions of this section.

(e) (i) The provisions of paragraphs (a) through (d) of this subsection shall continue to apply on and after September 30, 1989, to married couples who are living together.

(ii) Beginning September 30, 1989, eligibility for any married person living in a medical institution whose spouse does not live in a medical institution, shall be determined by evaluating income first by attributing such income to the individual or individuals in whose name or names such income is paid, and if such attribution exceeds the maximum eligibility limit, secondly by attributing income in accordance with the community property provisions of chapter 9, title 32, Idaho Code.

(iii) Beginning September 30, 1989, the post eligibility treatment of income of any married person living in a medical institution whose spouse does not live in a medical institution, shall be in accordance with section 1924(b) and (d) of the social security act regardless of whether eligibility was determined in accordance with the name or names by which income was paid or in accordance with the community property provisions of chapter 9, title 32, Idaho Code.

(iv) The provisions of paragraphs (a), (b) and (d) of this subsection as they relate to resources shall continue to apply on and after September 30, 1989, to couples separated because one (1) spouse entered a medical institution for a continuous stay on or before September 29, 1989; and the provisions of section 1924(c) of the social security act shall apply to couples separated because one (1) spouse enters a medical institution for a continuous stay on or after September 30, 1989.

(3) If any provision of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the section that can be given effect without the invalid provisions or applications, and to this end the provisions of this section are severable.

[56-209e, added 1988, ch. 50, sec. 1, p. 74; am. 1989, ch. 67, sec. 1, p. 107.]

56-209f. STATE FINANCIAL ASSISTANCE PROGRAM FOR MEDICALLY INDIGENT RESIDENTS. Beginning October 1, 1991, subject to the requirements and limitations of chapter 35, title 31, Idaho Code, the state shall fund the catastrophic health care cost program from the catastrophic health care cost account which shall provide financial assistance to medically indigent residents who are not eligible under the state plan for medicaid under title XIX of the social security act or medicare under title XVIII of that act, as amended.

[56-209f, added 1990, ch. 87, sec. 11, p. 182; am. 1991, ch. 233, sec. 16, p. 562; am. 2011, ch. 291, sec. 27, p. 812.]

56-209g. PHARMACY REIMBURSEMENT. (1) Medicaid pharmacy reimbursement levels are a combination of the cost of the drug and a dispensing fee which includes such pharmaceutical care services as counseling, obtaining a patient history, documentation and dispensing. Pharmacy reimbursement levels may be adjusted in accordance with rules promulgated by the director through

negotiated rulemaking with interested parties including representatives of the pharmacy profession.

(2) The department will pay the lesser of the provider's lowest charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee.

(a) The EAC is defined by the department as the average acquisition cost (AAC) of the drug, or when no AAC is available, reimbursement will be wholesale acquisition cost (WAC). WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter.

(b) The department shall establish pharmacy dispensing fee payments based on the results of surveys of pharmacies and dispensing rates paid to other payers. The dispensing fee structure will be tiered, with the tiers based on the annual medicaid claims volume of the enrolled Idaho retail pharmacy. All other pharmacy dispensing fees will be the lowest dispensing fee for the tiered structure.

(3) The AAC will be established by the department by state or national surveys to the pharmacy for the product. When surveys are requested by the department to pharmacies participating in the Idaho medicaid program, they are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. Participating pharmacies that refuse to respond to the periodic state surveys will be disenrolled as a medicaid provider.

[56-209g, added 1995, ch. 228, sec. 1, p. 780; am. 1998, ch. 187, sec. 1, p. 682; am. 2010, ch. 296, sec. 5, p. 805; am. 2011, ch. 164, sec. 8, p. 467.]

56-209h. ADMINISTRATIVE REMEDIES. (1) Definitions. For purposes of this section:

(a) "Abuse" or "abusive" means provider practices that are inconsistent with sound fiscal, business, child care or medical practices, and result in an unnecessary cost to a public assistance program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a public assistance recipient.

(b) "Claim" means any request or demand for payment, or document submitted to initiate payment, for items or services provided under a public assistance program, whether under a contract or otherwise.

(c) "Fraud" or "fraudulent" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

(d) "Intentional program violation" means intentionally false or misleading action, omission or statement made in order to qualify as a provider or recipient in a public assistance program.

(e) "Knowingly," "known" or "with knowledge" means that a person, with respect to information or an action:

(i) Has actual knowledge of the information or action; or

(ii) Acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or

(iii) Acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action.

(f) "Managing employee" means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization or agency.

(g) "Medicaid fraud control unit" means that medicaid fraud control unit as provided for in section 56-226, Idaho Code.

(h) "Ownership or control interest" means a person or entity that:

(i) Has an ownership interest totaling twenty-five percent (25%) or more in an entity; or

(ii) Is an officer or director of an entity that is organized as a corporation; or

(iii) Is a partner in an entity that is organized as a partnership; or

(iv) Is a managing member in an entity that is organized as a limited liability company.

(i) "Provider" means an individual, organization, agency or other entity providing items or services under a public assistance program.

(j) "Public assistance program" means assistance for which provision is made in any federal or state law existing or hereafter enacted by the state of Idaho or the congress of the United States by which payments are made from the federal government to the state in aid, or in respect to payment by the state for welfare purposes to any category of needy person, and any other program of assistance for which provision for federal or state funds for aid may from time to time be made.

(2) The department shall establish and operate an administrative fraud control program to enforce violations of the provisions of this chapter and of the state plan pursuant to subchapters XIX and XXI, chapter 7, title 42, U.S.C., that are outside the scope of the duties of the medicaid fraud control unit and to render and receive referrals from and to said unit.

(3) Review of documentation of services. All claims submitted by providers for payment are subject to prepayment and postpayment review as designated by rule. Except as otherwise provided by rule, providers shall generate documentation at the time of service sufficient to support each claim, and shall retain the documentation for a minimum of five (5) years from the date the item or service was provided. The department or authorized agent shall be given immediate access to such documentation upon written request.

(4) Immediate action. In the event that the department identifies a suspected case of fraud or abuse and the department has reason to believe that payments made during the investigation may be difficult or impractical to recover, the department may suspend or withhold payments to the provider pending investigation. In the event that the department identifies a suspected case of fraud or abuse and it determines that it is necessary to prevent or avoid immediate danger to the public health or safety, the department may summarily suspend a provider agreement pending investigation. When payments have been suspended or withheld or a provider agreement suspended pending investigation, the department shall provide for a hearing within thirty (30) days of receipt of any duly filed notice of appeal.

(5) Recovery of payments. Upon referral of a matter from the medicaid fraud control unit, or if it is determined by the department that any condition of payment contained in rule, regulation, statute, or provider agreement was not met, the department may initiate administrative proceedings to recover any payments made for items or services under any public assistance

contract or provider agreement the individual or entity has with the department. Interest shall accrue on overpayments at the statutory rate set forth in section 28-22-104, Idaho Code, from the date of final determination of the amount owed for items or services until the date of recovery.

(6) Provider status. The department may terminate the provider agreement or otherwise deny provider status to any individual or entity who:

(a) Submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item and amount is specifically identified; or

(b) Submits a fraudulent claim; or

(c) Knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the department; or

(d) Submits a claim for an item or service known to be medically unnecessary; or

(e) Fails to provide, upon written request by the department, immediate access to documentation required to be maintained; or

(f) Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments or other public assistance program payments; or

(g) Knowingly violates any material term or condition of its provider agreement; or

(h) Has failed to repay, or was a "managing employee" or had an "ownership or control interest" in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation or provider agreement; or

(i) Has been found, or was a "managing employee" in any entity that has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care or public assistance items or services; or

(j) Fails to meet the qualifications specifically required by rule or by any applicable licensing board.

Any individual or entity denied provider status under this section may be precluded from participating as a provider in any public assistance program for up to five (5) years from the date the department's action becomes final.

(7) The department must refer all cases of suspected medicaid provider fraud to the medicaid fraud control unit and shall promptly comply with any request from the medicaid fraud control unit for access to and free copies of any records or information kept by the department or its contractors, computerized data stored by the department or its contractors, and any information kept by providers to which the department is authorized access by law.

(8) Civil monetary penalties. The department may also assess civil monetary penalties against a provider and any officer, director, owner, and/or managing employee of a provider in the circumstances listed in paragraphs (a) and (b) of this subsection. The penalties provided for in this subsection are intended to be remedial, recovering, at a minimum, costs of investigation and administrative review, and placing the costs associated with noncompliance on the offending provider. The department shall promulgate rules clarifying the methodology used when computing and assessing a civil monetary penalty.

(a) For conduct identified in subsection (6)(a) through (i) of this section, the amount of the penalties shall be up to one thousand dollars ($1,000) for each item or service improperly claimed, except that in the case of multiple penalties the department may reduce the penalties to not less than ten percent (10%) of the amount of each item or service improperly claimed if an amount can be readily determined. Each line item of a claim, or cost on a cost report is considered a separate claim.

(b) For failing to perform required background checks or failing to meet required timelines for completion of background checks, the amount of the penalty shall be five hundred dollars ($500) for each month worked for each staff person for whom the background check was not performed or not timely performed up to a maximum of five thousand dollars ($5,000) per month. A partial month is considered a full month for purposes of determining the amount of the penalty.

(9) Exclusion. Any individual or entity convicted of a criminal offense related to the delivery of an item or service under any state or federal program shall be excluded from program participation as a medicaid provider for a period of not less than ten (10) years. Unless otherwise provided in this section or required by federal law, the department may exclude any individual or entity for a period of not less than one (1) year for any conduct for which the secretary of the department of health and human services or designee could exclude an individual or entity.

(10) Sanction of individuals or entities. The department may sanction individuals or entities by barring them from public assistance programs for intentional program violations where the federal law allows sanctioning individuals from receiving assistance. Individuals or entities who are determined to have committed an intentional program violation will be sanctioned from receiving public assistance for a period of twelve (12) months for the first violation, twenty-four (24) months for the second violation and permanently for the third violation.

(11) Individuals or entities subject to administrative remedies as described in subsections (4) through (10) of this section shall be provided the opportunity to appeal pursuant to chapter 52, title 67, Idaho Code, and the department's rules for contested cases.

(12) Adoption of rules. The department shall promulgate such rules as are necessary to carry out the policies and purposes of this section.

[56-209h, added 1998, ch. 311, sec. 2, p. 1031; am. 2007, ch. 341, sec. 2, p. 1002; am. 2008, ch. 187, sec. 1, p. 588; am. 2016, ch. 106, sec. 1, p. 307.]

56-209i. LEGISLATIVE FINDINGS. It is the intent of the legislature that the provisions of this act enhance the employability of participants in the temporary assistance for families in Idaho (TAFI) programs through substance abuse screening and, where appropriate, testing and treatment. The legislature finds that a significant number of employers use preemployment drug testing. Substance abuse adds to the difficulties such individuals have in securing employment. The legislature also finds that substance abuse in and of itself impairs personal responsibility and self-sufficiency and stands in the way of the very intent of the TAFI program to care for the health and welfare of certain qualified recipients and in so doing results in welfare costs that burden the state's taxpayers. The legislature further finds that substance abuse adversely affects a significant portion of the workforce, which results in billions of dollars of lost productivity each

year and poses a threat to the safety of the workplace and to the public safety and security. In balancing the interests of taxpayers, participants in the TAFI program and potential employers against the interests of those who will be screened and tested under this act, the legislature finds that screening, testing and treatment as provided for in this act are in the greater interests of all concerned.

[56-209i, added 2000, ch. 467, sec. 1, p. 1447.]

56-209j. SUBSTANCE ABUSE SCREENING AND TESTING PROGRAMS. (1) The department of health and welfare shall develop for implementation in fiscal year 2001, a program to screen each applicant who is otherwise eligible for temporary cash assistance provided under this chapter, and to subject to testing any applicant or participant who the department has reasonable suspicion to believe, based on the screening or other factors, is at risk of substance abuse.

(2) Prior to the first regular session of the fifty-sixth Idaho legislature, the department shall promulgate the necessary rules, pursuant to chapter 52, title 67, Idaho Code, to govern substance abuse screening and testing for TAFI programs. Rules shall, at a minimum:

(a) Specifically address the confidentiality of the screening and test results, and provide that individual results are protected under section 74-106(6), Idaho Code, and are not subject to disclosure except to an evaluating or treating substance abuse program, and cannot be released for use in any criminal investigation or proceeding;

(b) Provide notice of screening and testing requirements to each applicant at the time of application. The notice must, at a minimum, advise the applicant that substance abuse screening and possible testing will be conducted as a condition for receiving temporary assistance or services under this chapter. The applicant shall be advised that the required screening and possible testing may be avoided if the applicant does not apply for or receive assistance or services. The screening and testing program is not applicable in child only cases;

(c) Develop procedures for substance abuse screening and testing of applicants for and recipients of temporary assistance or services under the TAFI program;

(d) Provide a procedure to advise each person to be tested, before the test is conducted, that he or she may, but is not required to, advise the agent administering the test of any prescription or over-the-counter medication he or she is taking;

(e) Require each person to be tested to sign a written acknowledgment that he or she has received and understood the notice and advice provided under paragraphs (a) and (d) of this subsection;

(f) Provide a procedure to assure each person being tested a reasonable degree of dignity while producing and submitting a sample for drug testing, consistent with the state's need to ensure the reliability of the sample;

(g) Specify circumstances under which a person who tests positive has the right to take one (1) or more additional tests;

(h) Provide a procedure for appealing the results of a test by a person who tests positive, and denial of TAFI services or benefits;

(i) Provide a definition for reasonable suspicion and high risk;

(j) Delineate the substances which will be screened;

(k) Establish outcome measures which can substantiate program effectiveness.

[56-209j, added 2000, ch. 467, sec. 2, p. 1448; am. 2015, ch. 141, sec. 152, p. 498.]

56-209k. CHILDREN. If a parent is deemed ineligible for cash assistance due to the operation of this act, his or her dependent child's eligibility for cash assistance is not affected.

If a parent is deemed ineligible for cash assistance due to the operation of this act, an appropriate protective payee may be established for the benefit of the child.

If the parent refuses to cooperate in establishing an appropriate protective payee for the child, the department may appoint one.

[56-209k, added 2000, ch. 467, sec. 3, p. 1449.]

56-209l. TREATMENT PROVISIONS. The department shall refer for appropriate evaluation and provide for the treatment of any applicant or participant who, in the reasonable suspicion of the department, is engaged in substance abuse. Treatment shall be community-based and gender-specific. The department shall provide for the transportation and child care needs of the applicant if necessary. TAFI benefits or services may be denied to any applicant or participant who refuses to cooperate with reasonable screening, testing or treatment requests, or who, based on a preponderance of the evidence, engages in substance abuse following treatment. Any individual referred to treatment shall be notified of the local treatment programs appropriate to that person's needs.

[56-209l, added 2000, ch. 467, sec. 4, p. 1449.]

56-209n. MEDICAID FOR WORKERS WITH DISABILITIES. (1) The legislature finds that many individuals with disabilities would like to work but cannot afford to enter the workforce due to the fear of losing necessary medical services received through medicaid. Idaho hereby seeks to avail itself of the opportunity available through the federal ticket to work and work incentives improvement act of 1999, which allows states to establish new medicaid eligibility categories for working people with disabilities whose income or resources would otherwise make them ineligible for medicaid. Eliminating barriers to health care and other needed services and supports and creating financial incentives to work will greatly improve the short and long-term financial independence and well-being of people with disabilities. Medicaid for workers with disabilities will serve to increase the productivity of Idaho residents with disabilities and thereby enhance the economic and fiscal status of this state.

(2) An individual is eligible to participate in the medicaid for workers with disabilities program if the individual:

(a) Is at least sixteen (16) years of age and not more than sixty-four (64) years of age;

(b) Has a disability as defined in title XVI of the federal social security act, as amended. An individual shall be determined to be eligible under this section without regard to his or her ability to engage in, or actual engagement in, substantial gainful activity, as

defined in section 223(d)(4) of the social security act (42 U.S.C. section 423(d)(4));

(c) Is employed, including self-employment, and has provided the department of health and welfare with satisfactory written proof of employment. Hourly wage or hours worked shall not be used to determine employment;

(d) Has countable resources of ten thousand dollars ($10,000) or less. In calculating resources the following items shall be excluded: a second car, life insurance policies, retirement accounts, beneficial trusts, and any other resources excluded under current rules promulgated by the department of health and welfare for aid to aged, blind and disabled (AABD); and

(e) Has countable income, after exclusions and disregards as set forth in rules promulgated by the department of health and welfare for participants receiving AABD benefits, which do not exceed five hundred percent (500%) of the federal poverty level.

(3) An eligible individual who has an income as determined pursuant to subsection (2)(e) of this section less than one hundred thirty-three percent (133%) of the federal poverty level shall not be required to pay a premium for medicaid.

(4) The department of health and welfare may require an eligible individual who has an income as determined pursuant to subsection (2)(e) of this section of one hundred thirty-three percent (133%) to two hundred fifty percent (250%) of the federal poverty level to pay a monthly premium as set forth in rules promulgated by the department of health and welfare.

(5) An eligible individual who has an income as determined pursuant to subsection (2)(e) of this section in excess of two hundred fifty percent (250%) of the federal poverty level shall pay to the department of health and welfare a monthly premium as a condition for continued eligibility for medicaid. The monthly premium shall be calculated by multiplying seven and one-half percent (7.5%) by the amount of the individual's income as determined pursuant to subsection (2)(e) of this section which is above two hundred fifty percent (250%) of the federal poverty level.

[56-209n, added 2006, ch. 174, sec. 1, p. 533.]

56-209o. FAILURE TO RETAIN RECORDS. (1) Whoever receives payment for treatment, services or goods under the provisions of this chapter or under the state plan pursuant to subchapter XIX or XXI, chapter 7, title 42, U.S.C., shall retain for a period of at least five (5) years all records required to be maintained by rule of the department for administration of the medicaid program.

(2) It shall be unlawful with an intent to evade or avoid the provisions of this act: to fail to retain the records specified in subsection (1) of this section for a period of at least five (5) years from the date payment was claimed or received, whichever is later; or to knowingly destroy or cause the records specified in subsection (1) of this section to be destroyed within five (5) years from the date payment was claimed or received, whichever is later. Any person who, with an intent to evade or avoid the provisions of this act, fails to retain records or destroys records or causes records to be destroyed as provided in this subsection (2), with an intent to evade or avoid the provisions of this act, shall be subject to the following criminal sanctions:

(a) If the treatment, services or goods for which records were not retained or for which records were destroyed amount to not more than one thousand dollars ($1,000), the person shall be guilty of a misdemeanor and shall be sentenced pursuant to section 18-113, Idaho Code.
(b) If the value of the treatment, services or goods for which records were not retained or for which records were destroyed is more than one thousand dollars ($1,000), the person shall be guilty of a felony and shall be sentenced pursuant to section 18-112, Idaho Code.
(c) If the records not retained or destroyed were used in whole or in part to determine a rate of payment under the program, the person shall be guilty of a misdemeanor and shall be sentenced pursuant to section 18-113, Idaho Code.

[56-209o, added 2007, ch. 341, sec. 3, p. 1004.]

56-209p. PAYMENT FOR MIDWIFE SERVICES. A midwife licensed pursuant to chapter 55, title 54, Idaho Code, shall be entitled to payment under the rules of the medical assistance program for midwife services provided to an eligible recipient of medical assistance.

[56-209p, added 2011, ch. 182, sec. 1, p. 516.]

56-210. AMOUNT OF ASSISTANCE. (1) The amount of public assistance which any eligible person or family may receive shall be determined in accordance with the rules of the state department subject to the availability of funds for such assistance.
(2) Old age assistance, aid to the blind and aid to the permanently and totally disabled shall be granted to a person who is needy as defined by the department and who meets the nonfinancial requirements of title XVI of the social security act.
(3) The department may also increase or decrease the payment for groups of cases where the circumstances are specifically identified. The department shall be the single state agency for administration of public assistance programs or plans that receive federal funding.

[56-210, added 1941, ch. 181, sec. 10, p. 379; am. 1945, ch. 109, sec. 4, p. 165; am. 1951, ch. 246, sec. 2, p. 520; am. 1953, ch. 22, sec. 1, p. 38; am. 1961, ch. 57, sec. 1, p. 85; am. 1969, ch. 30, sec. 1, p. 51; am. 1978, ch. 246, sec. 5, p. 540; am. 1981, ch. 179, sec. 2, p. 314; am. 1994, ch. 287, sec. 1, p. 906; am. 1996, ch. 50, sec. 7, p. 150; am. 1997, ch. 32, sec. 1, p. 56.]

56-211. APPLICATION FOR PUBLIC ASSISTANCE -- VERIFICATION FOR FEDERAL FOOD STAMP PROGRAM. (1) Application for public assistance under this act shall be made in the manner and form prescribed by the state department and the application shall contain such information bearing on the applicant's eligibility as the state department may require and as required in subsection (2) of this section.
(2) Applicants seeking benefits under the federal food stamp program shall verify to the state department the identity of each household member the applicant lists on the application for such benefits. Identification may be verified either through readily available documentary evidence, such as a birth certificate, or through a collateral contact as set forth in federal law, 7 CFR 273.2. Upon a showing of good cause by the applicant as to why

such documentary evidence or collateral contact has not been provided, the state department shall grant an extension and the applicant may receive the public assistance for which he or she has applied for one (1) month. A showing of good cause shall be required each month the applicant fails to provide the state department with the required documentary evidence or collateral contact. Good cause is not shown where a delay in providing documentary evidence or providing a collateral contact is due to illness, lack of transportation or temporary absences. The provisions of this subsection shall not apply to applicants who provide, or who have previously provided, a document as set forth in section 67-7903(4)(b)(viii) or (ix), Idaho Code.

(3) The state department may promulgate rules to implement the provisions of this section.

[56-211, added 1941, ch. 181, sec. 11, p. 379; am. 2011, ch. 269, sec. 1, p. 729.]

56-212. INVESTIGATION OF APPLICATION. Whenever the state department shall receive an application for public assistance under this act, it shall promptly make an investigation and record of the circumstances of the applicant in order to ascertain the facts supporting the application and to obtain such other information as it may require.

[56-212, added 1941, ch. 181, sec. 12, p. 379.]

56-213. EXAMINATION TO DETERMINE BLINDNESS. No application for aid to the blind shall be approved until an ophthalmologist or physician skilled in diseases of the eye, or an optometrist, approved or designated by the state department, shall have examined the applicant and shall have certified his findings in the manner and form required by the state department.

[56-213, added 1941, ch. 181, sec. 13, p. 379; am. 1951, ch. 246, sec. 3, p. 520.]

56-214. AWARD OF PUBLIC ASSISTANCE -- INELIGIBILITY UPON TRANSFER OF PROPERTY. Upon the completion of the investigation, the state department shall determine whether the applicant is eligible for public assistance under the provisions of this act, the type and amount of public assistance he shall receive, and the date upon which such public assistance shall begin. Public assistance shall be paid in the manner prescribed by the state department.

(1) Assistance to families with children shall not be granted under this act to any person who within six (6) months prior to applying for or at any time during which such assistance is received, has either made an assignment or transfer of property for the purpose of rendering himself eligible for assistance under this act, or who has divested himself of any interest in property without adequate consideration which interest or proceeds therefrom could reasonably be expected to contribute to the support and maintenance of such person and his family, except that any person who is ineligible for public assistance due solely to such assignment or transfer shall become eligible provided:

(a) There is a showing that such person has caused such property to be assigned or transferred back to him; or

(b) There is a showing that the person to whom such property is assigned or transferred has, subsequent to such assignment or transfer,

met subsistence and medical care costs exclusive of any obligation for support, of such person or family, according to the department's assistance standard, equal to, or in excess of, the market value of the property so assigned or transferred; or

(c) There is a showing that the subsistence and medical care costs of such person, according to the department's assistance standard, subsequent to such assignment or transfer, equal or exceed the market value of the property so assigned or transferred.

(2) Eligibility for old age assistance under section 56-207, Idaho Code, or aid to the blind under section 56-208, Idaho Code, or aid to the disabled under section 56-209a, Idaho Code, shall be determined by continuing to consider as available any resource that was transferred prior to July 1, 1988, until such resource is fully accounted for under the provisions of section 1613(c) of the social security act as such section read on June 30, 1988.

(3) Eligibility for medical assistance under section 56-209b, Idaho Code, shall continue to apply the rules of the director of the department of health and welfare concerning transfer of property as such rules read on October 29, 1988, to transfers that occur prior to July 1, 1989, to persons other than to the spouse of the person receiving or applying for medical assistance, and to interspousal transfers that occur prior to October 1, 1989.

(4) The provisions of section 1917(c) of the social security act as amended by public law 100-360 and further amended by public law 100-485 and as hereafter amended shall apply as of July 1, 1989, to transfers of assets other than to the spouse, and as of October 1, 1989, to transfers between spouses, except that such provisions shall not apply either to transfers that occurred before July 1, 1988, or to transfers that have been fully accounted for under subsection (3) of this section. Notwithstanding the foregoing, any transfer of assets not otherwise specifically permitted by federal law or rule of the department not for fair market value is presumed to be for the purpose of sheltering assets to qualify for medical assistance. Such assets transferred shall be counted as available in determining eligibility, and will subject the applicant to penalties prescribed by the director, unless the applicant for assistance can demonstrate by clear and convincing evidence that the transfer was intended for another purpose.

(5) Any funds, securities, accounts, contracts and all other property held in or transferred to a special needs trust as provided in chapter 14, title 68, Idaho Code, section 15-5-409, Idaho Code, and section 15-5-409a, Idaho Code, shall not be considered by the state department in determining whether the applicant is eligible for public assistance under the provisions of this act, so long as the action is permitted under the provisions of section 1917(c) and (d) of the social security act, as amended.

(6) If any provision of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the section that can be given effect without the invalid provisions or applications, and to this end the provisions of this section are severable.

[56-214, added 1941, ch. 181, sec. 14, p. 379; am. 1943, ch. 119, sec. 1, p. 228; am. 1951, ch. 246, sec. 4, p. 520; am. 1974, ch. 233, sec. 8, p. 1590; am. 1978, ch. 74, sec. 1, p. 148; am. 1981, ch. 121, sec. 1, p. 208; am. 1989, ch. 67, sec. 2, p. 108; am. 1995, ch. 214, sec. 4, p. 746; am.

1996, ch. 50, sec. 8, p. 150; am. 2002, ch. 279, sec. 1, p. 815; am. 2007, ch. 248, sec. 1, p. 728; am. 2008, ch. 146, sec. 1, p. 430.]

56-214A. AWARD OF PUBLIC ASSISTANCE -- RECIPIENT'S RIGHT OF FREE CHOICE. If an award of public assistance which includes an eye examination is made to or in behalf of an individual, that individual or his legal custodian shall have the right to select any practitioner to perform such examination who is licensed by the state of Idaho to perform eye examinations. Whenever such an award is applied for or approved, the state department or its personnel shall not recommend any practitioner or system of practice from among those licensed to perform eye examinations.

[56-214A, added 1963, ch. 8, sec. 1, p. 19; am. 1965, ch. 62, sec. 1, p. 97.]

56-215. REDETERMINATION OF AWARDS. Awards of public assistance may be changed or withdrawn whenever the circumstances have altered sufficiently to warrant such action. If at any time during the continuance of public assistance the recipient thereof becomes possessed of income or resources in excess of the amount previously reported by him, it shall be his duty to notify the state department of this fact immediately on the receipt or possession of such additional income or resources.

[56-215, added 1941, ch. 181, sec. 15, p. 379.]

56-216. APPEAL AND FAIR HEARING. An applicant or recipient aggrieved because of the state department's decision or delay in making a decision shall be entitled to appeal to the state department in the manner prescribed by it and shall be afforded reasonable notice and opportunity for a fair hearing by the state department.

[56-216, added 1941, ch. 181, sec. 16, p. 379.]

56-217. COOPERATIVE AGREEMENTS. The state department and the several counties of the state or other branches of state, county or municipal government are authorized to enter into cooperative agreements, through their appropriate officials, with respect to the administration of public assistance and social services. Among other things such an agreement may provide for:

(a) The assumption by the state department of responsibilities involving public assistance or social services ordinarily incumbent upon the county or other branch of government;

(b) The direct administration through the state department of any form of public assistance or care of the poor now or hereafter authorized to be granted by a county, but subject to the financial control of the county;

(c) Mutual financial participation in programs of public assistance and social services in conformity with regulations of the department.

(d) The intake and investigation of applications for public assistance by the appropriate office of the state department;

(e) The granting of public assistance financed in whole or in part by county funds on the basis of policies, rules and regulations governing eligibility and amount of assistance adopted by the state department under this act.

[56-217, added 1941, ch. 181, sec. 17, p. 379.]

56-218. RECOVERY OF CERTAIN MEDICAL ASSISTANCE. (1) Except where exempted or waived in accordance with federal law medical assistance pursuant to this chapter paid on behalf of an individual who was fifty-five (55) years of age or older when the individual received such assistance may be recovered from the individual's estate, and the estate of the spouse, if any, for such aid paid to either or both:

(a) There shall be no adjustment or recovery until after the death of both the individual and the spouse, if any, and only at a time when the individual has no surviving child who is under twenty-one (21) years of age or is blind or permanently and totally disabled as defined in 42 U.S.C. 1382c.

(b) While one (1) spouse survives, except where joint probate will be authorized pursuant to section 15-3-111, Idaho Code, a claim for recovery under this section may be established in the estate of the deceased spouse.

(c) The claim against the estate of the first deceased spouse must be made within the time provided by section 15-3-801(b), Idaho Code, if the estate is administered and actual notice is given to the director as required by subsection (5) of this section. However, if there is no administration of the estate of the first deceased spouse, or if no actual notice is given to the director as required by subsection (5) of this section, no claim shall be required until the time provided for creditor claims in the estate of the survivor.

(d) Nothing in this section authorizes the recovery of the amount of any aid from the estate or surviving spouse of a recipient to the extent that the need for aid resulted from a crime committed against the recipient.

(2) Transfers of real or personal property, on or after the look-back dates defined in 42 U.S.C. 1396p, by recipients of such aid, or their spouses, without adequate consideration are voidable and may be set aside by an action in the district court.

(3) Except where there is a surviving spouse, or a surviving child who is under twenty-one (21) years of age or is blind or permanently and totally disabled as defined in 42 U.S.C. 1382c, the amount of any medical assistance paid under this chapter on behalf of an individual who was fifty-five (55) years of age or older when the individual received such assistance is a claim against the estate in any guardianship or conservatorship proceedings and may be paid from the estate.

(4) For purposes of this section, the term "estate" shall include:

(a) All real and personal property and other assets included within the individual's estate, as defined for purposes of state probate law; and

(b) Any other real and personal property and other assets in which the individual had any legal title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.

(5) Claims made pursuant to this section shall be classified and paid as a debt with preference as defined in section 15-3-805(5), Idaho Code. Any distribution or transfer of the estate prior to satisfying such claim is voidable and may be set aside by an action in the district court. The personal representative of every estate subject to a claim under this section

must, within thirty (30) days of the appointment, give notice in writing to the director of his or her appointment to administer the estate.

(6) The department may file a notice of lien against the property of any estate subject to a claim under this section.

(a) In order to perfect a lien against real or personal property, the department shall, within ninety (90) days after the personal representative or successor makes a written request for prompt action to the director, or three (3) years from the death of the decedent, whichever is sooner, file a notice of lien in the same general form and manner as provided in section 56-218A(3)(a), Idaho Code, in the office of the secretary of state, pursuant to section 45-1904, Idaho Code. Failure to file a notice of lien does not affect the validity of claims made pursuant to this section.

(b) The department may release the lien in whole or in part to permit the estate property to be administered by a court-appointed personal representative.

(c) The department may foreclose its lien, without probate, in any of the following circumstances:

(i) Where no personal representative has been appointed after one (1) year from the date of death of the survivor of both the individual and spouse, if any;

(ii) Where the property has been abandoned by the decedent's heirs or successors, if any;

(iii) Where the real property taxes that are due and payable have remained unpaid for two (2) years and, after demand by the department, the heirs or successors, if any, have failed to seek appointment or pay the property taxes; or

(iv) Where all parties interested in the estate consent to foreclosure of the lien.

(7) The director shall promulgate rules reasonably necessary to implement this section including, but not limited to, rules establishing undue hardship waivers for the following circumstances:

(a) The estate subject to recovery is income-producing property that provides the primary source of support for other family members; or

(b) The estate has a value below an amount specified in the rules; or

(c) Recovery by the department will cause the heirs of the deceased individual to be eligible for public assistance.

(8) The cause of action to void a transfer without adequate consideration established in this section shall not be deemed to have accrued until the department discovers, or reasonably could have discovered, the facts constituting the transfer without adequate consideration.

[56-218, added 1988, ch. 49, sec. 1, p. 73; am. 1994, ch. 329, sec. 1, p. 1059; am. 1995, ch. 105, sec. 1, p. 336; am. 1997, ch. 205, sec. 2, p. 612; am. 1998, ch. 9, sec. 1, p. 106; am. 2004, ch. 216, sec. 1, p. 650; am. 2005, ch. 304, sec. 1, p. 951; am. 2006, ch. 179, sec. 2, p. 554; am. 2008, ch. 182, sec. 7, p. 552.]

56-218A. MEDICAL ASSISTANCE LIENS DURING LIFE OF RECIPIENT. (1) The department may recover and may impose a lien against the real property of any individual prior to his death for medical assistance paid or about to be paid under this chapter on behalf of an individual:

(a) Who is an inpatient in a nursing facility, intermediate care facility for people with intellectual disabilities, or other medical in-

stitution, if such individual is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs; and

(b) With respect to whom the department has determined, after notice and opportunity for hearing, that he cannot reasonably be expected to be discharged from the medical institution and to return home.

(2) No lien may be imposed on the home of an individual under subsection (1) of this section if any of the following is lawfully residing in such home:

(a) The spouse of such individual;

(b) Such individual's child under age twenty-one (21) years;

(c) Such individual's child who is blind or permanently and totally disabled as defined in 42 U.S.C. 1382c; or

(d) A sibling of such individual who holds an equity interest in such home and who was residing in such home for a period of at least one (1) year prior to the individual's admission to the medical institution.

(3) (a) The lien shall be perfected by filing in the office of the secretary of state a notice of lien pursuant to section 45-1904, Idaho Code. The notice of lien shall include, in addition to the information required by section 45-1904, Idaho Code, the amount paid or about to be paid by the department on behalf of the individual, and, if applicable, the fact that the amount of the lien may increase over time.

(b) The department shall file any notice of lien under this section within ninety (90) days of the final determination of the department, after hearing if any, required in subsection (1)(b) of this section, with the exception of property against which the department is prevented from filing a lien pursuant to subsection (2) of this section. With respect to the property described in subsection (2) of this section, the department shall file a notice of lien within ninety (90) days after the department is notified in writing that subsection (2) of this section ceases to apply to the property.

(4) Any lien imposed in accordance with subsection (1) of this section shall dissolve upon the individual's discharge from the medical institution and return home.

(5) No recovery shall be made under this section for medical assistance correctly paid except from such individual's estate as defined in subsection (4) of section 56-218, Idaho Code, and subject to subsections (1)(d), (5) and (6) of section 56-218, Idaho Code, or upon sale of the property subject to a lien and may be made only after the death of such individual's surviving spouse, if any, and only at a time:

(a) When he has no surviving child who is under age twenty-one (21) years, or who is blind or permanently and totally disabled as defined in 42 U.S.C. 1382c; or

(b) In the case of a lien on an individual's home under subsection (1) of this section, when none of the following is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution:

(i) A sibling of the individual, who was residing in the individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the medical institution; or

(ii) A son or daughter of the individual, who was residing in the individual's home for a period of at least two (2) years immedi-

ately before the date of the individual's admission to the medical institution and who establishes to the satisfaction of the state that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution.

(6) The director shall promulgate rules reasonably necessary to implement this section including, but not limited to, rules establishing undue hardship waivers, as provided in section 56-218(7), Idaho Code, and a procedure for notice and opportunity for hearing on the department's determination that an individual cannot reasonably be expected to be discharged from a medical institution and to return home.

[56-218A, added 1995, ch. 105, sec. 2, p. 337; am. 1997, ch. 205, sec. 3, p. 613; am. 2006, ch. 179, sec. 3, p. 557; am. 2010, ch. 235, sec. 45, p. 583.]

56-219. PAYMENT FOR INCOMPETENT RECIPIENT -- APPOINTMENT OF GUARDIAN FOR PUBLIC ASSISTANCE. If the recipient is under legal disability, or is incompetent or unable to handle the assistance granted him under this act, and has no other legal guardian, the district court, after due notice and hearing, shall appoint, without fee, on petition of the state department, and with the consent of the recipient's nearest kin, next friend, natural guardian or custodian, a capable and trustworthy person as his guardian for public assistance, without bond, whose duty it shall be, without compensation, to receive and disburse the recipient's assistance on his behalf, and to make true and accurate account thereof as often as required by regulation to the state department, and as otherwise provided by law, to the district court. Funds in the hands of such guardian shall be disbursed only for the purposes contemplated by this act, or as directed in the grant thereof.

[56-219, added 1941, ch. 181, sec. 19, p. 379.]

56-220. PAYMENT ON DEATH OF RECIPIENT -- APPOINTMENT OF ADMINISTRATOR OF PUBLIC ASSISTANCE. In the event of the death of a recipient, leaving little or no estate requiring formal administration, but to whom a check for public assistance has been delivered prior to his death, or for whose interment burial relief has been granted, the district court, without fee, on petition of the state department, and with the consent of the deceased recipient's nearest kin, next friend, guardian, natural guardian or custodian, after due notice and hearing, shall appoint a capable and trustwarthy [trustworthy] person as his administrator for public assistance, without bond, whose duty it shall be, without compensation, to receive and disburse the recipient's assistance on behalf of the deceased recipient's estate, making true and accurate account thereof to the state department and the district court. Funds in the hands of such administrator shall be disbursed only for the purposes contemplated by this act, or as directed in the grant thereof.

[56-220, added 1941, ch. 181, sec. 20, p. 379.]

56-221. CONFIDENTIAL CHARACTER OF PUBLIC ASSISTANCE RECORDS. The rule-making power of the state department shall include the power to establish and enforce reasonable rules and regulations governing the custody, use and preservation of the records, papers, files and communications of the state department. Wherever, under provisions of law, names and addresses of re-

cipients of public assistance are furnished to or held by any state or county official, the names and addresses shall be subject to disclosure according to chapter 1, title 74, Idaho Code; but any exemption from disclosure shall not prevent the furnishing to a state or local law enforcement officer, upon his written request, with the current address of any AFDC recipient if the officer furnishes the state department with such recipient's name and social security account number and proof that such recipient is a convicted fugitive felon or an indicted fugitive felon, or a person for whom a fugitive warrant has been issued, and that the location or apprehension of such felon or person is within the officer's official duties, and that the request is made in the proper exercise of those duties.

[56-221, added 1941, ch. 181, sec. 21, p. 379; am. 1985, ch. 64, sec. 1, p. 135; am. 1990, ch. 213, sec. 83, p. 550; am. 2015, ch. 141, sec. 153, p. 499.]

56-222. MISUSE OF PUBLIC ASSISTANCE LISTS AND RECORDS. It shall be unlawful, except for purposes directly connected with the administration of public assistance and social services, and in accordance with the rules and regulations of the state department, for any person or persons to disclose, or make use of, or to authorize, knowingly permit, or participate in the use of, any list of names, or any information concerning, persons applying for or receiving such assistance or services, directly or indirectly derived from the records, papers, files or communications of the state or county or subdivisions or agencies thereof, or acquired in the course of the performance of official duties.

[56-222, added 1941, ch. 181, sec. 22, p. 379.]

56-223. PUBLIC ASSISTANCE NOT ASSIGNABLE. Public assistance awarded under this act shall not be transferable or assignable, and none of the money paid or payable under this act shall be subject to execution, attachment, or other legal process; except that the department may transfer funds to another public agency in lieu of payments to recipients, said funds to be transferred by such agency to project sponsors for payment as wages to said recipients participating in special work projects.

[56-223, added 1941, ch. 181, sec. 23, p. 379; am. 1969, ch. 30, sec. 2, p. 51; am. 1997, ch. 30, sec. 1, p. 55.]

56-224. RECOVERY. The department may recover the amount of any public assistance obtained by any person who was not entitled thereto. If at any time during the continuance of assistance, the recipient thereof becomes possessed of any property or income in excess of the amount stated in the application, it shall be the duty of the recipient to notify the state department immediately of the receipt or possession of such property or income. Any assistance granted after the recipient has come into possession of such property or income in excess of eligibility standards, may be recovered by the state department.

On the death of a recipient who has received public assistance to which he was not entitled, or who has received public assistance in an amount greater than that to which he was entitled, by reason of possession or having come into possession of resources which he did not disclose to the department, or which had, or which acquired, a greater value than was disclosed,

the total amount of such assistance paid to such recipient to which he was not entitled shall be allowed as a preferred claim against the estate of such recipient.

[56-224, added 1941, ch. 181, sec. 24, p. 379; am. 1951, ch. 246, sec. 5, p. 520; am. 1997, ch. 31, sec. 1, p. 55.]

56-225. REQUEST FOR NOTICE OF TRANSFER OR ENCUMBRANCE OF REAL PROPERTY -- RULEMAKING. (1) When an individual receives medical assistance subject to recovery under this chapter and the individual is the holder of record title to real property or the purchaser under a land sale contract, the department of health and welfare may present to the county recorder for recording in the grants and conveyances records of a county a request for notice of transfer or encumbrance of the real property. The department shall adopt a rule providing prior notice and hearing rights to the record titleholder or purchaser under a land sale contract.

(2) The department shall present to the county recorder for recording a termination of request for notice of transfer or encumbrance when, in the judgment of the department, it is no longer necessary or appropriate for the department to monitor transfers or encumbrances related to the real property.

(3) The department shall adopt by rule a form for the request for notice of transfer or encumbrance and the termination of request for notice of transfer or encumbrance that, at a minimum:

(a) Contains the name of the public assistance recipient, and the spouse of such public assistance recipient, if any, and a departmental case identifier or other appropriate information that links the individual who is the holder of record title to real property or the purchaser under a land sale contract to the individual's public assistance records;

(b) Contains the legal description of the real property;

(c) Contains a mailing address for the department to receive the notice of transfer or encumbrance; and

(d) Complies with the requirements for recording in section 55-805, Idaho Code, for those forms intended to be recorded.

(4) The request for notice of transfer or encumbrance described in this section does not affect title to real property and is not a lien on, encumbrance of, or other interest in, the real property.

[56-225, added 2010, ch. 90, sec. 2, p. 175.]

56-226. MEDICAID FRAUD CONTROL UNIT. (1) There is hereby established in the office of the attorney general the medicaid fraud control unit which shall have the authority and responsibilities as set forth in this section.

(2) Notwithstanding the authority and responsibility granted to the director of the department to provide for fraud control in other aspects of public assistance and public health programs, the medicaid fraud control unit shall have the authority and responsibility to conduct a statewide program for the investigation and prosecution of violations of all applicable Idaho laws pertaining to fraud in the administration of the medicaid program, the provision of medical assistance and in the activities of providers of medical assistance and services under the state plan. Further, upon approval of the inspector general of the relevant federal agency, the office of the attorney general shall have the authority and responsibility

to investigate and to prosecute violations of any aspect of the provision of health care services and activities of providers of such services under any federal health care program as defined in 42 U.S.C. section 1320(a)-7b(f)1, if the suspected fraud or violation of law in such investigation or prosecution is substantially related to the state plan. The medicaid fraud control unit shall be under the exclusive control of the attorney general and be separate and distinct from the department. No official from the department shall have authority to review or override the prosecutorial decisions made by the medicaid fraud control unit.

(3) The medicaid fraud control unit shall also:

(a) Review complaints of abuse or neglect of medicaid recipients in health care facilities which receive payment pursuant to the state plan and may review complaints of the misappropriation of patients' private funds in such facilities; and

(b) Review complaints of abuse or neglect of medicaid recipients residing in a board and care facility.

(4) The medicaid fraud control unit shall attempt to collect or refer to the department for collection overpayments that are made to providers of facilities under the state plan or under any federal health care program to health care facilities that are the result of fraudulent acts and that are discovered by the medicaid fraud control unit in carrying out its responsibilities under this section. Notwithstanding any other provision of Idaho Code, all funds collected by the medicaid fraud control unit in accordance with this subsection (4) shall be deposited into the state general fund.

(5) The office of the attorney general shall employ such auditors, attorneys, investigators and other personnel as are necessary to carry out the responsibilities of the medicaid fraud control unit as set forth under this section.

(6) The office of the attorney general shall submit to the secretary of the federal department of health and human services applications and reports containing such information as is determined by the secretary by regulation to be necessary to meet the requirements of subchapter XIX, chapter 7, title 42, U.S.C.

(7) In carrying out its duties and responsibilities under this section, the medicaid fraud control unit may:

(a) Request and receive the assistance of any prosecutor or law enforcement agency in the investigation and prosecution of any violation of any applicable Idaho laws pertaining to fraud in the administration of the medicaid program, the provision of medical assistance and in the activities of providers of medical assistance and services under the state plan;

(b) Enter upon the premises of any provider participating in the medicaid program to:

(i) Examine all accounts and records that are relevant in determining the existence of fraud in the medicaid program;

(ii) Investigate alleged abuse or neglect of medicaid recipients; or

(iii) Investigate alleged misappropriation of patients' private funds. The accounts or records of a nonmedicaid recipient may not be reviewed by, or turned over to the medicaid fraud control unit without the patient's written consent or a court order; and

(c) Notwithstanding any other provision of law, upon written request have full access to all records held by a medicaid provider, or by any

other person on his or her behalf, that are relevant to the determination of the:

(i) Existence of civil violations or criminal offenses under this chapter or related offenses;

(ii) Existence of medicaid recipient abuse, mistreatment or neglect; or

(iii) Theft of medicaid recipient funds.

No person holding such records shall refuse to provide the medicaid fraud control unit access to such records for the purposes described in this section on the basis that release would violate the medicaid recipient's right of privacy or privilege against disclosure or use or any professional or other privilege or right.

(8) The medicaid fraud control unit shall safeguard the privacy rights of medicaid recipients to avoid unnecessary disclosure of personal information concerning named medicaid recipients. The medicaid fraud control unit may transmit such information that it deems appropriate to the department and to other agencies concerned with the regulation of health care facilities or health professionals.

(9) The attorney general shall have the authority to adopt rules necessary to implement the duties and responsibilities assigned to the medicaid fraud control unit under this section.

(10) As used in this section:

(a) "Board and care facility" means a provider of medicaid services in a residential setting which receives payment from or on behalf of two (2) or more unrelated adults who reside in such facility, and for whom one (1) or more of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse or certified nurses aide; or

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer of positions, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry and housework.

(b) "Department" means the Idaho department of health and welfare.

(c) "Director" means the director of the Idaho department of health and welfare.

(d) "Medicaid" means Idaho's medical assistance program.

(e) "Provider" means any individual, partnership, association, corporation or organization, public or private, which provides residential or assisted living services, certified family home services, nursing facility services or services offered pursuant to medical assistance.

(f) "Recipient" means an individual determined eligible by the director for the services provided in the state plan for medicaid.

(g) "State plan" means the Idaho state plan pursuant to subchapter XIX, chapter 7, title 42 U.S.C.

[56-226, added 2007, ch. 341, sec. 4, p. 1005.]

56-227. FRAUDULENT ACTS -- PENALTY. (1) Whoever knowingly obtains, or attempts to obtain, or aids or abets any person in obtaining, by means of a willfully false statement or representation, material omission, or fraudulent devices, public assistance to which he is not entitled, or in an amount

greater than that to which he is justly entitled, shall be punished in the same manner and to the same extent as for larceny or theft of the money or value of the public assistance so obtained or attempted to be so obtained.

(2) Whoever sells, conveys, mortgages or otherwise disposes of his property, real or personal, or conceals his income or resources, for the purpose of rendering him eligible for public assistance, theretofore or thereafter applied for, to which he would not otherwise be entitled, shall be punished in the same manner and to the same extent as for larceny or theft of the money or value of the public assistance so obtained or so attempted to be obtained. Provided however, this provision shall not be construed to be more restrictive than federal or state provisions regarding the transfer of property for public assistance.

(3) Every person who knowingly aids or abets any person in selling, conveying, mortgaging or otherwise disposing of his property, real or personal, or in concealing his income or resources for the purpose of rendering him eligible for public assistance, theretofore or thereafter applied for and received, to which he would not otherwise be entitled, shall be punished in the same manner and to the same extent as for larceny or theft of the money or value of the public assistance so obtained or attempted to be obtained. Provided however, this provision shall not apply to any person who communicates information or renders advice to another regarding federal or state provisions regarding the transfer of property for public assistance.

(4) For the purpose of this section public assistance shall include the specific categories of assistance for which provision is made in any federal or state law existing or hereafter enacted by the congress of the United States or the state of Idaho by which payments are made from the federal government to the state in aid or in respect to payment by the state for welfare purposes to any category of needy person and any other program of assistance for which provision for federal or state funds for aid may from time to time be made.

(5) The state department of health and welfare shall establish and operate a fraud control program to investigate suspected fraud relating to applications for public assistance benefits, and public assistance benefits received by individuals or entities. Such activities shall be those which do not fall under the authority of the medicaid fraud control unit as provided in section 56-226, Idaho Code. The department shall establish a procedure to coordinate information with prosecuting attorneys to prosecute offenders who commit fraudulent acts pursuant to this chapter.

[56-227, added 1941, ch. 181, sec. 24-c, as added by 1943, ch. 119, sec. 2, p. 228; am. 1974, ch. 233, sec. 9, p. 1590; am. 1981, ch. 194, sec. 1, p. 343; am. 1988, ch. 246, sec. 1, p. 480; am. 2002, ch. 369, sec. 2, p. 1039; am. 2007, ch. 341, sec. 5, p. 1007; am. 2008, ch. 188, sec. 1, p. 592.; am. 2013, ch. 143, sec. 1, p. 340.]

56-227A. PROVIDER FRAUD -- CRIMINAL PENALTY. It shall be unlawful for any provider or person, knowingly, with intent to defraud, by means of a wilfully false statement or representation or by deliberate concealment of any material fact, or any other fraudulent scheme or device, to:

(a) present for allowance or payment any false or fraudulent claim for furnishing services or supplies; or

(b) attempt to obtain or to obtain authorization for furnishing services or supplies; or

(c) attempt to obtain or to obtain compensation from public funds greater than that to which he is legally entitled for services or supplies furnished or purportedly furnished.

Any provider or person who violates the provisions of this section shall be guilty of a felony. Nothing in this section shall prohibit or preclude a provider or person from being prosecuted under any other provision of the criminal code.

[56-227A, added 1977, ch. 226, sec. 2, p. 675.]

56-227B. PROVIDER FRAUD -- DAMAGES. Any provider who knowingly with intent to defraud by means of false statement or representation, obtains compensation from public funds greater than that to which he is legally entitled for services or supplies furnished or purportedly furnished shall be liable for civil damages equal to three (3) times the amount by which any figure is falsely overstated. The director of the department of health and welfare or the attorney general shall have the right to cause legal action to be taken for the recovery of such damages when persuaded that a reimbursement claim for payment is falsely overstated. The burden of proof for such recovery action shall be that which is used in other civil actions for the recovery of damages. The remedy provided by this section shall be in addition to any other remedy provided by law.

If any provider of services or supplies is required to refund or repay all or part of any payment received by said provider under the provisions of this section, said refund or repayment shall bear interest from the date payment was made to such provider to the date of said refund or repayment. Interest shall accrue at the rate of ten percent (10%) per annum. The prevailing party in an action, under this section shall be awarded costs and reasonable attorney's fees incurred in bringing or defending the action. Notwithstanding any other provision of the Idaho Code, all costs and attorney's fees awarded to the department of health and welfare or the attorney general pursuant to this section shall be deposited into the state general fund.

[56-227B, added 1977, ch. 226, sec. 3, p. 675; am. 2007, ch. 341, sec. 6, p. 1008.]

56-227C. SUBPOENA POWER. (1) The director, or his authorized representative, and the director of the Idaho state police or his authorized representative, for the purposes contemplated by this act, have power to issue subpoenas, compel the attendance of witnesses, administer oaths, certify to official acts, take depositions within and without the state of Idaho, as now provided by law, compel the production of pertinent books, payrolls, accounts, papers, records, documents and testimony. If a person in attendance before such director or his authorized representative refuses, without reasonable cause, to be examined or to answer a legal and pertinent question, or to produce a book or paper or other evidence when ordered so to do by the director or his authorized representative, said director or his authorized representative may apply to the judge of the district court of the county where such person is in attendance, upon affidavit for an order returnable in not less than two (2) or more than five (5) days, directing such person to show cause before such judge, or any other judge of such district, why he should not be punished for contempt; upon the hearing of such order, if the judge shall determine that such person has refused, without reasonable cause or legal excuse, to be examined or to answer a legal or pertinent question,

or to produce a book or paper which he was ordered to bring or produce, he may forthwith punish the offender as for contempt of court.

(a) If any person asks to be excused from attending or testifying or from producing any books, payrolls, accounts, papers, records, documents or other evidence in connection with any investigation or inquiry or upon any hearing before any officer so authorized pursuant to this subsection (1), or in any proceeding or action before any court upon a charge or violation of this subsection (1), on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to penalty or forfeiture, and if such person, notwithstanding such request, is directed to give such testimony or produce such evidence, the person must, if so directed by the director or his authorized representative, comply with such direction.

(b) After complying, and if, but for this subsection (1), the person would have been privileged to withhold the answer given or the evidence produced by him, then the answer, the evidence and any information directly or indirectly derived from the answer or evidence, may not be used against the compelled person in any manner in a criminal case, except that the person may nevertheless be prosecuted or subjected to penalty or forfeiture for any perjury, false swearing or contempt committed in answering or failing to answer or in producing or failing to produce evidence in accordance with the order. Such evidence may be used in the refusal, suspension or revocation of any license, permission or authority conferred, or to be conferred, pursuant to Idaho Code.

(2) The attorney general or any prosecuting attorney or the designated agent of either shall have the authority to issue subpoenas to an enrolled or formerly enrolled provider of services pursuant to the medicaid program to compel production of any books, payrolls, accounts, papers, records or documents that are required to be maintained under the medicaid provider agreement executed by such provider or formerly enrolled provider as may be relevant to an investigation of fraud or other crime directly related to the use of medicaid program funds or services provided through the medicaid program that are not already in the possession of the director of the department of health and welfare or his designated agent. The attorney general or any prosecuting attorney or the designated agent of either may also compel testimony by the custodian of the items subpoenaed concerning the production and authenticity of those items. Subpoenas for records or information which are not required to be maintained under a provider agreement shall only be issued through subpoena powers in judicial proceedings. A subpoena under this subsection (2) shall describe the items required to be produced with particularity and prescribe a return date of a reasonable period of time within which the items can be assembled and made available to the attorney general or any prosecuting attorney or the designated agent of either.

(3) Subpoenas issued pursuant to this section shall be served and witness fees and mileage paid as allowed in civil cases in the district courts of this state.

(4) Investigators employed by the attorney general for the investigation and prosecution of providers of services pursuant to the medicaid program shall have all the authority given by statute to peace officers of the state of Idaho, including, but not limited to, authority to obtain, serve and execute warrants of arrest and warrants of search and seizure.

[56-227C, added 1978, ch. 153, sec. 1, p. 336; am. 2000, ch. 469, sec. 128, p. 1587; am. 2007, ch. 341, sec. 7, p. 1009.]

56-227D. FEDERAL FOOD STAMPS, ALSO KNOWN AS SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM -- UNAUTHORIZED USE -- EXCEPTION -- DEFINITION. (1) It is a misdemeanor for any person to buy, receive, sell, give away, dispose of, exchange or barter any federal food stamp benefits of a value less than one hundred dollars ($100).

(2) It is a felony for any person to buy, receive, sell, give away, dispose of, exchange or barter any federal food stamp benefits of a value of one hundred dollars ($100) or more.

(3) This section does not apply to any person buying, receiving, selling, giving away, disposing of, exchanging or bartering any federal food stamp benefits subsequent to the redemption of such stamps in the manner provided by state or federal law.

(4) As used in this section, federal food stamp benefits refers to food stamp benefits issued in any form by the United States department of agriculture or its duly authorized agent for the sole purpose of purchasing food.

(5) This section shall be enforced by the director of the department of health and welfare in cooperation with local law enforcement and prosecuting agencies. Such enforcement shall not be the responsibility of the medicaid fraud control unit as provided in section 56-226, Idaho Code.

[56-227D, added 1981, ch. 193, sec. 1, p. 342; am. 2007, ch. 341, sec. 8, p. 1010.; am. 2011, ch. 193, sec. 1, p. 554; am. 2012, ch. 260, sec. 1, p. 722.]

56-227E. OBSTRUCTION OF INVESTIGATION. (1) An obstruction of investigation consists of knowingly:

(a) Providing false information to, or knowingly withholding information from, any person requesting such information if that person is authorized to investigate a violation of this chapter or to enforce the criminal or civil remedies of this chapter where that information is properly requested and is material to the investigation or enforcement; or

(b) Altering any document or record required to be retained pursuant to this chapter or any rule issued by the department of health and welfare, when the alteration is intended to mislead an investigation and concerns information material to that investigation.

(2) Whoever commits an obstruction of investigation shall be guilty of a felony and shall be sentenced pursuant to the provisions of section 18-112, Idaho Code.

[56-227E, added 2007, ch. 341, sec. 9, p. 1011.]

56-227F. PUBLIC ASSISTANCE BENEFIT CARDS -- PROHIBITED USES. (1) Any recipient of public assistance is prohibited from using public assistance benefit cards or cash obtained with public assistance benefit cards:

(a) For the purpose of participating in any of the activities described under chapters 38 and 49, title 18, Idaho Code, or authorized pursuant to any state-tribal gaming compact under section 67-429A, Idaho Code;

(b) For the purpose of pari-mutuel betting authorized under chapter 25, title 54, Idaho Code;

(c) To purchase lottery tickets or shares authorized under chapter 74, title 67, Idaho Code;

(d) For the purpose of participating in or purchasing tattoo, branding or body piercing services as defined in section 18-1523, Idaho Code;

(e) To purchase cigarettes as defined in section 39-7802(d), Idaho Code, or tobacco products or electronic smoking devices as defined in section 39-5702(13), Idaho Code;

(f) To purchase any items regulated under title 23, Idaho Code;

(g) For the purpose of adult entertainment at venues with performances that contain sexually oriented material where minors under the age of eighteen (18) years are prohibited; or

(h) For the purpose of purchasing or participating in any activities in any location listed in subsection (2) of this section.

(2) The following businesses are required to comply with the provisions of this section:

(a) Any establishment or business licensed under chapter 9, title 23, Idaho Code;

(b) State liquor stores defined under section 23-902, Idaho Code, with the exception of special distributors as referenced in chapter 3, title 23, Idaho Code;

(c) Any business or agency that issues or underwrites bail bonds as defined in section 41-1038(3), Idaho Code;

(d) Gambling establishments licensed under Idaho law;

(e) Any business or establishment that offers tattoo, body piercing or branding services as defined in section 18-1523, Idaho Code;

(f) Adult entertainment venues with performances that contain sexually oriented material where minors under the age of eighteen (18) years are prohibited; and

(g) Any establishment where persons under the age of eighteen (18) years are not permitted.

(3) The department shall notify any business determined to be in violation of the provisions of subsection (2) of this section and the licensing authority of any such business, if applicable, that such business has continued to allow the use of a public assistance benefit card in violation of subsection (2) of this section. The department may require the Idaho quest electronic benefits transfer (EBT) card business identification number (BIN) be disabled at any business found to be in violation of subsection (2) of this section. Any business in violation of subsection (2) of this section may also be required to deny all public assistance cash transactions made with an Idaho quest EBT card at any automated teller machine (ATM) located in their establishment. All costs associated with disabling the BIN and ATM will be the responsibility of such business owner.

(4) Only the recipient, an eligible member of the recipient's household or the recipient's authorized representative may use a public assistance benefit card or the benefit, and such use shall only be for the respective benefit program purposes. The recipient shall not sell, attempt to sell, exchange or donate a public assistance benefit card or any benefits to any other person or entity.

(5) A violation of subsection (1) or (4) of this section by a recipient constitutes a misdemeanor.

(a) The department shall notify all recipients of public assistance benefit cards that any violation of subsection (1) or (4) of this section could result in legal proceedings and forfeiture of all cash public assistance.

(b) Whenever the department has confirmed that a person has violated subsection (1) or (4) of this section, the department shall notify the

person in writing that the violation could result in legal proceedings and forfeiture of all cash public assistance.

(6) As used in this section, "public assistance" or "public assistance benefit" means benefits provided to a recipient pursuant to the temporary assistance for families in Idaho (TAFI) program on an Idaho quest EBT card account.

(7) This section shall be enforced by the director of the department of health and welfare in cooperation with local law enforcement and prosecuting agencies.

[56-227F, added 2012, ch. 182, sec. 1, p. 484; am. 2020, ch. 318, sec. 21, p. 917.]

56-228. LIMITATIONS OF ACT. All assistance awarded under this act shall be deemed to be awarded and to be held subject to the provisions of any amending or repealing act that may hereafter be passed, and no recipient shall have any claim for compensation, or otherwise, by reason of his assistance being affected in any way by any amending or repealing act.

[56-228, added 1941, ch. 181, sec. 25, p. 379.]

56-229. SEPARABILITY. If any portion of this act is for any reason held to be unconstitutional, such decision shall not affect the validity of the main portions thereof.

[56-229, added 1941, ch. 181, sec. 27, p. 379.]

56-230. SHORT TITLE. This act may be cited as the "Public Assistance Law."

[56-230, added 1941, ch. 181, sec. 28, p. 379.]

56-231. PUBLIC ASSISTANCE IN LOCATING AND DETERMINING THE FINANCIAL RESOURCES OF PARENTS AND OTHER PERSONS LIABLE FOR SUPPORT OF DEPENDENTS. To assist in locating and determining the financial resources of parents who have deserted their children and other persons liable for support of dependents, the department of health and welfare and county prosecuting attorneys may request and shall receive information from the records of all departments, boards, bureaus or other agencies of this state, and may request and may receive information from businesses and financial entities; and the same are authorized to provide such information as is necessary for this purpose, notwithstanding any provisions of chapter 1, title 74, Idaho Code, making the information exempt from disclosure. There shall be no legal sanctions imposed against a business or financial entity which refuses to provide requested information, unless the business or financial entity has been served with a subpoena requesting the information. Only information directly bearing on the identity, financial resources, and whereabouts of a person owing or asserted to be owing an obligation of support shall be requested and used or transmitted by the department of health and welfare and county prosecuting attorneys pursuant to the authority conferred by this act. The department of health and welfare and county prosecuting attorneys may make such information available only to public officials and agencies of this state, other states and the political subdivisions of this state and other states seeking to locate parents who have deserted their children and

other persons liable for support of dependents for the purpose of enforcing their liability for support.

[56-231, added 1965, ch. 42, sec. 1, p. 65; am. 1972, ch. 196, sec. 11, p. 483; am. 1974, ch. 23, sec. 165, p. 633; am. 1986, ch. 152, sec. 1, p. 438; am. 1990, ch. 213, sec. 84, p. 550; am. 2015, ch. 141, sec. 154, p. 500.]

56-232. MEDICAL ASSISTANCE PROGRAMS -- CONTRACTS WITH INDEPENDENT AGENCIES FOR ADMINISTRATION OF PROGRAMS. The agency, board, or governmental unit of the state of Idaho designated as the responsible agency for the administration of medical assistance programs which involve the participation of the federal government under the provisions of title XIX of the Social Security Act of 1965, as amended, is authorized to enter into contracts or agreements with life insurance companies qualified in this state, hospital or medical service corporations qualified in this state, or other appropriate independent organizations or corporations for the administration of such medical assistance programs, subject however, to the rules and regulations of the designated responsible governmental agency. Any such contract shall, among other provisions, set forth the term, consideration to be paid for such service, the general duties and procedures of the contract, accounting procedures, and such other matters as may be required to insure the proper administration of the benefits provided by the statutes of Idaho and the rules and regulations authorized therein with reference to the programs established by title XIX of the Social Security Act of 1965, as amended. Such contract shall be signed by the governor of the state of Idaho on behalf of the state.

[56-232, added 1969, ch. 201, sec. 1, p. 588.]

56-233. PROCEDURE FOR DISBURSEMENT OF FUNDS TO RECIPIENTS. Notwithstanding the provisions of section 56-405 and section 56-406, Idaho Code, any such contract entered into between the designated and responsible governmental agency and an independent contractor for the administration of such medical assistance programs may set forth therein a procedure for the disbursement of funds to the recipients of such program and, upon the approval of the procedures so established by the state controller, disbursements of funds shall be made by the state of Idaho to the independent contractor and by the independent contractor to the recipients in accordance with the procedures so established. Procedures established by contract for the disbursement of funds shall have reference only to such funds as involve the participation of the federal government under the provisions of title XIX of the Social Security Act of 1965, as amended.

[56-233, added 1969, ch. 201, sec. 2, p. 588; am. 1994, ch. 180, sec. 107, p. 498.]

56-234. LEGISLATIVE INTENT. It is hereby declared by the legislature that, in keeping with current state and national goals and best practice, increasing numbers of persons with developmental disabilities are being discharged to community facilities or private residences as an alternative to large public institutions licensed as intermediate care facilities for persons with intellectual disabilities. Such deinstitutionalization is highly desirable since it can lead to a fuller, richer and more independent life for

persons with developmental disabilities. Recognizing that every individual has unique needs and differing abilities, the purpose of the following provisions is to clarify the department of health and welfare's duties and responsibilities with respect to persons with developmental disabilities, who are or may become residents of the southwest Idaho treatment center. The following provisions shall be liberally construed to accomplish these purposes.

[56-234, added 2011, ch. 101, sec. 1, p. 256; am. 2012, ch. 107, sec. 7, p. 293; am. 2022, ch. 77, sec. 1, p. 216.]

56-234A. DEFINITIONS. As used in sections 56-234 through 56-235E, Idaho Code:

(1) "Admission-discharge committee" means an interdisciplinary team of at least three (3) individuals designated by the director to evaluate persons as required by the provisions of sections 56-234 through 56-235E, Idaho Code. Each committee member must be specially qualified by training and experience in the diagnosis and treatment of persons with a developmental disability.

(2) "Certified family home" means a family home as defined in section 39-3502, Idaho Code.

(3) "Community facility" means a privately owned or operated nursing facility, intermediate care facility for persons with intellectual disabilities, licensed residential or assisted living facility, other organization licensed, recognized, or certified by the department to provide care or treatment to persons with developmental disabilities, or a publicly owned or operated facility licensed for eight (8) beds or less as an intermediate care facility for persons with intellectual disabilities.

(4) "Department" means the Idaho department of health and welfare.

(5) "Developmental disabilities" means a chronic disability of a person as defined in section 66-402, Idaho Code.

(6) "Director" means the director of the Idaho department of health and welfare or his designee.

(7) "Discharge" means an admission-discharge committee has determined that there is an available community facility or private residence that is least restrictive, appropriate and consistent with the needs of the individual.

(8) "Medically fragile" means an individual with a developmental disability and a chronic medical condition that is characterized by periods of acute exacerbation or potentially life-threatening episodes and that may require frequent hospitalizations or prolonged recuperation periods and ongoing monitoring and assistance by a licensed registered nurse.

(9) "Private residence" means a certified family home or a single family dwelling or apartment in a multiple dwelling or apartment complex that is used by an individual as a place of abode and that is not used for commercial purposes.

(10) "Resident" means an individual who is admitted to or resides at the southwest Idaho treatment center.

(11) "Transfer" means relocating and moving a person who is a resident of the southwest Idaho treatment center from that institution to a community facility or private residence or from one (1) community facility or private residence to another. Transfer does not include relocating or moving a resident of the southwest Idaho treatment center between rooms or beds within the southwest Idaho treatment center.

[56-234A, added 2011, ch. 101, sec. 2, p. 257; am. 2012, ch. 107, sec. 8, p. 293.]

56-235. SOUTHWEST IDAHO TREATMENT CENTER. The establishment by law of the southwest Idaho treatment center at Nampa, Idaho, is hereby ratified and affirmed, and its operation continued; provided, however, that on and after the effective date of this act, the treatment center shall be in the general supervision, control and government of the state department of health and welfare. All rights and title to property, real and personal, belonging to or vested in the state board of health and welfare are hereby transferred and vested in the state department of health and welfare. The state department is empowered to acquire, by purchase or exchange, any property that in the judgment of the department is needful for the operation of the treatment center, and to dispose of, by sale or exchange, any property that in the judgment of the department is not needful for the operation of the same. The department of health and welfare shall have authority to administer the treatment center, to employ and release such personnel as are required for the operation of the treatment center, fix salaries, and to perform any other necessary and proper functions in the efficient and beneficial operation of the treatment center.

[56-235, added 1972, ch. 44, sec. 7, p. 67; am. 1974, ch. 23, sec. 166, p. 633; am. 2011, ch. 102, sec. 3, p. 262; am. 2022, ch. 60, sec. 3, p. 185.]

56-235A. PROHIBITIONS, RESTRICTIONS AND LIMITATIONS ON ADMISSION. (1) The southwest Idaho treatment center shall not admit, accept or receive any person unless an admission-discharge committee determines that:

(a) The individual has a developmental disability;

(b) The individual meets the level of care requirements and active treatment requirements for admission to an intermediate care facility for persons with intellectual disabilities;

(c) All community facilities, options and supports have been exhausted, and there is no available community facility or private residence that is least restrictive, appropriate and consistent with the needs of the individual; and

(d) The southwest Idaho treatment center is the least restrictive available residential placement consistent with the needs of the individual after considering all available and appropriate community facilities and private residences.

(2) The director may limit admissions and establish admission priorities to the southwest Idaho treatment center through rulemaking in order to ensure that expenditures for services do not exceed amounts appropriated by the legislature and allocated by the department to the facility. The southwest Idaho treatment center may refuse any applicant for voluntary admission.

(3) Subsections (1) and (2) of this section do not apply to:

(a) Temporary emergency admissions or placements for crisis stabilization only, for up to ninety (90) days, that are preauthorized by the director; or

(b) Admissions or placements made by the director pursuant to section 66-406, Idaho Code.

[56-235A, added 2011, ch. 101, sec. 3, p. 258; am. 2012, ch. 107, sec. 9, p. 294.]

56-235B. DISCHARGE PLANNING -- AUTHORIZATION TO DISCHARGE. The director may discharge a resident of the southwest Idaho treatment center on such terms and conditions as the director may determine whenever an admission-discharge committee determines there is an available community facility or private residence that is least restrictive, appropriate and consistent with the individual's needs. The director shall use reasonable efforts to discharge a resident to a community facility or private residence where the individual can be readily visited by those persons interested in his well-being.

[56-235B, added 2011, ch. 101, sec. 4, p. 258; am. 2012, ch. 107, sec. 10, p. 295.]

56-235C. NOTICE OF DISCHARGE -- REQUEST FOR HEARING. (1) Before a discharge plan is implemented, the resident and the resident's spouse, guardian, adult next of kin or friend, if any, shall be given an opportunity to participate in the development and review of the admission-discharge committee's discharge plan.

(2) If, after reasonable efforts have been exhausted, the resident or the resident's spouse, guardian, adult next of kin or friend, if any, does not agree with the admission-discharge committee's discharge plan, ninety (90) days prior to discharge, written notice shall be filed with the committing court, if any, and served by registered or certified mail upon the resident, resident's attorney, and either the resident's spouse, guardian, adult next of kin or friend, if any. The written notice must include a statement advising the resident of the right to request a hearing by the director and must also include a statement advising the resident of the right to judicial review.

(3) Within fifteen (15) days from receipt of the notice of discharge, the resident may serve a written request for hearing upon the director. Upon receipt of such request, the director shall fix a date for hearing, which date shall not be more than thirty (30) days from receipt of the request, and shall give the resident at least fifteen (15) days' written notice of said hearing date. Within thirty (30) days after the conclusion of the hearing, the director shall notify the resident in writing by registered or certified mail of his decision. A transfer shall not be implemented during any period in which a request for hearing is pending and undecided by the director. If no request for hearing is made within fifteen (15) days from receipt of the notice of discharge, the director may discharge the resident.

(4) The director shall periodically monitor the adjustment of the former resident to his transfer to a community facility or private residence. If within ninety (90) days following a transfer to a community facility or private residence, an admission-discharge committee determines that the former resident is not adjusting to the transfer and there is no other available community facility or private residence least restrictive, appropriate and consistent with the needs of the former resident, the director may make the determination that the former resident be readmitted to the southwest Idaho treatment center in accordance with section 56-235A, Idaho Code.

[56-235C, added 2011, ch. 101, sec. 5, p. 258; am. 2012, ch. 107, sec. 11, p. 295.]

56-235D. APPEALS. If a former resident feels aggrieved by a decision of the director rendered pursuant to a hearing as provided in section 56-235C, Idaho Code, appeal may be taken to the committing court or the court of the county in which such former resident is present. Appeal must be taken in the manner and form set forth in chapter 52, title 67, Idaho Code, provided however, the filing of a notice of appeal with the court shall not, unless otherwise ordered, stay the resident's discharge or the decision of the director.

[56-235D, added 2011, ch. 101, sec. 6, p. 259.]

56-235E. RULEMAKING AUTHORITY. The director, in addition to other duties imposed by law, is hereby authorized and directed through rulemaking to establish procedures necessary to implement these provisions. The rulemaking authority granted in this section shall be limited to the specific standards and procedures required by sections 56-234 through 56-235D, Idaho Code.

[56-235E, added 2011, ch. 101, sec. 7, p. 259.]

56-238. DEFINITIONS. As used in this section and section 56-239, Idaho Code:

(1) "CHIP Plan A" means the existing Idaho children's health insurance program for children eligible under federal title XXI whose families' modified adjusted gross incomes do not exceed one hundred fifty percent (150%) of the federal poverty guidelines.

(2) "CHIP Plan B" means the program created in section 56-239, Idaho Code.

(3) "Department" means the state department of health and welfare.

(4) "Director" means the director of the state department of health and welfare.

(5) "Eligible child" means a child under nineteen (19) years of age living in Idaho whose family's modified adjusted gross income falls within federal poverty guidelines for medicaid, CHIP Plan A or CHIP Plan B.

(6) "Modified adjusted gross income" means individual or family income as defined for state medicaid programs in the social security act and the Internal Revenue Code.

[56-238, added 2003, ch. 308, sec. 3, p. 845; am. 2006, ch. 270, sec. 1, p. 839; am. 2014, ch. 80, sec. 2, p. 218; am. 2021, ch. 22, sec. 4, p. 61.]

56-239. CHIP PLAN B. (1) There is hereby created in the department a CHIP Plan B that shall be made available by the department to eligible children, as defined in section 56-238, Idaho Code, whose family's modified adjusted gross income is between one hundred fifty percent (150%) and one hundred eighty-five percent (185%) of the federal poverty guidelines. The director shall implement the program by adopting rules recommended by the board of the Idaho individual high risk reinsurance pool created in section 41-5502, Idaho Code, that authorize policies of health insurance for children enrolled in the CHIP Plan B.

(2) There is hereby created a CHIP Plan B advisory board which shall advise the Idaho individual high risk reinsurance pool board concerning issues related to the CHIP Plan B. The board shall consist of eight (8) members, four (4) members to be appointed by the director and four (4) members to be ap-

pointed by the governor. At least two (2) members of the board shall be parents of children who are eligible to participate in the CHIP Plan B.

[56-239, added 2003, ch. 308, sec. 4, p. 846; am. 2014, ch. 80, sec. 3, p. 219.]

56-250. SHORT TITLE. This act shall be known and may be cited as the "Idaho Medicaid Simplification Act."

[56-250, added 2006, ch. 278, sec. 1, p. 853.]

56-251. LEGISLATIVE INTENT. (1) The legislature finds that the current federal medicaid law and regulations have not kept pace with modern health care management practices, create obstacles to quality care and impose unnecessary costs on the delivery of effective and efficient health care. The legislature believes that the state of Idaho must strive to balance efforts to contain medicaid costs, improve program quality and improve access to services. The legislature further believes that the state of Idaho could achieve improved health outcomes for medicaid participants by simplifying eligibility and developing health benefits for medicaid participants according to their health needs, including appropriate preventive and wellness services.

(2) The legislature supports development, at a minimum, of the following health-need categories:

(a) Low-Income Children and Working-Age Adults with No Special Health Needs. The broad policy goal for the medicaid program for low-income children and working-age adults with no special health needs is to achieve and maintain wellness by emphasizing prevention and by proactively managing health. Additional specific goals are:

(i) To emphasize preventive care and wellness;

(ii) To increase participant ability to make good health choices; and

(iii) To strengthen the employer-based health insurance system.

(b) Persons with Disabilities or Special Health Needs. The broad policy goal for the medicaid program for persons with disabilities or special health needs is to finance and deliver cost-effective individualized care. Additional specific goals are:

(i) To emphasize preventive care and wellness;

(ii) To empower individuals with disabilities to manage their own lives;

(iii) To provide opportunities for employment for persons with disabilities; and

(iv) To provide and to promote family-centered, community-based, coordinated care for children with special health care needs.

(c) Persons with Medicare and Medicaid Coverage. The broad policy goal for the medicaid program for persons with medicare and medicaid coverage is to finance and deliver cost-effective individualized care which is integrated, to the greatest extent possible, with medicare coverage. Additional specific goals are:

(i) To emphasize preventive care and wellness;

(ii) To improve coordination between medicaid and medicare coverage;

(iii) To increase nonpublic financing options for long-term care; and

(iv) To ensure participants' dignity and quality of life.

(3) To the extent practicable, the department shall achieve savings and efficiencies through use of modern care management practices, in areas such as network management, cost-sharing, benefit design and premium assistance.

(4) The department's duty to implement these changes in accordance with the intent of the legislature is contingent upon federal approval.

[56-251, added 2006, ch. 278, sec. 1, p. 853; am. 2007, ch. 200, sec. 1, p. 610.]

56-252. DEFINITIONS. As used in sections 56-250 through 56-255, Idaho Code:

(1) "Benchmark plan" means a package of health benefits coverage that provides coverage for a specified population in accordance with section 6044 of the deficit reduction act of 2005.

(2) "Benefit design" means selection of services, providers and beneficiary cost-sharing to create the scope of coverage for participants.

(3) "Community supports" means services that promote the ability of persons with disabilities to be self-sufficient and live independently in their own communities.

(4) "Cost-sharing" means participant payment for a portion of medicaid service costs such as deductibles, coinsurance or copayment amounts.

(5) "Department" means the department of health and welfare.

(6) "Director" means the director of the department of health and welfare.

(7) "Health risk assessment" means a process of assessing the health status and health needs of participants.

(8) "Medicaid" means Idaho's medical assistance program.

(9) "Medical assistance" means payments for part or all of the cost of services funded by titles XIX or XXI of the federal social security act as amended, as may be designated by department rule.

(10) "Medical home" means a primary care case manager designated by the participant or the department to coordinate the participant's care.

(11) "Network management" means establishment and management of contracts between the department and limited groups of providers or suppliers of medical and other services to participants.

(12) "Participant" means a person eligible for and enrolled in the Idaho medical assistance program.

(13) "Premium assistance" means use of medicaid funds to pay part or all of the costs of enrolling eligible individuals into private insurance coverage.

(14) "Primary care case manager" means a primary care physician who contracts with medicaid to coordinate the care of certain participants.

(15) "Provider" means any individual, partnership, association, corporation or organization, public or private, which provides residential or assisted living services, certified family home services, nursing facility services or services offered pursuant to medical assistance.

(16) "Self-determination" means medicaid services that allow persons with disabilities to exercise choice and control over the services and supports they receive.

(17) "State plan" means the contract between the state and federal government under 42 U.S.C. section 1396a(a).

[56-252, added 2006, ch. 278, sec. 1, p. 854; am. 2007, ch. 200, sec. 2, p. 611.]

56-253. POWERS AND DUTIES OF THE DIRECTOR. (1) The director is hereby encouraged and empowered to obtain federal approval in order that Idaho design and implement changes to its medicaid program that advance the quality of services to participants while allowing access to needed services and containing excessive costs. The design of Idaho's medicaid program shall incorporate the concepts expressed in section 56-251, Idaho Code.

(2) The director may create health-need categories other than those stated in section 56-251(2)(a), Idaho Code, subject to legislative approval, and may develop a medicaid benchmark plan for each category.

(3) Each benchmark plan shall include explicit policy goals for the covered population identified in the plan, as well as specific benefit packages, delivery system components and performance measures in accordance with section 67-1904, Idaho Code.

(4) The director shall establish a mechanism to ensure placement of participants into the appropriate benchmark plan as allowed under section 6044 of the deficit reduction act of 2005. This mechanism shall include, but not be limited to, a health risk assessment. This assessment shall comply with federal requirements for early and periodic screening, diagnosis and treatment (EPSDT) services for children, in accordance with section 1905(a)(4)(B) of the social security act. The health risk assessment shall include questions related to substance use disorders to allow referral to treatment for such disorders by the department.

(5) The director may require, subject to federal approval, participants to designate a medical home. Applicants for medical assistance shall receive information about primary care case management and, if required to so designate, shall select a primary care provider as part of the eligibility determination process.

(6) The director may, subject to federal approval, enter into contracts for medical and other services when such contracts are beneficial to participant health outcomes as well as economically prudent for the medicaid program.

(7) The director may obtain agreements from medicare, school districts and other entities to provide medical care if it is practical and cost-effective.

(8) The director shall research options and apply for federal waivers to enable cost-efficient use of medicaid funds to pay for substance abuse and/or mental health services in institutions for mental disease.

(9) The director shall, in cooperation with the director of the department of insurance, seek waivers from the federal government to provide that persons eligible for medicaid pursuant to section 56-267, Idaho Code, who have a modified adjusted gross income at or above one hundred percent (100%) of the federal poverty level shall receive the advance premium tax credit to purchase a qualified health plan through the Idaho health insurance exchange established by chapter 61, title 41, Idaho Code, instead of enrolling in medicaid, except as provided in paragraph (a) of this subsection.

(a) A person described in this subsection may choose to enroll in medicaid instead of receiving the advance premium tax credit to purchase a qualified health plan.

(b) If the waivers described in this subsection are not approved before January 1, 2020, then the persons described in this subsection shall be enrolled in medicaid.

(10) The director shall seek a waiver from the federal government consistent with the provisions of this subsection.

(a) A person participating in medicaid pursuant to section 56-267, Idaho Code, must be:

(i) Working at least twenty (20) hours per week, averaged monthly, or earning wages equal to or greater than the federal minimum wage for twenty (20) hours of work per week;

(ii) Participating in and complying with the requirements of a work training program at least twenty (20) hours per week, as determined by the department;

(iii) Volunteering at least twenty (20) hours per week, as determined by the department;

(iv) Enrolled at least half-time in postsecondary education or another recognized education program, as determined by the department, and remaining enrolled and attending classes during normal class cycles;

(v) Meeting any combination of working, volunteering, and participating in a work program for a total of at least twenty (20) hours per week, as determined by the department; or

(vi) Subject to and complying with the requirements of the work program for temporary assistance for needy families (TANF) or participating and complying with the requirements of a workfare program in the supplemental nutrition assistance program (SNAP).

(b) A person is exempt from the provisions of paragraph (a) of this subsection if the person is:

(i) Under the age of nineteen (19) years;

(ii) Over the age of fifty-nine (59) years;

(iii) Physically or intellectually unable to work;

(iv) Pregnant;

(v) A parent or caretaker who is the primary caregiver of a dependent child under the age of eighteen (18) years, as determined by the department;

(vi) A parent or caretaker personally providing care for a person with serious medical conditions or with a disability, as determined by the department;

(vii) Applying for or receiving unemployment compensation and complying with work requirements that are part of the federal-state unemployment insurance program;

(viii) Applying for social security disability benefits, until such time eligibility is determined;

(ix) Participating in a drug addiction or alcohol treatment and rehabilitation program, as determined by the department; or

(x) An American Indian or Alaska native who is eligible for services through the Indian health service or through a tribal health program pursuant to the Indian self-determination and education assistance act and the Indian health care improvement act.

(c) The department shall verify a medicaid participant's compliance with paragraph (a) of this subsection every six (6) months and shall promulgate rules based on federal final waiver approval relating to

the requirements of this subsection. A person who fails to comply with paragraph (a) of this subsection shall:

(i) Be ineligible for medicaid but may reapply for medicaid two (2) months after such determination is made or earlier if in compliance; or

(ii) If the provisions of subparagraph (i) of this paragraph are not federally approved or are found unlawful by a court of competent jurisdiction, be subject to the maximum allowable copayments on covered Idaho medicaid services for a period of six (6) months or until the person complies with paragraph (a) of this subsection, whichever is earlier.

(d) It is the intent of the legislature, in enacting the requirements of this subsection, to enable coverage of medicaid participants while also promoting the participants' health and financial independence.

(e) The department shall implement the waiver described in this subsection as soon as possible once federal approval has been obtained.

(11) The director is given authority to promulgate rules consistent with this act.

[56-253, added 2006, ch. 278, sec. 1, p. 855; am. 2007, ch. 200, sec. 3, p. 612; am. 2019, ch. 318, sec. 1, p. 943.]

56-254. ELIGIBILITY FOR MEDICAL ASSISTANCE. The department shall make payments for medical assistance to, or on behalf of, the following persons eligible for medical assistance.

(1) The benchmark plan for low-income children and working-age adults with no special health needs includes the following persons:

(a) Children in families whose family income does not exceed one hundred eighty-five percent (185%) of the federal poverty guideline and who meet age-related and other eligibility standards in accordance with department rule;

(b) Pregnant women of any age whose family income does not exceed one hundred thirty-three percent (133%) of the federal poverty guideline and who meet other eligibility standards in accordance with department rule, or who meet the presumptive eligibility guidelines in accordance with section 1920 of the social security act;

(c) Infants born to medicaid-eligible pregnant women. Medicaid eligibility must be offered throughout the first year of life as long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant;

(d) Adults in families with dependent children, as described in section 1931 of the social security act, who meet the requirements in the state's assistance to families with dependent children (AFDC) plan in effect on July 16, 1996;

(e) Families who are provided six (6) to twelve (12) months of medicaid coverage following loss of eligibility under section 1931 of the social security act due to earnings, or four (4) months of medicaid coverage following loss of eligibility under section 1931 of the social security act due to an increase in child or spousal support; and

(f) All other mandatory groups as defined in title XIX of the social security act, if not listed separately in subsection (2) or (3) of this section.

(2) The benchmark plan for persons with disabilities or special health needs includes the following persons:

(a) Persons under age sixty-five (65) years eligible in accordance with title XVI of the social security act, as well as persons eligible for aid to the aged, blind and disabled (AABD) under titles I, X and XIV of the social security act;

(b) Persons under age sixty-five (65) years who are in need of the services of a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, a state mental hospital, or home-based and community-based care whose income does not exceed three hundred percent (300%) of the social security income (SSI) standard and who meet the asset standards and other eligibility standards in accordance with federal law and regulation, Idaho law and department rule;

(c) Certain disabled children described in 42 CFR 435.225 who meet resource limits for aid to the aged, blind and disabled (AABD) and income limits for social security income (SSI) and other eligibility standards in accordance with department rule;

(d) Persons under age sixty-five (65) years who are eligible for services under both titles XVIII and XIX of the social security act;

(e) Children who are eligible under title IV-E of the social security act for subsidized board payments, foster care or adoption subsidies, and children for whom the state has assumed temporary or permanent responsibility and who do not qualify for title IV-E assistance but are in foster care, shelter or emergency shelter care, or subsidized adoption and who meet eligibility standards in accordance with department rule;

(f) Eligible women under age sixty-five (65) years with incomes at or below two hundred percent (200%) of the federal poverty level, for cancer treatment pursuant to the federal breast and cervical cancer prevention and treatment act of 2000;

(g) Low-income children and working-age adults under age sixty-five (65) years who qualify under subsection (1) of this section and who require the services for persons with disabilities or special health needs listed in section 56-255(3), Idaho Code;

(h) Persons over age sixty-five (65) years who choose to enroll in this state plan; and

(i) Effective January 1, 2018, children under age eighteen (18) years with serious emotional disturbance, as defined in section 16-2403, Idaho Code, in families whose income does not exceed three hundred percent (300%) of the federal poverty guideline and who meet other eligibility standards in accordance with department rule.

(3) The benchmark plan for persons over twenty-one (21) years of age who have medicare and medicaid coverage includes the following persons:

(a) Persons eligible in accordance with title XVI of the social security act, as well as persons eligible for aid to the aged, blind and disabled (AABD) under titles I, X and XIV of the social security act;

(b) Persons who are in need of the services of a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, a state mental hospital, or home-based and community-based care whose income does not exceed three hundred percent (300%) of the social security income (SSI) standard and who meet the assets standards and other eligibility standards in accordance with federal and state law and department rule;

(c) Persons who are eligible for services under both titles XVIII and XIX of the social security act who have enrolled in the medicare program; and

(d) Persons who are eligible for services under both titles XVIII and XIX of the social security act and who elect to enroll in this state plan.

[56-254, added 2006, ch. 278, sec. 1, p. 856; am. 2007, ch. 200, sec. 4, p. 612; am. 2017, ch. 66, sec. 1, p. 155; am. 2021, ch. 22, sec. 7, p. 61.]

56-255. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED. (1) The department may make payments for the following services furnished by providers to participants who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be reimbursed only when medically necessary within the appropriations provided by law and in accordance with federal law and regulation, Idaho law and department rule. Notwithstanding any other provision of this chapter, medical assistance includes the following benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined in subsection (5) of this section.

(2) Specific health benefits and limitations for low-income children and working-age adults with no special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found; and

(c) Cost-sharing required of participants. Participants in the low-income children and working-age adult group are subject to the following premium payments, as stated in department rules:

(i) Participants with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guideline are not required to pay premiums; and

(ii) Participants with family incomes above one hundred thirty-three percent (133%) of the federal poverty guideline will be required to pay premiums in accordance with department rule.

(3) Specific health benefits for persons with disabilities or special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found;

(c) Case management services as defined in accordance with section 1905(a)(19) or section 1915(g) of the social security act; and

(d) Long-term care services, including:

(i) Nursing facility services, other than services in an institution for mental diseases, subject to participant cost-sharing;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require nursing facility level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule; and

(iii) Personal care services in a participant's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse;

(e) Services for persons with developmental disabilities, including:

(i) Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined in accordance with section 1902(a)(31) of the social security act to be in need of such care, including such services in a public institution, or distinct part thereof, for persons with intellectual disabilities or persons with related conditions;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require an intermediate care facility for people with intellectual disabilities (ICF/ID) level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports and options for self-directed or family-directed services, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule. The department shall allow budget modifications only when needed to obtain or maintain employment or when health and safety issues are identified and meet the criteria as defined in department rule; and

(iii) Developmental disability services for children and adults shall be available based on need through state plan services or waiver services as described in department rule. The department shall develop a blended rate covering both individual and group developmental therapy services;

(f) Home health services, including:

(i) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area;

(ii) Home health aide services provided by a home health agency; and

(iii) Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility;

(g) Hospice care in accordance with section 1905(o) of the social security act;

(h) Specialized medical equipment and supplies;

(i) Medicare cost-sharing, including:

(i) Medicare cost-sharing for qualified medicare beneficiaries described in section 1905(p) of the social security act;

(ii) Medicare part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the social security act;

(iii) Medicare part B premiums for specified low-income medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the social security act; and

(iv) Medicare part B premiums for qualifying individuals described in section 1902(a)(10)(E)(iv) and subject to section 1933 of the social security act; and

(j) Nonemergency medical transportation.

(4) Specific health benefits for persons over twenty-one (21) years of age who have medicare and medicaid coverage include:

(a) All services described in subsection (5) of this section, other than if provided under the federal medicare program;

(b) All services described in subsection (3) of this section, other than if provided under the federal medicare program;

(c) Other services that supplement medicare coverage; and

(d) Nonemergency medical transportation.

(5) Benefits for all medicaid participants, unless specifically limited in subsection (2), (3) or (4) of this section, include the following:

(a) Health care coverage including, but not limited to, basic inpatient and outpatient medical services, and including:

(i) Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere;

(ii) Services provided by a physician or other licensed practitioner to prevent disease, disability and other health conditions or their progressions, to prolong life, or to promote physical or mental health; and

(iii) Hospital care, including:

1. Inpatient hospital services other than those services provided in an institution for mental diseases;

2. Outpatient hospital services; and

3. Emergency hospital services;

(iv) Laboratory and x-ray services;

(v) Prescribed drugs;

(vi) Family planning services and supplies for individuals of child-bearing age;

(vii) Certified pediatric or family nurse practitioners' services;

(viii) Emergency medical transportation;

(ix) Behavioral health services, including:

1. Outpatient behavioral health services that are appropriate, delivered by providers that meet national accreditation standards and may include community-based rehabilitation services and case management; and

2. Inpatient psychiatric facility services whether in a hospital, or for persons under the age of twenty-two (22) years in a freestanding psychiatric facility as permitted by federal law;

(x) Medical supplies, equipment, and appliances suitable for use in the home;

(xi) Physical therapy and speech therapies combined to align with the annual medicare caps; and

(xii) Occupational therapy to align with the annual medicare cap;

(b) Primary care medical homes;

(c) Dental services and medical and surgical services furnished by a dentist in accordance with section 1905(a)(5)(B) of the social security act;

(d) Medical care and any other type of remedial care recognized under Idaho law, furnished by licensed practitioners within the scope of their practice as defined by Idaho law, including:

(i) Podiatrists' services based on chronic care criteria as defined in department rule;

(ii) Optometrists' services based on chronic care criteria as defined in department rule;

(iii) Chiropractors' services, limited to six (6) visits per year; and

(iv) Other practitioners' services, in accordance with department rules;

(e) Services for individuals with speech, hearing and language disorders as defined in department rule;

(f) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;

(g) Services provided by essential providers, including:

(i) Rural health clinic services and other ambulatory services furnished by a rural health clinic in accordance with section 1905(l)(1) of the social security act;

(ii) Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 1905(l)(2) of the social security act;

(iii) Indian health services;

(iv) District health departments; and

(v) The family medicine residency of Idaho and the Idaho state university family medicine residency; and

(h) Physician, hospital or other services deemed experimental are excluded from coverage. The director may allow coverage of procedures or services deemed investigational if the procedures or services are as cost-effective as traditional, standard treatments.

[56-255, added 2006, ch. 278, sec. 1, p. 857; am. 2007, ch. 200, sec. 5, p. 614; am. 2009, ch. 34, sec. 4, p. 99; am. 2010, ch. 235, sec. 46, p. 585; am. 2011, ch. 164, sec. 9, p. 468; am. 2012, ch. 190, sec. 1, p. 510; am. 2013, ch. 25, sec. 1, p. 46; am. 2014, ch. 62, sec. 1, p. 147; am. 2014, ch. 109, sec. 1, p. 316; am. 2018, ch. 182, sec. 1, p. 397.]

56-256. PREVENTIVE HEALTH ASSISTANCE. (1) The department of health and welfare may establish preventive health assistance benefits available to a medicaid participant in order to provide incentives to promote healthy behavior and responsible use of health care services.

(2) Preventive health assistance benefits are available when the participant complies with recommended preventive care and demonstrates healthy behaviors or conducts other activities as specified in department rule. Preventive health assistance benefits are only available during a participant's period of eligibility.

(3) The uses of preventive health assistance may include, but not be limited to, participant payments for preventive health products and services and participant cost-sharing payments as specified in department rule.

(4) Preventive health assistance benefits may be used to cover delinquent cost-sharing obligations when participants have complied with recommended preventive care as described in department rule.

[56-256, added 2006, ch. 305, sec. 1, p. 943; am. 2007, ch. 200, sec. 6, p. 618.]

56-257. COPAYMENTS. (1) Within the limits of federal medicaid law and regulations, the department of health and welfare shall establish enforceable cost sharing in order to increase the awareness and responsibility of medicaid participants for the cost of their health care and to encourage use of cost-effective care in the most appropriate setting. Copayments established by department rule may include, but not be limited to, the following:

(a) Medicaid services including, but not limited to, chiropractic visits, podiatrist visits, optometrist visits, physical therapy visits, occupational therapy visits, speech therapy visits, outpatient hospital visits and physician office visits;

(b) Inappropriate use of emergency medicaid reimbursed services, including hospital emergency room and emergency transportation; and

(c) Missed appointments with health care providers when it is the practice of the health care provider to charge such copayments to all of their patients regardless of payer.

(2) The director may exempt, subject to federal approval, any group of medicaid participants from the cost-sharing provisions in this section.

[56-257, added 2006, ch. 305, sec. 1, p. 944; am. 2011, ch. 164, sec. 10, p. 471.]

56-260. SHORT TITLE. Sections 56-260 through 56-266, Idaho Code, shall be known and may be cited as the "Medicaid Cost Containment and Health Care Improvement Act."

[56-260, added 2011, ch. 164, sec. 11, p. 472.]

56-261. LEGISLATIVE FINDINGS AND INTENT. (1) The legislature finds that the current health care delivery system of payment to medicaid health care providers on a fee for service basis does not provide the appropriate incentives and can be improved by incorporating managed care tools, including capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.

(2) The legislature intends that the provisions of sections 56-260 through 56-266, Idaho Code, result in the improved health of public assistance recipients while, at the same time, increasing the choices and responsibilities of those recipients. The legislature further intends that these sections result in improved business practices of providers.

(3) The legislature directs the department to pursue opportunities in the medicaid program that result in safe and appropriate discharge from public and private institutions including nursing homes, intermediate care facilities and psychiatric facilities into community settings and that such results should be financially sustainable.

(4) Price increases should be implemented only through specific appropriation authority unless the adjustments are specified in federal law.

[56-261, added 2011, ch. 164, sec. 12, p. 472.]

56-262. DEFINITIONS. The definitions contained in section 56-252, Idaho Code, shall apply to sections 56-260 through 56-267, Idaho Code.

[56-262, added 2011, ch. 164, sec. 13, p. 473; amended 2018, Init Measure, No. 2, sec. 2.]

56-263. MEDICAID MANAGED CARE PLAN. (1) The department shall present to the legislature on the first day of the second session of the sixty-first Idaho legislature a plan for medicaid managed care with focus on high-cost populations including, but not limited to:

(a) Dual eligibles; and

(b) High-risk pregnancies.

(2) The medicaid managed care plan shall include, but not be limited to, the following elements:

(a) Improved coordination of care through primary care medical homes.

(b) Approaches that improve coordination and provide case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes, including mandatory enrollment in special needs plans, and that consider other managed care approaches.

(c) Managed care contracts to pay for behavioral health benefits as described in executive order number 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.

(d) The elimination of duplicative practices that result in unnecessary utilization and costs.

(e) Contracts based on gain sharing, risk-sharing or a capitated basis.

(f) Medical home development with focus on populations with chronic disease using a tiered case management fee.

(3) The department shall seek federal approval or a waiver to require that a medicaid participant who has a medical home as required in section 56-255(5)(b), Idaho Code, and who seeks family planning services or supplies from a provider outside the participant's medical home, must have a referral to such outside provider. The provisions of this subsection shall apply to medicaid participants upon such approval or the granting of such a waiver.

[56-263, added 2011, ch. 164, sec. 14, p. 473; am. 2019, ch. 318, sec. 3, p. 946.]

56-264. RULEMAKING AUTHORITY. In addition to the rulemaking authority granted to the department in this chapter and elsewhere in Idaho Code regarding the medicaid program and notwithstanding any other Idaho law to the contrary, the department shall have the authority to promulgate rules regarding:

(1) Medical services to:

(a) Change the primary case management paid to providers to a tiered payment based on the health needs of the populations that are managed. A lower payment is to be made for healthier populations and a higher payment is to be made for individuals with special needs, disabilities or are otherwise at risk. An incentive payment is to be provided to practices that provide extended hours beyond the normal business hours that help reduce unnecessary higher-cost emergency care;

(b) Provide that a healthy connections referral is no longer required for urgent care as an alternative to higher cost but unnecessary emergency services; and

(c) Eliminate payment for collateral contact;

(2) Mental health services to:

(a) Eliminate administrative requirements for a functional and intake assessment and add a comprehensive diagnostic assessment addendum;

(b) Restrict duplicative skill training from being provided by a mental health provider when the individual has chosen to receive skill training from a developmental disability provider. Mental health providers may not provide training for skills included in the individual's developmental disability plan, but may provide services related to the individual's mental illness that require specialized expertise of mental health professionals, such as management of mental health symptoms, teaching coping skills related to mental health diagnosis, assisting with psychiatric medical appointments and educating individuals about their diagnosis and treatment;

(c) Increase the criteria for accessing the partial care benefit and restrict to those individuals who have a diagnosis of serious and persistent mental illness;

(d) Eliminate the requirement for new annual plans; and

(e) Direct the department to develop an effective management tool for psychosocial rehabilitation services;

(3) In-home care services to:

(a) Eliminate personal care service coordination; and

(b) Restrict duplicative nursing services from a home health agency when nursing services are being provided through the aged and disabled waiver;

(4) Vision services to:

(a) Align coverage requirements for contact lenses with commercial insurers and other state medicaid programs; and

(b) Limit coverage for adults based on chronic care criteria;

(5) Audiology services to eliminate audiology benefits for adults;

(6) Developmental disability services to:

(a) Eliminate payment for collateral contact;

(b) Eliminate supportive counseling benefit;

(c) Reduce annual assessment hours from twelve (12) to four (4) hours and exclude psychological and neuropsychological testing services within these limits;

(d) Reduce plan development payment from twelve (12) to six (6) hours and reduce requirements related to adult developmental disabilities plan development;

(e) Restrict duplicative skill training from being provided by a developmental disabilities provider when an individual has chosen to receive skill training from his mental health provider. The individual may receive skill development services from a developmental disability provider only for skills that are not addressed by the mental health service provider's plan and that relate directly to the individual's developmental disability, such as skills related to activities of daily living and functional independence;

(f) Implement changes to certified family homes pursuant to chapter 35, title 39, Idaho Code, to:

(i) Create approval criteria and process for approving new certified family homes;

(ii) Recertify current certified family homes; and

(iii) Develop applicant and licensing fees to cover certifying and recertifying costs; and

(7) Institutional care services to discharge individuals from institutional settings where such services are no longer necessary.

[56-264, added 2011, ch. 164, sec. 15, p. 473; am. 2012, ch. 107, sec. 12, p. 295; am. 2012, ch. 190, sec. 2, p. 513.]

56-265. PROVIDER PAYMENT. (1) Where there is an equivalent, the payment to medicaid providers:

(a) May be up to but shall not exceed one hundred percent (100%) of the current medicare rate for primary care procedure codes as defined by the centers for medicare and medicaid services; and

(b) Shall be ninety percent (90%) of the current medicare rate for all other procedure codes.

(2) Where there is no medicare equivalent, the payment rate to medicaid providers shall be prescribed by rule.

(3) Notwithstanding any other provision of this chapter, if the services are provided by a private, freestanding mental health hospital facility that is an institution for mental disease as defined in 42 U.S.C. 1396d(i), the department shall reimburse for inpatient services at a rate not to exceed ninety-one percent (91%) of the current medicare rate within federally allowed reimbursement under the medicaid program. The reimbursement provided for in this subsection shall be effective until July 1, 2021.

(4) The department shall, through the annual budget process, include a line-item request for adjustments to provider rates. All changes to provider payment rates shall be subject to approval of the legislature by appropriation.

(5) Notwithstanding any other provision of this chapter, the department may enter into agreements with providers to pay for services based on their value in terms of measurable health care quality and positive impacts to participant health.

(a) Any such agreement shall be designed to be cost-neutral or cost-saving compared to other payment methodologies.

(b) The department is authorized to pursue waiver agreements with the federal government as needed to support value-based payment arrangements, up to and including fully capitated provider-based managed care.

(6) Medicaid reimbursement for critical access, out-of-state, and state-owned hospitals shall be as follows:

(a) In-state, critical access hospitals as designated according to 42 U.S.C. 1395i-4(c)(2)(B) shall be reimbursed at one hundred one percent (101%) of cost;

(b) Out-of-state hospitals shall be reimbursed at eighty-seven percent (87%) of cost;

(c) State-owned hospitals shall be reimbursed at one hundred percent (100%) of cost; and

(d) Out-of-state hospital institutions for mental disease as defined in 42 U.S.C. 1396d(i) shall be reimbursed at a per diem equivalent to ninety-five percent (95%) of cost.

(7) The department shall equitably reduce net reimbursements for all hospital services, including in-state institutions for mental disease but excluding all hospitals and institutions described in subsection (6) of this section, by amounts targeted to reduce general fund needs for hospital payments by three million one hundred thousand dollars ($3,100,000) in state fiscal year 2020 and eight million seven hundred twenty thousand dollars ($8,720,000) in state fiscal year 2021.

(8) The department shall work with all Idaho hospitals, including institutions for mental disease as defined in 42 U.S.C. 1396d(i), to establish

value-based payment methods for inpatient and outpatient hospital services to replace existing cost-based reimbursement methods for in-state hospitals, other than those hospitals and institutions described in subsection (6) of this section, effective July 1, 2021. Budgets for hospital payments shall be subject to prospective legislative approval.

(9) The department shall work with Idaho hospitals to establish a quality payment program for inpatient and outpatient adjustment payments described in section 56-1406, Idaho Code. Inpatient and outpatient adjustment payments shall be subject to increase or reduction based on hospital service quality measures established by the department in consultation with Idaho hospitals.

[56-265, added 2011, ch. 164, sec. 16, p. 475; am. 2015, ch. 301, sec. 1, p. 1182; am. 2016, ch. 173, sec. 1, p. 476; am. 2017, ch. 82, sec. 1, p. 226; am. 2020, ch. 35, sec. 2, p. 70.]

56-266. AUTHORIZATION TO OBTAIN FEDERAL APPROVAL. The department is authorized to obtain federal approval for the requirements set forth in sections 56-260 through 56-266, Idaho Code.

[56-266, added 2011, ch. 164, sec. 17, p. 475.]

56-267. MEDICAID ELIGIBILITY EXPANSION. (1) Notwithstanding any provision of law or federal waiver to the contrary, the state shall amend its state plan to expand medicaid eligibility to include those persons under sixty-five (65) years of age whose modified adjusted gross income is one hundred thirty-three percent (133%) of the federal poverty level or below and who are not otherwise eligible for any other coverage under the state plan, in accordance with sections 1902(a)(10)(A)(i)(VIII) and 1902(e)(14) of the social security act.

(2) No later than ninety (90) days after approval of this act, the department shall submit any necessary state plan amendments to the United States department of health and human services, centers for medicare and medicaid services to implement the provisions of this section. The department is required and authorized to take all actions necessary to implement the provisions of this section as soon as practicable.

(3) Eligibility for medicaid as described in this section shall not be delayed if the centers for medicare and medicaid services fail to approve any waivers of the state plan for which the department applies, nor shall such eligibility be delayed while the department is considering or negotiating any waivers to the state plan. The department shall not implement any waiver that would result in a reduction in federal financial participation for persons identified in subsection (1) of this section below the ninety percent (90%) commitment described in section 1905(y) of the social security act.

(4) If section 1905(y) of the social security act is held unlawful or unconstitutional by the United States supreme court, then the legislature shall declare this section to be null, void, and of no force and effect.

(5) If federal financial participation for persons identified in subsection (1) of this section is reduced below the ninety percent (90%) commitment described in section 1905(y) of the social security act, then the senate and house of representatives health and welfare committees shall, as soon as practicable, review the effects of such reduction and make a recommendation to the legislature as to whether medicaid eligibility expansion should remain in effect. The review and recommendation described in this subsection

shall be conducted by the date of adjournment of the regular legislative session following the date of reduction in federal financial participation.

(6) The department:

(a) Shall place all persons participating in medicaid pursuant to this section in a care management program authorized under section 56-265(5), Idaho Code, or in another managed care program to improve the quality of their care, to the extent possible; and

(b) Is authorized to seek any federal approval necessary to implement the provisions of this subsection.

(7) No later than January 31 in the 2023 legislative session, the senate and house of representatives health and welfare committees shall review all fiscal, health, and other impacts of medicaid eligibility expansion pursuant to this section and shall make a recommendation to the legislature as to whether such expansion should remain in effect.

[56-267, added 2018, Init Measure, No. 2, sec. 1; am. 2019, ch. 318, sec. 2, p. 945.]

56-268. SUPPLEMENTAL MEDICAID REIMBURSEMENT FOR GROUND EMERGENCY MEDICAL TRANSPORTATION. (1) An eligible provider, as described in subsection (2) of this section, in addition to the rate of payment that the provider would otherwise receive for medicaid ground emergency medical transportation services, shall receive supplemental medicaid reimbursement to the extent provided by law.

(2) A provider shall be eligible for supplemental reimbursement only if, during the state fiscal year, the provider:

(a) Provides ground emergency medical transportation services to medicaid beneficiaries;

(b) Is enrolled as a medicaid provider for the period being claimed; and

(c) Is owned or operated by the state or a political subdivision of the state that employs or contracts with persons who are licensed to provide emergency medical services in the state of Idaho.

(3) An eligible provider's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(a) The supplemental reimbursement to an eligible provider, as described in subsection (2) of this section, shall be equal to the amount of federal financial participation received because of the claims submitted pursuant to subsection (6)(b) of this section;

(b) In no instance may the amount certified pursuant to subsection (5)(a) of this section, when combined with the amount received from all other sources of reimbursement from the medicaid program, exceed one hundred percent (100%) of actual costs, as determined pursuant to the medicaid state plan, for ground emergency medical transportation services; and

(c) The supplemental medicaid reimbursement provided by this section must be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to medicaid beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The state department of health and welfare shall obtain approval from the centers for medicare and medicaid services for the payment methodology to be utilized and shall not make any payment pursuant to this section prior to obtaining that approval.

(4)(a) It is the legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the state general fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into and maintain an agreement with the state department of health and welfare for the purposes of implementing this section and reimbursing the state for the costs of administering this section.

(b) The nonfederal share of the supplemental reimbursement submitted to the centers for medicare and medicaid services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in subsection (2)(c) of this section and certified to the state as provided in subsection (5) of this section.

(5) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider, the governmental entity shall do the following:

(a) Certify, in conformity with the requirements of 42 CFR 433.51 or a successor regulation, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation;

(b) Provide evidence supporting the certification as specified by the state department of health and welfare;

(c) Submit data as specified by the state department of health and welfare to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation; and

(d) Keep, maintain, and have readily retrievable any records specified by the state department of health and welfare to fully disclose reimbursement amounts to which the eligible provider is entitled and any other records required by the centers for medicare and medicaid services.

(6) The state department of health and welfare shall promptly seek any necessary federal approval for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under title XIX of the social security act, 42 U.S.C. 1396 et seq. If federal approval is not obtained for implementation of this section, then this section shall not be implemented.

(a) The state department of health and welfare shall submit claims for federal financial participation for the expenditures for the services described in this section that are allowable expenditures under federal law.

(b) The state department of health and welfare shall submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

[56-268, added 2022, ch. 67, sec. 1, p. 203.]

56-269. CHANGES IN FINANCIAL ELIGIBILITY CRITERIA TO BE PROVIDED IN STATUTE. Effective July 1, 2023, any change in financial eligibility criteria for a public assistance program must be provided in statute and may not be provided in rule.

[56-269, added 2023, ch. 301, sec. 1, p. 911.]