IDAHO MEDICAL INDIGENT STATUTES
IDAHO CODE TITLE 31, CHAPTER 35
(IDAHO CODE SECTIONS 31-3501 THROUGH 31-3558)
[Current as of September 22, 2015]

31-3501. DECLARATION OF POLICY. (1) It is the policy of this state that each person, to the maximum extent possible, is responsible for his or her own medical care and that of his or her dependents and to that end, shall be encouraged to purchase his or her own medical insurance with coverage sufficient to prevent them from needing to request assistance pursuant to this chapter. However, in order to safeguard the public health, safety and welfare, and to provide suitable facilities and provisions for the care and hospitalization of persons in this state, and, in the case of medically indigent residents, to provide for the payment thereof, the respective counties of this state, and the board and the department shall have the duties and powers as hereinafter provided.

(2) The county medically indigent program and the catastrophic health care cost program are payers of last resort. Therefore, applicants or third party applicants seeking financial assistance under the county medically indigent program and the catastrophic health care cost program shall be subject to the limitations and requirements as set forth herein.

History:

[31-3501, added 1974, ch. 302, sec. 12, p. 1769; am. 1980, ch. 185, sec. 1, p. 410; am. 1996, ch. 410, sec. 2, p. 1358; am. 2009, ch. 177, sec. 3, p. 559; am. 2010, ch. 273, sec. 1, p. 691; am. 2011, ch. 291, sec. 3, p. 795; am. 2013, ch. 279, sec. 1, p. 721.]

31-3502. DEFINITIONS. As used in this chapter, the terms defined in this section shall have the following meaning, unless the context clearly indicates another meaning:

(1) "Applicant" means any person who is requesting financial assistance under this chapter.

(2) "Application" means the combined application for state and county medical assistance pursuant to sections 31-3504 and 31-3503E, Idaho Code. In this chapter an application for state and county medical assistance shall also mean an application for financial assistance.

(3) "Board" means the board of the catastrophic health care cost program, as established in section 31-3517, Idaho Code.

(4) "Case management" means coordination of services to help meet a patient's health care needs, usually when the patient has a condition that requires multiple services.

(5) "Catastrophic health care costs" means the cost of necessary medical services received by a recipient that, when paid at the then existing reimbursement rate, exceeds the total sum of eleven thousand dollars ($11,000) in the aggregate in any consecutive twelve (12) month period.

(6) "Clerk" means the clerk of the respective counties or his or her designee.

(7) "Completed application" shall include at a minimum the cover sheet requesting services, applicant information including diagnosis and requests for services and signatures, personal and financial information of the applicant and obligated person or persons, patient rights and responsibilities, releases and all other signatures required in the application.

(8) "County commissioners" means the board of county commissioners in their respective counties.
(9) "County hospital" means any county approved institution or facility for the care of sick persons.
(10) "Department" means the department of health and welfare.
(11) "Dependent" means any person whom a taxpayer claims as a dependent under the income tax laws of the state of Idaho.
(12) "Emergency service" means a service provided for a medical condition in which sudden, serious and unexpected symptoms of illness or injury are sufficiently severe to necessitate or call for immediate medical care, including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:
(a) Placing the patient's health in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of any bodily organ or part.
(13) "Hospital" means a facility licensed and regulated pursuant to sections 39-1301 through 39-1314, Idaho Code, or an out-of-state hospital providing necessary medical services for residents of Idaho, wherein a reciprocal agreement exists, in accordance with section 31-3503B, Idaho Code, excluding state institutions.
(14) "Medicaid eligibility review" means the process used by the department to determine whether a person meets the criteria for medicaid coverage.

(15) "Medical claim" means the itemized statements and standard forms used by hospitals and providers to satisfy centers for medicare and medicaid services (CMS) claims submission requirements.
(16) "Medical home" means a model of primary and preventive care delivery in which the patient has a continuous relationship with a personal physician in a physician directed medical practice that is whole person oriented and where care is integrated and coordinated.
(17) "Medically indigent" means any person who is in need of necessary medical services and who, if an adult, together with his or her spouse, or whose parents or guardian if a minor or dependent, does not have income and other resources available to him from whatever source sufficient to pay for necessary medical services. Nothing in this definition shall prevent the board and the county commissioners from requiring the applicant and obligated persons to reimburse the county and the catastrophic health care cost program, where appropriate, for all or a portion of their medical expenses, when investigation of their application pursuant to this chapter, determines their ability to do so.
(18) A. "Necessary medical services" means health care services and supplies that:
(a) Health care providers, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms;
(b) Are in accordance with generally accepted standards of medical practice;
(c) Are clinically appropriate, in terms of type, frequency, extent, site and duration and are considered effective for the covered person's illness, injury or disease;

(d) Are not provided primarily for the convenience of the person, physician or other health care provider; and
(e) Are the most cost-effective service or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury or disease.
B. Necessary medical services shall not include the following:
(a) Bone marrow transplants;
(b) Organ transplants;
(c) Elective, cosmetic and/or experimental procedures;
(d) Services related to, or provided by, residential, skilled nursing, assisted living and/or shelter care facilities;
(e) Normal, uncomplicated pregnancies, excluding caesarean section, and childbirth well-baby care;
(f) Medicare copayments and deductibles;
(g) Services provided by, or available to, an applicant from state, federal and local health programs;
(h) Medicaid copayments and deductibles; and
(i) Drugs, devices or procedures primarily utilized for weight reduction and complications directly related to such drugs, devices or procedures.
(19) "Obligated person" means the person or persons who are legally responsible for an applicant including, but not limited to, parents of minors or dependents.
(20) "Primary and preventive health care" means the provision of professional health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems and the overall management of an individual's health care services.

(21) "Provider" means any person, firm or corporation certified or licensed by the state of Idaho or holding an equivalent license or certification in another state, that provides necessary medical services to a patient requesting a medically indigent status determination or filing an application for financial assistance.
(22) "Recipient" means an individual determined eligible for financial assistance under this chapter.
(23) "Reimbursement rate" means the unadjusted medicaid rate of reimbursement for medical charges allowed pursuant to title XIX of the social security act, as amended, that is in effect at the time service is rendered. The "reimbursement rate" shall mean ninety-five percent (95%) of the unadjusted medicaid rate.
(24) "Resident" means a person with a home, house, place of abode, place of habitation, dwelling or place where he or she actually lived for a consecutive period of thirty (30) days or more within the state of Idaho. A resident does not include a person who comes into this state for temporary purposes, including, but not limited to, education, vacation, or seasonal labor. Entry into active military duty shall not change a person's residence for the purposes of this chapter. Those physically present within the following facilities and institutions shall be residents of the county where they were residents prior to entering the facility or institution:
(a) Correctional facilities;
(b) Nursing homes or residential or assisted living facilities;
(c) Other medical facility or institution.

(25) "Resources" means all property, for which an applicant and/or an obligated person may be eligible or in which he or she may have an interest, whether tangible or intangible, real or personal, liquid or nonliquid, or pending, including, but not limited to, all forms of public assistance, crime victims compensation, worker's compensation, veterans benefits, medicaid, medicare, supplemental security income (SSI), third party insurance, other insurance or apply for section 1011 of the medicare modernization act of 2003, if applicable, and any other property from any source. Resources shall include the ability of an applicant and obligated persons to pay for necessary medical services, excluding any interest charges, over a period of up to five (5) years starting on the date necessary medical services are first provided. For purposes of determining approval for medical indigency only, resources shall not include the value of the homestead on the applicant or obligated person's residence, a burial plot, exemptions for personal property allowed in section 11-605(1) through (3), Idaho Code, and additional exemptions allowed by county resolution.

(26) "Third party applicant" means a person other than an obligated person who completes, signs and files an application on behalf of a patient. A third party applicant who files an application on behalf of a patient pursuant to section 31-3504, Idaho Code, shall, if possible, deliver a copy of the application to the patient within three (3) business days after filing the application.

(27) "Third party insurance" means casualty insurance, disability insurance, health insurance, life insurance, marine and transportation insurance, motor vehicle insurance, property insurance or any other insurance coverage that may pay for a resident's medical bills.

(28) "Utilization management" means the evaluation of medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities. "Utilization management" may include, but is not limited to, preadmission certification, the application of practice guidelines, continued stay review, discharge planning, case management, preauthorization of ambulatory procedures, retrospective review and claims review. "Utilization management" may also include the amount to be paid based on the application of the reimbursement rate to those medical services determined to be necessary medical services.

History:
[31-3502, added 1974, ch. 302, sec. 12, p. 1769; am. 1976, ch. 121, sec. 6, p. 466; am. 1980, ch. 185, sec. 2, p. 410; am. 1982, ch. 190, sec. 1, p. 511; am. 1983, ch. 215, sec. 1, p. 595; am. 1984, ch. 99, sec. 1, p. 227; am. 1988, ch. 332, sec. 2, p. 994; am. 1989, ch. 374, sec. 1, p. 943; am. 1990, ch. 87, sec. 9, p. 180; 1991, 1990 am. to section repealed, ch. 233, sec. 1, p. 553; am. 1991, ch. 233, sec. 7, p. 557; am. 1992, ch. 83, sec. 4, p. 262; am. 1993, ch. 112, sec. 1, p. 284; am. 1996, ch. 410, sec. 3, p. 1358; am. 1998, ch. 109, sec. 1, p. 373; am. 2000, ch. 274, sec. 2, p. 802; am. 2000, ch. 317, sec. 1, p. 1068; am. 2004, ch. 300, sec. 1, p. 837; am. 2005, ch. 281, sec. 1, p. 915; am. 2009, ch. 177, sec. 4, p. 559; am. 2010, ch. 273, sec. 2, p. 692; am. 2011, ch. 291, sec. 4, p. 796; am. 2013, ch. 279, sec. 2, p. 722; am. 2014, ch. 258, sec. 1, p. 648.]

31-3503. POWERS AND DUTIES OF COUNTY COMMISSIONERS. The county commissioners in their respective counties shall, under such limitations and restrictions as are prescribed by law:

(1) Pay for necessary medical services for the medically indigent residents of their counties as provided in this chapter and as approved by the county commissioners at the reimbursement rate up to the total sum of eleven thousand dollars ($11,000) in the aggregate per resident in any consecutive twelve (12) month period or contract for the provision of necessary medical services pursuant to sections 31-3520 and 31-3521, Idaho Code.

(2) Have the right to contract with providers, transfer patients, negotiate provider agreements, conduct utilization management or any portion thereof, pay for authorized expenses directly, or indirectly through the use of alternative programs, that would assist in managing costs of providing health care for indigent persons, and all other powers incident to the county's duties created by this chapter.

(3) Cooperate with the department, the board and contractors retained by the department or the board to provide services including, but not limited to, medicaid eligibility review and utilization management on behalf of the counties and the board.

(4) Have the jurisdiction and power to provide county hospitals and public general hospitals for the county and others who are sick, injured, maimed, aged and infirm and to erect, enlarge, purchase, lease, or otherwise acquire, and to officer, maintain and improve hospitals, hospital grounds, nurses' homes, shelter care facilities and residential or assisted living facilities as defined in section 39-3301, Idaho Code, superintendent's quarters, medical clinics, as that

term is defined in section 39-1319, Idaho Code, medical clinic grounds or any other necessary buildings, and to equip the same, and to replace equipment, and for this purpose said commissioners may levy an additional tax of not to exceed six hundredths percent (.06%) of the market value for assessment purposes on all taxable property within the county. The term "public general hospitals" as used in this subsection shall be construed to include nursing homes.

History:
[31-3503, added 1974, ch. 302, sec. 12, p. 1769; am. 1980, ch. 185, sec. 3, p. 411; am. 1982, ch. 190, sec. 2, p. 512; am. 1983, ch. 215, sec. 2, p. 596; am. 1989, ch. 193, sec. 2, p. 476; am. 1990, ch. 87, sec. 10, p. 181; 1991, 1990 am. to section repealed, ch. 233, sec. 1, p. 553; am. 1991, ch. 233, sec. 8, p. 558; am. 1993, ch. 112, sec. 2, p. 285; am. 1995, ch. 9, sec. 1, p. 14; am. 1995, ch. 82, sec. 5, p. 222; am. 1996, ch. 322, sec. 14, p. 1042; am. 1996, ch. 410, sec. 4, p. 1361; am. 1997, ch. 174, sec. 1, p. 492; am. 2000, ch. 274, sec. 3, p. 804; am. 2009, ch. 177, sec. 5, p. 563; am. 2010, ch. 273, sec. 3, p. 694; am. 2011, ch. 291, sec. 5, p. 799; am. 2012, ch. 61, sec. 1, p. 163.]

31-3503A. POWERS AND DUTIES OF THE BOARD. The board shall, under such limitations and restrictions as are prescribed by law:
(1) Pay for the cost of necessary medical services for a medically indigent resident, as provided in this chapter, where the cost of necessary medical services when paid at the reimbursement rate exceeds the total sum of eleven thousand dollars ($11,000) in the aggregate per resident in any consecutive twelve (12) month period;

(2) Have the right to negotiate provider agreements, contract for utilization management or any portion thereof, pay for authorized expenses directly, or indirectly through the use of alternative programs, that would assist in managing costs of providing health care for indigent persons, and all other powers incident to the board's duties created by this chapter;
(3) Cooperate with the department, respective counties of the state and contractors retained by the department or county commissioners to provide services including, but not limited to, eligibility review and utilization management on behalf of the counties and the board;
(4) Require, as the board deems necessary, annual reports from each county and each hospital including, but not limited to, the following:
(a) From each county and for each applicant:
(i) Case number and the date services began;
(ii) Age;
(iii) Residence;
(iv) Sex;
(v) Diagnosis;
(vi) Income;
(vii) Family size;
(viii) Amount of costs incurred including provider, legal and administrative charges;
(ix) Approval or denial; and
(x) Reasons for denial.
(b) From each hospital:
(i) 990 tax forms or comparable information;
(ii) Cost of charges where charitable care was provided; and
(iii) Administrative and legal costs incurred in processing claims under this chapter.
(5) Authorize all disbursements from the catastrophic health care cost program in accordance with the provisions of this chapter;

(6) Make and enter into contracts;
(7) Develop and submit a proposed budget setting forth the amount necessary to perform its functions and prepare an annual report;
(8) Perform such other duties as set forth in the laws of this state; and
(9) Conduct examinations, investigations, audits and hear testimony and take proof, under oath or affirmation, at public or private hearings, on any matter necessary to fulfill its duties.

History:
[31-3503A, added 1996, ch. 410, sec. 5, p. 1361; am. 1997, ch. 174, sec. 2, p. 493; am. 2009, ch. 177, sec. 6, p. 564; am. 2010, ch. 273, sec. 4, p. 695; am. 2011, ch. 291, sec. 6, p. 799; am. 2012, ch. 61, sec. 2, p. 163.]

31-3503B. RECIPROCAL AGREEMENTS -- OUT-OF-STATE TREATMENT. (1) The governor of the state of Idaho or his or her designee is empowered to negotiate reciprocal agreements with other states for the provision of necessary medical services for residents of this and other states.
(2) No payment shall be made for necessary medical services to an out-of-state provider unless a reciprocal agreement has been entered into by the governor of this state, or unless contracted for pursuant to sections 31-3520 and 31-3522, Idaho Code.

History:
[31-3503B, added 1996, ch. 410, sec. 6, p. 1362.]

31-3503C. POWERS AND DUTIES OF THE DEPARTMENT. The department shall:
(1) Design and manage a utilization management program and third party recovery system for the medically indigent program.
(2) Have the authority to engage one (1) or more contractors or third party administrators to perform the duties assigned to it pursuant to this chapter including, but not limited to, utilization management and third party recovery for the medically indigent program.
(3) Implement a medicaid eligibility determination process for all potential applicants.
(4) Develop and implement by July 1, 2010, in cooperation with the Idaho association of counties and the Idaho hospital association, a uniform form to be used for both the initial review, pursuant to section 31-3503E, Idaho Code, and the application for financial assistance pursuant to section 31-3504, Idaho Code.
(5) Cooperate with the counties and the board in providing the services required of it pursuant to this chapter.
(6) Promulgate rules to implement its duties and responsibilities under the provisions of this chapter.

History:
[31-3503C, added 2009, ch. 177, sec. 7, p. 564; am. 2010, ch. 273, sec. 5, p. 695.]

31-3503D.COUNTY PARTICIPATION AND CONTRIBUTION. Every county shall fully participate in the utilization management program and third party recovery system and shall contribute to the medicaid eligibility review, utilization management program and third party recovery costs incurred by the department pursuant to section 31-3503E, Idaho

Code. The contribution of each county shall be calculated by the department as defined in rule.

History:
[31-3503D, added 2009, ch. 177, sec. 7, p. 565.]

31-3503E. MEDICAID ELIGIBILITY DETERMINATION. The department shall:
(1) Require the hospital to undertake an initial review of a patient upon stabilization to determine whether the patient may be medically indigent. If the hospital's initial review determines that the patient may be medically indigent, require that the hospital transmit a completed combined application for state and county medical assistance and a written request for medicaid eligibility determination to the department any time within thirty-one (31) days of the date of admission.
(2) Undertake a determination of possible medicaid eligibility upon receipt from the hospital of the completed combined application for state and county medical assistance and written request for medicaid eligibility determination. The department will use the medicaid eligibility guidelines in place as of the date of submission of the completed combined application for state and county medical assistance, apply categorical and financial eligibility requirements and use all sources available to the department to obtain verification in making the determination.
(3) In order to ascertain medicaid eligibility, require the patient or the obligated person to cooperate with the department according to its rules in investigating, providing documentation, submitting to an interview and notifying the department of the receipt of resources after the initial review form has been submitted to the department.

(4) Promptly notify the patient of medicaid eligibility.
(5) Act on the completed combined application for state and county medical assistance as an application for medicaid. An application for medicaid shall not be an application for financial assistance pursuant to section 31-3504, Idaho Code. Except as provided in this section, an application for financial assistance shall not be an application for medicaid.
(6) Utilize the verification and cooperation requirement in department rule to complete the eligibility determination.
(7) Notify the patient or the obligated person, the hospital or the clerk of a denial and the reason therefor. If, based on its medicaid eligibility review, the department determines that the patient is not eligible for medicaid, transmit a copy of the completed combined application for state and county medical assistance to the clerk. Denial of medicaid eligibility is not a determination of medical indigence.
(8) Make income and resource information obtained from the medicaid eligibility determination process available to the county to assist in determination of medical indigency at the time the department notifies the county of the final medicaid eligibility determination.
The completed combined application for state and county medical assistance shall be deemed consent for providers, the hospital, the department, respective counties and the board to exchange information pertaining to the applicant's health and finances for the purposes of determining medicaid eligibility or medical indigency.

History:
[31-3503E, added 2009, ch. 177, sec. 7, p. 565; am. 2010, ch. 273, sec. 6, p. 696; am. 2011, ch. 291, sec. 7, p. 800.]

31-3503F. MEDICAL HOME. The department shall create by rule a community-based system in which a medically indigent patient may be referred to a medical home upon discharge from hospital. The medical home shall provide ongoing primary and preventive care and case management with periodic reports to the department regarding the medically indigent patient's health status and participation in the patient's treatment plan. Appropriate reimbursement to the medical home provider for patient primary and preventive care services employing utilization management and case management shall be coordinated by the department.

History:
[31-3503F, added 2009, ch. 177, sec. 7, p. 566.]

31-3504. APPLICATION FOR FINANCIAL ASSISTANCE. (1) Except as provided for in section 31-3503E, Idaho Code, an applicant or third party applicant requesting assistance under this chapter shall complete a written application. The truth of the matters contained in the completed application shall be sworn to by the applicant or third party applicant. The completed application shall be deemed consent for the providers, the hospital, the department, respective counties and board to exchange information pertaining to the applicant's health and finances for the purposes of determining medicaid eligibility or medical indigency. The completed application shall be signed by the applicant or third party applicant, an authorized representative of the applicant, or, if the

applicant is incompetent or incapacitated, someone acting responsibly for the applicant and filed in the clerk's office. If the clerk determines that the patient may be eligible for medicaid, within one (1) business day of the filing of the completed application in the clerk's office, the clerk shall transmit a copy of the application and a written request for medicaid eligibility determination to the department.

(a) If, based on its medicaid eligibility review, the department determines that the patient is eligible for medicaid, the department shall act on the application as an application for medicaid.

(b) If, based on its medicaid eligibility review, the department determines that the patient is not eligible for medicaid, the department shall notify the clerk of the denial and the reason therefor, in accordance with section 31-3503E, Idaho Code. Denial of medicaid eligibility is not a determination of medical indigence.

(2) If a third party completed application is filed, the application shall be presented in the same form and manner as set forth in subsection (1) of this section.

(3) Follow-up necessary medical services based on a treatment plan, for the same condition, preapproved by the county commissioners, may be provided for a maximum of six (6) months from the date of the original application without requiring an additional application; however, a request for additional treatment not specified in the approved treatment plan shall be filed with the clerk ten (10) days prior to receiving services. Beyond the six (6) months, requests for additional treatment related to an original diagnosis in accordance with a preapproved treatment plan shall be filed ten (10) days prior to receiving services and an

updated application may be requested by the county commissioners.

(4) Upon application for financial assistance pursuant to this chapter an automatic lien shall attach to all real and personal property of the applicant and on insurance benefits to which the applicant may become entitled. The lien shall also attach to any additional resources to which it may legally attach not covered in this section. The lien created by this section may be, in the discretion of the county commissioners and the board, perfected as to real property and fixtures by recording a document entitled: notice of lien and application for financial assistance, in any county recorder's office in this state in which the applicant and obligated person own property. The notice of lien and application for financial assistance shall be recorded as provided herein within thirty (30) days from receipt of an application, and such lien, if so recorded, shall have a priority date as of the date the necessary medical services were provided. The lien created by this section may also be, in the discretion of the county commissioners and the board, perfected as to personal property by filing with the secretary of state within thirty (30) days of receipt of an application, a notice of application in substantially the same manner as a filing under chapter 9, title 28, Idaho Code, except that such notice need not be signed and no fee shall be required, and, if so filed, such lien shall have the priority date as of the date the necessary medical services were provided. An application for assistance pursuant to this chapter shall waive any confidentiality granted by state law to the extent necessary to carry out the intent of this section.

(5) In accordance with rules and procedures promulgated by the department or the board, each hospital and provider seeking reimbursement under this chapter shall submit all medical records and medical claims relevant to necessary medical services provided for an applicant in a standard or uniform format to the county clerk of the obligated county within ten (10) days after receiving a request from the county clerk; provided that, within the ten (10) day period if a provider presents a written request for suspension of the investigation, the investigation of the application shall be suspended for up to thirty (30) days. Upon receipt of the requested documentation, the investigation shall resume. A copy of the results of the reviewed medical records and medical claims shall be transmitted by the department's or the board's contractor to the clerk of the obligated county. Failure to provide the medical records and medical claims within the initial ten (10) day period and the suspension period, if any, shall result in denial of the application.

History:
[31-3504, added 1996, ch. 410, sec. 7, p. 1362; am. 1997, ch. 92, sec. 1, p. 218; am. 2000, ch. 317, sec. 2, p. 1070; am. 2009, ch. 177, sec. 8, p. 566; am. 2010, ch. 273, sec. 7, p. 697; am. 2011, ch. 291, sec. 8, p. 801; am. 2013, ch. 279, sec. 3, p. 725.]

31-3505. TIME AND MANNER OF FILING APPLICATIONS FOR FINANCIAL ASSISTANCE. Applications for financial assistance shall be filed according to the following time limits. Filing is complete upon receipt by the clerk or the department.

(1) A completed application for nonemergency necessary medical services shall be filed with the clerk ten (10) days prior to receiving services from the provider or the hospital.
(2) A completed application for emergency necessary medical services shall be filed with the clerk any time within thirty-one (31) days beginning with the first day of the provision of necessary medical services from the provider, except as provided in subsection (3) of this section.
(3) In the case of hospitalization, a completed application for emergency necessary medical services shall be filed with the department any time within thirty-one (31) days of the date of admission.
(4) Requests for additional treatment related to an original diagnosis in accordance with a preapproved treatment plan shall be filed ten (10) days prior to receiving services.
(5) A delayed application for necessary medical services may be filed up to one hundred eighty (180) days beginning with the first day of the provision of necessary medical services provided that:
(a) Written documentation is included with the application or no later than forty-five (45) days after an application has been filed showing that a bona fide application or claim has been filed for social security disability insurance, supplemental security income, third party insurance, medicaid, medicare, crime victims compensation, and/or worker's compensation. A bona fide application means that:
(i) The application was timely filed within the appropriate agency's application or claim time period; and

(ii) Given the circumstances of the patient and/or obligated persons, the patient and/or obligated persons, and given the information available at the time the application or claim for other resources is filed, would reasonably be expected to meet the eligibility criteria for such resources; and
(iii) The application was filed with the appropriate agency in such a time and manner that, if approved, it would provide for payment coverage of the bills included in the county application; and(iv) In the discretion of the county commissioners, bills on a delayed application which would not have been covered by a successful application or timely claim to the other resource(s) may be denied by the county commissioners as untimely; and
(v) In the event an application is filed for supplemental security income, an Idaho medicaid application must also have been filed within the department of health and welfare's application or claim time period to provide payment coverage of eligible bills included in the county application.
(b) Failure by the patient and/or obligated persons to complete the application process described in this section, up to and including any reasonable appeal of any denial of benefits, with the applicable program noted in paragraph (a) of this subsection, shall result in denial of the application.
(6) No application for financial assistance under the county medically indigent program or the catastrophic health care cost program shall be approved by the county commissioners or the board unless the provider or the hospital completes the application process and complies with the time limits prescribed by this chapter.

(7) Any application or request which fails to meet the provisions of this section, and/or other provisions of this chapter, shall be denied.
(8) In the event that a county determines that a different county is obligated, such county shall notify the applicant or third party applicant of the denial and shall also notify the county it believes to be the obligated county and provide the basis for the determination. An application may be filed by the applicant or third party applicant in the indicated county within thirty (30) days of the date of the initial county denial.

History:
[31-3505, added 1996, ch. 410, sec. 8, p. 1363; am. 2000, ch. 317, sec. 3, p. 1071; am. 2004, ch. 300, sec. 2, p. 839; am. 2009, ch. 177, sec. 9, p. 567; am. 2010, ch. 273, sec. 8, p. 698; am. 2011, ch. 291, sec. 9, p. 802; am. 2013, ch. 279, sec. 4, p. 726; am. 2014, ch. 97, sec. 20, p. 283.]

31-3505A. INVESTIGATION OF APPLICATION BY THE CLERK. (1) The clerk shall interview the applicant and investigate the information provided on the application, along with all other required information, in accordance with the procedures established by the county commissioners, the board and this chapter. The clerk shall promptly notify the applicant, or third party filing an application on behalf of an applicant, of any material information missing from the application which, if omitted, may cause the application to be denied for incompleteness. In addition, any provider requesting notification shall be notified at the same time. When necessary, such persons as may be deemed essential, may be compelled by the clerk to give testimony and produce documents and other evidence under oath in order to complete the

investigation. The clerk is hereby authorized to issue subpoenas to carry out the intent of this provision and to otherwise compel compliance in accordance with provisions of Idaho law.

(2) The applicant and third party filing an application on behalf of an applicant to the extent they have knowledge, shall have a duty to cooperate with the clerk in investigating, providing documentation, submitting to an interview and ascertaining eligibility and shall have a continuing duty to notify the obligated county of the receipt of resources after an application has been filed.

(3) The clerk shall have twenty (20) days to complete the investigation of an application for nonemergency necessary medical services.

(4) The clerk shall have forty-five (45) days to complete the investigation of an application for emergency necessary medical utilization management services or a portion thereof.

(5) In the case of follow-up treatment, the clerk shall have ten (10) days to complete an interview on a request for additional treatment to update the financial and other information contained in a previous application for an original diagnosis in accordance with a treatment plan previously approved by the county commissioners.

(6) Upon completion of the interview and investigation of the application or request, a statement of the clerk's findings shall be filed with the county commissioners. Such findings of indigency shall start on the date necessary medical services are first provided.

History:
[31-3505A, added 1996, ch. 410, sec. 9, p. 1364; am. 2010, ch. 273, sec. 9, p. 699; am. 2011, ch. 291, sec. 10, p. 803; am. 2013, ch. 279, sec. 5, p. 727.]

31-3505B. APPROVAL BY THE COUNTY COMMISSIONERS. The county commissioners shall approve an application for financial assistance if it determines that necessary medical services have been or will be provided to a medically indigent resident in accordance with this chapter; provided, the amount approved when paid, at the reimbursement rate, by the obligated county for any medically indigent resident shall not exceed the lesser of:
(1) The total sum of eleven thousand dollars ($11,000) in the aggregate per resident in any consecutive twelve (12) month period; or
(2) The reimbursement for services recommended by any or all of the utilization management activities pursuant to section 31-3502, Idaho Code.

History:
[31-3505B, added 1996, ch. 410, sec. 10, p. 1365; am. 2009, ch. 177, sec. 10, p. 568; am. 2010, ch. 273, sec. 10, p. 699; am. 2011, ch. 291, sec. 11, p. 804.]

31-3505C. INITIAL DECISION BY THE COUNTY COMMISSIONERS. (1) Except as otherwise provided in subsection (2) of this section, the county commissioners shall make an initial determination to approve or deny an application within fifteen (15) days from receipt of the clerk's statement and within five (5) days from receiving the clerk's statement on a request. The initial determination to approve or deny an application shall be mailed to the applicant or the third party making

application on behalf of the applicant, as the case may be, and each provider listed on the application within five (5) days of the initial determination.

(2) The county commissioners shall hold in suspension an initial determination to deny an application, if the sole basis for the denial is that the applicant may be eligible for other forms of public assistance, crime victims compensation, worker's compensation, veterans benefits, medicaid, medicare, supplemental security income, third party insurance or other insurance. The decision to hold an initial determination to deny an application in suspension shall be mailed to the applicant or the third party making application on behalf of the applicant, as the case may be, and each provider listed on the application within five (5) days of the decision to suspend.

(a) If an applicant is subsequently determined to be eligible for other forms of public assistance, crime victims compensation, worker's compensation, veterans benefits, medicaid, medicare, supplemental security income, third party insurance or other insurance, the application shall be denied. The applicant or the third party making application on behalf of the applicant, as the case may be, and each provider listed on the application shall be notified within five (5) days of the denial.

(b) If an applicant is subsequently determined not to be eligible for other forms of public assistance, crime victims compensation, worker's compensation, veterans benefits, medicaid, medicare, supplemental security income, third party insurance or other insurance, the application for financial assistance shall be approved. The applicant or the third party making application on behalf of the applicant, as the case may be, and each provider listed on the application shall be notified within five (5) days of the approval.

(3) If the county commissioners hold in suspension an initial determination to deny an application, any time limitation used in this chapter shall be tolled and not deemed to run during the period of suspension.

History:
[31-3505C, added 1996, ch. 410, sec. 11, p. 1365; am. 2010, ch. 273, sec. 11, p. 700; am. 2011, ch. 291, sec. 12, p. 804.]

31-3505D. APPEAL OF INITIAL DETERMINATION DENYING AN APPLICATION. An applicant, provider or third party applicant may appeal an initial determination of the county commissioners denying an application by filing a written notice of appeal with the county commissioners within twenty-eight (28) days of the date of the denial. If no appeal is filed within the time allowed, the initial determination of the county commissioners denying an application shall become final.

History:
[31-3505D, added 1996, ch. 410, sec. 12, p. 1365; am. 2010, ch. 273, sec. 12, p. 700; am. 2011, ch. 291, sec. 13, p. 805.]

31-3505E. HEARING ON APPEAL OF INITIAL DETERMINATION DENYING AN APPLICATION. The county commissioners shall hold a hearing on the appeal within seventy-five (75) days of receipt of the notice of appeal. The hearing may be continued by the county commissioners for not more than forty-five (45) days from the date of the hearing to allow the applicant to produce additional information, documents, records, testimony or other evidence required in the discretion of the county commissioners or to allow a decision on eligibility

of the applicant for benefits to be reached by another agency such as, but not limited to, the social security administration or the department. The hearing may be continued for additional periods by mutual stipulation of the county commissioners and the applicant. The county commissioners shall make a final determination within thirty (30) days of the conclusion of the hearing. The final determination of the county commissioners denying an application shall be mailed to the applicant, or the third party making application on behalf of an applicant, as the case may be and each provider listed on the application, within five (5) days of the date of the final determination.

History:
[31-3505E, added 1996, ch. 410, sec. 13, p. 1365; am. 2010, ch. 273, sec. 13, p. 701.]

31-3505F. ARBITRATION. In the event that a county determines that a service is not a necessary medical service, a provider may submit the issue to a panel for arbitration as follows:
(1) Within thirty (30) days of the determination, the county commissioners and the provider shall each appoint one (1) licensed medical or osteopathic doctor with expertise in the condition treated or to be treated. The two (2) appointees shall jointly select a third medical or osteopathic licensed doctor with equivalent expertise. The panel shall review such information as it deems necessary and render a decision within thirty (30) days as to whether the covered service is a necessary medical service.
(2) There shall be no judicial or other review or appeal of the findings of the panel. No party shall be obligated to comply with or otherwise be affected or prejudiced by the proposals,

conclusions or suggestions of the panel or any member or segment thereof; however, in the interest of due consideration being given to such proceedings and in the interest of encouraging consideration of claims informally and without the necessity of litigation, the applicable statute of limitations shall be tolled and not deemed to run during the time that such a claim is pending before the panel and for thirty (30) days thereafter.

(3) Expenses incurred by the members of the panel in the performance of their duties will be borne by the respective parties making their appointment, and expenses of the third member shall be divided equally among the respective parties.

History:
[31-3505F, added 1996, ch. 410, sec. 14, p. 1366; am. 2010, ch. 273, sec. 14, p. 701.]

31-3505G. PETITION FOR JUDICIAL REVIEW OF FINAL DETERMINATION. If, after a hearing as provided in section 31-3505E, Idaho Code, the final determination of the county commissioners is to deny an application for financial assistance, the applicant, or a third party applicant, may seek judicial review of the final determination of the county commissioners in the manner provided in section 31-1506, Idaho Code.

History:
[31-3505G, added 1996, ch. 410, sec. 15, p. 1366; am. 2010, ch. 273, sec. 15, p. 701; am. 2011, ch. 291, sec. 14, p. 805.]

31-3506. OBLIGATED COUNTY. The county obligated for payment shall be determined as follows:

(1) The obligated county for payment of pharmaceuticals for noninstitutionalized individuals shall be the county where the applicant currently resides.

(2) The obligated county for payment of necessary medical services for medical indigent individuals shall be as follows:

(a) The last county in which the applicant or head of household has maintained a residence for six (6) consecutive months or longer within the past five (5) years preceding incurrence shall be obligated. If the applicant or head of household maintains another residence in a different county or state for purposes of employment, the county where the family residence is maintained shall be deemed the applicant's or head of household's place of residence.

(b) If an individual has not resided in any county for a period of six (6) months within the five (5) years preceding incurrence of medical costs for which counties have a responsibility in whole or in part, then the county where the applicant maintained a residence for at least thirty (30) days immediately preceding such incurrence shall be the obligated county.

(c) Active military duty, or being admitted as a patient in a hospital, nursing home, other medical facility or institution, shall not change the obligated county. The county obligated shall remain the same county that would have been obligated prior to institutionalization as above described.

(d) For full-time students at public institutions of higher learning, the obligated county shall be the county of residence of the applicant unless an obligated person, for whom the applicant is claimed as a dependent, resides in another county or state.

(e) If an individual has not resided in any county for a consecutive period of thirty (30) days but has resided in the state of Idaho for a consecutive period of thirty (30) days then the county where the individual last resided prior to receiving medical services shall be the obligated county.

History:
[31-3506, added 1974, ch. 302, sec. 12, p. 1769; am. 1976, ch. 121, sec. 9, p. 468; am. 1988, ch. 332; sec. 3, p. 996; am. 1989, ch. 193, sec. 3, p. 476; repealed 1990, ch. 87, sec. 1, p. 178; reinstated 1991, ch. 233, sec. 1, p. 553; am. 1996, ch. 410, sec. 16, p. 1367; am. 2000, ch. 317, sec. 4, p. 1072; am. 2008, ch. 189, sec. 1, p. 593.]

31-3507. TRANSFER OF A MEDICALLY INDIGENT PATIENT. An obligated county or the board shall have the right to have an approved medically indigent resident transferred to a hospital or facility, in accordance with requirements of the federal emergency medical treatment and active labor act, 42 U.S.C., section 1395dd; provided however, treatment for the necessary medical service must be available at the designated facility, and the county contract physician, or the attending physician if no county contract physician is available, must certify that the transfer of such person would not present a significant risk of further injury. The obligated county, the board, and hospital from which or to which a person is taken or removed as herein provided, as well as the attending physician(s), shall not be liable in any manner whatsoever and shall be immune from suit for any causes of action arising from a transfer performed in accordance with this section. The immunities and freedom from liability granted pursuant to this section shall extend to any

person, firm or corporation acting in accordance with this section.

History:
[31-3507, added 1996, ch. 410, sec. 17, p. 1367; am. 2009, ch. 177, sec. 11, p. 568; am. 2010, ch. 273, sec. 16, p. 702; am. 2011, ch. 291, sec. 15, p. 805.]

31-3508. LIMITATIONS ON PAYMENTS FOR NECESSARY MEDICAL SERVICES. (1) Each hospital and provider seeking reimbursement under the provisions of this chapter shall fully participate in the utilization management program and third party recovery system. (2) The board and the county shall determine the amount to be paid based on the application of the appropriate reimbursement rate to those medical services determined to be necessary medical services. The board may use contractors to undertake utilization management review in any part of that analysis. The bill submitted for payment shall show the total provider charges less any amounts which have been received under any other federal or state law. Bills of less than twenty-five dollars ($25.00) shall not be presented for payment.

History:
[31-3508, added 1974, ch. 302, sec. 12, p. 1769; am. 1976, ch. 121, sec. 10, p. 468; am. 1983, ch. 215, sec. 3, p. 597; repealed 1990, ch. 87, sec. 1, p. 178; reinstated 1991, ch. 233, sec. 1, p. 553; am. 1996, ch. 410, sec. 18, p. 1368; am. 2009, ch. 177, sec. 12, p. 568; am. 2010, ch. 273, sec. 17, p. 702; am. 2011, ch. 291, sec. 16, p. 806.]

31-3508A. PAYMENT FOR NECESSARY MEDICAL SERVICES BY AN OBLIGATED COUNTY. (1) Upon receipt of a final determination by the county commissioners approving an application for financial assistance under the provisions of this chapter, an applicant, or the third party applicant on behalf of the applicant, shall, within sixty (60) days, submit any remaining medical claims pursuant to the procedures provided in chapter 15, title 31, Idaho Code.

(2) Payment shall be made to hospitals or providers on behalf of an applicant and shall be made on the next payment cycle. In no event shall payment be delayed longer than sixty (60) days from receipt of the county claim.

(3) Payment to a hospital or provider pursuant to this chapter shall be payment of the debt in full and the provider or hospital shall not seek additional funds from the applicant.

(4) Within fourteen (14) days after the county payment, the clerk of the obligated county shall forward to the board any application for financial assistance exceeding, at the reimbursement rate, the total sum of eleven thousand dollars ($11,000) in the aggregate per resident in any consecutive twelve (12) month period. A copy of the clerk's findings, the final decision of the county commissioners and a statement of which costs the clerk has paid shall be forwarded with the application to the board.

History:

[31-3508A, added 2011, ch. 291, sec. 17, p. 806; am. 2013, ch. 279, sec. 6, p. 728.]

31-3509. ADMINISTRATIVE OFFSETS AND COLLECTIONS BY HOSPITALS AND PROVIDERS. (1) Providers and hospitals shall accept payment made by an obligated county or the board as payment in full. Providers and hospitals shall not bill an applicant or any other obligated person for services that have been paid by an obligated county or the board pursuant to the provisions of this chapter for any balance on the amount paid.

(2) Hospitals and providers making claims for reimbursement of necessary medical services provided for medically indigent residents shall make all reasonable efforts to determine liability and attempt to collect for the account so incurred from all resources prior to submitting the bill to the county commissioners for review. In the event that a hospital or a provider has been notified that a recipient is retrospectively eligible for benefits or that a recipient qualifies for approval of benefits, such hospital(s) or provider(s) shall submit or resubmit a bill to third party insurance, medicaid, medicare, supplemental security income, crime victims compensation, worker's compensation, other insurance and/or other third party sources for payment within thirty (30) days of such notice. A hospital shall apply pursuant to section 1011 of the medicare modernization act of 2003 if funds are available or provide proof that funds are no longer available. In the event any payments are thereafter received for charges which have been paid by a county and/or the board pursuant to the provisions of this chapter, said sums up to the amount actually paid by the county and/or the board shall be paid over to such county and/or board within sixty (60) days of receiving such payment from other resources.

(3) Any amount paid by an obligated county or the board under the provisions of this chapter, which amount is subsequently determined to have been an overpayment, shall be an indebtedness of the hospital or provider due and owing to the obligated county and the board. Such indebtedness may include circumstances where the applicant is subsequently determined to be eligible for third party insurance, medicaid, medicare, supplemental security income, crime victims compensation, worker's compensation, other insurance or other third party sources.

(4) The obligated county and the board shall have a first lien prorated between such county and the board in proportion to the amount each has paid. The obligated county and the board may request a refund from a hospital or provider in the amount of the overpayment, or after notice, recover such indebtedness by deducting from and setting off the amount of the overpayment to a hospital or provider from any outstanding amount or amounts due and payable to the same hospital or provider pursuant to the provisions of this chapter.

History:

[31-3509, added 1974, ch. 302, sec. 12, p. 1769; am. 1976, ch. 121, sec. 11, p. 469; repealed 1990, ch. 87, sec. 1, p. 178; reinstated 1991, ch. 233, sec. 1, p. 553; am. 1992, ch. 83, sec. 5, p. 263; am. 1996, ch. 410, sec. 19, p. 1368; am. 2000, ch. 317, sec. 5, p. 1072; am. 2009, ch. 177, sec. 13, p. 569; am. 2010, ch. 273, sec. 18, p. 702; am. 2011, ch. 291, sec. 18, p. 807.]

31-3510. RIGHT OF SUBROGATION. (1) Upon payment of a claim for necessary medical services pursuant to this chapter, the obligated county and the board making such payment shall become jointly subrogated to all the rights of the hospital and other providers and to all rights of the medically indigent resident against any third parties who may be the cause of or liable for such necessary medical services. The board may pursue collection of the county's and the board's subrogation interests.

(2) Upon any recovery by the recipient against a third party, the obligated county and the board shall pay or have deducted from their respective subrogated portion thereof, a proportionate share of the costs and attorney's fees incurred by the recipient in obtaining such recovery, provided that such proportionate share shall not exceed twenty-five percent (25%) of the subrogated interest unless one (1) or more of the following circumstances exist:

(a) Otherwise agreed.

(b) If prior to the date of a written retention agreement between the recipient and an attorney, the obligated county and the board have reached an agreement with the third party, in writing, agreeing to pay in full the county and the board's subrogated interest.

(3) The obligated county and the board shall have joint subrogated interests in proportion to the amount each has paid.

History:

[31-3510, added 1974, ch. 302, sec. 12, p. 1769; repealed 1990, ch. 87, sec. 1, p. 178; reinstated 1991, ch. 233, sec. 1, p. 553; am. 1996, ch. 410, sec. 20, p. 1369; am. 2009, ch. 177, sec. 14, p.

569; am. 2010, ch. 273, sec. 19, p. 703; am. 2011, ch. 291, sec. 19, p. 807.]

31-3510A. REIMBURSEMENT. (1) Receipt of financial assistance pursuant to this chapter shall obligate an applicant to reimburse the obligated county and the board for such reasonable portion of the financial assistance paid on behalf of the applicant as the county commissioners may determine that the applicant is able to pay from resources over a reasonable period of time. Cash amounts received shall be prorated between the county and the board in proportion to the amount each has paid.

(2) A final determination shall not relieve the applicant's duty to make additional reimbursement from resources if the county commissioners subsequently find within a reasonable period of time that there has been a substantial change in circumstances such that the applicant is able to pay additional amounts up to the total claim paid on behalf of the applicant.

(3) A final determination shall not prohibit the county commissioners from reviewing a petition from an applicant to reduce an order of reimbursement based on a substantial change in circumstances.

(4) The automatic lien created pursuant to the chapter may be filed and recorded in any county of this state wherein the applicant has resources and may be liquidated or unliquidated in amount. Nothing herein shall prohibit an applicant from executing a consensual lien in addition to the automatic lien created by filing an application pursuant to this chapter. In the event that resources can be located in another state, the clerk may file the lien with the district court and provide notice to the recipient. The recipient

shall have twenty (20) days to object, following which the district court shall enter judgment against the recipient. The judgment entered may thereafter be filed as provided for the filing of a foreign judgment in that jurisdiction.

(5) The county shall have the same right of recovery as provided to the state of Idaho pursuant to sections 56-218 and 56-218A, Idaho Code.

(6) The county commissioners may require the employment of such of the medically indigent as are capable and able to work and whose attending physician certifies they are capable of working.

(7) That portion of the moneys received by a county as reimbursement that are not assigned to the catastrophic health care cost program shall be credited to the respective county medically indigent fund.

(8) If, after a hearing, the final determination of the county commissioners is to require a reimbursement amount or rate the applicant believes excessive, the applicant may seek judicial review of the final determination of the county commissioners in the manner provided in section 31-1506, Idaho Code.

History:

[31-3510A, added 1983, ch. 215, sec. 4, p. 597; repealed 1990, ch. 87, sec. 1, p. 178; reinstated 1991, ch. 233, sec. 1, p. 553; am. 1996, ch. 410, sec. 21, p. 1369; am. 2008, ch. 189, sec. 2, p. 594; am. 2010, ch. 273, sec. 20, p. 704; am. 2011, ch. 291, sec. 20, p. 808.]

31-3511. VIOLATIONS AND PENALTIES. (1) Any applicant or obligated person who willfully gives false or misleading information to the department, board, a hospital, a county or an agent thereof, or to any individual in order to obtain financial assistance under this chapter as or for a medically indigent resident, or any person who obtains financial assistance as a medically indigent resident who fails to disclose insurance, worker's compensation, resources, or other benefits available to him as payment or reimbursement of such expenses incurred, shall be guilty of a misdemeanor and punishable under the general provisions for punishment of a misdemeanor. In addition, any applicant or obligated person who fails to cooperate with the department, board or a county or makes a material misstatement or material omission to the department in a request for medicaid eligibility determination, pursuant to section 31-3504, Idaho Code, or a county in an application pursuant to this chapter shall be ineligible for nonemergency assistance under this chapter for a period of two (2) years.

(2) Neither the county commissioners nor the board shall have jurisdiction to hear and shall approve a completed application for necessary medical services unless an application in the form prescribed by this chapter is received by the clerk or the board in accordance with the provisions of this chapter.

(3) The county commissioners may deny an application if material information required in the application or request is not provided by the applicant or a third party or if the applicant has divested himself or herself of resources within one (1) year prior to filing an application in order to become eligible for assistance pursuant to this chapter. An applicant who is sanctioned by federal

or state authorities and loses medical benefits as a result of failing to cooperate with the respective agency or making a material misstatement or material omission to the respective agency shall be ineligible for assistance pursuant to this chapter for the period of such sanction.
(4) If the county commissioners fail to act upon an application within the timelines required under this chapter, the application shall be deemed approved and payment made as provided in this chapter.
(5) An applicant may appeal a decision rendered by the county commissioners pursuant to this section in the manner provided in section 31-1506, Idaho Code.

History:
[31-3511, added 1974, ch. 302, sec. 12, p. 1769; am. 1976, ch. 121, sec. 12, p. 469; repealed 1990, ch. 87, sec. 1, p. 178; reinstated 1991, ch. 233, sec. 1, p. 553; am. 1996, ch. 410, sec. 22, p. 1370; am. 2009, ch. 177, sec. 15, p. 569; am. 2010, ch. 273, sec. 21, p. 704; am. 2011, ch. 291, sec. 21, p. 808.]

31-3512. JOINT COUNTY HOSPITALS. Recognizing the need of hospitals for the public welfare and the burden for one (1) county to finance the cost of such construction, operation and maintenance thereof within its own boundaries under certain circumstances, the county commissioners in their respective counties shall have the power to jointly and severally enter into contracts or agreements with one (1) or more adjoining counties to construct, operate and maintain joint county hospitals, either within or without the boundaries of such counties, upon a finding of each such county commissioners that there is a public

necessity requiring the financing of such hospital facilities jointly with one (1) or more adjoining counties. The county commissioners shall have the same powers to operate, finance and bond for such joint county hospitals as they would have for a county hospital.

History:
[I.C., sec. 31-3512, as added by 1974, ch. 302, sec. 12, p. 1769; am. 2010, ch. 273, sec. 22, p. 705.]

31-3513. ELECTION FOR ISSUANCE OF BONDS. The county commissioners may, when they deem the welfare of their counties require it, or when petitioned thereto by a number of resident taxpayers of their respective counties equal to five percent (5%) of the number of persons voting for the secretary of state of the state of Idaho, at the election next preceding the date of such petition, submit to the qualified electors of said county at any election held as provided in section 34-106, Idaho Code, the proposition whether negotiable coupon bonds of the county to the amount stated in such proposition shall be issued and sold for the purpose of providing such hospital, hospital grounds, nurses' homes, nursing homes, residential or assisted living facilities, shelter care facilities, medical clinics, superintendent's quarters, or any other necessary buildings, and equipment, and may on their own initiative submit to the qualified electors of the county at any general election the proposition whether negotiable coupon bonds of the county to the amount stated in such proposition shall be issued and sold for the purpose of providing for the extension and enlargement of existing hospital, hospital grounds, nurses' homes, nursing homes, residential or

assisted living facilities, shelter care facilities, medical clinics or grounds, superintendent's quarters, or any other necessary buildings, and equipment, and when authorized thereto by two-thirds (2/3) vote at such election, shall issue and sell such coupon bonds and use the proceeds therefrom for the purposes authorized by such election. Said proposition may be submitted to the qualified electors at an election held subject to the provisions of section 34-106, Idaho Code, if the county commissioners shall by resolution so determine. No person shall be qualified to vote at any election held under the provisions of this section unless he shall possess all the qualifications required of electors under the general laws of this state.

The county commissioners shall be governed in calling and holding such election and in the issuance and sale of such bonds, and in the providing for the payment of the principal and interest thereon by the provisions of chapter 19, title 31, Idaho Code, and by the provisions of chapter 2, title 57, Idaho Code; provided, however, that when such bonds have been issued and sold and a period of two (2) years or more has elapsed from the date of sale of said bonds and for any reason the proceeds from the sale of said bonds or other moneys appropriated for the purpose for which said bonds were issued, have not been used for the purpose for which they were appropriated or said bond issue made, the county commissioners may, with the written consent of all of the bondholders first having been obtained, submit to the qualified electors, as herein defined, the question of spending such moneys for a definite purpose. The purpose for which it is decided to spend such moneys shall be clearly and plainly stated on the ballot. If a majority of the qualified electors

shall vote in favor of spending such moneys for the purpose stated, the county commissioners shall proceed in the same manner as if such different purpose had been the original purpose for such bond issue or appropriation. Provided, further that if less than a majority of the qualified electors shall vote in favor of spending such moneys for such different purpose, or if no such election should be had, when all of the bonds shall have been retired, such excess moneys shall be placed in the general fund.

History:
[I.C., sec. 31-3513, as added by 1974, ch. 302, sec. 12, p. 1769; am. 1980, ch. 185, sec. 4, p. 411; am. 1989, ch. 193, sec. 4, p. 477; am. 1993, ch. 112, sec. 3, p. 285; am. 1995, ch. 118, sec. 33, p. 457; am. 2000, ch. 274, sec. 4, p. 805; am. 2010, ch. 273, sec. 23, p. 705.]

31-3514. INTERNAL MANAGEMENT -- ACCOUNTS AND REPORTS. Such facilities as referred to in section 31-3503(2), Idaho Code, may suitably provide for and accept other patients and must charge and accept payments from such other patients as are able to make payments for services rendered and care given. The county commissioners may make suitable rules and regulations for the management and operation of such property by a suitable board of control, or otherwise, or for carrying out such hospital uses and purposes under a lease of the same.
The boards or officers or lessees of such hospital property shall render accounts and reports to the county commissioners as may be required by the county commissioners; and shall render accounts and deliver over any and all moneys received by them for the county to the county treasurer to be

credited to the operation expense of hospitals and indigent sick and otherwise dependent poor of the county in such manner as provided by law for the handling of funds of this kind.
Said board of control may permit persons from out of the county where such hospital is located to be admitted for hospitalization to such hospital. As to such cases special rates for the use and service of such hospital may be provided which rates shall apply equally to all such patients who do not pay taxes within the county where such hospital is located. The purpose of providing such special rates shall be to compel persons living out of the county where such hospital is located, and who receive hospitalization in such hospital, to bear a just burden of the cost of construction and maintenance of such hospital.

History:
[I.C., sec. 31-3514, as added by 1974, ch. 302, sec. 12, p. 1769; am. 1980, ch. 185, sec. 5, p. 412; am. 1982, ch. 340, sec. 10, p. 856; am. 1989, ch. 193, sec. 5, p. 478; am. 1993, ch. 112, sec. 4, p. 286; am. 2010, ch. 273, sec. 24, p. 706.]

31-3515. LEASE OR SALE. Such counties acting through their county commissioners shall have the right to lease such hospitals upon such terms and for such a length of time as they may decide, or to sell the same; provided, however, that no such lease or sale, except those leases entered into between such counties and the Idaho health facilities authority as provided in section 31-836, Idaho Code, shall be final or valid unless and until it has been approved by a majority of the qualified electors of said county voting on such question at an election held subject to the provisions of section 34-106, Idaho Code; except if

a hospital district has been created under the provisions of chapter 13, title 39, Idaho Code, county commissioners shall have the right to lease, as provided in section 31-836, Idaho Code, such hospitals within a created hospital district to the hospital district without submitting the question of lease or sale to the qualified electors of the county or the respective hospital district.

History:
[I.C., sec. 31-3515, as added by 1974, ch. 302, sec. 12, p. 1769; am. 1978, ch. 42, sec. 2, p. 76; am. 1980, ch. 57, sec. 1, p. 115; am. 1995, ch. 118, sec. 34, p. 458; am. 2010, ch. 273, sec. 25, p. 707.]

31-3515A. CONVEYANCE, LEASE OF COUNTY HOSPITAL TO NONPROFIT CORPORATION. (1) As an alternative to the procedure set forth in section 31-3515, Idaho Code, counties acting through their respective county commissioners may convey or lease county hospitals, and the equipment therein, subject to the following conditions:
(a) The entity to which the hospital is to be transferred shall be a nonprofit corporation;
(b) No lease term shall exceed ninety-nine (99) years. This subsection supersedes that part of section 31-836, Idaho Code, which is inconsistent herewith;
(c) The governing body of the nonprofit corporation must be composed initially of the incumbent members of the board of hospital trustees, as individuals. The articles of incorporation must provide for a membership of the corporation which is:
(i) Broadly representative of the public and includes residents of each incorporated city in the

county and of the unincorporated area of the county; or
(ii) A single nonprofit corporate member having articles of incorporation which provide for a membership of that corporation which is broadly representative of the public and includes residents of each incorporated city in the county and of the unincorporated area of the county.
The articles must further provide for the selection of the governing body by the membership of the corporation, or exclusively by a parent corporation which is the corporate member, with voting power, and not by the governing body itself, except to fill a vacancy for the unexpired term. The articles must further provide that no member of the governing body shall serve more than two (2) consecutive three (3) year terms.
(d) The nonprofit corporation must provide care for indigent patients, and receive any person falling sick or maimed within the county.
(e) The transfer agreement must provide for the transfer of patients, staff and employees, and for the continuing administration of any trusts or bequests or maintenance of records pertaining to the existing public hospital.
(f) The transfer or lease agreement shall provide for a transfer or lease price which shall be either of the following:
(i) The acceptance of all assets and assumption of all liabilities; or
(ii) Such other price as the commissioners and the nonprofit corporation may agree.
(2) If any hospital which has been conveyed pursuant to this section ceases to be used as a nonprofit hospital, unless the premises so conveyed are sold and the proceeds used to erect or enlarge another nonprofit hospital for the county, the hospital so conveyed reverts to the ownership of

the county. If any hospital which has been leased pursuant to this section ceases to be used as a nonprofit hospital, the lease shall terminate.
(3) The provisions of section 31-808, Idaho Code, with respect to the sale and disposition of real and personal property owned by the county, shall not apply to transactions covered by section 31-3515, Idaho Code, and this section.

History:
[31-3515A, added 1986, ch. 240, sec. 1, p. 652; am. 2010, ch. 273, sec. 26, p. 707.]

31-3516. SEPARABILITY. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this chapter, which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are declared to be severable.

History:
[I.C., sec. 31-3516, as added by 1974, ch. 302, sec. 12, p. 1769; am. 1996, ch. 410, sec. 23, p. 1370.]

31-3517. ESTABLISHMENT OF A CATASTROPHIC HEALTH CARE COST PROGRAM. (1) The governing board of the catastrophic health care cost program created by the counties pursuant to a joint exercise of powers agreement, dated October 1, 1984, and serving on June 30, 1991, is hereby continued as such through December 31, 1992, to complete the affairs of the board, to continue to pay for those medical costs incurred by participating counties prior to October 1, 1991, until all costs are paid or the moneys in the catastrophic health care cost account

contributed by participating counties are exhausted, and to pay the balance of such contributions back to the county of origin in the proportion contributed. County responsibility shall be limited to the first eleven thousand dollars ($11,000) per claim. The remainder of the eligible costs of the claim shall be paid by the state catastrophic health care cost program.

(2) Commencing October 1, 1991, a catastrophic health care cost program board is hereby established for the purpose of administering the catastrophic health care cost program. This board shall consist of twelve (12) members, with six (6) county commissioners, one (1) from each of the six (6) districts or regions established by the Idaho association of counties, four (4) members of the legislature, with one (1) each being appointed by the president pro tempore of the senate, the leader of the minority party of the senate, the speaker of the house of representatives and the leader of the minority party of the house of representatives, one (1) member appointed by the director of the department and one (1) member appointed by the governor.

(a) The county commissioner members shall be elected by the county commissioners of the member counties of each district or region, with each board of county commissioners entitled to one (1) vote. The process and procedures for conducting the election and determining the members shall be determined by the board itself, except that the election must be conducted, completed and results certified by December 31 of each year in which an election for members is conducted. The board recognized in subsection (1) of this section shall authorize and conduct the election in 1991.

(b) The term of office of a member shall be two (2) years, commencing on January 1 next following

election or appointment, except that for commissioner members elected in 1991, the commissioner members from districts or regions 1, 3 and 5 shall serve for a term of one (1) year, and the commissioner members from districts or regions 2, 4 and 6 shall serve for a term of two (2) years. Members may be reelected or reappointed. Election or appointment to fill vacancies shall be for the balance of the unexpired term.

(c) The board shall have an executive committee consisting of the chair, vice-chair, secretary and such other members of the board as determined by the board. The executive committee may exercise such authority as may be delegated to it by the board between meetings.

(d) The member appointed by the governor shall be reimbursed as provided in section 59-509(b), Idaho Code, from the catastrophic health care cost account.

(3) The board shall meet at least once each year at the time and place fixed by the chair. Other necessary meetings may be called by the chair by giving notice as may be required by state statute or rule. Notice of all meetings shall be given in the manner prescribed by law.

(4) Except as may otherwise be provided, a majority of the board constitutes a quorum for all purposes and the majority vote of the members voting shall constitute the action of the board. The secretary of the board shall take and maintain the minutes of board proceedings. Meetings shall be open and public except the board may meet in closed session to prepare, approve and administer applications submitted to the board for approval by the respective counties.

(5) At the first meeting of the board in January of each year, the board shall organize by electing a chair, a vice-chair, a secretary and such other officers as desired.
(6) [catastrophic health care cost] All moneys received or expended by the program shall be audited annually by a certified public accountant designated by the governing board, who shall furnish a copy of such audit to the director of legislative services.
(7) The board shall submit a request to the governor and the legislature in accordance with the provisions of chapter 35, title 67, Idaho Code, for an appropriation for the maintenance and operation of the catastrophic health care cost program.

History:
[31-3517, added 1982, ch. 190, sec. 3, p. 511; repealed 1990, ch. 87, sec. 1, p. 553; reinstated and am. 1991, ch. 233, sec. 11, p. 559; am. 1992, ch. 266, sec. 1, p. 821; am. 1993, ch. 387, sec. 4, p. 1419; am. 1995, ch. 9, sec. 2, p. 14; am. 2009, ch. 177, sec. 16, p. 570; am. 2010, ch. 273, sec. 27, p. 708; am. 2011, ch. 174, sec. 1, p. 495; am. 2011, ch. 291, sec. 22, p. 809.]

31-3518. ADMINISTRATIVE RESPONSIBILITY. (1) The board shall, in order to facilitate payment to providers participating in the county medically indigent program and the catastrophic health care cost program, have on file the reimbursement rates allowed for all participating providers of medical care and authorized by this chapter. However, in no event shall the amount to be paid exceed the usual, reasonable, and customary charges for the area.
(2) The board may contract with independent contractors to provide services to manage and operate the catastrophic health care cost program,

or the board may contract for or appoint agents, employees, professional personnel and any other personnel to manage and operate the catastrophic health care cost program.
(3) The board shall develop rules for the catastrophic health care cost program after consulting with the counties, organizations representing the counties, health care providers, hospitals and organizations representing health care providers and hospitals.
(4) The board shall submit all proposed rules to the legislative council for review prior to adoption, in a manner substantially the same as proposed executive agency rules are reviewed under chapter 52, title 67, Idaho Code. Following adoption, the board shall submit all adopted rules to the legislature for review in a manner substantially the same as adopted executive agency rules are reviewed under chapter 52, title 67, Idaho Code. The legislature, by concurrent resolution, may modify, amend, or repeal any rule of the board.

History:
[31-3518, added 1982, ch. 190, sec. 4, p. 511; am. 1983, ch. 215, sec. 5, p. 594; repealed 1990, ch. 87, sec. 1, p. 553; reinstated and am. 1991, ch. 233, sec. 12, p. 560; am. 2009, ch. 177, sec. 17, p. 571; am. 2010, ch. 273, sec. 28, p. 709; am. 2011, ch. 291, sec. 23, p. 810.]

31-3519. APPROVAL AND PAYMENT BY THE BOARD. (1) Upon receipt of the clerk's statement, a final determination of the county commissioners and the completed application, the board shall approve an application for financial assistance under the catastrophic health care cost program if it determines that:

(a) Necessary medical services have been provided for a medically indigent resident in accordance with this chapter;
(b) The obligated county paid the first eleven thousand dollars ($11,000) of necessary medical services; and
(c) The cost of necessary medical services when paid at the reimbursement rate exceeds the total sum of eleven thousand dollars ($11,000) in the aggregate per resident in any consecutive twelve (12) month period.
(2) Payment to a hospital or provider pursuant to this chapter shall be payment of the debt in full and the hospital or provider shall not seek additional funds from the applicant.
(3) In no event shall the board be obligated to pay a claim, pursuant to this chapter, in excess of an amount based on the application of the appropriate reimbursement rate to those medical services determined to be necessary medical services. The board may use contractors to undertake utilization management review in any part of that analysis.
(4) The board shall, within forty-five (45) days after approval by the board, submit the claim to the state controller for payment. Payment by the state controller shall be made pursuant to section 67-2302, Idaho Code.

History:
[31-3519, added 1982, ch. 190, sec. 5, p. 511; repealed 1990, ch. 87, sec. 1, p. 553; reinstated and am. 1991, ch. 233, sec. 13, p. 561; am. 1995, ch. 9, sec. 3, p. 16; am. 1996, ch. 410, sec. 24, p. 1371; am. 2009, ch. 177, sec. 18, p. 572; am. 2010, ch. 273, sec. 29, p. 709; am. 2011, ch. 291, sec. 24, p. 811.]

31-3520. CONTRACT FOR PROVISION OF NECESSARY MEDICAL SERVICES FOR THE MEDICALLY INDIGENT. The county commissioners in their respective counties, may contract for the provision of necessary medical services to the medically indigent and may, by ordinance, limit the provision of and payment for nonemergency necessary medical services to a contract provider. They shall require the contractor to enter into a bond to the county with two (2) or more approved sureties, in such sum as the county commissioners may fix, conditioned for the faithful performance of his duties and obligations as such contractor, and require him to report to the county commissioners quarterly all persons committed to his charge, showing the expense attendant upon their care and maintenance.

History:
[31-3520, added 1992, ch. 83, sec. 6, p. 264; am. 1996, ch. 410, sec. 25, p. 1371; am. 2010, ch. 273, sec. 30, p. 710; am. 2011, ch. 291, sec. 25, p. 812.]

31-3521. EMPLOYMENT OF PHYSICIAN. The county commissioners may employ a physician to attend, when necessary, the patients of the county hospital, provided however, that the county commissioners may enter into contracts with groups of licensed physicians for medical attendance upon patients of the county hospital or other persons receiving medical attendance at county expense. They may provide for the employment, at some kind of manual labor, of such of the patients as are capable and able to work and the attending physicians must certify to the person in charge or lessee of the county hospital the names of such of the patients as are incapable of manual labor, and

when any such patient becomes capable the physician shall certify that fact.

History:
[31-3521, added 1992, ch. 83, sec. 6, p. 264; am. 2010, ch. 273, sec. 31, p. 710.]

31-3550. DECLARATION OF PUBLIC POLICY. It is the declaration of the legislature to be in the public interest to encourage nonlitigation resolution of claims between the counties and health providers of the state of Idaho by providing for prelitigation screening of such claims contesting indigent resource eligibility by a hearing panel as provided in this chapter.

History:
[(31-3550) 31-A3501, as added by 1982, ch. 189, sec. 1, p. 509; am. and redesig. 2005, ch. 25, sec. 40, p. 98.]

31-3551. ADVISORY PANEL FOR PRELITIGATION CONSIDERATION OF INDIGENT RESOURCE ELIGIBILITY CLAIMS -- PROCEDURE. The counties in the state of Idaho and the health providers furnishing care to eligible medically indigent persons, as defined in section 31-3502, Idaho Code, are directed to cooperate in providing an advisory panel in the nature of a special civil grand jury and procedure for prelitigation consideration of claims arising out of contested resource availability of persons applying for indigent relief under the provisions of chapter 35, title 31, Idaho Code, which proceedings shall be informal and nonbinding, but nevertheless compulsory as a condition precedent to litigation. Proceedings conducted or maintained under the authority of this chapter shall be subject to disclosure according to chapter 1, title

74, Idaho Code. Formal rules of evidence shall not apply and all such proceedings shall be expeditious and informal. The panel, thus created, will render opinions where the resource eligibility of applicants, as herein described, has been contested.

History:
[(31-3551) 31-A3502, added 1982, ch. 189, sec. 1, p. 509; am. 1990, ch. 213, sec. 28, p. 480; am. and redesig. 2005, ch. 25, sec. 41, p. 99; am. 2015, ch. 141, sec. 56, p. 420.]

31-3552. APPOINTMENT AND COMPOSITION OF ADVISORY PANEL. The panel will consist of three (3) members to be designated as follows: the chairman of the panel shall be an appointed designee by and of the director of the department of health and welfare of the state of Idaho, and must be without bias or conflict of interest; one (1) member will be appointed by and represent the Idaho association of counties; and one (1) member will be appointed by and represent the Idaho hospital association. All panelists shall serve under oath that they are without bias or conflict of interest as respects any matter under consideration.

History:
[(31-3552) 31-A3503, as added by 1982, ch. 189, sec. 1, p. 509; am. and redesig. 2005, ch. 25, sec. 42, p. 99.]

31-3553. ADVISORY DECISIONS OF PANEL. The general responsibility of the advisory panel will be to consider the eligibility of applicants on claims referred to them and render written opinions regarding such eligibility of applicants as based upon review of analysis of the resources available to the applicant, as defined in section 31-3502, Idaho Code. Following proceedings on each claim, the advisory panel shall provide the affected parties with its comments and observations with respect to the claim. They shall indicate in such comments whether the applicant appears to have resources available to him or her sufficient to pay for necessary medical services; does not have adequate resources; or any comments or observations which may be relevant and appropriate. The findings of the advisory panel may be used by affected parties in resolving contested claims in a manner consistent with the findings presented. However, such findings will be advisory in nature only and not binding on any of the affected parties.

History:
[(31-3553) 31-A3504, as added by 1982, ch. 189, sec. 1, p. 509; am. 2004, ch. 300, sec. 3, p. 840; am. and redesig. 2005, ch. 25, sec. 43, p. 99; am. 2009, ch. 177, sec. 19, p. 572.]

31-3554. TOLLING OF LIMITATION PERIODS DURING PENDENCY OF PROCEEDINGS. There shall be no judicial or other review or appeal of such matters. No party shall be obligated to comply with or otherwise be affected or prejudiced by the proposals, conclusions or suggestions of the panel or any member or segment thereof; however, in the interest of due consideration being given to such proceedings and in the interest of encouraging consideration of claims informally and without the

necessity of litigation, the applicable statute of limitations shall be tolled and not deemed to run during the time that such a claim is pending before the panel and for thirty (30) days thereafter.

History:
[(31-3554) 31-A3505, as added by 1982, ch. 189, sec. 1, p. 509; am. and redesig. 2005, ch. 25, sec. 44, p. 100.]

31-3555. STAY OF COURT PROCEEDINGS IN INTEREST OF HEARING BEFORE PANEL. During said thirty (30) day period neither party shall commence or prosecute litigation involving the issues submitted to the panel and the district or other courts having jurisdiction of any such pending claims shall stay proceedings in the interest of the conduct of such proceedings before the panel.

History:
[(31-3555) 31-A3506, as added by 1982, ch. 189, sec. 1, p. 509; am. and redesig. 2005, ch. 25, sec. 45, p. 100.]

31-3556. EXPENSES FOR ADVISORY PANEL MEMBERS. Expenses incurred by the members of the advisory panel in the performance of their duties will be borne by the respective organizations making the appointment.

History:
[(31-3556) 31-A3507, as added by 1982, ch. 189, sec. 1, p. 509; am. and redesig. 2005, ch. 25, sec. 46, p. 100.]

31-3557. FREQUENCY OF AND AGENDA FOR MEETINGS. Frequency of and agenda for meetings of the advisory panel will be subject to the discretion of the chair, based upon criteria to be established by the members of the panel. However, there shall be no more than four (4) meetings of the panel per year.

History:
[(31-3557) 31-A3508, as added by 1982, ch. 189, sec. 1, p. 509; am. and redesig. 2005, ch. 25, sec. 47, p. 100.]

31-3558. NONDISCLOSURE OF PERSONAL IDENTIFYING INFORMATION. Personal identifying information about a particular utilization management reviewer or practitioner engaged by the department or the board shall not be disclosed without the prior written authorization of the reviewer or practitioner. Notwithstanding this nondisclosure of personal identifying information, redacted copies of all reports and recommendations of the department's or the board's utilization management reviewers or practitioners shall be maintained in the official record of the respective county commissioners and the board as described in chapter 52, title 67, Idaho Code, and chapter 15, title 31, Idaho Code.

History:
[31-3558, added 2011, ch. 291, sec. 26, p. 812.]