

CHAPTER 50-24.1 MEDICAL ASSISTANCE FOR NEEDY PERSONS

50-24.1-01. Purpose.

The purpose of this chapter is to provide medical care and services to persons whose income and resources are insufficient to meet such costs, and further to provide preventive, rehabilitative, and other services to help families and individuals to retain or attain capability for independence or self-care.

50-24.1-01.1. Department to submit plans and seek waivers.

The department of human services may submit state plans in forms that are consistent with and which meet requirements for such plans which are or may be imposed under the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100-360; 102 Stat. 729; 42 U.S.C. 1396a et seq., as amended]. The department may take such actions as are reasonably necessary to conform the administration of programs under its supervision and direction to the requirements of the Medicare Catastrophic Coverage Act of 1988 and the state plans submitted thereunder, including the issuance of policy manuals, forms, and program directives. The department may seek appropriate waivers of the requirements of the federal statutes or regulations as authorized by federal law.

50-24.1-01.2. Department may establish and administer state unified dental insurance coverage plan.

The department of human services may establish a state unified dental insurance coverage plan to provide dental service coverage to all persons eligible for medical assistance pursuant to section 50-24.1-02. The department, or a private entity under contract with the department, may administer the plan. Any private entity that contracts with the department under this section must have on its board of directors at least one dentist and one person to whom services are provided under the plan. The plan must provide insurance coverage of the general and usual services rendered and the care administered by licensed dentists. The department may apply for federal funds to administer the plan based on estimates of the medical assistance-eligible persons within this state. The department may apply for a waiver to allow the use of Medicaid funds to administer the plan and to provide the services determined by the department.

50-24.1-01.3. Department to comply with federal requirements - Interagency cooperation - Civil money penalty fund.

1. The department of human services shall take any action necessary to comply with the requirements of section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)], including establishing a process to enforce compliance by nursing facilities with requirements for participation in the medical assistance program that conforms to any federal regulations implementing that section.
2. The state department of health and the department of human services shall cooperate to achieve prompt and effective implementation of subsection 1.
3. The state treasurer shall establish a fund for the receipt of any civil money penalties imposed under subsection 1. Any civil money penalty paid to the department of human services under subsection 1 must be deposited in that fund and, subject to the limits of legislative appropriation, may be expended for the sole purpose of the protection of the health or property of residents of nursing facilities that the state or federal government finds deficient.
4. This section may not be construed to create any right or authorize any activity not provided for in section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)] or its implementing federal regulations.
5. Before the establishment and assessment of civil money penalties permitted by section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)], the department of human services is encouraged to submit a plan of alternative remedies in accordance with section 1919(h)(2)(B)(ii) of that Act.

50-24.1-02. Eligibility.

Within the limits of legislative appropriations, medical assistance may be paid for any person who either has income and resources insufficient to meet the costs of necessary medical care and services or is eligible for or receiving financial assistance under chapter 50-09 or title XVI of the Social Security Act, as amended, and:

1. Has not at any time before or after making application for medical assistance made an assignment or transfer of property for the purpose of rendering that person eligible for assistance under this chapter. For the purposes of making any determination or redetermination of eligibility, the phrase "assignment or transfer" includes actions or failures to act which effect a renunciation or disclaimer of any interest which the applicant or recipient might otherwise assert or have asserted, or which serve to reduce the amounts which an applicant or recipient might otherwise claim from a decedent's estate, a trust or similar device, or a person obligated by law to furnish support to the applicant or recipient.
2. Has applied or agrees to apply all proceeds received or receivable by that person or that person's eligible spouse from automobile accident medical benefits coverage and private health care coverage to the costs of medical care for that person and that person's eligible spouse and children. The department of human services may require from any applicant or recipient of medical assistance the assignment of any rights accruing under automobile medical benefits coverage or private health care coverage. Any rights or amounts so assigned must be applied against the cost of medical care paid on behalf of the recipient under this chapter. The assignment is not effective as to any carrier before the receipt of notice of assignment by such carrier.
3. Is eligible under rules and regulations established by the department of human services.

50-24.1-02.1. Assignment of claim.

1. Each applicant or recipient of benefits under this chapter must be deemed to have assigned, to the department of human services, any right of recovery the applicant or recipient may have for medical costs incurred under this chapter not exceeding the amount of funds expended by the department for the care and treatment of the applicant or recipient. The applicant or recipient, or other person empowered by law to act in the applicant's or recipient's behalf, shall execute and deliver an assignment of claim, assignment of rights, or other authorizations as necessary to secure fully the right of recovery of the department. The assignment:
 - a. Is effective as to both current and accrued medical support recovery obligations.
 - b. Takes effect upon a determination that an applicant is eligible for assistance under this chapter.
2. The department of human services may compromise claims arising out of assignments made under this section on such terms as it may deem just and appropriate. The department of human services may not be compelled to compromise any claim.

50-24.1-02.2. Community spouse resource allowance.

In determining eligibility for medical assistance applicants and recipients, the department of human services shall establish a community spouse resource allowance equal to the maximum community spouse resource allowance as provided by 42 U.S.C. 1396r-5(f)(2). This section applies to a community spouse of an institutionalized spouse. For purposes of this section, "institutionalized spouse" includes an individual who is described in 42 U.S.C. 1396a(a)(10)(A)(ii)(VI).

50-24.1-02.3. When designated pre-need funeral service contracts, prepayments, or deposits not to be considered in eligibility determination.

In determining eligibility for medical assistance, the department of human services may not consider as an available resource any pre-need funeral service contracts, prepayments, or deposits to a fund which total six thousand dollars or less designated by the applicant or

recipient as set-aside to pay for the applicant's or recipient's funeral. An applicant or recipient designates a prepayment or deposit for that applicant's or recipient's burial by providing funds that are to be used for the funeral or burial expenses of the applicant or recipient. If an applicant's or recipient's burial is funded by an insurance policy, the amount considered set-aside for burial is the lesser of the cost basis or the face value of the insurance policy. In addition, the applicant or recipient may designate all or a portion of the three thousand dollar asset limitation for funeral pre-need contracts, prepayments, or deposits. Interest or earnings retained in a funeral fund also may not be considered as an available resource. A pre-need funeral service contract, prepayment, or deposit designated under this section is not a multiple-party account for purposes of chapter 30.1-31. Any amount in a pre-need funeral service contract, prepayment, or deposit designated under this section which is not used for funeral or burial expenses must be returned to the estate of the medical assistance recipient and is subject to recovery by the department from the medical assistance recipient's estate. No claim for payment of funeral expenses may be made against the estate of a deceased medical assistance recipient except to the extent that funds maintained in accordance with this section total less than six thousand dollars.

50-24.1-02.4. Exempt income and resources.

The department may not consider, as an available asset for purposes of determining eligibility for benefits under this chapter, income and resources set aside by a blind or disabled person as part of a plan to achieve self-support, if the plan has been approved by the social security administration.

50-24.1-02.5. Effect of purchase of insurance on disqualifying transfer.

1. An individual who secures and maintains insurance that covers the cost of substantially all necessary medical care, including necessary care in a nursing home and necessary care for an individual who qualifies for admission to a nursing home but receives care elsewhere, for at least thirty-six months after the date an asset is disposed of, may demonstrate that the asset was disposed of exclusively for a purpose other than to qualify for medical assistance by providing proof of that insurance.
2. If purchased after July 31, 2003, the insurance coverage under this section must include home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage. The coverage required under this subsection must include a daily benefit equal to at least one and fifty-seven hundredths times the average daily cost of nursing care for the year in which the policy was issued and an aggregate benefit equal to at least one thousand ninety-five times that daily benefit.
3. This section applies only to policies purchased before the effective date of an approved amendment to the state plan for medical assistance that provides for a qualified state long-term care insurance partnership under section 1917(b) of the Social Security Act [42 U.S.C. 1396p].
4. The department of human services shall certify to the legislative council the effective date described in subsection 3.

50-24.1-02.6. Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:
 - a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and
 - b. Minors who have countable income that does not exceed an amount determined under subsection 3.
2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law.
4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

50-24.1-02.7. Workers with disabilities coverage.

The department of human services shall establish and implement a buyin program to provide medical assistance to an individual who, except for substantial gainful activity, meets the definition of disabled under the supplemental security income program under title XVI of the federal Social Security Act, who is at least sixteen but less than sixty-five years of age, and who is gainfully employed. The program must:

1. Be made available to an individual with a disability who is a member of a family the net income of which is less than two hundred twenty-five percent of the most recently revised official poverty line published by the federal office of management and budget for the family;
2. Allow up to an additional ten thousand dollars in assets;
3. Require the payment of a premium that is based upon a sliding scale which may not be less than two and one-half percent nor more than seven and one-half percent of the individual's gross countable income;
4. Include a one-time program enrollment fee of one hundred dollars; and
5. Provide that the failure of an enrolled individual to pay premiums for three months may result in the termination of enrollment in the program.

50-24.1-02.8. Transfers involving annuities.

1. For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two or more parties under which one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future.
2. An annuity purchased before August 1, 2005, is an available asset and its purchase is an uncompensated assignment or transfer of assets under section 50-24.1-02, resulting in a penalty under the applicable rules established by the department of human services unless the following criteria are met:
 - a. The annuity is a single premium immediate annuity or an annuity in which a settlement option has been selected, is irrevocable, and cannot be assigned to another person.
 - b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business.
 - c. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year.
 - d. The annuity will return the full principal and interest within the purchaser's life expectancy as determined by the life expectancy tables published by the centers for Medicare and Medicaid services.
 - e. The monthly payments from the annuity, unless specifically ordered otherwise by a court of competent jurisdiction, do not exceed the maximum monthly income amount allowed for a community spouse as determined under 42 U.S.C. 1396r-5.
3. Unless done in compliance with subsection 4, a provision in an annuity that purports to preclude assignment or transfer of any interest in the annuity is void as against public policy upon application of the purchaser, the purchaser's spouse, the annuitant, or the annuitant's spouse for benefits under this chapter. This subsection applies only to an annuity for which a payment option has been irrevocably selected after July 31, 2005.
4. An annuity, purchased after July 31, 2005, and before February 8, 2006, is not an available asset and the expenditure of funds to purchase such an annuity, instrument,

or other arrangement may not be considered to be a disqualifying transfer of an asset for purposes of this chapter if:

- a. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;
 - b. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;
 - c. The monthly payments from all annuities owned by the purchaser that comply with this subsection may not exceed the minimum monthly maintenance needs allowance for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5 and, when combined with the purchaser's other monthly income, at the time of application of the purchaser, the purchaser's spouse, the annuitant, or the annuitant's spouse, for benefits under this chapter, do not exceed one hundred fifty percent of the minimum monthly maintenance needs allowance allowed for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5;
 - d. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year;
 - e. The annuity will return the full principal and has a guaranteed period that is equal to at least eighty-five percent of the purchaser's life expectancy as determined by the life expectancy tables used by the department of human services; and
 - f. The annuity does not include any provision that limits the effect of subsection 5.
5. Before benefits under this chapter may be provided to an otherwise eligible applicant who is fifty-five years of age or older, the department of human services, or the successor of that department, must be irrevocably named on each annuity owned by that applicant, or by the spouse of that applicant, that complies with subsection 4, as primary beneficiary for payment of amounts due following the death of the applicant and the applicant's spouse, if any, not to exceed the amount of benefits paid under this chapter on behalf of that applicant after age fifty-five, plus interest on that amount at the legal rate from six months after the applicant's death. If the department receives notice within ninety days of the death of the applicant or the applicant's spouse that reliably demonstrates that the applicant is survived by a minor child who resided and was supported financially by the deceased or by a permanently and totally disabled child, the department shall remit any payments made to the department under this section to those survivors in equal shares. When the obligations to the minor child or children who resided and were supported financially by the deceased or the permanently and totally disabled child or children and the department are fulfilled, the department shall remit any future payments made to the department under this section to the contingent beneficiaries selected by the annuitant regarding each annuity owned by the applicant or by the spouse of the applicant.
6. The purchase of an annuity on or after February 8, 2006, or the selection or alteration on or after February 8, 2006, of a payment option for an annuity purchased at any time, is a disqualifying transfer of an asset for purposes of this chapter unless:
- a. The state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant or the state is named in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value;
 - b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;
 - c. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;
 - d. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest.

- Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year; and
- e. The annuity will return the full principal and interest within the purchaser's life expectancy as determined in accordance with actuarial publications of the office of the chief actuary of the social security administration.
7. An annuity purchased on or after February 8, 2006, or a payment option selected or altered on or after February 8, 2006, with respect to an annuity purchased at any time is an asset for purposes of this chapter unless:
 - a. The annuity meets all of the requirements of subsection 6;
 - b. The monthly payments from all annuities owned by the purchaser that comply with this subsection do not exceed the minimum monthly maintenance needs allowance for a community spouse of the maximum amount allowed pursuant to 42 U.S.C. 1396r-5 and, at the time of application for benefits under this chapter, the total combined income from all sources of the purchaser and the purchaser's spouse, or the annuitant and the annuitant's spouse, does not exceed one hundred fifty percent of the minimum monthly maintenance needs allowance allowed for a community spouse of the maximum amount allowed pursuant to 42 U.S.C. 1396r-5; and
 - c. The annuity will return the full principal and has a guaranteed period that is equal to at least eighty-five percent of the purchaser's life expectancy as determined by the life expectancy tables used by the department of human services.
 8. Except for the provision in subdivision a of subsection 6, this section does not apply to:
 - a. An annuity described in subsection b or q of section 408 of the Internal Revenue Code of 1986;
 - b. An annuity purchased with proceeds from an account or trust described in subsection a, c, or p of section 408 of the Internal Revenue Code of 1986;
 - c. A simplified employee pension within the meaning of subsection k of section 408 of the Internal Revenue Code of 1986; or
 - d. A Roth IRA described in section 408A of the Internal Revenue Code of 1986.

50-24.1-02.9. Effect of purchase of long-term care insurance on eligibility for medical assistance benefits.

Repealed by S.L. 2007, ch. 421, § 3.

50-24.1-02.10. Real estate taxes on rental property as deduction from rental income.

For purposes of determining the treatment of income and the application of income to the cost of care for medical assistance eligibility for an individual screened as requiring nursing care services, and who is receiving nursing care services, the department of human services shall allow as a deduction from countable gross rental income the real estate taxes for rental property if the individual is responsible for paying the real estate taxes for that property.

50-24.1-03. County share of medical assistance - Reimbursement for clinic services not required.

Repealed by S.L. 1997, ch. 403, § 13.

50-24.1-03.1. Duties of county agency.

In the administration of the medical assistance program, a county agency shall investigate and record the circumstances of each applicant or recipient of assistance, in order to ascertain the facts supporting the application, or the granting of assistance, and obtain such other information as may be required by the rules and regulations of the department of human services.

50-24.1-03.2. Investigations - Power of county agencies, department, and employees.

1. In the investigation of applications under the provisions of this chapter, the county agencies, the department of human services, and the officials and employees of such agencies charged with the administration and enforcement of this chapter may:
 - a. Conduct examinations;
 - b. Require the attendance of witnesses and the production of books, records, and papers; and
 - c. Make application to the district court of the county to compel the attendance of witnesses and the production of books, records, and papers.
2. The department of human services may request from other state, county, and local agencies information deemed necessary to carry out the medical support enforcement program. All officers and employees of state, county, and local agencies shall cooperate with the department of human services in locating absent spouses or parents of children to whom an obligation of support is owed or on whose behalf assistance is being provided and, on request, shall supply the department with available information relative to the location, income, social security number, and property holdings of the absent spouse or parent, notwithstanding any provision of law making that information confidential. Any person acting under the authority of the department of human services who pursuant to this subsection obtains information from the office of the state tax commissioner, the confidentiality of which is protected by law, may not divulge such information except to the extent necessary for the administration of the medical support enforcement program or when otherwise directed by judicial order or when otherwise provided by law.
3. The officers and employees designated by the county agencies or the department of human services may administer oaths and affirmations.

50-24.1-03.3. Criminal background investigation - Fingerprinting required.

1. When the department determines a criminal history record check is appropriate, a provider applicant, a provider, staff members of the applicant provider or provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider shall secure, from a law enforcement agency or any other agency authorized to take fingerprints, two sets of fingerprints and shall provide all other information necessary to secure state criminal history record information and a nationwide background check under federal law.
2. The applicant provider or provider shall assure the information obtained under subsection 1 is provided to the department within thirty days of the notice date.
3. The department shall submit the information and fingerprints to the bureau of criminal investigation to determine if there is any criminal history record information regarding the applicant provider, provider, staff members of the applicant provider or provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider in accordance with section 12-60-24.
4. The bureau of criminal investigation shall request a nationwide background check from the federal bureau of investigation and, upon receipt of response, provide the response of the federal bureau of investigation to the department. The bureau also shall provide any criminal history record information that lawfully may be made available under chapter 12-60 to the department.
5. The results of the investigations must be forwarded to the department.
6. Upon request by the applicant provider, provider, staff members of the applicant provider or provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider, a law enforcement agency shall take fingerprints of individuals described in this section if the request is made for purposes of this section.
7. The applicant provider, provider, staff members of the applicant provider or provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider shall pay the cost of securing fingerprints, any criminal

history record information made available under chapter 12-60, and a nationwide background check.

8. The department may charge a fee not to exceed the actual cost for the purpose of processing the background investigations.
9. An agency that takes fingerprints as provided under this section may charge a reasonable fee to offset the cost of the fingerprinting.
10. The department may use the background information findings to determine approval of Medicaid services provider application or termination of enrollment as a Medicaid services provider. An individual denied or terminated as a Medicaid service provider as a result of the background investigation may not be qualified to enroll as a provider, have five percent or greater ownership or control interest in a Medicaid services provider, or submit claims for reimbursement through the department's Medicaid management information system.

50-24.1-04. Authority of department.

The department of human services is authorized to promulgate such rules and regulations as are necessary to qualify for any federal funds available under this chapter.

50-24.1-05. Date effective.

The effective date of this chapter is the date on which federal funds become available for the purposes and program outlined herein.

50-24.1-06. Remedial eye care - When provided.

On the basis of the findings of an examination made by an ophthalmologist, optometrist, or physician skilled in the diseases of the eye, recommended remedial eye care services must be provided to any individual under the age of sixty-five who is in need of remedial eye care services if the individual is not blind as defined under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.], and the individual is otherwise qualified for assistance under this chapter. Except for services furnished in a medical emergency, the department may not pay for recommended remedial eye care services unless the individual receiving those services first applies for and receives authorization from the department. As used in this section, "remedial eye care services" mean services to prevent blindness or to restore an individual's eyesight, but does not include treatment of diseases causing an impairment or a loss of eyesight, such as diabetes and high blood pressure, ordinary eye examinations, eye glasses, physical examinations, or travel and other expenses necessary to receive treatment.

50-24.1-07. Recovery from estate of medical assistance recipient.

1. On the death of any recipient of medical assistance who was a resident of a nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institution and with respect to whom the department of human services determined that resident reasonably was not expected to be discharged from the medical institution and to return home, or who was fifty-five years of age or older when the recipient received the assistance, and on the death of the spouse of the deceased recipient, the total amount of medical assistance paid on behalf of the recipient following the institutionalization of the recipient who cannot reasonably be expected to be discharged from the medical institution, or following the recipient's fifty-fifth birthday, as the case may be, must be allowed as a preferred claim against the decedent's estate after payment, in the following order, of:
 - a. Recipient liability expense applicable to the month of death for nursing home or basic care services;
 - b. Funeral expenses not in excess of three thousand dollars;
 - c. Expenses of the last illness, other than those incurred by medical assistance;
 - d. Expenses of administering the estate, including attorney's fees approved by the court;
 - e. Claims made under chapter 50-01;

- f. Claims made under chapter 50-24.5;
 - g. Claims made under chapter 50-06.3 and on behalf of the state hospital; and
 - h. Claims made under subsection 4.
2.
 - a. A claim may not be required to be paid nor may interest begin to accrue during the lifetime of the decedent's surviving spouse, if any, nor while there is a surviving child who is under the age of twenty-one years or is blind or permanently and totally disabled, but no timely filed claim may be disallowed because of the provisions of this section.
 - b. The department may not file a claim against an estate to recover payments made on behalf of a recipient who was eligible for Medicaid under section 50-24.1-37 and who received coverage through a private carrier.
 3. Every personal representative, upon the granting of letters of administration or testamentary shall forward to the department of human services a copy of the petition or application commencing probate, heirship proceedings, or joint tenancy tax clearance proceedings in the respective district court, together with a list of the names of the legatees, devisees, surviving joint tenants, and heirs at law of the estate. Unless a properly filed claim of the department of human services is paid in full, the personal representative shall provide to the department a statement of assets and disbursements in the estate.
 4. A claim of the department of human services made against the decedent's estate of a recipient of medical assistance who was a full-benefit dual-eligible recipient, or against the decedent's estate of the spouse of a deceased recipient of medical assistance who was a full-benefit dual-eligible recipient, must include a claim for an amount equal to the amount required to be paid each month under 42 U.S.C. 1396u-5(c)(1)(A), or a substantially similar federal law, which reasonably may be attributable to benefits paid on behalf of the deceased recipient in a month during which the deceased recipient received medical assistance under this chapter and was eligible for Medicare.
 5. All assets in the decedent's estate of the spouse of a deceased medical assistance recipient are presumed to be assets in which that recipient had an interest at the time of the recipient's death.
 6. To the extent a claim for repayment of medical assistance arises for services provided in months during which the department of human services has in effect an approved state plan amendment that provides for the disregard of assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary of an insurance policy under a qualified state long-term care insurance partnership, the department's claim need not be paid out of assets of the decedent's estate of a recipient of medical assistance, or assets of the decedent's estate of the spouse of such a recipient, of a value equal to an amount the estate demonstrates was paid for long-term care provided to the recipient of medical assistance during those months by that insurance policy.
 7. For purposes of this section:
 - a. "Full-benefit dual-eligible" has the meaning provided in 42 U.S.C. 1396u-5; and
 - b. "Qualified state long-term care insurance partnership" has the meaning provided in 42 U.S.C. 1396p(b).

50-24.1-08. Statute of limitations does not run.

The statute of limitations does not run against claims of the state of North Dakota for repayment of medical assistance provided under this chapter.

50-24.1-09. Reimbursement of long-term care facility - Limitation - Allowable costs.

Repealed by S.L. 1987, ch. 582, § 30.

50-24.1-10. Joint Medicaid payment account - Educationally related services.

The state treasurer shall establish a joint Medicaid payment account for the department of human services and the department of public instruction to pay for services provided

handicapped children allowed under the Medicare Catastrophic Act of 1988. This account shall be for the receipt and payment of department of public instruction matching funds and department of human services federal Medicaid funds for the purpose of making payments to the provider or providers of services as directed by the department of human services. The department of public instruction shall provide the department of human services such administrative services in the documentation and payment of these funds as the department of human services may request.

50-24.1-11. Joint Medicaid payment account - North Dakota vision services - school for the blind.

The state treasurer shall establish a joint Medicaid payment account for the department of human services and the North Dakota vision services - school for the blind for purposes of providing services including alternative living arrangements for persons determined eligible for the receipt of residential and other services by the North Dakota vision services - school for the blind. This account shall be for the receipt and payment of North Dakota vision services - school for the blind matching funds and department of human services federal Medicaid funds for the purpose of making payments to the provider or providers of service as directed by the department of human services. The North Dakota vision services - school for the blind shall provide the department of human services such administrative services in the documentation and payment of these funds as the department of human services may request.

50-24.1-12. Medical assistance - Services provided by psychologists.

Within the limits of legislative appropriations, the department of human services shall provide medical assistance to eligible recipients for services provided by psychologists licensed under chapter 43-32.

50-24.1-13. Provider reimbursement rates.

If sufficient general fund appropriations are available to increase provider reimbursement rates, the department shall review reimbursement rates paid to providers under this chapter and shall increase the reimbursement rates accordingly.

50-24.1-14. Responsibility for expenditures.

Expenditures required under this chapter are the responsibility of the federal government or the state of North Dakota.

50-24.1-15. Prehospital emergency medical services.

Medical assistance coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part. A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the prehospital emergency medical services were not medically necessary or that a medical emergency did not exist.

50-24.1-16. Reimbursement of ambulance services.

1. Medical assistance coverage must include reimbursement of ambulance services for responding to calls to assist covered individuals which do not result in transport. The reimbursement must be at a rate negotiated by the department and the ambulance service.
2. For purposes of classifying ambulance services under this section:
 - a. An emergency response is one that at the time the ambulance is called the ambulance responds immediately. An immediate response is one in which the

ambulance begins as quickly as possible to take the steps necessary to respond to the call.

- b. An advanced life support assessment is an assessment performed by an advanced life support crew as part of an emergency response that was necessary because the patient's reported condition at the time of the dispatch was such that only an advanced life support crew was qualified to perform the assessment. An advanced life support assessment does not necessarily result in a determination that the patient requires an advanced life support level of service.

50-24.1-17. Medical assistance for breast or cervical cancer.

The department of human services may provide medical assistance for women screened and found to have breast or cervical cancer in accordance with the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 [Pub. L. 106-354; 114 Stat. 1381; 42 U.S.C. 1396a et seq.]. The department shall establish an income eligibility limit that may not exceed two hundred percent of the poverty line for payments made under this section. For purposes of this section, poverty line means the official income poverty line as defined by the United States office of management and budget and revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved.

50-24.1-18. Personal care option - Basic care facilities.

The department of human services may implement a personal care option benefit program. Personal care option benefits may only be made available to qualifying individuals who reside in basic care facilities. As used in this section, "basic care facility" has the meaning provided in section 23-09.3-01.

50-24.1-18.1. Consumer-directed health maintenance services - Residing at home.

The department of human services shall provide a personal care services program for eligible medical assistance recipients. The department shall provide an attendant care program to permit health maintenance services authorized under this section to be provided by nonlicensed care providers. Health maintenance services means care that enables an individual to live at home, and which is based upon the determination of a physician which concludes that the individual is medically stable and is competent to direct the care provided by a nonlicensed care provider. Health maintenance services include assistance with the activities of daily living such as getting in and out of bed, wheelchair, or motor vehicle; assistance with routine bodily functions such as bathing and personal hygiene, dressing, and grooming; and feeding, including preparation and cleanup. Health maintenance services also include any other medical, nursing, or home health care services that will maintain the health and well-being of the individual and will allow the individual to remain in the community and which are services that an individual without a functional disability would customarily and personally perform without the assistance of a licensed health care provider, such as catheter irrigation, administration of medications, or wound care.

50-24.1-19. Oral maxillofacial services - Medical necessity.

The department of human services shall make oral maxillofacial surgical services and orthodontic services in conjunction with, or in lieu of, such surgical services available through the Medicaid program to anyone who is a Medicaid recipient if such services are reasonably likely to correct or mitigate a congenital or acquired deformity associated with a significant functional impairment in drinking, eating, swallowing, or speaking.

50-24.1-20. Home and community-based living - Choice of options.

Any aged or disabled individual who is eligible for home and community-based living must be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. To the extent permitted by any applicable waiver, the individual's medical assistance funds must follow the individual for whichever service option the individual selects, not to exceed the cost of the service. The department of human services shall apply for

the waivers and grants necessary to implement this section under existing or future federal legislation.

50-24.1-21. Department to submit plans and seek waivers.

Repealed by S.L. 2007, ch. 421, § 3.

50-24.1-22. Long-term care facility information.

A long-term care facility may request that an applicant for admission, a resident of the facility, or the applicant's or resident's legal representative furnish financial information regarding income and assets, including information regarding any transfers or assignments of income or assets. A long-term care facility may deny admission to an applicant for admission who is unable to verify a viable payment source.

50-24.1-23. Long-term care facility resident - Medical assistance eligibility.

An individual is not ineligible for medical assistance if application of disqualifying transfer provisions would deprive the individual of nursing care and services and the individual makes a satisfactory showing that:

1. For periods after the return, all income or assets constituting the disqualifying transfer have been transferred or assigned back to the individual and the individual is otherwise eligible for medical assistance; or
2. Compensation equal to the fair market value of the income or asset at time of transfer is paid to, or on behalf of, the individual for nursing care and services provided by a long-term care facility and the individual is otherwise eligible for medical assistance.

50-24.1-24. Provider appeals - Definitions.

1. For purposes of this section:
 - a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided.
 - b. "Department" means the department of human services.
 - c. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department.
2. A provider may request a review of denial of payment under this section by filing within thirty days of the date of the department's denial of the claim a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service.
3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits, and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.
4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the department for an informal conference regarding the review anytime before the department has issued its final decision.
5. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. The department's final decision must conform to the requirements of section 28-32-39. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42, and the district court shall review the department's final decision in the manner provided in section 28-32-46. The judgment of the district court in an appeal

from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.

6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits, and other written information submitted by the provider or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44.

50-24.1-25. Operating costs for developmental disabilities service providers.

The department of human services shall determine annual payment rates for private, licensed developmental disability providers by applying the inflation rate for these providers used to develop the legislative appropriation for the department.

50-24.1-26. Medicaid waiver - In-home services.

The department shall apply for a Medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care. The department may limit the waiver to fifteen participants and may prioritize applicants by degree of need.

50-24.1-27. Medical assistance program management.

The department of human services, with respect to the state medical assistance program, shall:

1. Provide statewide targeted case management services to include a concentrated, but not an exclusive, emphasis for the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases and the families of neonates that can benefit from case management services. Case management services must focus on those recipients in these groups which will result in the most cost-savings, taking into consideration available resources, and may include a primary pharmacy component for the management of medical assistance recipient medication.
2. Require medical assistance providers to use the appropriate diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursement; review and develop recommendations to identify instances in which a provider of services is not properly reporting diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursements; and review and recommend any specific providers from which a potential benefit might be obtained by requiring additional diagnosis or reason and procedure codes.
3. Review and develop recommendations for the improvement of mental health treatment and services including the use of prescription drugs for medical assistance recipients.
4. Review and develop recommendations regarding whether the number of medical assistance recipients who are placed in out-of-state nursing homes should be reduced.
5. Review and develop recommendations regarding whether the use of post-office addresses or street addresses are the appropriate mailing addresses for medical assistance recipients.
6. Review and develop recommendations regarding whether to require medical assistance providers to secure prior authorization for certain high-cost medical procedures.
7. Review and develop recommendations regarding whether a system for providing and requiring the use of photo identification medical assistance cards for all medical assistance recipients should be implemented.
8. Review and develop recommendations regarding whether medical assistance providers should be required to use tamper-resistant prescription pads.

9. Develop a plan to provide information to blind and disabled medical assistance recipients who may be eligible for part D benefits under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1]. The information must inform recipients of part D benefits for which the recipient may be eligible.
10. Review and recommend a plan for implementing the necessary infrastructure to permit risk-sharing arrangements between the department and medical assistance providers.

50-24.1-28. Medical assistance and Medicare prescription drug management program.

The department of human services, with respect to the state medical assistance program, shall develop a plan for the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1]. The department may purchase the services of an outside consultant to assist in the development of the plan. The requirements of chapter 54-44.4 do not apply to the purchase of the consultant services. The department may not pay for:

1. A prescription drug that is within a class of drugs covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1] and which is prescribed to a medical assistance recipient who is also a Medicare beneficiary.
2. A prescription drug that is not covered and for which no drug in its class is covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1] and which is prescribed for an individual who is a medical assistance recipient and a Medicare beneficiary unless federal medical assistance matching funds are available at no less than the federal medical assistance percentage and the department determines that the drug is medically necessary for the individual.
3. A prescription drug for which federal medical assistance matching funds are not available except that until February 15, 2006, the department may pay for the drug in an emergency to ensure that a medical assistance recipient who is also a Medicare beneficiary may continue to receive appropriate medications after implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1].

50-24.1-29. Insurers to provide certain information to the department of human services.

1. For purposes of this section:
 - a. "Department" means the department of human services or its agent.
 - b. "Health insurer" includes self-insured plans, group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that legally are responsible by statute, contract, or agreement for payment of a claim for a health care item or service.
 - c. "Medical assistance" means benefits paid under chapter 50-24.1 and title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].
2. As a condition of doing business in this state, health insurers shall provide to the department upon its request and in a manner prescribed by the department information about individuals who are eligible for medical assistance so the department may determine during what period the individual or the individual's spouse or dependents may be or may have been covered by a health insurer and the nature of the coverage provided by the health insurer, including the name, address, and identifying number of the plan. Notwithstanding any other provision of law, every health insurer, not more frequently than twelve times in a year, shall provide to the department upon its request information, including automated data matches conducted under the direction of the department, as necessary, to:

- a. Identify individuals covered under the insurer's health benefit plans who are also recipients of medical assistance;
 - b. Determine the period during which the individual or the individual's spouse or the individual's dependents may be or may have been covered by the health benefit plan; and
 - c. Determine the nature of the coverage.
- The insurer must provide the information required in this subsection to the department at no cost if the information is in a readily available structure or format. If the department requests the information in a structure or format that is not readily available, the insurer may charge a reasonable fee for providing the information, not to exceed the actual cost of providing the information.
3. To facilitate the department in obtaining the information required by this section, a health insurer shall:
 - a. Cooperate with the department to determine whether a medical assistance recipient may be covered under the insurer's health benefit plan and is eligible to receive benefits under the health benefit plan for services provided under the medical assistance program.
 - b. Respond to the request for information within ninety days after receipt of written proof of loss or claim for payment for health care services provided to a recipient of medical assistance who is covered by the insurer's health benefit plan.
 - c. Accept the department's right of recovery and the assignment to the department of any right of an individual or other entity to payment from a liable third party for an item or service for which payment has been made under the state medical assistance plan.
 - d. Respond to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the health care item or service.
 - e. Agree not to deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type of format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim if:
 - (1) The claim is submitted by the department within the three-year period beginning on the date on which the item or service was furnished; and
 - (2) Any action by the department to enforce its rights with respect to such claim is commenced within six years of the department's submission of the claim.
 4. A health insurer is prohibited, in enrolling an individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance.
 5. The department may not use or disclose any information provided by the insurer other than as permitted or required by law. The insurer may not be held liable for the release of insurance information to the department or a department agent if the release is authorized under this section.

50-24.1-30. Third-party liability recovery.

1. For purposes of this section:
 - a. "Department" means the department of human services.
 - b. "Third party" means an individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under this chapter.
2. The department shall seek recovery of reimbursement from a third party up to the full amount of medical assistance paid.
3. A medical assistance recipient shall inform the department of any rights the recipient has to third-party benefits and shall inform the department of the name and address of any individual, entity, or program that is or may be liable to provide third-party benefits.
4. A release or satisfaction of a cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement is not valid or effectual as against a

- claim created under this chapter unless the department joins in the release or satisfaction or executes a release of its claim.
5. The department shall recover the full amount of all medical assistance provided on behalf of a recipient to the full extent of third-party benefits received by the recipient or the department for medical expenses. The department shall recover the third-party benefits directly from any third party or from the recipient or legal representative, if the recipient or legal representative has received third-party benefits, up to the amount of medical assistance provided to the recipient.
 6. An applicant for or recipient of medical assistance shall cooperate in the recovery of third-party benefits.
 7. To enforce its rights to third-party benefits, the department may institute, intervene in, or join any legal or administrative proceeding in its own name.
 - a. If either the recipient or the department brings an action against a third party, the recipient or the department must provide to the other within thirty days after commencing the action written notice by personal delivery or registered mail of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If either the department or the recipient brings an action, the other may become a party to or may consolidate an action brought independently with the other.
 - b. A judgment, award, or settlement of a claim in an action by a recipient to recover damages for injuries or other third-party benefits in which the department has an interest may not be satisfied or released without first giving the department notice and a reasonable opportunity to file and satisfy its claim or proceed with any action as otherwise permitted by law.
 8. Any transfer or encumbrance of any right, title, or interest to which the department has a right with the intent, likelihood, or practical effect of defeating, hindering, or reducing recovery by the department for reimbursement of medical assistance provided to a recipient is void and of no effect against the claim of the department.
 9. A recipient who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the department within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total medical assistance provided or to place a sum equal to the full amount of the total medical assistance provided in a trust account pending judicial or administrative determination of the department's right to the third-party benefits.
 10. Notwithstanding any provision in this section to the contrary, the department is not required to seek reimbursement from, or may reduce or compromise a claim against, a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost-effectiveness is determined based on the following:
 - a. Actual and legal issues of liability as may exist between the recipient and the liable party;
 - b. Total funds available for settlement; and
 - c. An estimate of the cost to the department of pursuing its claim.

50-24.1-31. Optional medical assistance for families of children with disabilities.

The department of human services shall establish and implement a buyin program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred percent of the federal poverty line.

50-24.1-32. Medical assistance - Services provided by physician assistants and advanced registered nurse practitioners.

The medical assistance program must recognize physician assistants and advanced registered nurse practitioners as primary care providers with the same rights and responsibilities

given primary care physicians under the medical assistance program. Any care provided by the physician assistant or advanced registered nurse practitioner as a primary care provider under the medical assistance program must be within the scope of the physician assistant's or advanced registered nurse practitioner's respective license.

50-24.1-33. Brain injury - Home and community-based services - Outreach activities - Quality control.

1. As part of the personal care services program for eligible medical assistance recipients and as part of the department's services for eligible disabled and elderly individuals, the department shall provide home and community-based services to individuals who have moderate or severe impairments as a result of a brain injury. The department shall give priority under this section to individuals whose impairments are less severe or similar to those of individuals who are eligible for Medicaid waivers.
2. The department shall conduct outreach and public awareness activities regarding the availability of home and community-based services to individuals who have moderate or severe impairments as a result of a brain injury.
3. The department shall conduct quality control activities and make training available to case managers and other persons providing services to individuals under this section.

50-24.1-34. Processing of claims submitted on behalf of inmates.

The department of human services shall process claims submitted by enrolled medical providers on behalf of inmates at county jails. Each county shall pay the department a processing fee for each claim submission. The department shall establish a processing fee that may not exceed thirty dollars and shall update the fee annually on July first. The processing fee must be based on the annual costs to the department of the claims processing operations divided by the annual volume of claims submitted. The department shall invoice each county for payment of the processing fee. Beginning July 1, 2011, the department of human services shall increase the claims processing fee to recover the cost of the Medicaid claims system changes. The department shall deposit the portion of the fee associated with recovering the costs of the Medicaid claims system changes in the general fund.

50-24.1-35. Department to expand Medicaid coverage. (Contingent effective date - [See note](#))

After implementation of the Medicaid management information system, the department of human services shall expand Medicaid coverage to include Medicaid-covered services provided to an inmate of the state penitentiary or a county jail who would be eligible for Medicaid if the inmate were not incarcerated and who is admitted to an inpatient hospital setting.

50-24.1-36. Civil sanction - Costs recoverable - Interest - Appeals.

1. For purposes of this section:
 - a. "Affiliate" means a person having an overt or covert relationship each with another person in a manner that one person directly or indirectly controls or has the power to control another.
 - b. "Department" means the department of human services.
 - c. "Provider" means any individual or entity furnishing Medicaid services under a provider agreement with the department of human services.
2. A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to twenty-five percent of the amount the department was induced to pay as a result of each act of fraud or abuse. This sanction is in addition to the applicable rules established by the department.
3. A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to five thousand dollars on each act of fraud or abuse which did not induce the department to make an erroneous payment. This sanction is in addition to the applicable rules established by the department.

4. A provider, an affiliate of a provider, or any combination of provider and affiliates, that is assessed a civil sanction by the department also shall reimburse the department investigation fees, costs, and expenses for any investigation and action brought under this section.
5. Unless otherwise provided in a judgment entered against a provider or against an affiliate of the provider, overpayments and sanctions accrue interest at the legal rate beginning thirty days after the department provides written notice to the provider or the affiliate of the provider.
6.
 - a. A provider or an affiliate of a provider who is assessed a sanction may request a review of the sanction by filing within thirty days of the date of the department's notice of sanction a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute.
 - b. A provider or an affiliate of a provider may not request review under this section if the sanction imposed is termination or suspension and the notice of sanction states that the basis for the sanction is either:
 - (1) The provider's or affiliate's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the Medicaid program; or
 - (2) The provider or affiliate has been similarly sanctioned by the Medicare program or by another state's Medicaid program.
 - c. Within thirty days after requesting a review, a provider or affiliate shall provide to the department all documents, written statements, exhibits, and other written information that supports the request for review.
 - d. The department shall assign a provider's or affiliate's request for review to someone other than an individual who was involved in imposing the sanction. A provider or affiliate who has requested review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.
 - e. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. The department's final decision must conform to the requirements of section 28-32-39. A provider or affiliate may appeal the final decision of the department to the district court in the manner provided in section 28-32-42, and the district court shall review the department's final decision in the manner provided in section 28-32-46. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.
 - f. Upon receipt of notice that the provider or affiliate has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits, and other written information submitted by the provider, affiliate, or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44.
7. Determinations of medical necessity may not lead to imposition of remedies, duties, prohibitions, and sanctions under this section.
8. The remedies, duties, prohibitions, and sanctions of this section are not exclusive and are in addition to all other causes of action, remedies, penalties, and sanctions otherwise provided by law or by provider agreement.
9. The state's share of all civil sanctions, investigation fees, costs, expenses, and interest received by the department under this section must be deposited into the general fund.

50-24.1-37. Medicaid expansion - Legislative management report. (Effective January 1, 2014, through July 31, 2019 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty level, based on modified adjusted gross income.
2. The department of human services shall inform new enrollees in the medical assistance program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.
4. The contract between the department and the private carrier must:
 - a. Provide a reimbursement methodology for all medications and dispensing fees which identifies the minimum amount paid to pharmacy providers for each medication. The reimbursement methodology, at a minimum, must:
 - (1) Be available on the department's website; and
 - (2) Encompass all types of pharmacy providers regardless of whether the pharmacy benefits are being paid through the private carrier or contractor or subcontractor of the private carrier under this section.
 - b. Provide full transparency of all costs and all rebates in aggregate.
 - c. Allow an individual to obtain medication from a pharmacy that provides mail order service; however, the contract may not require mail order to be the sole method of service and must allow for all contracted pharmacy providers to dispense any and all drugs included in the benefit plan and allowed under the pharmacy provider's license.
 - d. Ensure that pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification.
 - e. Ensure the payments to pharmacy providers do not include a required payback amount to the private carrier or one of the private carrier's contractors or subcontractors which is not representative of the amounts allowed under the reimbursement methodology provided in subdivision a.
5. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.
6. Provider reimbursement rate information received by the department under this section and any information provided to the department of human services or any audit firm by a pharmacy benefit manager under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

50-24.1-38. Health-related services - Licensed community paramedics.

The department of human services shall adopt rules governing payments to licensed community paramedics, advanced emergency medical technicians, and emergency medical technicians for health-related services provided to recipients of medical assistance, subject to necessary limitations and exclusions. A physician or an advanced practice registered nurse must supervise any care provided by a licensed community paramedic, an advanced emergency medical technician, or emergency medical technician.

50-24.1-39. Behavioral health services - Licensed marriage and family therapists.

Beginning January 1, 2016, the department of human services shall allow licensed marriage and family therapists to enroll and be eligible for payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary.