2600.11 STATE ORGANIZATION AND GENERAL ADMIISTRATION 11-91

2600.11 Form HCFA-25D.3, Medicaid Program Budget Report - Medical Assistance Payments - Budget Year +1. --Complete this form in its entirety for each quarterly submission. Round all dollar amounts to the nearest thousand. Update the Budget year +1 as the fiscal year progresses to reflect new or revised quarterly budget estimates.

A. Line Headings -- Lines 1 to 28. --Follow instructions for the Form HCFA-25D.1. (See §2600.9.)

B. Column Headings --Columns A, C, E and G. -- Enter the estimated Medical assistance payments computable for Federal funding for each quarter of the budget fiscal year +1.

Columns B, D, F and H. --Enter the Federal share of the total computable amounts entered in columns A, C, E, and G for each quarter of the Budget fiscal year +1.

C. Footnotes. --This space highlights any additional relevant information pertaining to the Budget fiscal year; e.g., short explanations of large changes in any service category during the quarter that affects the next budget year. Provide comprehensive explanation/analysis of changes on Forms HCFA-25J(1) and J(2). (See §2600.8.)

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MEDICAID PROGRAM BUDGET REPORT

MEDICAL ASSISTANCE PAYMENTS(IN THOUSANDS)

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11-91 STATE ORGANIZATION AND STATE ADMINISTRATION 2600.12

2600.12 Form HCFA-25I.1, Medicaid Program Budget Report - State and Local Administration for the Current Year. -- To meet needs expressed by EOMB for comparable breakdowns of budget and expenditure information so that HCFA may be able to make more accurate budget forecasts, forms have been developed to capture quarterly reporting of State and Local Administration for the current and the budget fiscal years.

Complete this form in its entirety for each quarterly submission. Round all dollar amounts to the nearest thousand. Update the current year as the fiscal year progresses to reflect new or revised quarterly Budget estimates.

A. Line Headings for Lines 1 to 17. -- Administrative services listed in lines 1 to 14 are defined in §2600.7. Make entries for each service for which estimates are reported on Form HCFA-25I. Line 15 reflects the sum of lines 1 to 14. For lines 16 and 16A, enter the total of all collections and prior period adjustments, respectively, that are related to State and local administration for the Medical Assistance Program. Line 17 is the net total of line 14 less the sum of lines 16 and 16A.

B. Column Headings for Columns A, C, E, and G. -- Enter the estimated State and Local Administration expenditures computable for Federal funding for each quarter of the current fiscal year.

Columns B, D, F, and H. -- Enter the Federal share of the total computable amounts entered in columns A, C, E, and G for each quarter of the current fiscal year.

C. Footnotes. -- This space highlights any additional relevant information pertaining to the current fiscal year; e.g., short explanations of large changes in any administrative cost category during the quarter. Provide comprehensive explanations/analysis of changes on Forms HCFA-25J(1) and J(2). (See §2600.8.)

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STATE AND LOCAL ADMINISTRATION(IN THOUSANDS)

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11-91 STATE ORGANIZATION AND GENERAL ADMINISTRATION 2600.13

2600.13 Form HCFA-25I.2, Medicaid Program Budget Report - State and Local Administration for the Budget Year. -- Complete this form in its entirety for each quarterly submission. Round all dollar amounts to the nearest thousand. Update the Budget year as the fiscal year progresses to reflect new or revised quarterly Budget estimates.

A. Line Headings for Lines 1 to 17. -- Follow instructions for the Form HCFA-25I.1. (See §2600.12.)

B. Column Headings for Columns A, C, E and G. -- Enter the estimated State and Local Administration expenditures computable for Federal funding for each quarter of the budget fiscal year.

Columns B, D, F, and H. -- Enter the Federal share of the total computable amounts entered in columns A, C, E, and G for each quarter of the Budget fiscal year.

C. Footnotes. -- This space highlights any additional relevant information pertaining to the Budget fiscal year; e.g., short explanations of large changes in any administrative cost category during the quarter. Provide comprehensive explanations/analysis of changes on Forms HCFA-25J(1) and J(2). (See §2600.8.)

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STATE AND LOCAL ADMINISTRATION(IN THOUSANDS)

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11-91 STATE ORGANIZATION AND GENERAL ADMINISTRATION 2600.14

2600.14 Form HCFA-25I.3, Medicaid Program Budget Report - State and Local Administration for the Budget Year +1. -- Complete this form in its entirety for each quarterly submission. Round all dollar amounts to the nearest thousand. Update the Budget Year +1 as the fiscal year progresses to reflect new or revised quarterly Budget estimates.

A. Line Headings for Lines 1 to 17. -- Follow instructions for the Form HCFA-25I.1. (See §2600.12.)

B. Column Headings for Columns A, C, E,and G. -- Enter the estimated State and Local Administration expenditures computable for Federal funding for each quarter of the budget fiscal year.

Columns B, D, F, and H. -- Enter the Federal share of the total computable amounts entered in columns A, C, E, and G for each quarter of the Budget fiscal year +1.

C. Footnotes. -- This space highlights any additional relevant information pertaining to the Budget fiscal year; e.g., short explanations of large changes in any administrative cost categories during the quarter. Provide comprehensive explanations/analysis of changes on Forms HCFA-25J(1) and J(2). (See §2600.8.)

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STATE AND LOCAL ADMINISTRATION (IN THOUSANDS)

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11-91 STATE ORGANIZATION AND GENERAL ADMINISTRATION 2601

2601. DEFINITIONS - MEDICAID PROGRAM BUDGET REPORT (FORM HCFA-25)

A. Service Types.--

1. Inpatient Hospital Services. - (Other Than Services in an Institution for Mental Diseases. (See 42 CFR 440.10.) --These are services that are:

o Ordinarily furnished in a hospital for the care and treatment of inpatients;

o Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services per 42 CFR 440.165); and

o Furnished in an institution that:

- Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

- Is licensed and formally approved as a hospital by an officially designated authority for State standard setting;

- Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services per 42 CFR 440.165); and

- Has in effect a utilization review plan that meets the requirements of 42 CFR 482.30 and applies to all Medicaid patients unless a waiver has been granted by the Secretary of Health and Human Services.

NOTE: Inpatient hospital services do not include NF or ICF services furnished by a hospital with swing-bed approval. However, include services provided in a psychiatric wing of a general hospital, if the psychiatric wing is not administratively separate from the general hospital.

2. Mental Health Facility Services - Inpatient Hospital Services, Nursing Facility Services, and Intermediate Care Facility Services in Institutions for Mental Diseases. (See 42 CFR 440.140 and 440.160.) --Report mental services which are not provided in an inpatient setting in the other appropriate service categories, e.g., Physician services, Clinic services.

o Mental Hospital Services for the Aged. --This refers to those inpatient hospital services for individuals age 65 or older provided under the direction of a physician for the care and treatment of recipients in an institution for mental disease that meets the Conditions of Participation under 42 CFR 482.

o NF Services for the Aged. --This refers to those NF services as defined in 42 CFR 483, Subpart B provided in an institution for mental diseases to recipients determined to be in need of such services. (See 42 CFR 440.140.)

o Inpatient Psychiatric Facility Services for Individuals Age 21 and Under. --This refers to those services defined in 42 CFR 440.160 that:

- Are provided under the direction of a physician;

- Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Health Care Organizations; and

- Meet the requirements in 42 CFR 441, Subpart D (Inpatient

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Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs).

3. Nursing Facility (NF) Services. - Other Than Services in an Institution for Mental Diseases. (See 42 CFR 483.5.) --These are services provided by an institution (or a distinct part of an institution) which:

o Is primarily engaged in providing to residents:

- Skilled nursing care and related services for residents who require medical or nursing care,

- Rehabilitation services for the rehabilitation of injured, disabled or sick persons, or

- On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,and is not primarily for the care and treatment of mental diseases; and

o Meets the requirements for a nursing facility described in subsections 1919 (b), (c) and (d) of the Act regarding:

- Requirements relating to Provision of Services,

- Requirements relating to Residents Rights, and

- Requirements relating to Administration and Other Matters.

4. Intermediate Care Facility (ICF) Services for Mentally Retarded. (See 42 CFR 440.150(c).) --ICF/MR services (other than in an institution for mental disease) mean services defined in 42 CFR 440.150 and may include services provided in an institution for the mentally retarded or persons with related conditions if:

o The primary purpose of the institution is to provide health or rehabilitative services to such individuals;

o The institution meets the standards in 42 CFR 442, Subpart E (Intermediate Care Facility Requirements; All Facilities); and

o The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009.

5. Physician Services. (See 42 CFR 440.50.) --Whether furnished in the office, the recipient’s home, a hospital, an NF, or elsewhere, physician services mean services provided:

o Within the scope of practice of medicine or osteopathy as defined by State law; and

o By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

NOTE: Exclude all services that are provided and billed for by a clinic or laboratory. Include any services provided and billed by a physician with the exception of lab and X-ray services as these latter services are reported under the lab and X-ray services category.

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6. Outpatient Hospital Services. (See 42 CFR 440.20.) --These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

o Are furnished to outpatients;

o Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under the direction of, a physician or dentist; and

o Are furnished by an institution that:

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and

- Except in the case of medical supervision of nurse-midwife services (see 42 CFR 440.165) meets the requirements for participation in Medicare.

7. Prescribed Drugs. (See 42 CFR 440.120(a).) --These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

o Prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional practice as defined and limited by Federal and State law;

o Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

o Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist§s or practitioner§s record.

7A. Drug Rebate Offset --This is a rebate from the manufacturer to the State medical assistance plan for single source drugs and innovator multiple source drugs that are dispersed to Medicaid recipients. Rebates are to take place quarterly.

NOTE: Vaccines are not subject to the rebate agreements.

8. Dental Services. (See 42 CFR 440.100.) --These are services that are diagnostic, preventive or corrective procedures provided by, or under the supervision of, a dentist in practice of his or her profession including treatment of :

o The teeth and associated structures of the oral cavity; and

o Disease, injury, or impairment that may affect the oral or general health of the recipient.

Dentist means an individual licensed to practice dentistry or dental surgery. Report all EPSDT dental services under the Dental Services line.

NOTE: Exclude all such services provided as part of inpatient hospital, outpatient hospital, nondental clinic or laboratory services and billed by the hospital, nondental clinic or laboratory.

9. Other Practitioners Services. (See 42 CFR 440.60 and 440.80.) --

These are any medical or remedial care or services (other than physician

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2601 (Cont.) STATE ORGANIZATION AND GENERAL ADMINISTRATION 11-91

services or services of a dentist) provided by licensed practitioners within the scope of practice as defined under State law. Examples of other practitioners (if covered under State law) are:

o Chiropractors;

o Professional nurses;

o Podiatrists;

o Psychologists;

o Optometrists, and

o Christian Science Practitioners.

Certain exceptions are:

o Services of professional nurses including private duty nursing services as defined in 42 CFR 440.80 when recognized in the State plan.

o If services of other practitioners are billed for by a hospital, consider them inpatient or outpatient services, as applicable;

o Eyeglasses or hearing aids billed by the professional practitioner under Other Practitioner Services. If they are billed by a physician, include them under physician services. Otherwise, bill them under Other.

o Speech therapists, audiologists, opticians, physical therapists and occupational therapists under other care.

NOTE: Chiropractors’ services include only services that are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary found in 42 CFR 410.22 and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

10. Clinic Services. (See 42 CFR 440.90.) --These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

o Are provided to outpatients;

o Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. For reporting purposes, consider a group of physicians who share space, services of supporting staff, etc., only for mutual convenience, as physicians, rather than a clinic, even though they practice under the name of clinic; and

o Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by or under the direction of a physician.

NOTE: Place dental clinics under dental services. Report any services not included above under other care. A clinic staff may include practitioners with different specialties.

11. Laboratory and Radiological Services. (See 42 CFR 440.30.) --These are professional or technical laboratory and radiological services:

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o Ordered and provided by, or under, the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory;

o Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and

o Provided by a laboratory that meets the requirements for participation in Medicare.

NOTE: Report X-rays by dentists under the Dental Service category.

12. Home Health Services. (See 42 CFR 440.70.) --These are services provided at the patient’s place of residence in compliance with a physician’s written plan of care that is renewed every sixty days. These services include the following services and items. The services in the first three paragraphs are required. The services in the fourth paragraph are optional.

o Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by an HHA (a public or private agency or organization, or part of an agency or organization, that meets the requirements for participation in Medicare) or if there is no agency in the area, a registered nurse who:

- Is currently licensed to practice in the State;

- Receives written orders from the patient’s physician;

- Documents the case and services provided; and

- Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.

o Home health aide services provided by a HHA,

o Medical supplies, equipment, and appliance suitable for use in the home, and (optionally)

o Physical therapy, occupational therapy, or speech pathology and audiology services provided by a HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15.)

Place of residence is normally interpreted to mean the patient’s home and does not apply to hospitals or nursing facilities. Services received in an NF that are different from those normally provided as part of the institution’s care may qualify as home health services. For example, a registered nurse may provide short-term care for a recipient in an NF during an acute illness to avoid the recipient’s transfer to another NF.

13. Sterilizations. (See 42 CFR 441, Subpart F.) --These are medical procedures, treatment, or operations for the primary purpose of rendering an individual permanently incapable of reproducing.

14. Abortions. (See 42 CFR 441, Subpart E.) --FFP is available when a physician has certified in writing to the Medicaid agency, that on the basis of professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient. FFP is not available for an abortion under any other circumstances.

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15. EPSDT Screening Services. --As described in §5122, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit consists of five elements: screening services, vision services, dental services, hearing services and other necessary health care.

Line 15A is only for data relating to EPSDT screening services which include all of the following initial and periodic services:

o A comprehensive health and developmental history (including assessment of both physical and mental health development),

o A comprehensive unclothed physical examination,

o Appropriate immunizations according to age and health history,

o Laboratory tests (including lead blood level assessment appropriate to age and risk), and

o Health education (including anticipatory guidance).

Line 15B is for reporting data on interperiodic screenings which are provided when medically necessary to determine the existence of suspected illnesses and conditions.

NOTE: Do not report in this entry data for the other EPSDT services. Report dental services, including dental examinations and preventive services under item 8 "Dental". Report vision and hearing services under item 9 "Other Practitioners". Other necessary health care is claimed according to the approprieate medical assistance category and so reported.

16. Rural Health Clinic Services. (See 42 CFR 550.20(b).) --If a State permits the delivery of primary care by a nurse practitioner (NP) or physician’s assistant (PA), rural health clinic means the following services furnished by a rural health clinic that has been certified in accordance with the conditions of 42 CFR 491 (Certification of Certain Health Facilities):

o Services furnished by a physician within the scope of his or her profession under State law, whether the physician performs these services in the clinic or away from the clinic and the physician has an agreement with the clinic providing that he/she will be paid by it for such services.

o Services furnished by a PA, NP, nurse-midwife or other specialized nurse practitioner (as defined in 42 CFR 405.2401 and 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2414(a).

o Services and supplies that are furnished as incident to professional services furnished by a physician, NP, nurse-midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included here.)

o Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if:

- The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417);

- The services are furnished by an RN or LPN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

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- The services are furnished under a written plan of treatment established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse-midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

- The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. He or she may be considered homebound if he or she leaves the place of residency infrequently. Place of residence does not include a hospital or a SNF.

17. Health Insurance Payments. (See 42 CFR 431.625.) --Include Part A and Part B Premiums and Coinsurance and Deductible payments, as well as any Group Health Plan payments or other per capita insurance payments (e.g., payments for HMO, HIO and PHP enrollment). Except for Part A and Part B premiums, Group Health Plan Payments, HMO and HIO payments, distribute Health Insurance Payments of all types to the appropriate service category and exclude them from this category. Report HMO and HIO payments on line 17E, Other. Group Health Plan Payments are covered in §1906 of the Act.

18. Home and Community-Based Waivers. (See 42 CFR 440.180(a).) --These are services that are furnished under a waiver granted under the provisions of 42 CFR 441, Subpart G (Home and Community-Based Services; Waiver Requirements.)

19. Home and Community-Based Care for the Functionally Disabled Elderly. (See §1930 of the Act.) --This is an option provided to the States to provide home and community-based care to functionally disabled individuals age 65 of over who are otherwise eligible for Medicaid. Federal matching payments are capped at $580 million over five years and allocated by the Secretary among the States that choose to provide these services.

20. Community Supported Living Arrangements. (See §1929 of the Act.) This is also an option to provide community supported living arrangements to individuals with mental retardation or a related condition who are otherwise eligible for Medicaid. Benefits are limited to individuals living in their own or family’s home, apartment of other rental unit in which no more than three individuals receiving these services reside. Federal matching payments are capped at $100 million over five years and are provided to two to eight States selected by the Secretary.

21. Personal Care Services. (See 42 CFR 440.170(f).) --These are services performed in a recipient’s home as prescribed by a physician in accordance with the recipient’s plan of treatment and provided by an individual who is:

o Qualified to provide the services,

o Supervised by a registered nurse, and

o Not a member of the recipient’s family.

22. Targeted Case Management Sevices. (See §1905 (a)(19).) --These services are those that are furnished to individuals eligible under the plan in gaining access to needed medical, social, educational and other services. Your agency may make case management services available to:

o Specific geographic areas within a State, without regard to the statewide requirement in 42 CFR 431.50, and

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o Groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.250.

The agency must permit individuals to freely choose any qualified Medicaid provider when obtaining case management services in accordance with 42 CFR 431.51.

23. Hospice Benefits. (See §1905 (a)(18).) --These are services that are:

o Covered in 42 CFR 418.202;

o Furnished to a terminally ill individual, as defined in 42 CFR 418.3;

o Furnished by a hospice program, as defined in 42 CFR 418.3, that meets the requirements for participation in Medicare as specified in 42 CFR 418, Subpart C, or by others, under an arrangement made by a hospice program that meets those requirements as a participating Medicaid provider; and

o Furnished under a written plan that is established and periodically reviewed by the attending physician, the medical director of the program, as described in 42 CFR 418.54, or by the interdisciplinary group described in 42 CFR 418.68.

24. Federally Qualified Health Center Services. --These centers, called FQHCs, are more commonly known as Community Health Centers, Migrant Health Centers and Health Care Centers for the Homeless. FQHC services are defined the same as the services provided by rural health clinics and include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician’s services. In certain cases, ambulatory service included in the State’s plan is considered a covered FQHC service if the center offers it.

FQHCs qualify to provide covered services under Medicaid if:

o They receive grants under §§329, 330 or 340 of the Public Health Service (PHS) Act;

o The Health Resources and Services Administration, PHS certifies the center as meeting FQHC requirements; or

o The Secretary determines that the center qualifies through waiver of the requirements.

25. Other Care Services. (See 42 CFR 440.110, 440.120, 440.130 and 440.170(a), (b) and (c).) --These are any medical or remedial services recognized under State law and specified by the Secretary. Such services do not meet the definition of, and are not classified under, any of categories of service included in lines 1 through 24. They may include, but are not limited to:

o Transportation which includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined, is furnished only by a provider to whom a direct payment can appropriately be made by the agency. If

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other arrangements are made to assure transportation under 42 CFR 431.53, FFP is available as administrative costs.

o Physical Therapy which means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. (See 42 CFR 440.10(a)(2).) It includes any necessary supplies and equipment.

o Occupational Therapy which means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist (See 42 CFR 440.10(b)(2).) It includes any necessary supplies and equipment.

o Services for individuals with speech, hearing, and language disorders (also see Other Practitioner Services) which mean diagnostic, screening, preventive, or corrective services provided by or under the direction of other than a licensed speech pathologist or audiologist (see 42 CFR 440.10(c)(2)) for which a patient is referred by a physician. It includes any necessary supplies and equipment.

o Dentures, prosthetic devices, and eyeglasses (also see Other Practitioner Services). Dentures mean artifical structures made by, or under the direction of, a dentist to replace a full or partial set of teeth. Prosthetic devices mean replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law to:

- Artificially replace a missing portion of the body;

- Prevent or correct physical deformity or malfunctions; or

- Support a weak or deformed portion of the body.

o Eyeglasses which mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye, an optometrist or an optician. Also include optician fees for services.

o Diagnostic, screening, preventive and rehabilitative services. Diagnostic services, except as otherwise provided under 42 CFR 440, Subpart A, include any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law, to enable him/her to identify the existence, nature or extent of illness, injury, or other health deviation in a recipient.

Screening services mean the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. Preventive services mean services provided by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under the State law to:

o Prevent disease, disability, and other health conditions or their progression,

o Prolong life, and

o Promote physical and mental health and efficiency.

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Rehabilitative services, except as otherwise provided in 42 CFR 440, Subpart A, include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

Nurse-midwife services may be included under inpatient hospital, outpatient hospital, rural clinics or other practitioners depending upon how the service is billed.

Emergency hospital services may be included under various reporting categories depending upon how the service is billed.

B. Recipient Categories. --

1. Maintenance Assistance Status. --Identify individuals for HCFA reporting purposes under one of the following appropriate maintenance assistance status categories:

o Categorically Needy - Receiving Maintenance Assistance Payments. Report the following groups as Categorically Needy Receiving Maintenance Assistance Payments (cash payments):

- Individuals receiving Aid to Families with Dependent Children.

- Individuals receiving Supplementary Security Income (SSI) benefits.

- Individuals receiving mandatory State supplements.

- Individuals receiving only optional State supplements.

o Categorically Needy - Not Receiving Maintenance Assistance Payments. --Report all Categorically Needy individuals, except those groups listed above, as Not Receiving Maintenance Assistance Payments.

o Medically Needy. --The Medically Needy are individuals who have insufficient finances to meet the cost of their medical care, meet the categorical requirements for Medicaid, but who are not eligible for cash assistance because their income and/or resource levels are too high. Their resources must be within State limits, and the amount of their incurred medical expenses must equal or exceed the amount of income they have above the State income level.

o Qualified Medicare Beneficiaries. --A Qualified Medicare Beneficiary (QMB) is an individual who is entitled to Medicare hospital insurance benefits under Part A whose income does not exceed 100 percent of the official, Federal poverty level and whose resources do not exceed twice the SSI resource limit. QMBs are addressed in more detail in §3490.

If you decide to cover any medically needy groups, the following requirements apply:

o Provide ambulatory services to children and prenatal and delivery services for pregnant women;

o Groups covered for institutional services must also be covered for ambulatory services;

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o If ICF/MR or psychiatric hospital services are covered for any group, then the current mandatory services, or seven services from the entire list, must also be covered for that group; and

o Groups covered for NF services must also be covered for Home Health services.

Include in the State Plan a description of the criteria for determining eligibility of individuals in covered medically needy groups, and the amount, duration, and scope of services made available to individuals in the group.

2. Basis of Eligibility. --Identify individuals certified as eligible for Medicaid for HCFA reporting purposes under one of the following bases of eligibility.

o Aged, Blind, or Disabled. --Age, blindness, and disability eligibility criteria for Medicaid are generally those used by the Social Security Administration to determine eligibility for SSI cash assistance benefits, although a few States utilize more restrictive definitions for Medicaid. Report eligible individuals under the appropriate category.

o Adults in Families with Dependent Children. --Report eligible individuals in this category if they are individuals in a family with dependent children who meet the definitions of a caretaker relative. Besides a parent, a caretaker relative may be any blood relative, stepparents and stepbrother and sisters, persons who legally adopt a child or his/her parents and their relatives, or the spouses of any persons named in the above groups. Individuals under age 21 who are caretaker relatives are considered adults for reporting purposes.

o Children in Families with Dependent Children. --Report eligible individuals in this category if they are under age 21, dependent children, and members of a family with dependent children (a family with one parent dead, absent or incapacitated, or in some States, a two-parent family with an unemployed or underemployed parent). Also, report in this category those children who are in AFDC foster care.

o Other Title XIX Individuals. --If you choose to make eligible for Medicaid those individuals under age 21 who meet AFDC income and resource limits but who do not meet the definition of a dependent child under the AFDC program, classify these individuals as "Other Title XIX" individuals. Restrict the reporting of "Other Title XIX" individuals to this group.

NOTE: If an individual can be classified by more than one categorical factor, use the factor used in determining Medicaid eligibility.

3. Eligibility Group Definitions and Instructions. --The instructions are intended to provide general definitions and instructions for classifying each Medicaid eligibility group into the appropriate recipient category. If additional clarification is required, the instructions for preparation of Form HCFA-2082 (Annual Statistical Report on Medical Care) provide an in-depth breakout of covered eligibility groups, regulatory citations and the category under which to report each group. (See §2700.)

Rev. 74 2-131.10

2602 STATE ORGANIZATION AND GENERAL ADMINISTRATION 11-91

2602. SUBMISSION SCHEDULE - MEDICAID PROGRAM BUDGET REPORT (FORM HCFA-25)

STARTING DATE OF FEDERAL FISCAL

SUBMISSION DATE QUARTER BEING CERTIFIED YEARS REPORTED

February 15, 1991 April 1, 1991

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May 15, 1991 July 1, 1991

August 15, 1991 October 1, 1991 Fiscal Year 1 = FY 1991

Fiscal Year 2 = FY 1992

November 15, 1991 January 1, 1992 Fiscal Year 3 = FY 1993

February 15, 1992 April 1, 1992

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May 15, 1992 July 1, 1992

August 15, 1992 October 1, 1992 Fiscal Year 1 = FY 1992

Fiscal Year 2 = FY 1993

November 15, 1992 January 1, 1993 Fiscal Year 3 = FY 1994

February 15, 1993 April 1, 1993

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May l5, 1993 July l, 1993

August l5, 1993 October l, 1993 Fiscal Year 1 = FY 1993

Fiscal Year 2 = FY 1994

November l5, 1993 January l, 1994 Fiscal Year 3 = FY 1995

February l5, 1994 April l, 1994

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May 15, 1994 July 1, 1994

August 15, 1994 October 1, 1994 Fiscal Year 2 = FY 1994

Fiscal Year 3 = FY 1995

November 15, 1994 January 1, 1995 Fiscal Year 3 = FY 1996

February 15, 1995 April 1, 1995

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