Revision by FCHPG/DEHPG: **JULY 10, 2008**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: _____

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. Categorically Needy

The following items, numbered 1 though 30, identify the medical and remedial service provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services.

1. Inpatient hospital services, other than those provided in an institution for mental diseases, (provided in accordance with section 1905(a)(1) of the Social Security Act and 42 CFR 440.10 and, for infants and children, provided in accordance with 1902(e)(7) of the Social Security Act).

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

2. Outpatient hospital services, rural health clinic and federally qualified health center services (provided in accordance with section 1905(a)(2) of the Social Security Act).

a. Outpatient hospital services (provided in accordance with 42 CFR 440.20).

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the state plan.

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

c. Federally-qualified health center (FQHC) services and other ambulatory services that are offered by a Federally-qualified health center and which are otherwise included in the plan.

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

3. Other laboratory and x ray services (provided in accordance with section 1905(a)(3) of the Social Security Act and 42 CFR 440.30).

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

4. Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease), EPSDT, and family planning services and supplies (provided in accordance with section 1095(a)(4) of the Social Security Act).

a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older. (See preprint item 28(d) for "Nursing facility services under 21 years of age for cross-reference.)

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations for NF 21 years and older, not in IMDs.

b. Early and periodic screening, diagnostic and treatment services for individuals who are eligible under the plan and are under the age of 21 (provided in accordance with 1902(a)(43), 1905(a)(4) and 1905(r)).

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations. (Note: The limits applied elsewhere in the State Plan do not apply to EPSDT eligibles. Services provided to EPSDT eligibles are limited only by medical necessity.)

c. Family planning services and supplies for individuals of child bearing age (provided in accordance with 1905(a)(4)(C), 42 CFR 441.20 and 42 CFR 441 Subpart F) .

Provided: No limitations ☐ With limitations ☐

(**When** the State attests "No limitations" **or** "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
• Identify the codes for **contraception and sterilization** to be covered at 90% FFP. (Develop a code matrix that distinguishes between those codes which are **always** considered family planning services and those which require a family planning diagnosis in theV25 series (ICD-9-CM code) or family planning (FP) modifier. There should be a distinct family planning code matrix for women and one for men) • Also, if the State is covering **infertility** services, describe these services and their codes. (A coding matrix like the one above should be used for infertility services, one for women and one for men.)

5. Physicians' services and medical and surgical services of a dentist (provided in accordance with section 1905(a)(5) of the Social Security Act and 42 CFR 440.50).

a. Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere.

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

b. Medical and surgical services furnished by a dentist.

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

6. Medical care and any other type of remedial care provided by licensed practitioners within their scope of practice (provided in accordance with section 1905(a)(6) of the Social Security Act and 42 CFR 440.60).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
List each type of Other Licensed Practitioner (other than those specified elsewhere in 1905(a) such as, physician, dentist, nurse practitioner, etc.) covered along with any coverage limitations.

7. Home health services (provided in accordance with section 1905(a)(7) of the Social Security Act, 42 CFR 440.70 and 42 CFR 441.15).

a. Home health services are provided to categorically needy recipients age 21 or over.

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

b. Home health services are provided to all categorically needy recipients under age 21.

Provided: No limitations □ With limitations □

Not Provided: □ (The State plan does not provide for skilled nursing facility services for such recipients.)

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

c. Nursing service that is provided on a part-time or intermittent basis by a home health agency or if there is no agency in the area, a registered nurse.

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

d. Home health aide services provided by a home health agency.

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

e. Medical supplies, equipment, and appliances suitable for use in home.

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

f. Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services (also provided in accordance with 42 CFR 440.110).

Provided: No limitations ☐ With limitations ☐

Not Provided: ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

8. Private duty nursing services (provided in accordance with section 1905(a)(8) of the Social Security Act and 42 CFR 440.80).

Provided: No limitations ☐ With limitations ☐

Not Provided: ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
The State must provide a description for each specific service covered. The description will include the following information: For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

9. Clinic services (provided in accordance with section 1905(a)(9) of the Social Security Act and 42 CFR 440.90).

Provided: ☐

Not Provided: ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations.

10. Dental services (provided in accordance with section 1905(a)(10) of the Social Security Act and 42 CFR 440.100).

Provided: ☐

Not Provided: ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations.

11. Physical therapy and related services (provided in accordance with section 1905(a)(11) of the Social Security Act and 42 CFR 440.110).

a. Physical therapy.

Provided: No limitations ☐ With limitations ☐

Not Provided: ☐

(**If** State attests "With Limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
The State must provide a description for each specific service covered. The description will include the following information: For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

b. Occupational therapy.

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
The State must provide a description for each specific service covered. The description will include the following information: For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

c. Services for individuals with speech, hearing, and language disorders.

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
The State must provide a description for each specific service covered. The description will include the following information: For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (provided in accordance with section 1905(a)(12) of the Social Security Act and 42 CFR 440.120).

a. Prescribed drugs.

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a detailed description for each specific service provided. For prescribed drugs, the description may include the following information:

Details regarding coverage limitations such as prior authorization, supplemental rebate agreements, preferred drug lists, coverage of excluded drugs, quantity limits, monthly/annual prescription limits, refill limits, generic drug substitution, and step therapy. States should refer to the additional guidance below regarding requirements for prior authorization and supplemental rebate agreements.

Prior Authorization

A State that uses prior authorization must provide response by telephone or other telecommunication device within 24 hours of a request for prior authorization. The State must also provide for the dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation.

Supplemental Rebate Agreements

A State that enters into a supplemental rebate agreement that differs from the model supplemental rebate agreement must submit the agreement to CMS for authorization in addition to submitting a State plan amendment. The State must also include in the State plan amendment the name of the agreement and the date when the agreement was submitted to CMS.

Multi-State supplemental rebate agreements should include the following:

- Standard multi-state pooling language incorporated into the supplemental rebate agreement portion of the state plan. Specifically, this language should read as follows: "CMS has authorized the State of [insert State name] to enter into the [insert the name of the multi-state pooling agreement]. This Supplemental Drug Rebate Agreement was submitted to CMS on [insert submittal date] and has been authorized by CMS."

- A supplemental rebate agreement template. Consistent with section 1902(a)(19) of the Social Security Act, we expect that the SPA would include a standard template, to ensure uniformity of the pool's supplemental rebate agreements and for ease of administration. The template should be the same

for each participating State and should not include an effective date that is earlier than the first day of the quarter in which the SPA was submitted. In addition, as a template, the model agreement should not contain any manufacturer-specific information.

- A document referenced in the supplemental rebate agreement template that indicates the State's participation in the purchasing pool. This document will serve as the mechanism by which other states will be added to the multi-state pooling agreement and should be filled in with any necessary state-specific information. This document will also serve as a template; therefore, it should be the same for each participating state and should not contain any manufacturer-specific information.

- A document that indicates if a state joining the pool intends to include its non-Medicaid program in the supplemental rebate program that has been approved by CMS, if applicable. States that intend to include non-Medicaid programs must receive approval from CMS prior to joining the pool under the procedures outlined in the letter from Dennis Smith, Director, Center for Medicaid and State Operations, to all State Medicaid Directors (Sept. 18, 2002). In addition, each State should provide specific evidence to demonstrate that its prior authorization requirement furthers Medicaid goals and objectives and is designed to increase the efficiency and economy of the Medicaid program.

Excluded Drugs

A State that chooses to cover excluded drugs must include a list of the therapeutic drug classes that it covers. In the summer of 2005, we provided an optional template that several States used to amend their State plans upon the implementation of the Medicare Part D prescription drug benefit.

b. Dentures.

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Describe any coverage limitations.

c. Prosthetic devices.

Provided: ☐

Not Provided: ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

d. Eyeglasses.

Provided: ☐

Not Provided: ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

13. Other diagnostic, screening, preventive, and rehabilitative services (provided in accordance with section 1905(a)(13) of the Social Security Act and 42 CFR 440.130).

a. Diagnostic services-

Provided: ☐

Not Provided: ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations.

b. Screening services.

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations.

c. Preventive services.

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations

d. Rehabilitative services.

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, should appears for the State to supply information.)

Instructions:
The State must provide a description of each service it plans to provide. Please list and describe the components of each service. Also include a service description for each specific service provided within a model of care or program. The description will include the following information: For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications. Provider qualifications must include the level of education/degree required, and any additional general information related to licensing, credentialing, registration, and relevant supervisory arrangements.

14. **Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases (IMD) that are Medicaid certified facilities (provided in accordance with section 1905(a)(14) of the Social Security Act , 42 CFR 431.620(c)&(d), 42 CFR 440.140, 42 CFR Part 441 Subpart C).**

a. Inpatient hospital services.

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

b. Nursing facility services.

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

15. **Services in an intermediate care facility for persons with mental retardation or a related condition (ICFs/MR) who are in need of such care (provided in accordance with section 1905(a)(15) of the Social Security Act, 42 CFR 440.150, and 42 CFR 435.1010).**

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

16. **Inpatient psychiatric facility services for individuals under 21 years of age (provided in accordance with section 1905(a)(16) of the Social Security Act and 42 CFR 440.160).**

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Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
The State must provide a description for each specific service covered. The description will include the following information: For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

17. **Nurse-midwife services (provided in accordance with section 1905(a)(17) of the Social Security Act and 42 CFR 440.165).**

Provided: No limitations □ With limitations □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe any coverage limitations.

18. **Hospice care (provided in accordance with section 1905(a)(18)(subsection (o)) of the Social Security Act and 42 CFR section 418).**

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

19. Case management services (provided in accordance with section 1905(a)(19) of the Social Security Act).

a. Case management services (provided in accordance with section 1905(a)(19) or 1915(g) of the Social Security Act, 42 CFR 440.169 and 42 CFR 441.18).

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Target Group:

Please describe target group.

For case management services provided to individuals in medical institutions:

□ Target group is comprised of individuals transitioning to a community setting and case-management services will be made available for up to _____ **[*insert a number; not to exceed 180*]** consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

□ Entire State

□ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

□ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

□ Services are not comparable in amount duration and scope.

Definition of services:
Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the

following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Development (and periodic revision) of a specific care plan that:
  - Is based on the information collected through the assessment;
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities:
  - To help an eligible individual obtain needed services including activities that help link an individual with:
    - Medical, social, educational providers; or
    - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:
  - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate; and
    - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Case management may include:

- Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community: Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

<u>Qualifications of providers:</u>

Please specify provider qualifications that are reasonably related to the population being served and the case management services furnished.

Freedom of choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services;
- Individuals will receive comprehensive, case management services, on a one-to-one basis, through one case manager; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community, the State assures that:

- The amount, duration, and scope of the case management activities would be documented in an individual's plan of care which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community; and
- Case management is only provided by and reimbursed to community case management providers.

Case Records:
Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for

reevaluation of the plan.

Payment:
Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case management providers are paid on a unit-of-service basis as specified in case management regulations. A detailed description of the reimbursement methodology, identifying the data used to develop the rate, is included in Attachment 4.19B.

Limitations:
Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- Activities integral to the administration of foster care programs; or
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

Additional limitations:

Please specify any additional limitations.

b. Special tuberculosis (TB) related services (provided in accordance with section 1905(a)(19) and 1902 (z)(2) of the Social Security Act).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations.

20. Respiratory care services (in accordance with section 1905(a)(20) and as defined in section 1902(e)(9) of the Social Security Act and 42 CFR 440.185).

Provided: No limitations □ With limitations □

Not Provided: □

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

21. Certified pediatric nurse practitioner or certified family nurse practitioner services (in accordance with section 1905(a)(21) of the Social Security Act and 42 CFR 440.166).

Provided: No limitations ☐ With limitations ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Describe any coverage limitations.

22. Reserved

23. Reserved

24. Personal care services (in accordance with section 1905(a)(24) of the Social Security Act and 42 CFR 440.167).

Provided: No limitations ☐ With limitations ☐

Not Provided: ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description for each specific service covered. The description will include the following information:

For each of the specific 1905(a) services, the State must identify the providers of the service(s) as well as the provider qualifications.

25. Primary care case management services (in accordance with section 1905(a)(25) of the Social Security Act and 42 CFR 440.168).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations

26. PACE program services (in accordance with section 1905(a)(26) and 1934 of the Social Security Act and 42 CFR Part 460).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** the State is redirected to Enclosures 3, 4, 5, 6, and 7 (page 1 through 5) to supply additional information. Please note that the above referenced "Enclosures" have gone through the PRA process and were approved in November 2007.)

Enclosure 3 Enclosure 4 Enclosure 5 Enclosure 6 Enclosure 7, Page 1 Enclosure 7, Page 2 Enclosure 7, Page 3 Enclosure 7, Page 4 Enclosure 7, Page 5 Enclosure 7, Page 6

27. Sickle Cell Disease services (in accordance with section 1905(a)(27) of the Social Security Act).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170).

a. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service) excluding "school-based" transportation.

☐ Not Provided:

☐ Provided without a broker as an optional medical service:

(**If** state attests "Provided without a broker as an optional medical service" **then** a text box, with header, appears for the State to supply supplement information.)

Instructions:

Describe how the transportation program operates including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

☐ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(**If** the State attests that non-emergency transportation is being provided through a brokerage program **then** a text box, with a header, appears for the State to supply information about the brokerage program.)

Instructions:

☐ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

☐ (1) state-wideness (indicate areas of State that are covered)

☐ (10)(B) comparability (indicate participating beneficiary groups)

☐ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☐ wheelchair van

☐ taxi

☐ stretcher car

☐ bus passes

□ tickets

□ secured transportation

□ other transportation

(**If** State attests "other transportation" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Describe other transportation.

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

□ Low-income families with children (section 1931)

□ Deemed AFCD-related eligibles

□ Poverty-level related pregnant women

□ Poverty-level infants

□ Poverty-level children 1 through 5

□ Poverty-level children 6 – 18

□ Qualified pregnant women AFDC – related

□ Qualified children AFDC – related

□ IV-E foster care and adoption assistance children

□ TMA recipients (due to employment) (section 1925)

□ TMA recipients (due to child support)

□ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy

optional populations:

- Optional poverty-level - related pregnant women
- Optional poverty-level - related infants
- Optional targeted low income children
- Non IV-E children who are under State adoption assistance agreements
- Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
- Individuals who meet income and resource requirements of AFDC or SSI
- Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- Children aged 15-20 who meet AFDC income and resource requirements
- Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- Individuals infected with TB
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits
- Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
- Individuals terminally ill if in a medical institution and will receive hospice Care
- Individuals aged or disabled with income not above 100% FPL
- Individuals receiving only an optional State supplement in a 209(b) State
- Individuals working disabled who buy into Medicaid (BBA working disabled group)
- Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other (e.g., brokerage fee and direct payment to providers)

(**If** the State attests to "other" t**hen** a text box will appear with the instructions to describe

the other payment methodology.)

Instructions:
Describe any other payment methodology.

(B) Who will pay the transportation provider?

- (i) Broker
- (ii) State
- (iii) other

(**If** the State attests to "other" t**hen** a text box will appear with the instructions to describe who other than the state will pay the transportation provider.)

Instructions:
Describe who will pay the transportation provider.

(C) What is the source of the non-Federal share of the transportation payments?

Instructions:

What is the source of the non-Federal share of the transportation payments proposed under this State plan amendment? If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

(7) The broker is a non-governmental entity:

The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) ☐ transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker

(ii) ☐ transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) ☐ the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

(9) ☐ Please describe how the NEMT brokerage program operates.

(**If** State attests it "will describe how the NEMT brokerage program will operate" t**hen** a text box, with header, appears for the state to supply supplement information.)

Instructions:

Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

b. Services furnished in a religious non-medical health care institution.

Provided ☐

Not Provided ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Describe services covered including any limitations.

c. Reserved

d. Nursing facility services for individuals under age 21.

Provided: No limitations ☐ With limitations ☐

Not Provided: ☐

(**If** State attests "With limitations" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Describe any coverage limitations.

e. Emergency hospital services.

Provided: ☐

Not Provided: ☐

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Describe services covered including any limitations.

f. Reserved

g. Critical access hospital (CAH)

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe services covered including any limitations.

29. Enhanced services for pregnant women (provided in accordance with 1902(a)(10)(end)(V) and 42 CFR 440.250(p)).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:
Describe additional pregnancy related services.

30. State Plan Home and Community Based Services Benefit (in accordance with section 1915(i) of the Social Security Act and 42 CFR Part 441 Subpart K).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** the State is redirected to 1915(i) preprint pages to supply additional information. Please note that the following referenced "1915(i) preprint pages" are currently going through the PRA process.)

1915(i) preprint OMB Approval pending

31. Self-Directed Personal Assistance Services (in accordance with section 1915(j) of the Social Security Act and 42 CFR Part 441).

Provided: □

Not Provided: □

(**If** State attests "Provided" **then** the State is redirected to 1915(j) preprint pages to supply additional information. Please note that the following referenced "1915(j) preprint pages" have gone through the PRA process and were approved in June 2007.)

1915(j) preprint
OMB Approved 0938-1024
Version: June 2007

32. Limited Coverage for Certain Aliens (provided in accordance with section 1903(v) of the Social Security Act, sections 401-403 of PRWORA, 42 CFR 435.139, 435.406(a)(2)(ii), 435.406(b), and 440.255(b)(1)&(c)).

Illegal or otherwise ineligible aliens, who meet the eligibility conditions under this plan except the alien eligibility requirements, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including labor and delivery) as defined in section 1903(v)(3)of the Act.

33. Limited Coverage for Poverty Level Pregnant Women (provided in accordance with 1902(a)(10)(G)(VII) of the Social Security Act).

Coverage for pregnant or postpartum women who are eligible as categorically needy under 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(ii)(IX), 1902(e)(5) or 1902(e)(6) of the Social Security Act is limited to services related to pregnancy (including prenatal, labor and delivery, postpartum and family planning services) and to other conditions which may complicate pregnancy.

B. Medically Needy

The following identifies the medical and remedial service covered for medically needy groups, specifies all limitations on the amount, durations and scope of those services.

- ☐ **Medically Needy not covered.**
- ☐ **The same amount, duration and scope of services covered for the Medically Needy as the Categorically Needy.**
- ☐ **The amount, duration and scope of services covered for the Medically Needy are different than the services covered for the Categorically Needy.***

(**If** the State attests "The amount, duration and scope of services covered for the Medically Needy are different than the services covered for the Categorically Needy" **then** a text box, with header, appears for the State to supply information.)

Instructions:

The State must provide a description of the service(s) it plans to cover for the Medically Needy. The description will include the specific differences in service(s) between the Categorically Needy group(s), as identified in 3.1(A)(1-32), and the Medically Needy group(s).

C. <u>Benchmark Benefit Package and Benchmark Equivalent Benefit Package</u> (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State elects to provide alternative benefits:

Provided: ☐

Not Provided: ☐

(**If** the State attests "Provided", **then** the State is redirected to a Pre-print to supply additional information. Please note that the above referenced "Pre-print" has gone through the PRA process and was approved in October 2006.)

Pre-print **OMB-0938-0993**

D. Methods of Providing Transportation as an Administrative Activity in accordance with 1902(a)(4)(A) of the Act and 42 CFR 431.53 (excluding "school based" transportation).

Provided: ☐

Not Provided: ☐

(**If** the State attests that transportation is provided as an administrative activity, **then** a text box with header appears for the State to supply supplemental information.)

Instructions:
Describe how the transportation program operates including the types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Note: transportation provided as an administrative expense should be reported on the CMS-64.10 and/or CMS-64.10P. Additionally, the information should be separately broken out and identified on the CMS-64Narr (narrative page).

E. <u>Standards for the coverage of organ transplant services.</u>

Section 1903(i)(1) requires written standards in the State plan for coverage of organ transplants. Such standards must provide that individuals with the same/similar medical conditions and risk factors are treated alike and that any restriction/s on the facilities or practitioners providing organ transplantation procedures are consistent with the accessibility of high quality care to those individuals eligible for the procedures under the State plan. (Organ transplants for children under the age of 21 must be covered if determined to be medically necessary.)

Provided: □

Not Provided: □

(**If** the State attests that organ transplant services are provided, **then** a text box with header appears for the State to supply supplement information.)

Instructions:

Describe the standards for the coverage of transplant services.

F. <u>Provisions Relating to Managed Care</u> (provided in accordance with 1932 of the Social Security Act and 42 CFR 438.50).

Provided: ☐

Not Provided: ☐

(**If** the State attests "Provided", **then** the State is redirected to a Pre-print to supply additional information. Please note that the above referenced "Pre-print" has gone through the PRA process and was approved in August 2008.)

Pre-print
OMB-0938-0933

G. <u>Families Receiving Transitional Medical Assistance (TMA) Benefits</u> (provided in accordance with 1902(a)(52) and 1925 of the Act and 42 CFR 435.112)

1. Services provided to families during the first 6-month period of extended Medicaid benefits under section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy recipients eligible under section 1931, as described in Section 3.1(A); or may be greater if provided through a health insurance plan of the caretaker relative's employer.

2. Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy recipients eligible under section 1931, as described in Section 3.1(A); or may be greater if provided through a health insurance plan of the caretaker relative's employer.

- ☐ Provided
- ☐ Provided; minus one or more of the following non-acute care services:
  - ☐ Other diagnostic, screening, preventive, and rehabilitative services.
  - ☐ Inpatient hospital services and nursing facility services for individuals 65 years old or older in an institution for mental diseases.
  - ☐ Intermediate care facility services for individuals with mental retardation or a related condition.
  - ☐ Inpatient psychiatric hospital services for individuals under age 21.
  - ☐ Hospice care.
  - ☐ Respiratory care services.
  - ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

3. Payments for premiums, deductibles and coinsurance.

☐ The agency provides wrap-around coverage by paying the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health insurance or other health coverage offered by the caretaker relative's or absent parent's employer as payments for medical assistance.

- ☐ Provided the first 6-month period.
- ☐ Provided the second 6-month period.

☐ The agency requires caretaker relatives to enroll in employers' health plans as a condition of the extended eligibility, but only if the caretaker relative is not required to make financial contributions for such coverage and the State provides for the payments of any costs that the employee is otherwise required to pay.

☐ Provided the first 6-month period.

☐ Provided the second 6-month period.

4. Alternative assistance during the second 6-month period of extended Medicaid benefits.

☐ Provided; through enrollment of the caretaker relative and dependent children under one or more of the following:

☐ Enrollment in family option of an employer's health plan.
☐ Enrollment in family option of a State employee health plan.
☐ Enrollment in State health plan for the uninsured.
☐ Enrollment in Medicaid managed care organization (as defined in section 1903(m)(1)(A) of the Act and the applicable requirements of section 1932).

☐ Not Provided

(**If** State attests "Provided" **then** a text box, with header, appears for the State to supply information.)

Instructions:

1. By providing alternative assistance during the second 6-month period of extended Medicaid benefits the State shall pays all premiums and enrollment fees imposed on the family for such plan(s). The State also:

   ☐ Pays all deductibles and coinsurance imposed on the family for such plan(s).
   ☐ Imposes a premium for a family for the 2nd six months in the extension period in accordance with §1925(b)(5) of the Act, if the family's gross monthly earnings (less the average monthly costs for child care necessary for the caretaker relative's employment) for the premium base period exceed 100 percent of the official Federal poverty level for the family size involved, as revised annually in the Federal Register.

2. Describe the alternative health care plans(s) offered, including requirements for assuring that recipients have access of adequate quality.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: _____

SECTION 3 – SERVICES: GENERAL PROVISIONS; continued

H. <u>Health Opportunity Accounts Demonstration Program</u> (provided in accordance with 1938 of the Act).

The State Participates: ☐

The State Does Not Participate: ☐

(**If** the State attests that "Participates", **then** the State is redirected to a Pre-print to supply additional information. Please note that the above referenced "Pre-print" has gone through the PRA process and was approved in August 2007.)

Pre-print **OMB-0938-1007**

I. <u>Standards and Methods to Assure High Quality</u> Care (provided in accordance with 1902(a)(30)(A) of the Social Security Act and 42 CFR 440.260)

Standards and quality of care are assured by the medical community. All hospitals and skilled nursing facilities have utilization review processes. All medical and dental procedures must be provided by duly licensed and qualified practitioners.

3.2 Coordination of Medicaid with Medicare and Other Insurance

Medicaid is provided in accordance with requirements of sections 1843, 1902(a), 1902(n), 1902(u), 1905(a), 1905(p), 1905(s), 1906, 1916, 1933 of the Act; and 42 CFR 431.625.

A. States

The following items, numbered 1 though 3, identify the coordination of Medicaid with Medicare and other insurance provided by States and specifies all limitations on the amount, duration and scope of those services.

1. Medicare Part A and/or Part B Premiums

a. The Medicaid Agency has a Buy-in agreement under section 1843 of the Act for:

☐ Part A Premiums

☐ Part B Premiums

b. The Medicaid agency pays Medicare premiums for the following individuals:

i. Qualified Medicare Beneficiary (QMB) (provided in accordance with sections 1902(a)(10)(E)(i) and 1905(p)(1) of the Act).

The Medicaid agency pays Part A and Part B premiums under the State Buy-in process for individuals in the QMB group, as defined in ATTACHMENT 2.2-A, item 24 of this plan.

ii. Qualified Disabled Working Individual (QDWI) (provided in accordance with sections 1902(a)(10)(E)(ii) and 1905(s) of the Act).

The Medicaid agency pays Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group, as defined in ATTACHMENT 2.2-A, item 25 of this plan.

iii. Specified Low-Income Medicare Beneficiary (SLMB) (provided in accordance with sections 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act).

The Medicaid agency pays Medicare Part B premiums under the State Buy-in process for individuals in the SLMB group, as defined in ATTACHMENT 2.2-A, item 26 of this plan.

iv. Qualified Individuals (QI) (provided in accordance with sections 1902(a)(10)(E)(iv) and 1933 of the Act).

The Medicaid agency pays Medicare Part B premiums under the State Buy-in process for individuals in the QI group as defined in ATTACHMENT 2.2-A, item 27 of this plan, subject to the limitations set forth in section 1933 of the Social Security Act.

v. Other Medicaid Recipients (provided in accordance with sections 1843(b) and 1905(a) of the Act and 42 CFR 431.625).

☐ Medicaid agency pays Medicare Part B premiums, for which FFP is available, for certain individuals.

(**If** State attests "Medicaid agency pays Medicare Part B premiums for which FFP is available" **then** a text box, with header, appears for the State to supply information.)

Instructions:

In accordance with 42 CFR 407.42(b) the Medicaid agency pays Medicare Part B premiums, for which FFP is available to all individuals in Buy-in group _____.

☐ Medicaid agency pays Medicare Part B premiums, for which FFP is not available, for certain individuals

(**If** State attests "Medicaid agency pays Medicare Part B premiums for which FFP is not available" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Medicaid agency pays Medicare Part B premiums, for which FFP is not available, for the following individuals (specify):

2. Medicare Deductibles and Coinsurance

a. Medicare Part A & B (provided in accordance with 1902(a)(30), 1902(n) and 1916 of the Act).

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

b. Qualified Medicare Beneficiary (QMB) (provided in accordance with 1902(a)(10)(E)(i) and 1905(p)(3) of the Act).

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid co-payment) for all services

available under Medicare, including Part A and B services received through a plan operating under Medicare Part C.

c. Other Medicaid Recipients- Non-QMB Dual Eligibles (provided in accordance with 1902(a), 1902(a)(30) and 1905(a) of the Act and 42 CFR 431.625).

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid co-payment). For services furnished to individuals who are not QMB, but who are eligible for both Medicaid and Medicare, payment is made as follows:

- For the entire range of services available under Medicare Part B.
- Only for the amount, duration and scope of services otherwise available under this plan.

d. Qualified Medicare Beneficiary Plus Medicaid (QMB Plus) Eligibles (provided in accordance with 1902(a)(10), 1902(a)(30), 1905(a) and 1905(p) of the Act).

The Medicaid agency pays Medicare Part A and Part B 1905(a) deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible as both QMB and categorically or medically needy (subject to any nominal Medicaid co-payment).

3. Other Health Insurance

- **The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to an eligible individual (except individuals 65 years of age or older and disabled individuals who are entitled to Medicare Part A but who are not enrolled in Medicare Part B) (provided in accordance with 1902(a)(30) and 1905(a) of the Act).**

- **COBRA Continuation (provided in accordance with 1902(a)(10)(f) and 1902(u) of the Act).**

  The Medicaid agency pays premiums for individuals, as described in ATTACHMENT 2.2-A, item 20.

- **Health Insurance Premium Payment Program (HIPP) (in accordance with 1906 of the Act).**

  When cost effective, the Medicaid agency elects to pay premiums for enrollment of eligible individuals in employer based group health plans. The Medicaid agency pays all deductibles, coinsurance and other cost sharing obligations for items and services covered under both the group health plan and the state plan (subject to any nominal Medicaid co-payment). Eligible individuals are entitled to all services under the state plan that are not covered by the group health plan.

a. The Medicaid agency uses the following guidelines to determine the cost effectiveness of an employer-based group health plan:

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

☐ The State's method for determining cost effectiveness.

(**If** State attests "The State's method" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Please describe the State's method for determining cost effectiveness.

b. When eligible family members may not enroll in a cost-effective group health insurance plan unless ineligible family members are also enrolled, the Medicaid agency pays premiums for the ineligible family members, if cost effective. Ineligible family members so enrolled are not entitled to payment of any deductibles, coinsurance or other cost sharing obligations, nor are they entitled to any other services under the state plan.

3.2 Coordination of Medicaid with Medicare and Other Insurance

Medicaid is provided in accordance with requirements of sections 1843, 1902(a), 1902(n), 1902(u), 1905(a), 1905(p), 1905(s), 1906, 1916, 1933 of the Act; and 42 CFR 431.625.

B. Territories

The following items, numbered 1 though 3, identify the coordination of Medicaid with Medicare and other insurance provided by Territories and specifies all limitations on the amount, duration and scope of those services.

1. Medicare Part A and/or Part B Premiums

a. The Medicaid Agency has a Buy-in agreement under section 1843 of the Act for:

☐ Part A Premiums

☐ Part B Premiums

b. The Medicaid agency pays Medicare premiums for the following individuals:

☐ **Qualified Medicare Beneficiary (QMB) (provided in accordance with sections 1902(a)(10)(E)(i) and 1905(p)(1) & (4) of the Act).**

The Medicaid agency pays Part A and Part B premiums under the State Buy-in process for individuals in the QMB group, as defined in ATTACHMENT 2.2-A, item (D)(1) of this plan.

☐ **Qualified Disabled Working Individual (QDWI) (provided in accordance with sections 1902(a)(10)(E)(ii) and 1905(s) of the Act).**

The Medicaid agency pays Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group, as defined in ATTACHMENT 2.2-A, item (D)(2) of this plan.

☐ **Specified Low-Income Medicare Beneficiary (SLMB) (provided in accordance with sections 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act).**

The Medicaid agency pays Medicare Part B premiums under the State Buy-in process for individuals in the SLMB group, as defined in ATTACHMENT 2.2-A, item (D)(3) of this plan.

☐ **Qualified Individuals (QI) (provided in accordance with sections 1902(a)(10)(E)(iv) and 1933 of the Act).**

The Medicaid agency pays Medicare Part B premiums under the State Buy-in process for individuals in the QI group, as defined in ATTACHMENT 2.2-A, item 27 of this plan and subject to the limitations set forth in section 1933 of the Social Security Act.

☐ **Other Medicaid Recipients (provided in accordance with sections 1843(b) and 1905(a) of the Act and 42 CFR 431.625).**

☐ Medicaid agency pays Medicare Part B premiums, for which FFP is available, for certain individuals.

(**If** State attests "Medicaid agency pays Medicare Part B premiums for which FFP is available" **then** a text box, with header, appears for the State to supply information.)

Instructions:

In accordance with 42 CFR 407.43(b) the Medicaid agency pays Medicare Part B premiums, for which FFP is available to all individuals in Buy-in group _____.

☐ Medicaid agency pays Medicare Part B premiums, for which FFP is not available, for certain individuals

(**If** State attests "Medicaid agency pays Medicare Part B premiums for which FFP is not available" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Medicaid agency pays Medicare Part B premiums, for which FFP is not available, for the following individuals (specify):

2. Medicare Deductibles and Coinsurance

a. Medicare Part A & B (provided in accordance with 1902(a)(30), 1902(n) and 1916 of the Act).

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

b. Qualified Medicare Beneficiary (QMB) (provided in accordance with 1902(a)(10)(E)(i) and 1905(p)(3) of the Act).

☐ The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid co-payment) for all services

available under Medicare, including Part A and B services received through a plan operating under Medicare Part C.

c. Other Medicaid Recipients- Non-QMB Dual Eligibles (provided in accordance with 1902(a), 1902(a)(30) and 1905(a) of the Act and 42 CFR 431.625).

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid co-payment). For services furnished to individuals who are not QMB, but who are eligible for both Medicaid and Medicare, payment is made as follows:

- For the entire range of services available under Medicare Part B.
- Only for the amount, duration and scope of services otherwise available under this plan.

d. Qualified Medicare Beneficiary Plus Medicaid (QMB Plus) Eligibles (provided in accordance with 1902(a)(10), 1902(a)(30), 1905(a) and 1905(p) of the Act).

- The Medicaid agency pays Medicare Part A and Part B 1905(a) deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible as both QMB and categorically or medically needy (subject to any nominal Medicaid co-payment).

3. Other Health Insurance

- **The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to an eligible individual (except individuals 65 years of age or older and disabled individuals who are entitled to Medicare Part A but who are not enrolled in Medicare Part B) (provided in accordance with 1902(a)(30) and 1905(a) of the Act).**

- **COBRA Continuation (provided in accordance with 1902(a)(10)(f) and 1902(u) of the Act).**

  The Medicaid agency pays premiums for individuals, as described in ATTACHMENT 2.2-A, item (B)(16).

- **Health Insurance Premium Payment Program (HIPP) (in accordance with 1906 of the Act).**

  When cost effective, the Medicaid agency elects to pay premiums for enrollment of eligible individuals in employer based group health plans. The Medicaid agency pays all deductibles, coinsurance and other cost sharing obligations for items and services covered under both the group health plan and the state plan (subject to any nominal Medicaid co-payment). Eligible individuals are entitled to all services under the state plan that are not covered by the group health plan.

a. The Medicaid agency uses the following guidelines to determine the cost effectiveness of an employer-based group health plan:

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

☐ The State's method for determining cost effectiveness.

(**If** State attests "The State's method" **then** a text box, with header, appears for the State to supply information.)

Instructions:

Please describe the State's method for determining cost effectiveness.

b. When eligible family members may not enroll in a cost-effective group health insurance plan unless ineligible family members are also enrolled, the Medicaid agency pays premiums for the ineligible family members, if cost effective. Ineligible family members so enrolled are not entitled to payment of any deductibles, coinsurance or other cost sharing obligations, nor are they entitled to any other services under the state plan.

3.3 Integrated Medicare and Medicaid Services

A. State Plan for Integrated Care Programs

1. The Integrated Care Preprint is an optional tool for use by States to highlight the arrangements provided between a State and Medicare Advantage (MA) organizations offering MA Special Needs Plans (SNP) that also contract with the State to provide Medicaid services to dual eligible individuals enrolled in the SNP. The Preprint also provides the opportunity for States to confirm that their integrated care model complies with both federal statutory and regulatory requirements.

   The State opts to use the tool: ☐

(**If** State attests "opts to use the tool" **then** the State is redirected to "Integrated Medicare and Medicaid State Plan Preprint Instructions" and "State Plan Preprint for Integrated Care Programs" preprint pages to supply additional information. Please note that the following referenced instructions and preprint pages are currently going through the PRA process.)

Integrated Medicare and Medicaid State Plan Preprint Instructions
State Plan Preprint for Integrated Care Programs
OMB Approval pending