CENTERS FOR MEDICARE & MEDICAID SERVICES

Supporting Statement – Part A
Medicaid Program Budget Report
Form CMS-37 (OMB 0938-0101)

A. Background

The Medicaid Program Budget Report, Form CMS-37 is prepared and submitted to the Centers for Medicare & Medicaid Services (CMS) by State Medicaid agencies. Form CMS-37 is the primary document used by CMS in developing the national Medicaid budget estimates that are submitted to the Office of Management and Budget and the Congress.

The Form CMS-37 fulfills two of CMS' most essential data needs for formulating and executing the national Medicaid budget as well as forecasting the potential impact of proposed legislation and other changes on the Medicaid program.

- It provides a statement of each State's funding requirements for the upcoming quarter and certifies the availability of the requisite State and local funds. This information is required for the issuance of the quarterly grant awards to the States.

- Its schedules provide the States' budget estimates for two fiscal years and the explanations for changes in their estimates. This information is needed by CMS to formulate and execute the national Medicaid budget as well as to forecast the potential impact of proposed legislation and other changes on the Medicaid program.

Details of each supporting CMS-37 form are outlined in the ADDENDUM.

B. Justification

1. Need and Legal Basis - - The Form CMS-37 is approved under OMB control number 0938-0101.

   Section 1903 (d) (1) of the Social Security Act provides the need and legal basis for the collection of Medicaid budget and expenditure information from States:

   "Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary. The MBES/CBES system added a

calculation to account for a temporary increase in the federal medical assistance percentage (FMAP) enacted under Section 5001 of the Affordable Care Act (ACA) of 2009. In addition, Sections 2301, 2501, 2703, and 4107 enacted under the ACA, established a Freestanding Birth Center Category of Service (COS), Prescription Drug Rebate COS, Health Homes for Enrollees with Chronic Conditions, and a Tobacco Cessation for Pregnant Women COS respectively. To account for this legislation, CMS expanded the MBES/CBES through the addition of new COS Line items.

2. Information Users - - CMS requires that each State Medicaid agency quarterly submit the Form CMS-37 via the web-based Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). Due dates are November 15, February 15, May 15 and August 15 of each fiscal year. The ADDENDUM provides a description of forms contained in this package.

   All submissions represent equally important components of the grant award cycle, but the May and November submissions are particularly significant for budget formulation. The November submission introduces a new fiscal year to the budget cycle and serves as the basis for the formulation of the Medicaid portion of the President's Budget, which is presented to Congress in January. The February and August submissions are used primarily for budget execution in providing interim updates to CMS' Office of Financial Management, the Department of Health and Human Services, the Office of Management and Budget and/or Congress depending on the scheduling of the national budget review process in a given fiscal year.

   These submissions provide CMS with base information necessary to track current year obligations and expenditures in relation to the current year appropriation and to notify senior managers of any impending surpluses or deficits.

3. Use of Information Technology - - Since May 2000, all Medicaid State agencies submit their Form CMS-37 over the web-based MBES/CBES which has been instrumental in easing input problems relating to dropped phone lines and slow response time and has provided the States and CMS with a much more user friendly input and output reporting system. A completed signature form is transmitted as part of the Form CMS-37. CMS accepts this signature form in lieu of a separate hard copy submission. However, the State must keep actual signed copies in their files that can be made available to CMS upon request. Over the years CMS has implemented several operating systems, web server and hardware upgrades to enhance the system. Beginning with the first quarter of the FY 2010 budget reporting cycle, the MBES/CBES system was upgraded and redesigned, and we received favorable responses from both the State and CMS personnel. During the planning phase of the MBES/CBES redesign, CMS saw the need to reorganize and create a System’s team to assist with the development, migration and maintenance of the MBES/CBES system. The system’s team consults with the contractor regularly to ensure that the MBES/CBES is functioning according to its business rules, and to provide guidance to the State and CMS personnel should they have questions. Should a glitch be discovered, the team coordinates with the contractor to resolve the matter in a timely manner. As a result of this process, the MBES/CBES

system continually evolves to meet the needs of MBES/CBES users and stay true to the MBES/CBES system's purpose.

The redesigned MBES has many advantages over the old system. For instance, the MBES system's user-interface is more intuitive than the previous version. The new System's layout utilizes state of the art technology providing a screen or form that has the appearance and functionality of other Web-Based systems frequently used by the public in everyday situations (e.g., banking, renewing driver's license etc.). The System is more user-friendly permitting users to change their own email, reset their password and customize the screen's color and contrast. In addition, the Header columns are now fixed which assists in streamlining a particular task by reducing the time that a user had to scroll up and down to view the headers. As a result of additional COS Line items and enhanced graphics, the loading time has increased for many of the larger forms. To continually enhance the system's performance, a "quick entry" solution was implemented for the largest forms, and it is CMS' intent to apply this function more frequently to the larger forms.

Prior to the redesign, many COS Lines were claimed on the Line titled "Other Financial Participation". This Line was used when a particular expenditure did not have a corresponding COS Line item. When used, States are required to complete a narrative that describes and accounts for the amounts budgeted. The MBES/CBES redesign, however, added more service-specific COS Line items (e.g., Inpatient Hospital Supplemental Payments, Outpatient hospital supplemental payments etc.) reducing the need for this Line. The additional COS Lines assists the States as well as CMS by simplifying the identification, reporting and analysis of these budgeted figures. Moreover, the new platform has significantly less down time which helps to optimize the overall performance of the MBES/CBES system.

Although there are new COS Lines items, they do not result in an increase in burden as this information was reported on the "Other Financial Participation" Line item and/or 37.3I and 37.10I Informational Forms (I-Forms). In addition, the Line items added in accordance with ACA do not result in an increase in burden because the updated MBES/CBES system's intuitive, efficient nature, and reduced down time offsets any increase in time to input this data.

4. Duplication of Efforts - - There is no duplication associated with this request. Although the Form CMS-64 collects and reports similar data, it reports actual expenditures while the Form CMS-37 reflects projections of expenditures.

5. Small Businesses - - This request does not affect small businesses.

6. Less Frequent Collection - - CMS utilizes this information to produce quarterly grant awards to the Medicaid State agencies and to provide periodic budget updates. Less frequent collection could result in possible delays in ensuring appropriate grant funds are in State accounts when needed.

7. Special Circumstances - - This request conforms to the guidelines in 5 CFR 1320.6.

8. Federal Register Notice/Outside Consultations - - A 60-day Federal Register notice published on December 10, 2010 (75 FR 76988). No comments were received.

9. Payments/Gifts to Respondents - - There were no payments/gifts to respondents.

10. Confidentiality - - There are no confidentiality requirements associated with this report.

11. Sensitive Questions - - There are no questions of a sensitive nature associated with this report.

12. Burden Estimate (Total Hours & Wages) - - Respondents are 56 State or territorial Medicaid agencies. Each respondent will make four quarterly submissions to CMS with an estimated average staff hour requirement of 34 hours per submission and an average cost per submission of $38*/hour. The Federal government shares in 50% of the State cost. Since reports are submitted electronically, there are negligible printing and distribution costs to the respondent. Therefore, the total annual respondents cost is as follows:

Respondent Hours

Number of Submissions	224 (56/qtr x 4 qtrs)
Preparation Hours per Submission	x 34
Total Annual Preparation Hours	**7,616 hr**

Respondent Cost

Total Annual Preparation Hours	7,616 hr
Average Staff Costs per Hour	x $38.00
Total Respondents Cost (Rounded)	$289,408
Less 50% Federal Match	- 144,704
Respondents Share of Cost	**$144,704**

* Bureau of Labor Statistics - State and Local Government Workers Total Hourly Compensation (12/2007) – rounded to the nearest dollar.

13. Capital Costs - - There are no capital costs.

14. Cost to Federal Government - - The annual $1,006,256 cost to the Federal government includes Federal analytical and travel costs, and the Federal share of the total respondent cost as follows.

a. Federal analytical costs of $816,873 for the Form CMS-37 are based primarily on CMS regional office review costs in the FY 2010 workplans. Federal

clerical, printing and distribution costs are negligible since the form is submitted electronically.

b. Additional Federal travel costs to perform on-site reviews are approximately $44,679 based on the FY 2010 workplans.

c. The Federal share of the total respondent cost is $144,704 (see B.12 above).

15. Changes to Burden – There are no burden changes. However, the MBES/CBES System was redesigned and updgraded. New Lines items were added in pursuant to ACA, and to better to assist to input, identify and analyze data input into the MBES/CBES system.

16. Publication/Tabulation Dates - - There are no publication or tabulation dates.

17. Expiration Date - - CMS would like to display the expiration date.

18. Certification Statement - - There are no exceptions to the certification statement.

C. Collection of Information Employing Statistical Methods

This section does not apply because statistical methods were not used in developing this collection.

ADDENDUM
Description of Form CMS-37
Medicaid Program Budget Report

Beginning with FFY 2010, the following describes the component schedules and features of the CMS-37 series of forms:

A. **Form CMS-37.1, Medicaid Program Budget Report, State Estimate of Quarterly Grant Awards** - - This form summarizes and provides a quarterly breakout of the State's estimates of medical assistance payments and State and local administration detailed on Forms CMS-37.3 and CMS-37.10, respectively. It also provides the State's certification as to the availability of the requisite State and local funds and contains the address to CMS.

B. **Form CMS-37.3, Medicaid Program Budget Report, Estimated Medical Assistance by Type of Service** - - This form contains States' estimates of total budgeted services by medical assistance service category for the current and budget years.

C. **Form CMS-37.7, Medicaid Program Budget Report, Estimated Average Number of Eligibles During the Year** - - This form is for States to report the average number and changes in eligible individuals under selected eligibility categories.

D. **Form CMS-37.9, Medicaid Program Budget Report, State and Local Administration (Summary)** - - Form CMS-37.9 provides a summary of State estimates for Medicaid State and local administration. ***This is a system-generated form*** from State entries on Form CMS-37.10.

E. **Form CMS-37.10, Medicaid Program Budget Report, State and Local Administration** - - This form provides State estimates of Medicaid State and local administration. Reporting of estimates of administrative expenditures in columns is broken out under the two categories of salaries and expenses and other administration. Full-Time-Equivalents are also reported.

F. **Form CMS-37.12, Medicaid Program Budget Report Other Budget Narratives** - - Other Narrative Explanations.

G. **Form CMS-37.3I, Medicaid Program Budget Report, Information-Estimated Medical Assistance by Type of Service** - - This form is designed to capture the medical assistance estimates of special program issues that are of heightened interest to the Federal Medicaid budget process. Each quarterly budget submission, the States must address these information forms for amounts included in their base Form CMS-37.3 for the particular issue(s) selected by CMS. The U.S. commonwealths and territories are excluded. Since these are information only forms, the MBES/CBES does not add the amounts on the information forms to the Form CMS-37.3; rather, the estimates reported by States on the information form(s) provide further detail for estimates already included on the Form CMS-37.3.

H. **Form CMS-37.10I, Medicaid Program Budget Report, Information-State and Local Administration** - - This form is designed to capture the Medicaid State and local administration estimates of special program issues that are of heightened interest to the Federal Medicaid budget process. Each quarterly budget submission, the States must address these information forms for amounts included in their base Form CMS-37.10 for the particular issue(s) selected by CMS. The U.S. commonwealths and territories are excluded. Since these are information only forms, the MBES/CBES does not add the amounts on the information forms to the Form CMS-37.10; rather, the estimates reported by States on the information form(s) provide further detail for estimates already included on the Form CMS-37.10.

I. **Form CMS-37.1V, Medicaid Program Budget Report, Variance in Certification Quarter Estimate From Recent Expenditures, Medical Assistance, Medicaid CHIP Expansions State and Local Administration** - - ***This is a system-generated form designed to assist the States in comparing their quarterly certification request with recent expenditures.*** The MBES/CBES generates a comparison of the bottom line total computable estimate for the certification quarter reported on the Form CMS-37.1 with the reported Form CMS-64 expenditure for (1) the most recently available expenditure quarter and (2) the same quarter of the previous FY for medical assistance, M-CHIP, and administration. States should be prepared to explain variances in their certification estimate to CMS. The States may also provide brief explanations on the Form CMS 37.12.

J. **Medicaid Program Budget Report, Form CMS-37.4, Medical Assistance Payments, Explanations of Changes Between Submissions, Fiscal Years and Base Year** - - This form asks the States to briefly explain changes in their bottom-line total computable MAP estimates between quarterly submissions for reported FYs and between the base year and the reported FYs when certain thresholds are met for each submission. After completion of the Form CMS-37.3, all States must browse the category-specific variance analysis Form CMS-37.4V, Variances Between Submissions and Fiscal Years and Base Year (See G. below.). The data on this report is system generated based on the information the State has supplied on the Form CMS-64 (for the base year) and from the Form CMS-37.3 for the current and budget years. This variance form is beneficial to both the State and the CMS regional offices in tracking changes to State estimates. Before being allowed to certify the Form CMS-37 package, States must complete the Form CMS-37.4 if their overall MAP estimate changes exceed certain thresholds.

K. **Medicaid Program Budget Report, Form CMS-37.4M, Medicaid CHIP Expansion Program Benefits, Explanations of Changes Between Submissions, Fiscal Years and Base Year** - - This form asks the States to briefly explain changes in their bottom-line Medicaid State Children's Health Insurance Program (M-CHIP) benefit estimates between quarterly submissions for reported FYs and between the base year and the reported FYs when certain thresholds are met for only the May and November submissions.

L. **Medicaid Program Budget Report, Form CMS-37.4V, Medical Assistance Payments, Category-Specific Variances in Estimates Between Submissions, Fiscal Years and Base Year** - - ***This is a system-generated form designed to assist the States in completing their***

explanations of changes in estimates for the Form CMS-37.4. This form is a category-specific variance analysis that compares MAP estimates provided by the State on Form CMS-37.3 with the prior quarterly submission, between FYs and the Base Year.

M. **Form CMS-37.11, State and Local Administration Payments, Explanation of Changes Between Submissions, Fiscal Years, and the Base Year** - The Form CMS-37.11 requires States to provide narrative explanations of changes between submissions, fiscal years and the base year for Medicaid State and local administration.

N. **Form CMS-37.11V, Medicaid Program Budget Report, State and Local Administration, Category-Specific Changes in Estimates Between Submissions, Fiscal Years and Base Year** - - ***This is a system-generated form designed to assist the States in completing their explanation of changes in ADM estimates for the Form CMS-37.11***. The form is a category-specific variance analysis that compares ADM estimates provided by the State on Form CMS-37.10 with the prior quarterly submission, between FYs and the Base Year. _ _

O. **Form CMS-37.12, Medicaid Program Budget Report, Other Budget Narratives** - - This form is for States to report any other budget narratives or additional explanations of entries on other schedules.

Prior to the implementation of the updated MBES/CBES system, many payments without a defined category of service (COS) Line item were noted on an informational form I-Form (e.g., inpatient supplemental payments, physician supplemental, and outpatient supplemental payments), and then claimed on the COS Line titled "Other Care Services". The redesign provided the MBES/CBES with the capacity to expand, and more efficiently respond to State and/or Federal changes in the program. The following COS Line items were added to the 37.3 and 37.3I series of Medicaid budget expenditure forms:

- Line 1C Inpatient Hospital Services – Supplemental Payments, These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.
- Line 1D Inpatient Hospital Services – Graduate Medical Education Payments, GME payments include supplemental payments for direct medical education (DME) (i.e. costs of training physicians such as resident and teaching physician salaries/benefits, overhead and other costs directly related to the program) and indirect medical education (IME) costs hospitals incur for operating teaching programs. Report all supplemental payments for DME and IME that are provided for in the State plan.
- Line 3B Nursing Facility Services – Supplemental Payments, These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to

specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.

- Line 4C Intermediate Care Facility Services-Mentally Retarded Supplemental Payments, These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.
- Line 5B Physician and Surgical Services – Supplemental Payments, These are payments for physician and other practitioner services that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit.
- Line 6B Outpatient Hospital Services – Supplemental Payments, These are payments for outpatient hospital services as defined in line 6A that are made in addition to the base fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. The combined standard payment and supplemental payment cannot exceed the Federal upper payment limit.
- Line 7A3 MCO – National Agreement –FMAP Rate, Managed Care Organizations (MCO) – National Agreement: The Affordable Care Act requires manufacturers that participate in the Medicaid Drug Rebate Program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs, effective March 23, 2010. This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients who are enrolled in a Medicaid MCO. Rebates are to take place quarterly.
- Line 7A4 MCO – State Sidebar Agreement – FMAP Rate,
- Line 7A5 Increased ACA OFFSETT – Fee for Service – 100%, Fee for Service - 100% Section 2501 of the Affordable Care Act increased the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs) and noninnovator multiple source drugs (generic drugs), and drugs that are line extensions of a single source drug or an innovator multiple source drug, effective January 1, 2010. The Affordable Care Act also required that amounts “attributable” to these increased rebates be remitted to the Federal Government.
- Line 7A6 MCO – Increased ACA OFFSETT-MCO – 100% Increased ACA OFFSET – MCO: Similar to the increased ACA offset for fee-for-service, for covered outpatient drugs that are dispensed to Medicaid MCO enrollees, the Affordable Care Act also required that amounts “attributable” to the increased rebates be remitted to

the Federal Government.

- Line 9B Other Practitioner Services – Supplemental Payments, These are payments for other practitioner services as defined in Line 9A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit.
- Line 19B Home and Community-Based Services – State Plan 1915(i) Only Payment, Only the home and community based services elected and defined in the approved State plan may be claimed on this line.
- Line 19C Home & Community-Based Services - St. Plan 1915(j) Only Payments. 42 CFR Part 441 – Self-Directed Personal Assistance Services Program State Plan Option. These are PAS services provided under the self-directed service delivery model authorized by 1915(j) including any approved home and community-based services otherwise available under a 1915(c) waiver.
- Line 23B Personal Care Services – Self Directed Services SDS 1915(i), Self-Directed Personal Assistance Services (PAS) State Plan Option. These are PAS provided under the self-directed service delivery model authorized by 1915(j) for State plan personal care and related services.
- Line 24B Case Management – State Wide, (See §1915(g)(2) of the Act.).--These are services that assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. The agency must permit individuals to freely choose any qualified Medicaid provider when obtaining case management services in accordance with 42 CFR 431.51.
- Line 29 Non-Emergency Medical Transportation, (see 42CFR431.53; 440.170; 440.170(a); 440.170(a)(4))--A ride, or reimbursement for a ride, provided so that a Medicaid beneficiary with no other transportation resources can receive services from a medical provider. (NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room for life-threatening situations.
- Line 30 Physical Therapy, (See 42CFR440.110(a)(1)).--Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction f a qualified physical therapist. It includes any necessary supplies and equipment.
- Line 31 Occupational Therapy, (see 42CFR440.110(b))--Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.
- Line 32 Services for Speech, Hearing and Language, --Services for individuals with speech, hearing, and language disorders (See 42CFR440.110(c)). Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or correction services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment, including hearing aids.
- Line 33 Prosthetic Devices, Dentures, Eyeglasses, (See 42 CFR 440.120) Prosthetic

devises means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner to:
1. Artificially replace a missing portion of the body;
2. Prevent or correct physical deformity or malfunction;
3. Support a weak or deformed portion of the body.

- Line 34 Diagnostic Screening & Preventive Services, (see 42CFR440.130)--(a) "Diagnostic services", includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.
- Line 35 Nurse Mid-Wife, See 42 CFR 440.165) "Nurse-midwife services" means services that are furnished within the scope or practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse mid-wife to the extent permitted by the facility. Unless required by required by State law or regulations or a facility, are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. See 42 CFR 441.21 for provisions on independent provider agreements for nurse-midwives.
- Line 36 Emergency Hospital Services, Emergency hospital services means services that:
  1. Are necessary to prevent the death or serious impairment of the health of the recipient; and 2. Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet-
  (i) The conditions for participation under Medicare; or
  (ii) The definitions of inpatient or outpatient hospital services under 42 CFR 440.10 and 440.20.
- Line 37 Critical Access Hospitals, (See 42 CFR 440.170) -- Critical access hospital services that are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of 42 CFR part 485), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary. Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.
- Line 38 Nurse Practitioner Services, (See 42 CFR 440.166) services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. See 42 CFR 440.166 for requirements related to certified pediatric nurse practitioner and certified family nurse practitioner.
- Line 39 School Based Services, (See section 1903(c) of the Act)--These services include medical assistance for covered services (see section 1905(a)) furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan.
- Line 40 Rehabilitative Services (non-school-based), (see 42CFR440.130(d))--Rehabilitative services includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, with the scope of his

practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

- Line 41 Private Duty Nursing (see 42CFR440.80)--Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:
  (a) by a registered nurse or a licensed practical nurse;
  (b) under the direction of the recipient's physician ; and
  (c) to a recipient in one or more of the following locations at the option of the State:
  (1) his or her own home;
  (2) a hospital; or
  (3) a skilled nursing facility.
- Line 42 Freestanding Birth Centers – A line added to the CMS-37.3 and CMS-64.9 series of forms Form pursuant to Section 2301 of ACA.
- Line 43 Home Health for Enrollees with Chronic Conditions A line added to the CMS-37.3 and CMS-64.9 series of forms Form pursuant to Section 2703 of ACA.
- Line 44 Tobacco Cessation for Pregnant Women A line added to the CMS-37.3 and CMS-64.9 series of forms Form pursuant to Section 4107 of ACA.

Beginning with FFY 2010, the following Line Items were added to the 37.9, 37.10, and 37.10I administrative cost series of forms:

- Line 3B Skilled Professional Medical Personnel – Other Agency, These are administrative expenses for Skilled Professional Medical Personnel (SPMP) and directly supporting staff of the state (other than the Single State Medicaid Agency) and local public agencies as defined in 42 CFR 432.2. These costs must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 5C Planning for Health Homes for Enrollees with Chronic Conditions, Not Approved under MMIS Procedures: Interagency - Enter in Column (A) the total computable amount of expenditures for the costs related to the design, development, installation, improvement or operation of a mechanized claims processing and information retrieval system of a state-level public agency other than the Single State Agency and not approved under MMIS procedures. These costs must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 16 - TANF Secondary Allocation 75% matching Line 16 is the total computable and federal share (75%) costs for Medicaid administrative TANF activities allowable at the 75% Federal share rate against the secondary allocation. (See Federal Register notice MB-103-NC, May 14, 1997.)
- Line 19 School Based Administration: This line captures the total computable school-based Medicaid administrative costs incurred under the authority of an approved Medicaid Administrative Claiming Plan as required in the Claiming Guide issued by CMS in May 2003. These costs must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 20 Program Integrity/Fraud, Waste, and Abuse Activities - These costs include activities of the Surveillance and Utilization Review Units or other similar units of

the State Agency. These costs may also include the costs of special provider audits (does not include routine audits of providers for cost-settlement purposes), data mining, and other administrative and legal costs related to program integrity activities. Any costs incurred by public agencies other than the single State Agency must be supported by an interagency agreement in accordance with 45 CFR 95.507(b)(6).

- Line 21 County / Local Administrative Costs - These costs must be in accordance with cost principles contained in OMB Circular A-87 and must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 22 Interagency Costs (State Level) - Administrative costs of a state-level public agency other than the Single State Agency. These costs must be in accordance with cost principles contained in OMB Circular A-87 and must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 23 Translation and Interpretation – these activities may be allowable as an administrative cost if it is not included and paid for as part of a direct medical service and if it is necessary for the proper and efficient administration of the State plan. However, in order for translation to be claimable as administration, it must be provided either by separate units or separate employees performing solely translation activities and it must facilitate access to Medicaid covered services.
- Line 24A Health Information Technology (HIT): Planning: Cost of In-house Activities Planning Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers.
- Line 24B Health Information Technology: Cost of Private Sector Contractors. Planning Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers directly attributable to the design, development, and installation of the planning activities related to the administration of the Medicaid EHR incentive payment program.
- Line 24C Health Information Technology: Implementation and Operation - Cost of Private Contractors. Cost of In-house Activities - Implementation Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers expenditures directly attributable to the design, development, and installation of the planning activities related to the administration of the Medicaid EHR incentive payment program.
- Line 24D Implementation and Operation: Cost of Private Contractors Health Information Technology Implementation Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers directly attributable to the design, development, and installation of the planning activities related to the administration of the Medicaid EHR incentive payment program.
- Line 25 Citizenship Verification Technology (CVT) –CHIPRA: (Section 211 CHIPRA)
- Line 25A CVT Operation –CHIPRA: CVT Development (Section 211 CHIPRA)—There is a 90% FMAP for expenditures for the design, development, or installation of Citizenship Verification technology.
- Line 25B CVT Operation – CHIPRA - (Section 211 CHIPRA)- There is a 75% FMAP for the operation of CVT technology.
- Line 26 Home Health for Enrollees with Chronic Conditions - (Section 211 CHIPRA)- There is a 75% FMAP for the operation of CVT technology.