Crosswalk for the Implementation of the Affordable Care Act of 2009 and Additional Revisions for Certification (CMS-37) MBES/CBES

Section # on Current CMS-37 (8/31)	Type of Change	Rational for Change
CMS Form 37.3 and CMS 37.9	New Line item 1C. - Inpatient Hospital Services.-- Supplemental Payments.--Other than services in an institution for mental diseases. (See 42 CFR 440.10). These are services that: - Are ordinarily furnished in a hospital for the care and treatment of inpatients; - Are furnished under the direction of a physician or dentist (except in the case of nurse-midwife services under 42 CFR 440.165); and - Are furnished in an institution that: - Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; - Is licensed and formally approved as a hospital by an officially designated authority for State standard setting; - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services under 42 CFR 440.165); and - Has, in effect, a utilization review plan (that meets the requirements under 42 CFR 482.30 applicable to all Medicaid patients, unless a waiver has been granted by DHHS.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	1D. - Inpatient Hospital Services.-- GME Payments.--Other than services in an institution for mental diseases. (See 42 CFR 440.10). These are services that: - Are ordinarily furnished in a hospital for the care and treatment of inpatients; - Are furnished under the direction of a physician or dentist (except in the case of nurse-midwife services under 42 CFR 440.165); and - Are furnished in an institution that: - Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; - Is licensed and formally approved as a hospital by an officially designated authority for State standard setting; - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services under 42 CFR 440.165); and - Has, in effect, a utilization review plan (that meets the requirements under 42 CFR 482.30 applicable to all Medicaid patients, unless a waiver has been granted by DHHS.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 3B. - Nursing Facility Services.--Supplemental Payments.-- (Other than services in an institution for mental diseases). (See 42 CFR 483.5).--These are services provided by an institution (or a distinct part of an institution) which: - Is primarily engaged in providing to residents: - Skilled nursing care and related services for residents who require medical or nursing care; - Rehabilitation services for the rehabilitation of injured, disabled or sick persons; or - On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and - Meet the requirements for a nursing facility described in subsections 1919 (b), (c) and (d) of the Act regarding: - Requirements relating to Provision of Services, - Requirements relating to Residences Rights, and - Requirements relating to Administration and Other Matters.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.

CMS Form 37.3 and CMS 37.9	New Line item - Line 4C. Intermediate Care Facility Services (ICF/MR) - Supplemental Payments (Refer to the definition on LIne 4A above). 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 can not exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for ICF/MR services associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 5B. - Physician and Surgical Services.--Supplemental Payments.-- (refer to definition for Line 5A above)--Payments for physician and other practitioner services as defined in Line 5A that are made in addition to the standard fee schedule payment for those services. Address supplemental payments for physicians and practitioners associated with (1) governmental hospitals or university medical schools, (2) private hospitals or university medical schools, and (3) other supplemental payments.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 6B. - Outpatient Hospital Services.--Supplemental Payments.-- (refer to definition for Line 6A above)--payments for outpatient hospital services as defined in line 6A that are made in addition to the base outpatient hospital payment. Address outpatient hospital services supplemental payments associated with (1) government hospitals or university medical schools, (2) private hospital or university medical schools, and (3) other supplemental payments.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 7.A.5. Increased ACA OFFSET - 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. Below is a description of how the offset is calculated: Brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications are subject to a minimum rebate percentage of 23.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 23.1 percent of AMP, then we do not plan to take any offset amount. Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount. For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we	Added pursuant to the Affordable care Act of 2009.

CMS Form 37.3 and CMS 37.9	New Line item - 7.A.6. Increased ACA OFFSET - MCO - 100% 7A6. 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. Below is a description of how the offset is calculated: Brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications are subject to a minimum rebate percentage of 23.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 23.1 percent of AMP, then we do not plan to take any offset amount. Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount. For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in	Added pursuant to the Affordable care Act of 2009.
CMS Form 37.3 and CMS 37.9	New Line item - 9B. - Other Practitioners Services - Supplemental Payments NOTE: payments for other practitioner services (as defined in line 9A) that are made in addition to the standard fee for service payment to practitioners associated with university or teaching hospitals.	Previously claimed on a nondescript Line item. The new line item streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 23B. - Personal Care Services.--SDS 1915(j).-- (See 42 CFR Part 441).-- 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. NOTE: 1915(j) PAS that are using the self-directed service delivery model for section 1915(c) home and community-based services should be claimed separately on line 19C.	Previously claimed on a nondescript Line item. The new line item streamlines data entry and simplifies the identification of these budgeted figures.
CMS Form 37.3 and CMS 37.9	New Line item - 24A. - Targeted Case Management Services (see section 1915(g)(1) of the Social Security Act) are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas. Case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (See section 1915(g)(2) of the Act).	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted figures.
CMS Form 37.3 and CMS 37.9	New Line item - 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. NOTE: Transportation provided via the State is consider an administrative cost and should be reported on the form CMS-64.10.	Previously reported on a nondescript Line item. The new line item streamlines data entry and simplifies the identification of these budgeted figures.

CMS Form 37.3 and CMS 37.9	New Line item - 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 Stae law and provided to a recipient by or under the direction f a qualified physical therapist. It includes any necessary supplies and equipment.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted figures.
CMS Form 37.3 and CMS 37.9	New Line item - 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 recepient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted figures.
CMS Form 37.3 and CMS 37.9	New Line item - 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.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted figures.
CMS Form 37.3 and CMS 37.9	New Line item - 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. Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth. Eyeglasses means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist. Eyeglasses means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted figures.

CMS Form 37.3 and CMS 37.9	New Line item - 34. - Diagnostic Screening & Preventive Services (see 42CFR440.130)--(a) "Diagnostic services", except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts withing the scope of his or her practice under State law, to enable him to identify the exist4ence, nature, or extent of illness, injury, or other health deviation in a recipient. (b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. (c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under Stae law to: (1)Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency. NOTE: This does not include Rehabilitative services.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted amounts.
CMS Form 37.3 and CMS 37.9	New Line item - Line 35 - Nurse Mid-Wife - "Nurse-midwife services" means services that are 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 CFR 441.21) of this chapter for provisions on independent provider agreements for nurse-midwives).	If reported, these expenditures were previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 36. - Emergency Hospital Services Emergency may be included under various reporting categories depending upon how the service is billed. However, emergency health services provided to undocumented aliens and funded under an allotment established under §4723 of the Balanced Budget Act of 1997 P.L. 105-33 should be reported on line 27.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted amounts.
CMS Form 37.3 and CMS 37.9	New Line item - Line 37 - Critical Access Hospitals -- 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 part 485 of this chapter), 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.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted amounts.
CMS Form 37.3 and CMS 37.9	New Line item - Line 38 - Nurse Practitioner Services -- nurse practitioner services means 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.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted amounts.
CMS Form 37.3 and CMS 37.9	New Line item - 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.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these budgeted amounts.

CMS Form 37.3 and CMS 37.9	New Line item - 40. - Rehabilitative Services (non-school-based) (see 42CFR440.130(d))--Except as otherwise provided under this subpart, 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. NOTE: Do not include any costs for rehabilitative services provided under the school based environment.	To remove this line item from an informational only form and create a separate expenditure line item. This streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - 41. - Private Duty Nursing (see 42CFR440.60)--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.	Previously reported on a nondescript Line. The new line item streamlines data entry and simplifies the identification of these expenditures.
CMS Form 37.3 and CMS 37.9	New Line item - Line 42 - Freestanding Birth Center -- COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES Section 2301 of the Affordable Care Act amended section 1905(a) of the Social Security Act (the Act) to provide coverage for freestanding birth center services, as defined in section 1905(l)(3)(A) of the Act. In that provision, the benefit is defined as services furnished at a freestanding birth center, which is defined in new subparagraph 1905(l)(3)(B) as a health facility: • that is not a hospital; • where childbirth is planned to occur away from the pregnant woman's residence; • that is licensed or otherwise approved by the State to provide prenatal, labor and delivery, or postpartum care and other ambulatory services included in the State plan; and • that must comply with a State's requirements relating to the health and safety of individuals receiving services delivered by the facility. In addition to payment for freestanding birth center facilities, section 1905(l)(3)(C) of the Act requires separate payment for the services furnished by practitioners providing prenatal, labor and delivery, or postpartum care in a freestanding birth center facility, such as nurse midwives and birth attendants. Payment must be made to these practitioners directly, regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. It is important to note that section 2301 of the Affordable Care Act does not require States to license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities if they do not already do so. Coverage and payment are limited to only those facilities and practitioners licensed or otherwise recognized under State law. Prior to passage of the Affordable Care Act, only nurse midwife	Added pursuant to the Affordable care Act of 2009.
CMS Form 37.3 and CMS 37.9	New Line item - 43. Health Home for Enrollees w Chronic Conditions - Health Home services which includes - Comprehensive care Management - Care Coordination - Health promotion - Comprehensive transitional care (Planning and coordination) - Individual and Family Support - Referral to community/social supports - Use of Health Information Technology to link services as feasible and appropriate	Added pursuant to the Affordable care Act of 2009.
CMS Form 37.3 and CMS 37.9	New Line item - 44. Tobacco Cessation for Preg Women - ACA Section 4107 Payments for tobacco cessation counseling services for pregnant women and smoking/tobacco cessation outpatient drugs for pregnant women.	Previously claimed on a nondescript line item. Enacted pursuant to the Affordable care Act of 2009.