Medicaid Expenditure Data: TAF and the CMS-64

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TAF Methodology Brief

Summary

There are two principal sources of data on Medicaid spending: TAF and the CMS-64. This brief describes the similarities and differences between the two data sources and when and how they could be aligned.

TAF data

The Transformed Medicaid Information System (T-MSIS) contains comprehensive and detailed information reported monthly by states about enrolled Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and their characteristics, service use, and associated expenditures, along with information about managed care plans and providers. T-MSIS is used to monitor and improve the quality of care received by Medicaid beneficiaries, to monitor Medicaid program integrity, and to meet stakeholder needs.

States' monthly T-MSIS submissions include expenditure data in the form of original, voided, denied, and replacement claims, as well as non-claim financial records such as capitation payments made to managed care organizations. To make the data more accessible to a broad set of users, the Centers for Medicare & Medicaid Services (CMS) consolidates T-MSIS data by limiting claims to those that are final-action, not voided, not fully denied, and not duplicated. From there, it creates the T-MSIS Analytic Files (TAF), which is organized by service date.[1]

CMS-64 data

To claim federal matching funds (Federal Financial Participation payments) for their medical assistance programs, states report aggregate Medicaid expenditure data quarterly to CMS electronically through the Medicaid Budget and Expenditures System (MBES) for Medicaid beneficiaries covered under Title XIX of the Social Security Act (the Act) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (MAP) Form CMS-

[1] For more information, see TAF Technical Documentation for Claims Files at https://resdac.org/sites/datadocumentation.resdac.org/files/2021-01/TAF_TechGuide_Claims_Files.pdf.

64, commonly referred to as the CMS-64.[2] Because CMS applies different federal matching rates to expenditures for Medicaid and CHIP beneficiaries, it collects expenditure data on Medicaid and CHIP expenditures on separate forms. CHIP expenditures are reported to CMS quarterly through the CHIP Budget and Expenditures System (CBES). States report expenditures for separate CHIP (S-CHIP) beneficiaries covered under Title XXI of the Act to CMS on the Quarterly Children's Health Insurance Program Statement of Expenditures for Title XXI (Form CMS-21). States report expenditures for Medicaid expansion CHIP (M-CHIP) beneficiaries, also under Title XXI of the Act, to CMS on Form CMS-64.21U.[3] The CMS-64 and CMS-21 data are organized by payment date and contain expenditures related to medical services and financial transactions.

Selecting a data source for analysis: TAF versus the CMS-64

When comparing Medicaid expenditures in the TAF and CMS-64 or deciding which data source to use for analysis, it is important to understand the purpose and structure of each. Table 1 summarizes the purpose and key characteristics of the TAF and CMS-64 data sets.

Table 1. Characteristics of TAF and CMS-64 expenditure data

	TAF	CMS-64
Purpose	Program monitoring and analysis	Determining federal financial participation payments to states
Data structure	• Individual medical and pharmacy claims, with associated payment amounts • Non-claim financial transaction records that may be reported (1) at the beneficiary level or (2) as a lump sum payment to a specific provider that is not tied to individual beneficiaries	Aggregate statewide medical and financial expenditures made by the Medicaid agency on behalf of Medicaid beneficiaries during the quarter, reported in approximately 100 categories and subcategories of services[a]
Data organization	Based on date of service. If a service is delivered in one month, and the claim is paid in a later month, the expenditures will be in the file representing the month in which the service was delivered, with the claim payment adjudicated to reflect any subsequent adjustments.	Based on payment date. If a service is delivered in one quarter, and the payment is made in a later quarter, the expenditures will be in the file representing the quarter in which the payment was made, with prior period adjustments appearing in the quarter in which they were made.[b]

[2] Form CMS-64 also has an Expenditures for State and Local Administrative Form (CMS-64.10). In this brief, we only discuss the Medical Assistance Program form and refer to it as CMS-64. The CMS-64 data discussed here include all MAP categories of service, all 64.9 series of forms (64.9 Base, 64.9 Waiver, 64.9 VIII, 64.9E, 64.9 PE), and the prior period's expenditures adjustment forms (64.9P). It does not include M-CHIP expenditures from Form 64.21U.

[3] States may cover children using CHIP funds by expanding their Medicaid programs (referred to as Medicaid expansion CHIP, or M-CHIP); creating a program separate from their existing Medicaid programs (referred to as separate CHIP, or S-CHIP); or adopting a combination of both approaches. States report expenditures for M-CHIP beneficiaries on Form CMS-64.21U and expenditures for S-CHIP beneficiaries on Form CMS-21.

	TAF	CMS-64
Access	T-MSIS, TAF, and the TAF Research Identifiable Files (RIF) data are only accessible to approved users within the Center for Medicaid and CHIP Services data environment or on the Chronic Conditions Data Warehouse.	• Publicly available state aggregated expenditure information covering four quarters of the fiscal year are released on Medicaid.gov. • Users who need a specific quarter of data or wish to sum expenditures for the calendar year must have access to the Medicaid Budget and Expenditure System (which is limited to CMS staff and contractors) or request specific data extracts from CMS staff.
Submission frequency	Monthly	Quarterly
Review and approval process	Incoming submissions undergo several automated data quality checks. Submissions are accepted even if data quality checks are not passed, but a dedicated technical assistance team gives states regular feedback on data quality and guidance for improving quality.	States certify submissions and CMS reviews submissions, provides technical assistance, and provides reporting guidance to states.

[a] See Appendix Table 1 for a full listing of all categories and subcategories of service.

[b] Prior period adjustments could be associated with any of the previous reporting quarters, but most are reported within a two-year window of the original expenditure's reporting quarter.

Because of the oversight involved in ensuring states receive the correct Federal Financial Participation payments, the CMS-64 data are seen as a highly complete source of expenditure information. In contrast, T-MSIS data are more likely to have missing expenditure information, particularly for some types of non-claims-based financial transactions.[4] Still, many users may prefer or need to use TAF data to access more granular information than is available in the CMS-64. For example, the TAF can be used to identify expenditures for specific beneficiaries or beneficiary groups, for specific types of services such as Medication Assisted Treatment (MAT), and for payments received by a specific provider or type of provider. This level of detail is not available in the CMS-64.

Classifying expenditures

Both the TAF and the CMS-64 allow some disaggregation of total expenditures into service categories. On the CMS-64, states report net medical spending over the quarter for Medicaid beneficiaries in total and broken down into categories of service.[5] The CMS-64 categories of service are based on definitions from the Code of Federal Regulations (CFR). In some cases,

[4] Under the previous MSIS data collection, states were not expected to report certain types of non-claim financial transactions such as Medicare premium payments for dually eligible beneficiaries or drug rebates. Although these transactions are now in the scope of T-MSIS data collection, many states do not currently report them. Other financial transactions in TAF are mostly captured on service tracking claims. Service tracking claims include lump-sum payments made for services that cannot be attributed to a specific beneficiary, such as disproportionate share hospital (DSH) payments or payments to providers made under the Upper Payment Limit (UPL) demonstration. The completeness of service tracking claims in TAF has not been directly assessed.

[5] The CMS-64 categories of service and their definitions as of 2021 are included in Appendix Table 1 of this brief.

an individual service may meet the definition of more than one service category.[6] Although CMS reviews CMS-64 data submissions to detect misclassified expenditures, states can vary in how they classify certain types of expenditures into CMS-64 categories of service.

States are required to add information to each claim and non-claim financial record submitted to T-MSIS that would allow data users to classify the service and associated expenditures into categories. The data elements that can be used to disaggregate total expenditures into distinct categories are the Type of Service (TOS) code, the Federally Assigned Service Category (FASC)[7], and the Title XIX or XXI service category codes. The TOS code is fairly complete in nearly all years of TAF data, but there is little documentation or guidance on how states should apply the TOS valid values.[8] Internal CMS analyses have shown that although some TOS code values have the same names as CMS-64 categories of service, the TOS code cannot be used to reliably replicate how states distribute expenditures into those categories in their CMS-64 reporting. To address some of the issues related to the use of the TOS code, CMS developed the FASC, which identifies 21 distinct types of records and services present in the TAF claims files. Because the FASC field is constructed using the most reliable data elements for each type of service, it maximizes consistency within service category classification across states and promotes alignment with other data sources. Although the FASC was added to improve data usability for a range of end users, it was not designed for specific analyses or benchmarking to external data sources such as the CMS-64 and therefore does not align directly with CMS-64 categories of service. The Title XIX and XXI service category codes in T-MSIS, on the other hand, are defined to let states indicate the CMS-64 or CMS-21 category of service they are using to report the expenditure associated with the claim. However, as of 2021, these data elements have high rates of missingness or inconsistent information, limiting their use.[9]

As a result of the data and documentation limitations in both data sets, it is difficult to map the expenditures in TAF to the expenditures that states report in the CMS-64 categories of service.

Differences in total expenditures reported in the TAF and the CMS-64

Although it is challenging to make direct comparisons of expenditures for a specific category of service for the reasons noted above, users may expect the total expenditures reported in each

[6] For example, many states use managed care to deliver some of the Home and Community Based Services provided under a 1915(c) waiver. Some states may be reporting the expenditures for these services in the CMS-64 category 18 (Medicaid managed care), whereas other states may report the expenditures in category 19A (1915c HCBS services).

[7] More information can be found in the guide, “Assigning TAF Records to a Federally Assigned Service Category,” on the DQ Atlas Resources page.

[8] Internal CMS analyses have shown substantial variation across states in how similar services are classified into TOS codes, resulting in guidance that TAF users should be cautious in using this variable for cross-state comparisons.

[9] An example of inconsistent information is a claim with a valid Title XIX service category code (mapping the CMS-64) that links to a beneficiary eligibility record indicating enrollment in Title XXI S-CHIP. The expenditures for S-CHIP beneficiaries should be reported on the CMS-21, not the CMS-64, and so we would expect the Title XIX service category code on the claim to be missing and the Title XXI category of service code to be populated.

data set to match. However, there are some important structural differences that will prevent the two data sources from exactly matching. These differences are summarized in Table 2.

Table 2. Structural differences in the TAF and CMS-64 data

	TAF	CMS-64
Populations included	Expenditures for both Title XIX Medicaid and Title XXI CHIP	Only expenditures for Title XIX Medicaid[a]
Time frame covered by expenditure data	Includes final payments on all claims with service dates during the month (regardless of when payment was made). Includes non-claim financial transaction payments based on the service date the state reported for the transaction (typically the date on which the period of coverage ends).	• *Current expenditures* include claims and other expenses paid by the state during the quarter, regardless of when the service was delivered. Users cannot identify the service dates to which these expenditures apply. • *Prior period adjustments* include expenditures paid by the state during the quarter that serve as corrections to prior quarterly submissions. Users cannot identify which prior quarter these adjustments apply to.
How adjustments are handled	Adjustments to original claims are consolidated into a single record that is assigned to a file based on the original service date.[b] In some cases, adjustments to non-claim financial records (such as managed care capitation payments) may not be consolidated and could appear as a series of positive and negative lump sum payments in the TAF files in different months.	A prior period adjustment is submitted as a marginal adjustment, which is the difference between the corrected payment value and the old payment value. Adjustments are not consolidated with the original payment and may be reported in a different quarter's submission. Prior period adjustments are submitted in aggregate and represent all adjustments made to submissions in previous quarters. In other words, it is not possible to allocate adjustments to the period in which the expenditure needing adjustment was originally reported.
Kinds of expenditures included	**Both data sources:** • Fee-for-service expenditures • Monthly beneficiary payments • Disproportionate Share Hospital payments[c] • Lump-sum payments[c] • Upper Payment Limit supplemental payments[c] • Drug rebates[d] • Medicare premiums[d] • Graduate medical education payments[c] **TAF only:** • Electronic health record payments[e]	**Both data sources:** • Fee-for-service expenditures • Monthly beneficiary payments • Disproportionate Share Hospital payments • Lump-sum payments • Upper Payment Limit supplemental payments • Drug rebates • Medicare premiums • Graduate medical education payments **CMS-64 only:** • Collections (adjustments related to third party liability, probate, fraud, waste, and abuse)

[a] States report expenditures for M-CHIP beneficiaries (covered under Title XXI) on the CMS-64.21U and CMS-64.21UP forms. This table focuses on the CMS-64.9 and CMS-64.9U forms.

[b] The T-MSIS claims consolidation process is known as the Final Action Claim algorithm and is described in the "Final Action Status in T-MSIS Claims" resource hosted on *DQ Atlas*: https://www.medicaid.gov/dq-atlas/downloads/supplemental/3011_Final_Action_Status.pdf.

[c] Disproportionate Share Hospital, lump-sum, graduate medical payments, and Upper Payment Limit supplemental payments are found on service tracking records and supplemental payment claims. For more information about these records and any known data quality issues, see the topics "Service Tracking Claims" and "Supplemental Payments" in *DQ Atlas*, available at https://www.medicaid.gov/dq-atlas/.

[d] Although states are expected to report drug rebates and Medicare premiums in T-MSIS, only a few states are currently doing so.

[e] Electronic health record payments are considered administrative costs—and not expenditures for medical assistance programs—in the CMS-64.

Some of the structural differences between TAF and the CMS-64 can be overcome with the approaches listed below, but they have varying levels of difficulty.

- **Aligning the populations.** TAF records can be subset to the same population included in the CMS-64 by using one of two approaches. The choice of which method to use is generally driven by data quality.
  - Three variables on the claims form can be used to differentiate between expenditures related to Title XIX Medicaid (reported on the CMS-64.9 form) and those related to Title XXI CHIP (reported on the CMS-64.21U and the CMS-21 forms). These include the federal reimbursement category code, the Title XIX service category code, and the Title XXI service category code. However, the quality and completeness of these data elements vary.[10]
  - If the federal reimbursement category code and both the Title XXI service category code and Title XIX service category code are missing or have been deemed unreliable in a state's TAF data, users can instead link records in the claims files to eligibility records via the beneficiary ID. Records that link to beneficiaries enrolled in Title XIX Medicaid contain expenditures that should be reported on the CMS-64. One limitation of this approach is how to classify lump-sum financial transaction records that do not contain beneficiary-level information. Often, these records have other information in the TOS code or service tracking payment type code that would let a TAF user identify the type of payment and associate it with either Title XIX or Title XXI. For example, Disproportionate Share Hospital payments and Upper Payment Limit payments are associated with Title XIX Medicaid. Another limitation to this approach is that non-claims financial transactions such as capitation payments can sometimes be made in a month when the beneficiary is not enrolled. Because some beneficiaries may move between Title XIX Medicaid and Title XXI CHIP during the year, linking financial transactions to beneficiaries to allocate the expenditures could result in some level of error.
- **Aligning the time periods.** TAF data are organized by service date and calendar year, whereas the CMS-64 data are organized by payment date and federal fiscal year. This difference results in the same expenditures being captured in files covering different time periods for each data source. For example, an inpatient hospital stay that occurred in September 2018 and was paid in January 2019 would be found in the 2018 calendar year files for the TAF, and the fiscal year 2019 files for the CMS-64.

  One option for users who need to align these data sources would be to use the paid date on the TAF claims to reorganize the files and mimic the structure of the CMS-64. Internal CMS analyses have revealed that claims or adjustments continue to be submitted by states for at least two years after the initial service date, suggesting that users who want to make this adjustment should work with a minimum of three years of TAF data when reorganizing the data by paid date.

[10] See the topics, "Consistency of Federal Reimbursement Category Code" and "Consistency of Category of Service Code" in *DQ Atlas* for more information on the completeness and reliability of the claim-level information in TAF for identifying expenditures reported on the CMS-64.

Given the level of effort and years of data required to reorganize the TAF, most users may instead elect to assume that the length of time between service delivery and claim payment is relatively constant. Under this assumption, the claims that are "missing" from a given year of TAF in comparison with the CMS-64—those that are captured in an earlier year of TAF based on service date—are likely to be offset by a roughly equal-sized set of expenditures that are present in TAF but not in the corresponding CMS-64, representing claims with a service date in the year of interest but a payment date in a later year. This is the assumption used in *DQ Atlas*[11] when benchmarking TAF to the CMS-64 data. However, users should take care to allow for a higher level of discrepancy between data sources when they are not reorganizing TAF by paid date.

- **Aligning the types of expenditures.** Some types of expenditures are only present in one of the data sources, the most significant of which are the collections reported in the CMS-64 that are not captured in TAF. Collections include adjustments that reduce the total expenditures made by Medicaid agencies, often related to recouping payments due to third party liability, probate, fraud, waste, and abuse. Users who are trying to align the data sources should be careful to remove from their comparisons any expenditure types that are not fully present in both data sources.[12]

Even after implementing the changes above to align the TAF with the CMS-64, there will still be significant differences between the data sets that cannot be eliminated. The discrepancy with the most impact involves the treatment of adjustments to expenditures reported in previous periods. In the TAF, any corrections or adjustments to claims that fell into a prior period are consolidated into the original claim and reported in the monthly file based on the service date of the original claim. In contrast, and by design, CMS-64 reflects unconsolidated payment data. If a claim requires correction in the CMS-64, a marginal adjustment reflecting the difference between the corrected payment value and the original payment value is recorded. If the original claim and adjusted claims are submitted in different quarters, they will be attributed to different submission periods, and the adjustment will be considered a prior period adjustment. The prior period adjustment adjustments on the CMS-64 are not broken out by the quarter they are adjusting, which does not allow users to consolidate the prior period adjustments to make the data a better match with the TAF.

The different approaches to consolidating adjustments also affect the accuracy of the alignment strategies noted above. For example, when an original, voided, and replacement claim are consolidated into a single record in the TAF, the paid date reflects the replacement claim and not the original claim. For these claims, reorganizing the file by paid date will not

[11] In August 2020, CMS released a public online tool called "Data Quality (DQ) Atlas". *DQ Atlas* is an interactive, web-based tool to help policymakers, analysts, researchers, and other stakeholders explore the quality and usability of the TAF to determine if the data can meet their analytic needs. Available at https://www.medicaid.gov/dq-atlas/.

[12] For more information on how to do this removal, see *DQ Atlas* background and methods for the "Total Medicaid Expenditures," "Total FFS Expenditures," or "Total Monthly Beneficiary Payments" topics.

necessarily align the claim with the quarter that the original payment was reported on in the CMS-64.

On the CMS-64, states may submit prior period adjustments two years (or more) after reporting the initial expenditure. This means that expenditures reported in a particular quarter could be associated with adjustments in future reporting periods, and that total net expenditures in a given reporting period could include adjustments for payments originally made seven (or more) reporting periods prior. For some states, prior period adjustments represent a large proportion of total net expenditures in a given reporting period; in other states, prior period adjustments are trivial.[13]

For all of these reasons, users should expect some level of variation between the CMS-64 and the TAF expenditure data.

[13] For example, in fiscal year 2020, California's prior period adjustments are nearly as high as the state's current expenditures; in Tennessee, there are no prior period adjustments reported.

Appendix Table 1. Line definitions for the categories of service on the CMS 64.9 base form

Line	Line Form Display	Line Definition
1A	Inpatient Hospital - Reg. Payments	Inpatient Hospital Services.—Regular 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. NOTE: Inpatient hospital services do not include NF services furnished by a hospital with swing-bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.
1B	Inpatient Hospital - DSH	Inpatient Hospital Services — DSH Adjustment Payment. - Other than services in an institution for mental diseases. DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act. —Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs.
1C	Inpatient Hospital - Sup. Payments	Inpatient Hospital Services.—Supplemental Payments.—Other than services in an institution for mental diseases. (Refer to the definition on LIne 1A 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 cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for inpatient hospitals 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.
1D	Inpatient Hospital - GME Payments	Inpatient Hospital Services.—Graduate Medical Education (GME) 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.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
2A	Mental Health Facility Services - Reg. Payments	Mental Health Facility Services - Report Institution for Mental Disease (IMD) services for individuals age 65 or older and/or under age 21 (See 42 CFR 440.140 and 440.160.). — Report Other Mental Services which are not provided in an inpatient setting in the Other Appropriate Service categories, e.g., Physician Services, Clinic Services. 1. Mental Hospital Services for the Aged.—Refers to those inpatient hospital services provided under the direction of a physician for the care and treatment of recipients in an institution for mental disease that meets the Conditions of Participation under 42 CFR Part 482. Institution for mental diseases means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical care, nursing care, and related services. (See 42 CFR 440.140(a)(2).) 2. NF Services for the Aged.—Means those NF services (as defined at 42 CFR 440.40) and those ICF services (as defined at 42 CFR 483, Subpart B) provided in an institution for mental diseases to recipients determined to be in need of such services. (See 42 CFR 440.140.) 3. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under. (See 42 CFR 441.151) —Means those services that: – Are provided under the direction of a physician; – Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Health Care Organizations; and – Meet the requirements set forth at Subpart D of Part 441 (Inpatient Psychiatric Services for Individuals Age 21 and under in Psychiatric Facilities or Programs).
2B	Mental Health Facility - DSH	Mental Health Facility Services — DSH Adjustment Payments.- (See 42 CFR 440.140 and 440.160). DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act. —Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs.
2C	Certified Community Behavior Health Clinic Payments	Certified Community Behavior Health Clinic Payments On April 1, 2014, the Protecting Access to Medicare Act of 2014 (Public Law 113-93) was enacted. The law included “Demonstration Programs to Improve Community Mental Health Services” at Section 223 of the Act. This eight-state demonstration will be made operational January 1, 2017 through July 1, 2017 and will serve adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. The eight states selected for the demonstration (see state listing below) must pay certified clinics using a prospective payment system (PPS) that applies to fee for service (FFS) payment and payment made through managed care. Demonstration expenditures are eligible for enhanced federal matching funds. States must stop reporting demonstration expenditures eligible for enhanced FMAP at the end of their programs. In accordance with Section 1132 of the Social Security Act and the implementing regulations at 45 CFR, Part 95, Subpart A states can make claim adjustments within two years after the calendar quarter in which the state agency made the original expenditure for their demonstrations. When states end their programs, they will cease reporting demonstration expenditures on the new CMS-64/64.21 lines. A demonstration state may choose to continue services in another form through the state plan or through their managed care programs but these expenditures would be reported using the established 1905a reporting categories and existing FMAPs, not enhanced FMAP.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
3A	Nursing Facility Services - Reg. Payments	Nursing Facility Services.—Regular Payments.— (Other than services in an institution for mental diseases). (See 42 CFR 483.5 and 440.155).—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.
3B	Nursing Facility Services - Sup. Payments	Nursing Facility Services.—Supplemental Payments.— (Other than services in an institution for mental diseases). (Refer to the definition on LIne 3A 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 cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for nursing facility 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.
4A	Intermediate Care Facility Services - Ind. with Intellectual Disabilities: Public Providers	Intermediate Care Facility Services - Public Providers - Individuals with Intellectual Disabilities (ICF/IID) (See 42 CFR 440.150). — These include services provided in an institution for the Intellectual Disabled or persons with related conditions if: • The primary purpose of the institution is to provide health or rehabilitative services to such individuals; • The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and • The Intellectual Disabled recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.)

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
4B	Intermediate Care Facility Services - Ind. with Intellectual Disabilities: Private Providers	Intermediate Care Facility Services - Private Providers - Individuals with Intellectual Disabilities (ICF/IID). (See 42 CFR 440.150).—These include services provided in an institution for the Intellectual Disabled or persons with related conditions if: • The primary purpose of the institution is to provide health or rehabilitative services to such individuals; • The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and • The Intellectual Disabled recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.)
4C	Intermediate Care Facility Services - Ind. with Intellectual Disabilities: Supplemental Payments	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.
5A	Physician & Surgical Services - Reg. Payments	Physician and Surgical Services.—Regular Payments.— (See 42 CFR 440.50.).—Whether furnished in the office, the recipient's home, a hospital, a NF, or elsewhere, physicians' services are services provided: • Within the scope of practice of medicine or osteopathy as defined by State law; and • By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy. NOTE: Exclude all services provided and billed for by a hospital, clinic, or laboratory. Include any services provided and billed by a physician under physician services with the exception of lab and X-ray services. Include such services provided and billed for by a physician under the lab and X-ray services category. In a primary care case management system under a Freedom of Choice waiver, you sometimes use a physician as the case manager. In these situations, the physician is allowed to charge a flat fee for each person. Although this fee is not truly a physician service, report the expenditures for the fee on this line.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
5B	Physician & Surgical Services - Sup. Payments	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. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for physicians and practitioners associated with (1) governmental hospitals or university teaching hospitals, (2) private hospitals, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet.
5C	Physician & Surgical Services - Evaluation and Management	Physician & Surgical Services - Evaluation and Management ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
5D	Physician & Surgical Services - Vaccine codes	Physician & Surgical Services - Vaccine codes ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share Matching Rate
6A	Outpatient Hospital Services - Reg. Payments	Outpatient Hospital Services.—Regular Payments.— (See 42 CFR 440.20.).—These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: • Are furnished to outpatients; • Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under the direction of, a physician or dentist; and • Are furnished by an institution that: – Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and – Except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare. (See 42 CFR 440.165.)
6B	Outpatient Hospital Services - Sup. Payments	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 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 can not exceed the Federal upper payment limit. Address outpatient hospital services supplemental payments associated with (1) state owned or operated hospitals, (2) non state government owned or operated hospitals and (3) private hospitals by entering payment information on the pop-up feeder sheet.
7	Prescribed Drugs	Prescribed Drugs. (See 42 CFR 440.120(a).).—These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are: • Prescribed by a physician or other licensed practitioner of the healing arts within the scope of a professional practice as defined and limited by Federal and State law; • Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and • Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's record.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
7A1	Drug Rebate Offset - National	Drug Rebate Offset.—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. Rebates are to take place quarterly. Report these offsets as (1) National Agreement or (2) State Sidebar Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers' agreements with CMS under OBRA 1990 provisions. State Sidebar Agreements refer to rebates manufacturers pay under an agreement directly with your State. These may have been entered into before January 1, 1991, the effective date of the OBRA rebate program. Or they may represent agreements your State entered into with a given manufacturer on or after January 1, 1991, under which the manufacturer pays at least as great a rebate as it would under the National Agreement. All States receive rebates under the National Agreements. A few States receive most of their rebates under the National Agreement, but some States receive other rebates under their State Sidebar Agreement with specific manufacturers. All manufacturer rebates received under CMS's National Agreement are reported on Line 7.A.1, National Agreement. All rebates received under State Sidebar Agreements are reported on Line 7.A.2, State Sidebar Agreement. NOTE: Vaccines are not subject to the rebate agreements.
7A2	Drug Rebate Offset - State Sidebar Agreement	Drug Rebate Offset.—This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A1 (National Drug Rebate).
7A3	MCO - National Agreement	National Agreement 7A3. 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. Report these offsets as MCO National Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers agreements with CMS under OBRA 1990 provisions. All States receive rebates under the National Agreement. For rebates for Medicaid MCO drugs, there will be no rebates under their State Sidebar Agreement with specific manufacturers. All MCO manufacturer rebates received under CMS National Agreement are reported on Line 7.A.3, National Agreement. NOTE: Vaccines are not subject to the National agreement.
7A4	MCO - State Sidebar Agreement	MCO State Sidebar Agreement. This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A3 (National Drug Rebate).

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
7A5	Increased ACA OFFSET - Fee for Service - 100%	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 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 accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
7A6	Increased ACA OFFSET - MCO - 100%	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 accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).
8	Dental Services	Dental Services (See 42 CFR 440.100.).—These are services that are diagnostic, preventive, or corrective procedures provided by, or under the supervision of, a dentist in the practice of his/her profession including treatment of: • The teeth and associated structures of the oral cavity; and • Disease, injury, or impairment that may affect the oral or general health of the recipient. Report all EPSDT dental services on this line. Dentist means an individual licensed to practice dentistry or dental surgery. NOTE: Exclude all such services provided as part of inpatient hospital, outpatient hospital, nondental, clinic or laboratory services and billed for by the hospital, nondental clinic, or laboratory.
9A	Other Practitioners Services - Reg. Payments	Other Practitioners Services - Regular Payments (see CFR 440.60). Any medical or remedial care or services, other than physicians' services, provided by licensed practitioners with the scope of practice defined under State law. Chiropractors' services may be included here as long as the services that (1) are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under section 405.232(b), and (2) consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
9B	Other Practitioners Services - Sup. Payments	Other Practitioners Services - Supplemental Payments 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. Address supplemental payments for other practitioners associated with (1) governmental hospitals or university medical schools, and (2) private hospitals or university medical schools, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet.
10	Clinic Services	Clinic Services (See 42 CFR 440.90.).—These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that: • Are provided to outpatients; • Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of supporting staff, etc., as physicians, rather than a clinic, even though they practice under the name of a clinic; and • Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician. NOTE: Place dental clinics under Dental Services. Report any services not included above under Other Care Services. A clinic staff may include practitioners with different specialties.
11	Laboratory/Radiological	Laboratory And Radiological Services (See 42 CFR 440.30.).—These are professional, technical laboratory and radiological services: • Ordered and provided by, or under, the direction of a physician or other licensed practitioner of the healing arts within the scope of a practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory; • Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and • Provided by a laboratory that meets the requirements for participation in Medicare. NOTE: Report X-rays by dentists under Dental Services, Line 8.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
12	Home Health Services	Home Health Services (See 42 CFR 440.70.).—These are services provided at the patient's place of residence in compliance with a physician's written plan of care that is renewed every 60 days and includes the following items and services: • Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency (HHA) (a public or private agency or organization, or part of an agency or organization, that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who: – Is licensed to practice in the State; – Receives written orders from the patient's physician; – Documents the case and services provided; and – Has had orientation to acceptable clinical and administrative record keeping from a health department nurse. • Home health aide services provided by an HHA; • Medical supplies, equipment, and appliances suitable for use in the home; and • Physical therapy, occupational therapy, or speech pathology and audiology services provided by an HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15 - Home Health Services.) Place of residence is normally interpreted to mean the patient's home, and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as Home Health Services. For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF.
13	Sterilizations	Sterilizations (See 42 CFR 441, Subpart F.).—These are medical procedures, treatments, or operations for the primary purpose of rendering an individual permanently incapable of reproducing.
14	Abortions	Abortions (See 42 CFR 441, Subpart E.).—FFP is available when a physician has certified, in writing, to the Medicaid agency, that on the basis of professional judgment the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. The certification must contain the name and address of the patient. The revision to the Hyde Amendment, P.L. 103-112, Health and Human Services Appropriations Bill, made FFP available for expenditures for abortions when the pregnancy is a result of an act of rape or incest. This reimbursement is effective for dates of service October 1, 1993 and thereafter. Provide a breakout of the number of abortions and associated expenditures in the following cases: • Abortions performed to save the life of the mother, • Abortions performed in the case of pregnancies resulting from incest, and • Abortions performed in the case of pregnancies resulting from rape. NOTE 1: Report all abortions on this line regardless of the type of provider. For prior period adjustments to abortions, only include any entry in number of abortions if, for increasing claims, it is a new abortion that has not been previously reported, or, for decreasing claims, you want to remove an abortion previously claimed. Make no entry in number of abortions if all you are changing is the dollar amount claimed. NOTE 2: The "morning after pill" (ECP) is not considered an abortion as it is a contraceptive to prevent pregnancy. However, the drug Mifepristone (RU486) should be counted as an abortion procedure as long as all Hyde amendment and other Federal requirements are met.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
15	EPSDT Screening	EPSDT Screening Services - Physical and mental assessment given to Medicaid eligibles under age 21 to carry out the screening provisions of the EPSDT program. However, the agency must provide at least the following services through consultation with health experts, determine the specific health evaluation procedures to be used, and the mechanisms needed to carry out the screening program. • A comprehensive health and developmental history (including assessment of both physical and mental health development); • A comprehensive unclothed physical exam; • Appropriate immunizations according to the Advisory Committee on Immunization Practices • Laboratory tests (including blood lead level assessment according to age/risk factors); • Health education (including anticipatory guidance); and • Dental Services - Referral to a dentist in accordance with the States' periodicity schedule. • Vision Services The above services may be provided by any qualified Medicaid provider. NOTE: Do not include data for dental, hearing, or vision services here. Report dental examinations and preventative dental services on Line 8, Dental Services. Report hearing services, including hearing aids, on Line 32, Services for Speech, Hearing and Language. Report vision services rendered by professionals (e.g. – examinations, etc.) on Line 9, Other Practitioners' Services. Note that the cost of eyeglasses and other aids to vision is to be reported on Line 33, Prosthetic Devices, Dentures, and Eyeglasses. Report other necessary health care according to the appropriate category.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
16	Rural Health	Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).).—If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities): • Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. • Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). • Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) • Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: – The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); – The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; – The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and – The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition, and leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or an NF.
17A	Medicare - Part A	Part A Premiums—(See §301 P.L. 100-360 and §1902 (a)(10) (E)(ii) of the Act)—Include Part A premiums paid for Qualified Disabled and Working Individuals (QWDIs) under §1902(a)(10)(E)(ii) of the Act.
17B	Medicare - Part B	Part B Premiums—(See §1902(a). Part B Premiums - Include premiums paid through Medicare buy-in under 1843 for Qualified Medicare Beneficiaries (QMBs) under 1902(a)(10)(E)(i), Specified Low-Income Medicare Beneficiaries (SLMBs) under 1902(a)(10)(E)(iii), and other Medicare/Medicaid dual eligibles covered in 1902(a)(10) of the Act. Do not include part B premiums for line 17C (Qualifying Individuals). This amount is shown on the bottom of each monthly bill sent to you on the summary accounting statement Form CMS-1604.
17C1	120% - 134% Of Poverty	120% - 134% of Poverty - Include premiums paid for Medicare Part B under §1902(a)(10)(E)(iv)(I).

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
17D	Coinsurance	Coinsurance and Deductibles— Include Medicare deductibles and coinsurance required to be paid for QMBs under §1905 (p)(3). (Do not include any Medicare deductibles and coinsurance for other Medicare/Medicaid dual eligibles. Report expenditures for Medicaid services also covered by Medicare under the appropriate Medicaid service category.) Coinsurance is a joint assumption of risk by the insured and the insurer, whereby each shares on a specific basis, the applicable medical expenses of the insured. The insured's share of coinsurance may be paid on his/her behalf. For example, under part B of Medicare, the beneficiary's coinsurance responsibility is a percent of reasonable and customary expenses greater than the stipulated deductible. A deductible is that portion of applicable medical expenses which must be borne by the insured (or be paid on his/her behalf) before insurance benefits for the calendar year begin. EXCEPTION: REPORT ALL ABORTIONS ON LINE 14.
18A	Medicaid - MCO	Managed Care Organizations (MCOs)— (See §1903(m)(1)(A) of the Act revised by BBA §4701(b)). - Include capitated payments made to a Medicaid Managed Care Organization which is defined as follows: A Medicaid Managed Care Organization (MCO) means a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare+ Choice organization with a contract under part C of title XVIII, a provider sponsored organization, which meets the requirements of §1902(w) and - (I) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for Medical Assistance under the State plan) not enrolled with the organization, and (ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency. An organization that is a qualified health maintenance organization (as defined in §1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (I) and (ii).
18A1	Medicaid MCO - Evaluation and Management	Medicaid MCO - Evaluation and Management ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18A2	Medicaid MCO - Vaccine codes	Medicaid MCO - Vaccine codes ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate
18A3	Medicaid MCO - Community First Choice	Medicaid MCO - Community First Choice. 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18A4	Medicaid MCO - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	Medicaid MCO - Preventive Services Grade A or B, ACIP Vaccines and their Admin. 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
18A5	Medicaid MCO - Certified Community Behavior Health Clinic Payments	Medicaid MCO - Certified Community Behavior Health Clinic Payments
18A6	Medicaid MCO - Services Subject to Electronic Visit Verification Requirements	Medicaid MCO - Services Subject to Electronic Visit Verification Requirements
18B1	Prepaid Ambulatory Health Plan	A Prepaid Ambulatory Health Plan (PAHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PAHP does not provide or arrange for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. NOTE: Include dental, mental health, transportation and other plans covering limited services (without inpatient hospital or institutional services) under PAHP.
18B1a	MCO PAHP - Evaluation and Management	MCO PAHP - Evaluation and Management ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18B1b	MCO PAHP - Vaccine codes	MCO PAHP - Vaccine codes ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate.
18B1c	MCO PAHP - Community First Choice	MCO PAHP - Community First Choice. 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18B1d	MCO PAHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	MCO PAHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin. 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1,
18B1e	Medicaid PAHP - Certified Community Behavior Health Clinic Payments	Medicaid PAHP - Certified Community Behavior Health Clinic Payments
18B1f	MCO PAHP - Services Subject to Electronic Visit Verification Requirements	MCO PAHP - Services Subject to Electronic Visit Verification Requirements

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
18B2	Prepaid Inpatient Health Plan	A Prepaid Inpatient Health Plan (PIHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PIHP provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees. A PIHP does not have a comprehensive risk contract. NOTE: Include dental, mental health, transportation and other plans covering limited services (with inpatient hospital or institutional services) under PIHP.
18B2a	MCO PIHP - Evaluation and Management	MCO PIHP - Evaluation and Management ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18B2b	MCO PIHP - Vaccine codes	MCO PIHP - Vaccine codes ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate
18B2c	MCO PIHP - Community First Choice	MCO PIHP - Community First Choice. 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18B2d	MCO PIHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	MCO PIHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin. 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1,
18B2e	Medicaid PIHP - Certified Community Behavior Health Clinic Payments	Medicaid PIHP - Certified Community Behavior Health Clinic Payments
18B2f	MCO PIHP - Services Subject to Electronic Visit Verification Requirements	MCO PIHP - Services Subject to Electronic Visit Verification Requirements
18C	Medicaid - Group Health	Group Health Plan Payments— Include payments for premiums for cost effective employer group health insurance under §1906 of the Act.
18D	Medicaid - Coinsurance	Coinsurance and Deductibles— Include payments for coinsurance and deductibles for cost employer group health insurance under §1906 of the Act.
18E	Medicaid - Other	Other—Include premiums paid for other insurance for medical or any other type of remedial care in order to maintain a third party resource under §1905(a). (Report expenditures here only if you have elected to pay these premiums in item 3.2(a)(2) on page 29b of your State Plan Preprint.) EXCEPTION: REPORT ALL ABORTIONS ON LINE 14.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
19A	Home & Community-Based Services - Regular Payment (1915(c) Waiver)	Home and Community-Based Services (See 42 CFR 440.180.(a).).—These are services furnished under a 1915(c) waiver approved under the provisions in 42 CFR 441, Subpart G (Home and Community-Based Services; Waiver Requirements). NOTE: Report only approved waiver services as designated in the State's approved waiver applications which are provided to eligible waiver recipients. Some states have approved 1115 Waivers with 1915 C services. These states are maintained in a separate MBES table.
19B	Home & Community-Based Services - St. Plan 1915(i) Only Pay.	Other Practitioners 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 and form. Enter cost data on the lines in the pop-up feeder sheet that match the services approved in the State plan.
19C	Home & Community-Based Services - St. Plan 1915(j) Only Pay.	Home and Community Based Services – State Plan 1915(j) Only Payment – 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. The MBES will automatically enter in row 19C the totals from the pop-up 1915(j) Self-Directed Personal Assistance Services Feeder Form. Expenditures for 1915(c) waiver like services provided under 1915(j) Self Direction are entered on the line 19C Feeder Form rather than on the Line 19A Waiver Form which is reserved for approved waiver expenditures. NOTE: 1915(j) services that are using the self-directed service delivery model for State Plan Personal Care and related services should be claimed separately on Line 23B.
19D	Home & Community Based Services State Plan 1915(k) Community First Choice	Home and Community Based Services State Plan 1915(k) Community First Choice ACA Section 2401 - The provision establishes a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, ore, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
22	All-Inclusive Care Elderly	Programs of All-Inclusive Care for the Elderly (PACE)(See 42 CFR Part 460).—PACE provides pre-paid, capitated, comprehensive health care services designed to enhance the quality of life and autonomy for frail, older adults. Required services (See 42 CFR 460.92) The PACE benefit package for all participants, must include: (a) All Medicaid-covered services, as specified in the State's approved Medicaid plan. NOTE: This is a option within the Medicaid Program to establish Programs of All-Inclusive Care for the Elderly beginning August 5, 1998. (See §1905(a)(26) and §1934 of the Act.) Do not report payments for PACE programs which continue to operate under §1115 authority on this line. Report payments for PACE programs continuing to operate under §1115 waiver authority on the appropriate waiver forms under the appropriate categories of services.
23A	Personal Care Services - Reg. Payments	Personal Care Services.—Regular Payment.— (See 42 CFR 440.167).— Unless defined differently by a State agency for purposes of a waiver granted under Part 441, subpart G of this chapter— Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are— (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) Furnished in a home, and at the State's option in another location.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
23B	Personal Care Services - SDS 1915(j)	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.
24A	Targeted Case Management Services - Com. Case-Man.	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).
24B	Case Management - State Wide	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.
25	Primary Care Case Management	Primary Care Case Management Services (PCCM) (See §1905(a)(25) and §1905 (t)— These are case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract. Currently most PCCM programs pay the primary care case manager a monthly case management fee. Report service costs and/or related fees on this line. Report other service costs and/or related fees on the appropriate type of service line. NOTE: Where the fee includes services beyond case management, report the fees under line 18B.
26	Hospice Benefits	Hospice Benefits (See Section1905(o)(1)(A) of the Act.).—The care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected to have payment made for hospice care instead of having payment made for certain benefits described under 1812(d)(2)(A) and for which payment may otherwise be made under Title XVIII and intermediate care facility services under the plan. Hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care. NOTE: These are services that are: • Covered in 42 CFR 418.202; • Furnished to a terminally ill individual, as defined in 42 CFR 418.3; • Furnished by a hospice, as defined in 42 CFR 418.3, that: • Meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements; and • Is a participating Medicaid provider; • Furnished under a written plan that is established and periodically reviewed by: • The attending physician; • The medical director of the program, as described in 42 CFR 418.54; or • The interdisciplinary group described in 42 CFR 418.68.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
27	Emergency Services for Undocumented Aliens	Emergency Services Undocumented Aliens Pursuant to the Act - The Medicaid program pays for emergency medical services provided to certain aliens. Section §1903(v) of the Act sates that "...no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted... " The only exception is if such care and services are for 1) an emergency medical condition, 2) if such alien otherwise meets the eligibility requirements for medical assistance under the State Plan, and 3) such care and services are not related to an organ transplant procedure.
28	Federally-Qualified Health Center	Federally-Qualified Health Center (FQHC) (See §1905(a)(2) of the Act.) —These are services performed by facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. FQHCs qualify to provide covered services under Medicaid if: • They receive grants under §§329, 330, or 340 of the Public Health Service (PHS) Act; • The Health Resources and Services Administration, PHS certifies the center as meeting FQHC requirements; or • The Secretary determines that the center qualifies through waiver of the requirements.
29	Non-Emergency Medical Transportation	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 can be considered as either an administrative cost or a direct service. If it is considered as a direct service, it should be reported on the Form CMS-64.9 and 64.9VIII series of forms.
30	Physical Therapy	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. NOTE: Do not include any costs for physical therapy serivces provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for physical therapy serivces provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below.
31	Occupational Therapy	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. NOTE: Do not include any costs for occupational therapy serivces provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for occupational therapy serivces provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
32	Services for Speech, Hearing & Language	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. NOTE: Do not include any costs for speech and language services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for speech / language therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below. It includes any necessary supplies and equipment.
33	Prosthetic Devices, Dentures, Eyeglasses	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.
34	Diagnostic Screening & Preventive Services	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 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. (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 State 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 - those services are reported on the pop-up feeder sheet for line 40 below.
34A	Preventive Services Grade A OR B, ACIP Vaccines and their Admin	Preventive Services Grade A OR B, ACIP Vaccines and their Admin. 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106- Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
35	Nurse Mid-Wife	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.
36	Emergency Hospital Services	Emergency Hospital Services (See 42 CFR 440.170) 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. NOTE: 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.
37	Critical Access Hospitals	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.
38	Nurse Practitioner Services	Nurse Practitioner Services (See 42 CFR 440.166) 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.
39	School Based Services	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.
40	Rehabilitative Services (non-school-based)	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 serivces provided under the school based environment which should be reported on Line 39.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
41	Private Duty Nursing	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.
42	Freestanding Birth Center	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 services were mandatory services under section 1905(a)(17) of the Act and implementing regulations at 42 CFR 440.165. In addition, States had the option to cover the services of other practitioners who are licensed by the State to provide midwifery services such as Certified Professional Midwives (CPM) under section 1905(a)(6) of the Act and implementing regulations at 42 CFR 440.60. These practitioner services are now mandatory when provided in a freestanding birth center as defined above. Further, other practitioner services, such as those furnished by so-called direct entry or lay midwives or birth attendants, who are not licensed but are recognized under State law to provide these services, are now required to be covered when provided in the freestanding birth center. Submission of State Plan Amendments These provisions became effective with the enactment of the Affordable Care Act, beginning March 23, 2010. To implement these provisions, States will need to submit amendments to their State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services. Unless the compliance exception discussed below applies, or the State does not license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities, States must submit a State plan amendment (SPA) not later than the end of the next calendar quarter that follows the date of this guidance.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
		In accordance with section 2301(c) of the Affordable Care Act, States that require State legislation (other than appropriation legislation) to meet the new requirements related to their Medicaid coverage of freestanding birth center services will not be regarded as out of compliance with the standards governing this coverage option as long as they come into compliance not later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of the Affordable Care Act. For example, if the next regular legislative session beginning after March 23, 2010, is from January 1 through April 30, 2011, then the State would have until September 30, 2011, to submit the required SPA with an effective date of July 1, 2011. In the case of the State that has a 2-year legislative session, each year is treated as a separate regular session of the State legislature. For example, if a legislature is in session from January 1, 2010, through December 31, 2012, then the State would have until March 31, 2011, to submit a SPA with an effective date that is no later than January 1, 2011. A State should promptly notify its CMS regional office if this compliance exception is applicable. We encourage any State that has questions about this guidance to contact Ms. Vikki Wachino, Director, Family and Children's Health Programs Group, who may be reached at 410-786-5647. As always, CMS is available to help in making changes to your State plan. Please contact your servicing CMS regional office should you want to schedule a technical assistance session
43	Health Home for Enrollees w Chronic Conditions	Health Home for Enrollees w Chronic Conditions ACA 2703- 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
44	Tobacco Cessation for Preg Women	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.
45	Health Home for Enrollees w Substance-Use-Disorder	Health Home for Enrollees with Substance Use Disorder - Pursuant to Section 1006 of the recently signed Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018. States that have an approved Health Home Spa will receive 90% FMAP for 10 consecutive quarters from Approval Date.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
46	OUD Medicaid Assisted Treatment – Drugs	OUD Medication Assisted Treatment – Drugs: total spending on FDA approved Medication Assisted Treatment (MAT) drugs and biologicals when used for opioid use disorder (OUD). ‘‘(1) DEFINITION.—For purposes of subsection (a)(29), the term ‘medication-assisted treatment’— ‘‘(A) means all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and ‘‘(B) includes, with respect to the provision of such drugs and biological products, counseling services and behavioral therapy. H. R. 6—22 ‘‘(2) EXCEPTION.—The provisions of paragraph (29) of subsection (a) shall not apply with respect to a State for the period specified in such paragraph, if before the beginning of such period the State certifies to the satisfaction of the Secretary that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1903(m) or under section 1905(t)(3).’’. (4) EFFECTIVE DATE.— (A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall apply with respect to medical assistance provided on or after October 1, 2020, and before October 1, 2025. (B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by the amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.
46A1	OUD MAT DRUG REBATE/National Agreement	Total rebates collected by states on MAT drugs when used for OUD. These are rebates that would have otherwise been reported under line 46A1. Drug Rebate Offset.—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. Rebates are to take place quarterly. Report these offsets as (1) National Agreement or (2) State Sidebar Agreement National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers' agreements with CMS under OBRA 1990 provisions. State Sidebar Agreements refer to rebates manufacturers pay under an agreement directly with your State. These may have been entered into before January 1, 1991, the effective date of the OBRA rebate program. Or they may represent agreements your State entered into with a given manufacturer on or after January 1, 1991, under which the manufacturer pays at least as great a rebate as it would under the National Agreement. All States receive rebates under the National Agreements. A few States receive most of their rebates under the National Agreement, but some States receive other rebates under their State Sidebar Agreement with specific manufacturers. All manufacturer rebates received under CMS's National Agreement are reported on Line 46.A.1, National Agreement. All rebates received under State Sidebar Agreements are reported on Line 46.A.2, State Sidebar Agreement. NOTE: Vaccines are not subject to the rebate agreements.

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
46A2	OUD MAT DRUG REBATE/State Sidebar	Total rebates collected by states on MAT drugs when used for OUD. These are rebates that would have otherwise been reported under line 46A2. Drug Rebate Offset.—This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 46A1 (National Drug Rebate).
46A3	OUD MAT DRUG REBATE MCO /National Agreement	Total rebates collected by states on MAT drugs when used for OUD. These are rebates that would have otherwise been reported under line 46A3. National Agreement 46A3. 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. Report these offsets as MCO National Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers agreements with CMS under OBRA 1990 provisions. All States receive rebates under the National Agreement. For rebates for Medicaid MCO drugs, there will be no rebates under their State Sidebar Agreement with specific manufacturers. All MCO manufacturer rebates received under CMS National Agreement are reported on Line 46.A.3, National Agreement NOTE: Vaccines are not subject to the National agreement.
46A4	OUD MAT DRUG REBATE MCO /State Sidebar	Total rebates collected by states on MAT drugs when used for OUD. These are rebates that would have otherwise been reported under line 46A4.MCO State Sidebar Agreement. This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 46A3 (National Drug Rebate).

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
46A5	OUD MAT DRUG REBATE/Increased ACA Offset Fee for Service - 100%	Total rebates collected by states on MAT drugs when used for OUD. These are rebates that would have otherwise been reported under line 46A5. 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 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 accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

Appendix Table 1 (*continued*)

Line	Line Form Display	Line Definition
46A6	OUD MAT DRUG REBATE/Increased ACA Offset MCO – 100%	Total rebates collected by states on MAT drugs when used for OUD. These are rebates that would have otherwise been reported under line 46A6. Increased ACA OFFSET - MCO - 100% 46A6. 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 accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).
46B	OUD Medicaid Assisted Treatment Services	OUD Medicaid Assisted Treatment Services - (See §1905(a)(29) of the Social Security Act.)— This mandatory benefit (§1905(ee)(1) of the Act) requires coverage of counseling and behavioral therapies associated with provision of the required drug and biological coverage.
47	ARP Section 9811 COVID Vaccine/Vaccine Administration	ARP Section 9811 COVID Vaccine/Vaccine Administration - Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment Under Medicaid. Federal Share matching rate is 100%.
49	Other Care Services	Other Care Services —These are any medical or remedial care services recognized under State law and authorized by the approved Medicaid State Plan. Such services do not meet the definition of, and are not classified under, any category of service included on Lines 1 through 46.
50	Total	TOTAL.

Source: Medicaid and Children's Health Insurance Program Budget and Expenditure System, Line Definition Report of the CMS-64.9 Base form.

Cara Stepanczuk[1], Allison Barrett[1], and Linda Nguyen[1]. “Medicaid Expenditure Data: TAF and the CMS-64.” TAF DQ Brief #9020. Baltimore, MD: CMS, 2021.

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