

2500.2 Preparation of the Statement of Medical Assistance Expenditures By Type Of Service For The Medical Assistance Program - Forms HCFA-64.9 and HCFA-64.9p. -

A. General Information. -Section 1903(A)(1) of the Act authorizes payment to the States of an amount equal to the FMAP of the total amount expended during the quarter as medical assistance under an approved State plan.

These instructions prescribe the use of the quarterly form for claiming FFP for medical assistance expenditures made in accordance with a State plan approved under title XIX. Use Form HCFA-64.9 to report current period medical assistance expenditures by type of service. Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Your supporting documentation includes as a minimum the following: date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service. Do not report estimated amounts. Claims developed through the use of sampling, projections, or other estimating techniques are estimates and are not allowable.

Report payments made in a prior period but not included on the expenditure report for that period, and payments made as adjustments to amounts claimed in prior periods on the Form HCFA-64.9p. Use this form to support amounts reported on Lines 7, 8, 10.A and 10.B of the Form HCFA-64 Summary Sheet. The same categories of services are reported on the Form HCFA-64.9p for prior periods with the expenditures identified by fiscal year.

NOTE: For the HCFA-64.9p and HCFA-64.10p forms, you have the option of reporting each fiscal year on a separate form or reporting the current and the two previous fiscal years on individual forms and combining the remaining fiscal years on one form, i.e., report current year, current year minus one, current year minus two and compile all previous fiscal year expenditures in current year minus three. For example, for pre FY 1987, you may report the expenditures on one Form HCFA-64.9p as FY 1986 and prior or report the years individually. Note that increasing adjustment payments made in the current quarter to private providers are reported on the Form HCFA-64.9, as they are considered current expenditures. However, report decreasing adjustments made in the current quarter to private, as well as public, providers are reported on the Form HCFA-64.9p. Such decreasing adjustments may not be netted out of payments reported on the Summary Sheet, Line 6 and supporting Form HCFA-64.9.

For reporting purposes, use a base (one form) Form HCFA-64.9 summarizing all current quarter expenditures. Where separate HCFA-64.9 forms are prepared to report such items as individual waiver expenditures and other current quarter expenditures, the base Form HCFA-64.9 includes the expenditures reported on the separate HCFA-64.9 forms. Amounts shown on the separate HCFA-64.9 forms are informational and support amounts contained in the base Form HCFA-64.9 figures. Enter the totals of the base Form HCFA-64.9 on the Form HCFA-64 Summary Sheet.

Reporting on the Form HCFA-64.9p is different from Form HCFA-64.9 in that a single form is not used to summarize the data. Transfer amounts reported on each Form HCFA-64.9p directly to the appropriate line on Form HCFA-64 Summary Sheet. Where two or more HCFA-64.9p forms are used to report expenditures for the same Form HCFA-64 Summary Sheet line, add the totals and report them on the appropriate line.

Report the data on each Form HCFA-64.9p by fiscal year, not by quarter.

Definitions used in the preparation of Form HCFA-64 are compatible with those used for the HCFA-25 and HCFA-2082 forms.

B. Waiver Reporting. -

1. Home and Community-Based (HCBS) Waivers. -Section 2176 of the Omnibus Budget Reconciliation Act of 1981, (P. L. 97-35), amended §1915(c) of the Act to permit you to offer a wide array of services to Medicaid eligibles who otherwise would require institutional care. Information regarding the implementation of this section is in 42 CFR Part 441, Subpart G. Additionally, §4102 of OBRA 1987 amended §1915(d) to add HCBS waivers for the elderly.

Line 18 of the HCFA-64.9 and HCFA-64.9p forms captures HCBS waiver expenditures. If you have a HCBS waiver, attach a separate Form HCFA-64.9 showing the current quarter expenditures for each. For current quarter expenditures, the total computable amount and Federal share amounts reported on Line 18 of the base Form HCFA-64.9 summarize the HCBS amounts reported on the separate HCFA-64.9 forms. Transfer amounts for prior period expenditures, reported on separate HCFA-64.9p forms, to the appropriate line of the Form HCFA-64 Summary Sheet. Prepare a separate HCFA-64.9p form for each approved waiver.

2. Other Waivers. -You may obtain waivers under §402(A) of the Social Security Amendments of 1967, §222(a)(1) of the Social Security Amendments of 1972, §§1110 and 1115 of the Social Security Act and §966 of the Omnibus Reconciliation Act of 1980.

States with any of these waivers submit a separate Form HCFA-64.9 for each waiver with the expenditures arrayed by service category. Amounts shown on the separate HCFA-64.9 forms are for reporting purposes. The expenditures are included in the figures shown on the base Form HCFA-64.9. Carry forward only the figures on the base Form HCFA-64.9 to the Form HCFA-64 Summary Sheet. Report prior period expenditures for these waivers on a separate Form HCFA-64.9p for each waiver. Include them on the appropriate line of the Form HCFA-64 Summary Sheet.

For waiver reporting purposes, use the complete waiver number including the waiver year identification at the end as assigned by HCFA. Report waiver expenditures by fiscal year. Where expenditures during a quarter are made for a different waiver year, support each by a separate Form HCFA-64.9 and/or HCFA-64.9p. For example, one waiver year ends on May 31, the new waiver year begins on June 1; there are current quarter expenditures of \$15,000; \$10,000 for the 01 waiver year and \$5,000 for the 02 waiver year.

The base Form HCFA-64.9 includes the \$15,000 and a separate Form HCFA-64.9 reports the expenditures under each waiver year; one for the 01 year reporting the \$10,000 and one for the 02 year reporting the \$5,000. These two additional HCFA-64.9 forms support the base Form HCFA-64. The informational HCFA-64.9 forms identify the waiver type (e.g., §1115 or §1110) and especially the waiver year (e.g., 01, 02, 03).

If expenditures under the above waiver types, except HCBS waivers, cannot be identified by service category, report the amounts on Line 25 of either the Form HCFA-64.9 or HCFA-64.9p.

3. Report State and Local Administration Expenditures Related to Waivers on Forms HCFA-64.10 and HCFA-64.10p. -Do not report any waiver service expenditures as administration expenditures. (See §2500.5.)

C. Reporting Medical Assistance Expenditures in Accordance with the Indian Health Care Improvement Act (P.L. 94-437). -

1. General Instructions. -The FMAP is 100 percent for services received by Indians through an Indian Health Service (IHS) facility, whether operated by the IHS, an Indian Tribe, or a tribal organization.

Use Column (c) of Form HCFA-64.9 to report expenditures for medical assistance made in accordance with the Indian Health Care Improvement Act (P. L. 94-437).

You may combine medical assistance expenditures made in accordance with the Indian Health Care Improvement Act reported as an increasing adjustment to claims for prior quarters (Line 7), other expenditures (Line 8), or a decreasing adjustment to claims for prior quarters (Line 10.A or 10.B) on the Form HCFA-64 Summary Sheet, on the same line with other medical assistance expenditures. However, submit a separate Form HCFA-64.9p for each Summary Sheet line that has an adjustment.

2. Detailed Instructions. -Enter in Column (c) of Form HCFA-64.9 or HCFA-64.9p the Federal share of medical assistance expenditures made in accordance with the Indian Health Care Improvement Act.

Make no entries on Lines 3 or 4 of Form HCFA-64.9 until the IHS has established skilled or intermediate care nursing facilities for the mentally retarded that meet Medicaid requirements.

D. Preparation of the Statement of Medical Assistance Expenditures By Type Of Service For The Medical Assistance Program, Form HCFA-64.9, Expenditures In This Quarter. -Complete the heading sections of the report by entering the name of the State, title of the State agency, and the ending date of the quarter reported.

The columns separate medical assistance expenditures into total computable payments for Federal funding, the different rates of Federal sharing, and the total Federal share.

Report all current quarter expenditures on the base (one form) Form HCFA-64.9. Additional HCFA-64.9 forms, prepared to show current quarter waiver expenditures or other breakouts of current quarter expenditures, are informational and report amounts included in the figures on the base form. Space has been provided to report the waiver type and number.

The sum of the amounts reported in Columns (b)-(e) for each line item equal the amounts reported in Column (f).

NOTE: Under type of waiver, report one of the following:

<u>WAIVER TYPE</u>	<u>EXPLANATION</u>
HCBWAG	Home and Community-Based Waiver for aged
HCBWAGPD	Home and Community-Based Waiver for aged and physically disabled
HCBWAGD	Home and Community-Based Waiver for aged and physically and developmentally disabled
HCBWPDSD	Home and Community-Based Waiver for physically disabled
HCBWMRDD	Home and Community-Based Waiver for mentally retarded and

	developmentally disabled
HCBWMI	Home and Community-Based Waiver for mentally ill
HCBWMOD	Model Home and Community-Based Waiver
HCBWCAP	Home and Community-Based Waiver defined under §1915(d)
HCBWAARC	Home and Community-Based Waiver for Individuals with AIDS and/or AIDS Related Complex
HCBW	For any other type of Home and Community-Based Waiver not defined above or a combination of two or more of the above
<u>§1115</u>	<u>Waivers defined under §1115 of the Act</u>
FOC	Freedom of Choice Waivers

Column (a) - Total Computable. -Enter the total computable expenditures for MAP made during the quarter reported.

Include:

- o Payments to suppliers of medical services.
- o Premiums paid to health insuring organizations (the total amount paid the organization for carrying out the provisions of the insurance contract is a medical assistance cost).
- o Payments to fiscal agents for medical assistance claims.
- o Payments for supplemental medical insurance (Buy-In) premiums, coinsurance or deductibles under Part B of title XVIII.
- o Payments to prepaid health plan.
- o Payments to other insuring and governmental agencies providing medical services and care to recipients.

Do not include amounts paid a fiscal agent for performing agreed upon functions (e.g., processing claims). Include these amounts in the expenditure statement for State and Local Administration, Form HCFA-64.10 or HCFA-64.10p.

Column (b) - Federal Medical Assistance Percentage (FMAP). -Enter the State's current FMAP in the space provided at the top of Column (b). Enter the product of the FMAP times the portion of the total computable amount entered in Column (a) which is reimbursable at the FMAP. (See §2501.)

Column (c) - Indian Health Service (IHS) Facility Services - 100 Percent. -Enter the Federal share of medical assistance expenditures made in accordance with the Indian Health Care Improvement Act.

Column (d) - Family Planning Services - 90 Percent. -Enter the FFP at 90 percent times the total computable amount in Column (a) for Family Planning Services. Family Planning Services mean consultation (including counseling and patient education), examination, and treatment, furnished by or under the supervision of a physician or prescribed by a physician; laboratory examination; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; natural family planning methods; diagnosis and treatment for infertility; and voluntary sterilizations and drugs.

Column (e) - (RESERVED). -Enter the appropriate FMAP and the Federal share for any expenditure, which cannot be included in Columns (b) through (d), on its respective line.

Column (f) - Total Federal Share. -Enter the total of Columns (b)-(e) for each line item.

Lines 1 through 25 - Medical Assistance Payments. -Enter the amount of medical assistance payments by type of service. In Column (a), enter the total computable amount of expenditures for Federal funding. In Columns (b)-(e), compute the Federal share by rate of Federal sharing.

In Column (f), report the total Federal share by line item and the sum of each line item for Columns (b)-(e). Definitions for the various types of services are given below.

Line 26 - Total. -Enter the sum of Columns (a)-(f) for each of the line items 1 through 25.

Enter the total of Columns (a) and (f) on Form HCFA-64 Summary Sheet, Line 6, Columns (a) and (b), respectively.

E. Specific definitions for FFP purposes of the types of services to report on Lines 1 through 25 of Form HCFA-64.9. -

1. Inpatient Hospital Services - Other than services in an institution for mental diseases. (See 42 CFR 440.10.). -These are services that are:

- o Ordinarily furnished in a hospital for the care and treatment of inpatients;
- o Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services under 42 CFR 440.165); and
- o Furnished in an institution that:
 - Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
 - Is licensed and formally approved as a hospital by an officially designated authority for State standard setting;
 - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services 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.

2. Mental Health Facility Services - Inpatient Hospital Services and Nursing Facility (NF) Services. (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.

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).)

NF services for the aged (see 42 CFR 440.140) means those NF services as defined in 42 CFR 440.40 and those ICF services as defined in 42 CFR 483, Subpart B that are provided in an institution for mental diseases to recipients determined to be in need of such services.

Inpatient psychiatric facility services for individuals age 21 and under are services that:

- o Are provided under the direction of a physician;
- o Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Health Care Organizations; and
- o Meet the requirements set forth in 42 CFR 441, Subpart D (Inpatient Psychiatric Services for Individuals Age 21 and under in Psychiatric Facilities or Programs).

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

- o Is primarily engaged in providing to residents:
 - Skilled nursing care and related services for residents who require medical or nursing care,
 - Rehabilitation services for the rehabilitation of injured, disabled or sick persons,
- or
- On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and

o 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.

4. Intermediate Care Facility (ICF) Services - Mentally Retarded. (See 42 CFR 440.150(c).) -These include services provided in an institution for the mentally retarded or persons with related conditions if:

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

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

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

NOTE: Line 4 is divided into sections for public providers and private providers.

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.)

5. Physicians' Services. (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:

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

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

NOTE: Exclude all services 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.

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

o Are furnished to outpatients;

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

o Are furnished by an institution that:

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

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

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

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

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

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

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

NOTE: Vaccines are not subject to the rebate agreements.

On the Form HCFA-64 Certification Sheet, indicate the portion of the Federal share relating to agreements entered into due to OBRA 1990 provisions and the portion relating to sidebar agreements. Sidebar rebate agreements are refund arrangements that were entered into before January 1, 1991 and have remained in effect.

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

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

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

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.

9. Other Practitioners' Services. (See 42 CFR 440.60 and 440.80.) -This is medical or other remedial care provided by licensed practitioners. This care includes any medical or remedial care or services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. Examples of other practitioners (if covered under State law) are:

o Chiropractors;

o Professional nurses;

o Podiatrists;

- o Psychologists;
- o Optometrists; and
- o Christian Science Practitioners.

Certain exceptions are:

- o Services of professional nurses including private duty nursing services as defined in 42 CFR 440.80 when recognized in the State plan;
- o Services of other practitioners that are billed by a hospital. Consider them as inpatient or outpatient services, as applicable;
- o Eyeglasses or hearing aids billed by the professional practitioner under Other Practitioner Services. If they are billed by a physician, include them under physician services, otherwise, bill them under Other Care Services.
- o Speech therapists, audiologists, opticians, physical therapists and occupational therapists under Other Care Services.

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

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

- o Are provided to outpatients;
- o Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. For reporting purposes, consider a group of physicians who share, 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
- o Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

NOTE: Place dental clinics under Dental Services. Report any services not included above under Other Care Services. A clinic staff may include practitioners with different specialties.

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

- o 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;
- o Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and
- o Provided by a laboratory that meets the requirements for participation in Medicare.

NOTE: Report X-rays by dentists under Dental Services, Line 8.

12. Home Health Services. (See 42 CFR 440.70.) -These are services provided at the patient's place of residence in compliance with a physician's written plan of care that is renewed every sixty days and includes the following items and services:

o 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.

o Home health aide services provided by an HHA;

o Medical supplies, equipment, and appliances suitable for use in the home; and

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

15. EPSDT Screening Services. -Section 1905(r) of the Social Security Act mandates two sets of screenings:

o Periodic Screenings -These are provided at regular intervals and must include all of the following services:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);

- A comprehensive unclothed physical exam;
- Appropriate immunizations according to age and health history;
- Laboratory tests; and
- Health education (including anticipatory guidance).

o Interperiodic Screenings - These are provided when medically necessary to determine the existence of suspected physical or mental illness or conditions.

NOTE: Do not include data for dental, hearing, or vision services here. Report dental examinations and preventive dental services on Line 8, Dental Services. Report hearing and vision services, including hearing aids and eyeglasses, on Line 9, Other Practitioners' Services. Report other necessary health care according to the appropriate category, for example, Line 1, Inpatient Hospital Services.

16. 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):

o 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.

o 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).

o 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.)

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

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

- The services are furnished by an RN or 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.

17. Health Insurance Payments. (See 42 CFR 431.625.) -Include Part A Premiums, Part B Premiums, Coinsurance and Deductible payments and Group Health Plan Payments, as well as any other per capita insurance payments (for example, payments for HMO, HIO, and PHP enrollment). Whenever possible, (except for Part A, Part B Premiums, Group Health Plan Payments, HMO and HIO payments), distribute these payments, of all types, to the appropriate service category and exclude them from this category.

NOTE: Group Health Plan Payments are covered under §1906 of the Act.

The total computable amount for Part B Premiums is shown on the bottom of each monthly bill sent to you on the Summary Accounting Statement, Medicare Insurance Premiums (Form HCFA-1604).

Report your private health insurance premiums (except for Group Health Plan Payments), whenever possible, under the appropriate service category. If you are unable to distribute them, report them on Line 17.E, Other.

Report your HMO and HIO (Comprehensive Risk Contracts) payments on Line 17.E.

18. Home and Community-Based Services. (See 42 CFR 440.180.(a).) -These are services furnished under a 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 which are provided to eligible waiver recipients.

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

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

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

- o Qualified to provide the services;
- o Supervised by an RN; and
- o Not a member of the recipient's family.

22. Targeted Case Management Services. (See §1905(a)(19) of the Act.) These are services that:

- o Are furnished to individuals eligible under the plan to gain access

to needed medical, social, educational and other services;

o The agency may make available case management services to:

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

- Specific groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.250.

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

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

o Covered in 42 CFR 418.202;

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

o Furnished by a hospice, 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;

o Furnished under a written plan that is established and periodically reviewed by:

- The attending physician;

- The medical director of the program, as described in 42 CFR 418.54; or

- The interdisciplinary group described in 42 CFR 418.68.

24. 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:

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

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

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

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

They may include, but are not limited to:

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

NOTE: Transportation, as defined above, is furnished only by a provider to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation under 42 CFR 431.53, FFP is available as an administrative cost.

o Physical Therapy which means services prescribed by a physician and provided to a recipient by, or under the direction of, a qualified physical therapist. (See 42 CFR 440.110(a)(2).) It includes any necessary supplies and equipment.

o Occupational Therapy which means services prescribed by a physician and provided to a recipient by, or under the direction of, a qualified occupational therapist. (See 42 CFR 440.110(b)(2).) It includes necessary supplies and equipment.

o Services for individuals with speech, hearing, and language disorders (see Other Practitioners' Services) which mean diagnostic, screening, preventive, or corrective services provided by, or under the direction of, other than a licensed speech pathologist or audiologist (see 42 CFR 440.110(c)(2)), for which a patient is referred by a physician. It includes necessary supplies and equipment.

o Dentures, eyeglasses and prosthetic devices. (See 42 CFR 440.120 and Other Practitioners' Services.) Dentures mean artificial structures made by, or under the direction of, a dentist to replace a full or partial set of teeth. Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist. It includes optician fees for services. Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice as defined by State law to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunctions; or
- Support a weak or deformed portion of the body.

o Diagnostic, screening, rehabilitative and preventative services. (See 42 CFR 440.130.)

Diagnostic services, except as otherwise provided under 42 CFR 440, Subpart A include any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, to enable him/her to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient. Screening services mean the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

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

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

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

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

F. Preparation of the Statement of Medical Assistance Expenditures By Type Of Service For The Medical Assistance Program, Form HCFA-64.9p, Prior Period Adjustments. -Report payments made in a prior period but not included on the expenditure report for that period, and payments made as adjustments to amounts claimed in prior periods on Form HCFA-64.9p. Use this form to support amounts reported on Lines 7, 8, 10.A, and 10.B of the Form HCFA-64 Summary Sheet. Prepare a separate Form HCFA-64.9p for each FY for which expenditures are reported except for FYs over 2 years prior to the current fiscal year. Combine these years and report only the totals on the form as the latest combined fiscal year. For example, if the current expenditure quarter being reported is in FY 1990, then report separately FY 1990, 1989, 1988 and report FY 1987 and prior as FY 1987 expenditures. Report the same categories of services reported on the Form HCFA-64.9 on the Form HCFA-64.9p for prior periods with the expenditures identified by fiscal year.

Note that increasing adjustment payments made in the current quarter to private providers are reported on the Form HCFA-64.9 as they are considered current expenditures. However, decreasing adjustments made in the current quarter to private, as well as public providers, are reported on Form HCFA-64.9p. Such decreasing adjustments may not be netted out of payments reported on the Summary Sheet, Line 6 and supporting Form HCFA-64.9.

Since State cost settlement adjustments with public providers (typically hospitals or long-term care facilities) usually relate to a 12-month cost reporting period, it may be impractical to allocate the adjustment amount precisely by fiscal year. Where this is the case, spread the adjustment equally among the affected quarters. For example, if a \$32,000 increasing adjustment payment is made to a public provider for the period January 1, 1988 through December 31, 1988, and you can not accurately identify the payments made by FY, allocate the total on the basis of the number of quarters covered in each FY. In this case, you report \$24,000 for FY 1988 on the basis of three quarters occurring in FY 1988, and \$8,000 for FY 1989 on the basis of one quarter occurring in FY 1989.

Complete the heading sections of the report by entering the name of the State and SA, the FY reported, and the ending date of the quarter for which the Form HCFA-64 is submitted. Check the box on the form to indicate the line being supported (Line 7, 8, 10.A or 10.B).

If you use the Form HCFA-64.9p to report prior period expenditures under a waiver, enter the type of waiver and complete waiver number in the space provided.

The sum of the amounts reported in Columns (b)-(e) for each line item equal the amounts reported in Column (f).

Column (a) - TOTAL COMPUTABLE. -Enter the total computable expenditures for MAP made in, or for, prior periods. Expenditures to include and exclude are in the instructions for Form HCFA-64.9. See §2500.2 D.

Column (b) - FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP). -Enter your appropriate FMAP in the space provided at the top of Column (b). Enter the product of the FMAP times the portion of the total computable amount entered in Column (a) which is reimbursed at the FMAP.

Column (c) - INDIAN HEALTH SERVICE (IHS) FACILITY SERVICES - 100 PERCENT. -Enter the Federal share of medical assistance expenditures made in accordance with the Indian Health Care Improvement Act.

Column (d) - FAMILY PLANNING SERVICES - 90 PERCENT. -Enter the FFP at 90 percent times the total computable amount in Column (a) for family planning services. See definition of Family Planning Services in the instructions for Form HCFA-64.9 in §2500.2,D.

Column (e) - (RESERVED). -Enter the appropriate FMAP for any expenditure which cannot be included in Columns (b) through (d) on its respective line and the Federal share.

Column (f) - TOTAL FEDERAL SHARE. -Enter the total of Columns (b)-(e) for each line item.

Column (g) - DEFERRAL, DISALLOWANCE OR C.I.N. NO.. -Enter the deferral, disallowance and/or the audit common identification number (CIN) as appropriate by category of service.

Lines 1 through 25. -Follow instructions for the Form HCFA-64.9. (See §2500.2.D.)

Line 26 - TOTAL. -Enter the sum of Columns (a)-(f) for each of the line items 1 through 25.

Enter the total amounts in Columns (a) and (f) on the Form HCFA-64 Summary Sheet Columns (a) and (b), Line 7, 8, 10.A or 10.B as appropriate.

Transfer amounts reported on each Form HCFA-64.9p directly to the appropriate line on Form HCFA-64 Summary Sheet. Where two or more HCFA-64.9p forms are used to report expenditures for the same Form HCFA-64 Summary Sheet line, add the Total Computable amounts (column a) on each. Enter that total on the appropriate line under column (a) on the Summary Sheet. Add the Total Federal Share amounts (column f). Enter that total on the appropriate line under column (b) on the Summary Sheet.

THIS PAGE RESERVED FOR MEDICAL ASSISTANCE
EXPENDITURES BY TYPE OF SERVICE FOR THE
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2500.3 Preparation of the Quarterly Statement of Third Party Liability (TPL) Collections And Cost Avoidance, Form HCFA-64.9a. -

A. General Information. -Use Section A to report TPL collections by source and Section B to report cost avoidance resulting from payments by liable third parties.

Section 1902(a)(25) of the Act and 42 CFR 433.135 through 433.140 require that States take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan. Minimum requirements which constitute reasonable measures are in 42 CFR 433.138. The requirements for claims payments are in 42 CFR 433.139.

If the agency has established the probable existence of TPL at the time the claim is filed, reject the claim and return it to the provider for a determination of the amount of liability. When the amount of liability is determined, pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if it has obtained approval of a waiver of the cost avoidance requirement above.

If the probable existence of TPL cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, pay the full amount allowed under the agency's payment schedule.

If the agency has an approved waiver of the cost avoiding requirements, learns of the existence of a liable third party, or benefits become available after a claim is paid, seek recovery to the limit of legal liability 60 days after the end of the month in which payment was made or 60 days after the end of the month you learn of the existence of a liable third party, unless you determine that recovery is not cost effective.

Report to the Federal government its pro rata share of any funds received representing reimbursements from third parties if Federal participation has been claimed by the SA.

B. Definitions. -Third party means any individual, entity or program that is, or may be, liable to pay all, or part of, the expenditures for medical assistance furnished under an approved State plan. See 42 CFR 433.136.

Third party liability means payment resources, available from both private and public health insurance, and other liable third parties, that can be applied toward a Medicaid recipient's medical and health benefit expenses. See 42 CFR 433.203.

Examples of third party resources include (not a comprehensive list):

- o Medicare (title XVIII),
- o Insurance policies,
- o Private health,
- o Group health,
- o Liability,

- o Automobile medical insurance,
- o Family health insurance carried by an absent parent, and
- o Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Cost avoidance means requiring that health care providers obtain payment from identified third party resources before billing Medicaid.

C. Preparation of Form HCFA-64.9a. -Complete the heading sections of the report by entering the name of the State and SA, and the ending date of the quarter.

Column (a) - Total Computable. -Enter the total computable amounts for Federal sharing.

Column (b) - Federal Share. -Enter the Federal share of the computable amounts reported in Column (a), applying the appropriate FMAP.

Section A - TPL Collections

Line 1 - Amount of TPL Collections Made In This Quarter By Source.

Line 1(a) - Medicare Title XVIII. -Enter the total computable and Federal share amount of refunds or collections from the Medicare program, e.g., a refund for erroneous payments to providers made by the SA that is returned to you by the Medicare Program.

Line 1(b) - Other Collections. -Do not enter collections made under cooperative agreements (see §1903(p) of the Act and P. L. 95-142) or assignment of rights (see §1912 of the Act) on these lines.

Line 1(b)(1) - Health Insurance. -Enter the total computable and Federal share amount of collections received from private or group health insurers (e.g., Blue Cross/Blue Shield, Mutual of Omaha) or prepaid medical plans (e.g., Kaiser Permanente). Health insurance includes disability compensation insurance (per day payment while in the hospital), major medical supplements to basic health insurance, and health insurance coverage through unions.

Enter the total computable and Federal share amount of collections received from family health insurance carried by an absent parent and not collected under a cooperative agreement authorized under §1903(p) of the Act.

Enter the amount received as a refund or collection from CHAMPUS.

Line 1(b)(2) - Casualty Insurance. -Enter the total computable and Federal share amount collected from casualty insurers such as general casualty insurance companies, automobile medical insurance, liability policies (such as home owners), workers' compensation judgments, and tort judgments awarded by the State and local court systems.

Line 1(c) - Total Collections Under Cooperative Agreements Section 1903(p) And Assignment Of Rights, Section 1912. -Enter only the total computable amount collected from absent parents under a cooperative agreement established under §1903(p) for the enforcement and collection of rights of support or payment assigned under §1912. Report amounts collected under the assignment of rights which are not covered by a §1903(p) cooperative agreement under the proper category, that is, health or casualty insurance.

Line 1(c)(1) - Less: Excess Paid To Individuals. -Enter the total computable amount collected under an assignment which exceeds the amount necessary to reimburse the medical assistance payments. This amount should have been paid to the individual.

Line 1(c)(2) - Net Collections To Reimburse State Title XIX Medical Payments. Enter the difference between Line 1(c) and 1(c)(1).

Line 1(c)(3) - Less: 15 Percent Incentive Actually Paid Under Section 1903(p)(1). -Enter the amounts paid or offset as an incentive payment to a locality or to another State securing collections on your behalf. These incentive payments (authorized in §1903(p)(1) of the Act) must be paid under a cooperative agreement which meets the requirements of §1903(p) of the Act and 42 CFR 433.151 - 433.154. Report only the amounts paid or offset by the State to a local entity or other State. See §2500.6.K.

Line 1(c)(4) - Net Federal Share Of Collections Reportable. -Enter the difference between Line 1(c)(2) and 1(c)(3).

Line 2 - Total TPL Collections. -Enter in the total computable amount column the sum of Lines 1(a), 1(b)(1)-(2) and 1(c)(2). Enter in the Federal share column the sum of Lines 1(a), 1(b)(1)-(2), and 1(c)(4). Enter the total computable and Federal share on Line 9.A of Form HCFA-64 Summary Sheet.

Section B - Cost Avoidance

Section 1902(a)(25) of the Act requires that State or local Medicaid agencies take all reasonable measures to ascertain the legal liability of third parties to pay for care and services of Medicaid recipients.

Line 1 - Medicare Title XVIII. -Enter the amount of claims not paid because of either full or partial payment for services by the Medicare program. The Federal share amount reported is limited by the maximum amount of Medicaid liability for the services furnished.

Line 2 - Health Insurance. -Enter the dollar amount of health insurance claims not paid, only to the extent allowed under the SA's payment schedule, because of either full or partial payment available from third party resources.

Line 3 - Other Cost Avoidance. -Enter the dollar amount of claims not paid, only to the extent allowed under the SA's payment schedule, because of either full or partial payment available from third party resources.

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THIRD PARTY LIABILITY COLLECTIONS
AND COST AVOIDANCE CHART

2500.4 Preparation of the Statement of Medicaid Overpayment Adjustments, Form HCFA 64.9o.A. General Information. -

1. Statutory Basis. -Section 1903(d)(2) of the Act requires that FFP be reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made to a State.

Additionally, §1903(d)(3) of the Act states that the Secretary considers the pro rata Federal share of the net amount recovered during any quarter by a State to be an overpayment.

Section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that you have 60 days from the date an overpayment to a provider is discovered to recover or attempt to recover that overpayment before the Federal share of the overpayment must be refunded. The Federal government shares in any overpayment which you are unable to recover because the provider is bankrupt or out of business.

2. Discovery. -Discovery signifies the date upon which the 60 calendar-day period for recovering or attempting to recover an overpayment commences. Guidelines for establishing this date are in §2853.2. During the 60-day counting period, partial State collection of an overpayment amount from a provider does not extend the 60-day time limit allowed from discovery for attempting to recover the total outstanding balance.

Once discovery occurs, any increasing or decreasing adjustments to the overpayment amount originally communicated, which are made in accordance with the approved State plan, Federal Medicaid laws and regulations, and the appeals resolution processes specified in your administrative policies and procedures are subject to the following conditions. Downward adjustment to the overpayment amount, while reducing dollars subject to recovery, has no effect on the 60-day recovery period for the outstanding balance. Upward adjustment to the overpayment amount does not affect the 60-day recovery period for the original amount. However, a new 60-day period begins, for the incremental amount only, on the date of the your written notice to the provider specifying the additional overpayment amount subject to recovery. Thus, for reporting purposes, such an increment is considered a separate overpayment amount.

3. Adjustment to the Federal Payment. -Refund the Federal share of an overpayment on the Medicaid expenditure report (Form HCFA-64) for the quarter no later than the report in which the 60-day period discovery ends.

If, for any valid reason, the amount credited the Federal government in refunding an overpayment is later adjusted downward, you may then make an adjustment on Form HCFA-64. Retroactive claims are allowed only for adjustments which are legitimately based upon the approved State plan, Federal Medicaid laws and regulations, and the appeal resolution processes specified in your administrative policies and procedures. The normal 2-year filing limit for retroactive claims does not apply to such adjustments, as downward adjustments to overpayment amounts are not retroactive claims but reflect the reclaiming of costs previously claimed.

NOTE: Overpayments recovered solely by reducing the current year per diem rate are not subject to the refund requirements. The refund of the Federal share does not occur until you claim the expenditures at the reduced rate.

You are not required to refund the Federal share of overpayment if the Federal share is collected and you report the collection on the appropriate line or you submit an expenditure claim reduced by a discrete amount to recover the overpayment prior to the end of the 60-day period following discovery.

You are not required to report as a collection any overpayment previously reported on Line 10.C. In addition, if you have refunded the Federal share of an overpayment and you subsequently make recovery by reducing future provider payments by a discrete amount, do not reflect that reduction in your claim for FFP.

Depreciation payments are considered overpayments if you require their recapture in a discrete amount upon gain on sale of assets.

4. Hold-Harmless Provisions. -Section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that the Federal government share in overpayments which constitute debts discharged in bankruptcy or which are otherwise uncollectible. If the provider files for bankruptcy or goes out of business before the 60-day period following discovery ends, you need not refund the Federal share of the overpayment. However, if the 60-day limit expires before the bankruptcy petition is filed or the provider is found to be out of business, you must refund the Federal share, regardless of your recovery. You must credit HCFA with the Federal share of any overpayment amounts which you recover under a court approved discharge of bankruptcy on the first Form HCFA-64 filed after their receipt. You must also refund the Federal share of any overpayment to a provider whose petition for bankruptcy is denied in Federal court on the later of the next Form HCFA-64 submission following the date of the court decision or the Form HCFA-64 submission for the quarter in which the 60-day period following discovery of the overpayment ends. Exemptions due to bankruptcy or out of business providers may be claimed only subject to the conditions specified in §2853.4.

5. Implementation Dates. -Overpayments which occurred before the October 1, 1985 effective date of the statute, must be reflected immediately on Line 10.B of the next Form HCFA-64 submission if they have not been already credited to HCFA. The date upon which an overpayment occurs is the date that you make the payment involving unallowable costs to a provider using your normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer).

Credit all overpayments which occurred on or after October 1, 1985 to HCFA on Line 10.C of the Form HCFA-64 for the quarter no later than the report in which the 60-day period following discovery ends. Any overpayments for which the 60-day recovery period has ended and for which a refund has not yet been made are due on the next Form HCFA-64 submission.

Collections related to overpayments that were adjusted on Line 10.B or 10.C need not be reported.

For each form filed, complete the heading sections by entering the name of the State and the SA and the ending date of the quarter reported.

The columns of the Form HCFA-64.9o separate expenditures into total payments computable for Federal sharing, the Federal share by FY, and the total Federal share.

B. Detailed Instructions. -Complete the Heading Sections of the report by entering the name of the State, title of the SA, the ending date of the quarter reported, and the appropriate FY as necessary.

Column (a) - Total Computable. -Enter the total computable amounts for Federal sharing.

Columns(b) - (e) - Federal Share. -Enter the Federal share of the computable amounts reported in Column (a), applying the appropriate FMAP for each FY.

Column (f) - Total Federal Share. -Enter the total Federal share of expenditures claimed for FFP (sum of Columns (b)-(e) for each line item).

Line 1 - Overpayment Not Collected Or Adjusted But Refunded Because Of The Expiration Of The 60-Day Time Limit. -Enter the total computable and Federal share amounts of overpayment which you are crediting the Federal government because 60 days have elapsed since discovery. Enter any incremental amounts which relate to overpayment previously refunded and for which the 60-day time limit following their discovery has expired.

Line 2 - Decreasing Adjustments To Amounts Previously Reported on Line 1. -Enter any downward adjustment to overpayment previously refunded. You may only report downward adjustments made in accordance with the approved State plan, Federal Medicaid laws and regulations, and the appeals resolution processes specified in State administrative policies and procedures.

Line 3 - Subtotal. -Enter the difference of Line 1 minus Line 2.

Line 4 - Previously Reported Overpayment To Providers Certified This Quarter As Bankrupt Or Out Of Business. -Enter previously reported overpayments to providers certified this quarter as bankrupt or out of business, subject to the following guidelines.

If you have previously refunded an overpayment for a provider which has filed for bankruptcy, the overpayment is considered uncollectible as of the date the bankruptcy petition is filed in court. The Federal share may be reclaimed. You must be on record with the court as a creditor in the amount of the Medicaid overpayment and refund the Federal share of whatever amounts you recover under the court-approved discharge of bankruptcy. Also refund the Federal share of any overpayment to a provider whose petition is denied.

If you have previously refunded an overpayment for a provider which has gone out of business, this overpayment is considered uncollectible and the Federal share may be reclaimed. However, mere transfer of ownership within your State does not ordinarily entitle you to this waiver unless State law and procedures deem a provider which has transferred ownership to be out of business and preclude collection of the overpayment from the provider.

In either the bankruptcy or out of business scenario, the Federal share of the overpayment refunded may be subsequently reclaimed only if, until the date of bankruptcy or closing of the business, you vigorously pursued recovery, at least according to your standard policy as prescribed in administrative procedures and State law, though without complete success. In asserting that a provider or other entity is out of business, document your efforts to locate the party and its assets and provide certification from the attorney general establishing that the provider is out of business and the effective date of that decision under State law.

Line 5 - Total Overpayment Adjustments This Quarter. -Enter the difference of Line 3 minus Line 4. Enter the amounts reflected in Columns (a) of Form HCFA-64.9o on Line 10.C, Columns (a) of the Form HCFA-64 Summary Sheet. Enter the amounts reflected in Columns (f) of Form HCFA-64.9o on Line 10.C, Columns (b) of the Form HCFA-64 Summary Sheet.

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MEDICAID OVERPAYMENT ADJUSTMENTS
CHART

2500.5 Preparation of the Statement of Expenditures For State And Local Administration For The Medical Assistance Program, Forms HCFA-64.10 and HCFA-64.10p. -

A. General Information. -Section 1903(a)(2) through 1903(a)(7) of the Act authorizes FFP in State expenditures the Secretary deems necessary for the proper and efficient administration of the State title XIX plan. The basic categories of costs and Federal matching rates are:

1. Section 1903(a)(2)(A). -Seventy-five percent FFP is available for compensation and training of skilled professional medical personnel and staff directly supporting such personnel of the SA or any other public agency. (See 42 CFR 432.2, 432.50 and 433.15(b)(5).)

NOTE: Report as MMIS operational costs the costs of personnel qualified as skilled professional medical personnel who are engaged in the MMIS functions.

2. Section 1903(a)(2)(B). -This section was added by OBRA 1987 and provides that 50 percent FFP is available for expenditures directly attributable to nurse aide training and competency evaluation programs as described in §1919(e)(1). Additionally, OBRA 1987 provides that expenditures for nurse aide training and competency evaluation programs for calendar quarters during Federal fiscal years 1988 and 1989 are reimbursed at your Federal medical assistance percentage plus 25 percentage points, but not to exceed 90 percent. OBRA 1990 extends the termination date to October 1, 1990.

3. Section 1903(a)(2)(C). -This section was added by OBRA 1987 and provides that 75 percent FFP is available for expenditures directly attributable to preadmission screening and resident review activities under §1919(e)(7).

4. Section 1903(a)(3)(A) and (B). -Ninety percent FFP is available for design, development, installation, or improvement, and 75 percent FFP for the operation (by the State or a contractor) of mechanized claims processing and information retrieval systems (commonly referred to as a MMIS). (See 42 CFR 433.112 and 433.116 and (4); 45 CFR Part 74 and Part 95, Subpart F; and Part 11, State Medicaid Manual.) Note that §1903(r) of the Act provides for reductions in the Federal matching rate for an operational MMIS which fails to meet specified Federal performance standards.

NOTE: Regulatory requirements regarding procurement of ADP equipment and services require that you obtain prior written approval from HCFA of any APD involving a request for 90 percent FFP. (See §2500.6.L.)

5. Section 1903(a)(3)(C). -Seventy-five percent FFP of costs attributable to the performance of medical and utilization reviews by a utilization and quality control Peer Review Organization (PRO) under a contract entered into under §1902(d) is available.

6. Section 1903(a)(4). -One hundred percent FFP is available for the costs directly attributable to the implementation and operation of the immigration status verification system described in §1137(d) of the Act. (See §2500.6.N.)

7. Section 1903(a)(5). -Ninety percent FFP is available for costs attributable to the offering, arranging, and furnishing of family planning services and supplies. (42 CFR 433.15(b)(2).)

8. Section 1903(a)(6). -Ninety percent FFP is available for the

first 12-quarter period beginning with the first quarter in which payment is made to you, and 75 percent FFP thereafter, of costs attributable to the establishment and operation of a State Medicaid fraud control unit. (See §1903(q) of the Act.)

NOTE: These costs are not reported on the Form HCFA-64.

9. Section 1903(a)(7). -Fifty percent FFP is available in the remainder of amounts expended as found necessary by the Secretary for the proper and efficient administration of the State plan.

10. Section 1903(a)(3)(A)(i). -This section was added by OBRA 1990 and provides that 90 percent FFP is available for State acquisition of electronic point-of-sale claims management systems. (See §1927(h)(2) of the Act.)

11. Section 1903(a)(3)(D). -This section was added by OBRA 1990 and provides that 75 percent FFP is available for States to provide prospective drug use utilization review (including counseling) and retrospective drug use review. (See §1927(g) of the Act.)

12. Section 1903 (a)(7). -This section was added by OBRA 1990 and provides that 75 percent FFP is available to assist States with start-up administrative costs of the drug rebate system.

Use, for reporting purposes, a base (one form) Form HCFA-64.10 summarizing all current quarter expenditures. Where separate HCFA-64.10 forms are prepared to report such items as individual waiver expenditures and other current quarter expenditures, the base Form HCFA-64.10 includes the expenditures reported on the separate forms. Amounts shown on the separate forms are informational and support amounts contained in the base Form HCFA-64.10 figures. Enter the totals on the base Form HCFA-64.10 on Line 6 of the Form HCFA-64 Summary Sheet.

Reporting on the Form HCFA-64.10p is different from the reporting on the Form HCFA-64.10 in that a single form is not used to summarize the data. Transfer amounts reported on each Form HCFA-64.10p directly to the appropriate line on the Form HCFA-64 Summary Sheet. Where two or more HCFA-64.10p forms are used to report expenditures for the same Form HCFA-64 Summary Sheet line, add the totals and report them on the appropriate line.

Report Medicaid costs associated with survey and certification of long term care facilities to:

Health Care Financing Administration
Health Standards and Quality Bureau
2-D-2 Meadows East Bldg.
6325 Security Blvd.
Baltimore, MD 21207

These costs are not reported on the Form HCFA-64.

Report costs in accordance with an approved cost allocation plan on file with DHHS. (See 42 CFR 433.34; 45 CFR Part 74, Subpart Q, and Part 95, Subpart E; and OMB Circular A-87, Attachment A.) Many States contract with a fiscal agent to perform MMIS and related functions. Because certain fiscal agent costs may not be eligible for Federal reimbursement at the operational MMIS matching rate, as specified in Part 11 and related guidelines, utilize a cost allocation plan for fiscal agent costs to ensure their proper reporting on the Form HCFA-64.

Use the Form HCFA-64.10 to report current period State and Local Administration expenditures of the Medical Assistance program. Report only expenditures for which supporting documentation, in readily reviewable form, has been compiled and is immediately available. Do not report estimated amounts. Report payments made in a prior period but not included on the expenditure report for that period, and payments made as adjustments to payments made in prior periods, on Form HCFA-64.10p. Use the same categories of expenditures as on the Form HCFA-64.10, but distribute them by Federal FY. Use this form to support amounts reported on Lines 7, 8, 10.A and 10.B of Columns (c) and (d) of the Form HCFA-64 Summary Sheet.

Report current quarter State and local administration expenditures related to waivers described in §2500.2.B on the appropriate line on the base Form HCFA-64.10. Use a separate Form HCFA-64.10 to report expenditures under a waiver. Enter the type of waiver and complete waiver number assigned by HCFA in the space provided. Report waiver related administrative expenditure payments made in a prior period on Form HCFA-64.10p.

NOTE: Report expenditures related to all services (e.g., approved waiver case management) listed in the State's approved HCBS waiver as a service. Claim them at the FMAP rate on Line 18 of the Form HCFA-64.9 or 64.9p. (See §2500.2.B.) Report only administrative costs related to the approved HCBS waiver on Form HCFA-64.10.

B. Preparation of the Quarterly Statement of Expenditures For State And Local Administration For The Medical Assistance Program Expenditures In This Quarter, Form HCFA-64.10. -Use Form HCFA-64.10 to report current period expenditures for State and local administration made in accordance with a State plan approved under title XIX of the Act.

Complete the heading sections of the report by entering the name of the State, title of the SA, and the ending date of the quarter reported.

Report all current quarter expenditures on the base (one form) Form HCFA-64.10. Additional HCFA-64.10 forms prepared to show current quarter waiver expenditures or other breakouts of current quarter expenditures are informational and identify specific amounts included in the figures on the base form. Space is provided to report the waiver type and number.

Report increasing adjustment payments made in the current quarter to private providers on Form HCFA-64.10, as they are considered current expenditures. However, report decreasing adjustments made in the current quarter to private as well as public providers on Form HCFA-64.10p. Such decreasing adjustments may not be netted out of payments reported on the Form HCFA-64.10.

The columns on Form HCFA-64.10 separate State and local administration expenditures into total payments computable for Federal funding, the different rates of Federal sharing and the total Federal share.

The sum of the amounts reported in Columns (b) - (e) for each line item equal the amounts reported in Column (f).

Column (a) - Total Computable. -Enter the total computable expenditures for Federal funding made during the quarter for State and local administration.

Columns (b), (c), and (d) - Federal Share. -Enter in Columns (b), (c), and/or (d), the Federal share of expenditures included in Column (a) for which 90, 75 and/or 50 percent FFP, respectively, is claimed.

Column (e) - Percent. -Enter in Column (e) the appropriate FMAP rate and the

Federal share of expenditures other than 90, 75 or 50 percent on its respective line. For example, report MMIS costs matchable at a reduced FFP rate due to imposition of a penalty under §1903(r) with the reduced FFP rate entered at the top. All amounts reported in this column must be footnoted and explained.

Column (f) - Total Federal Share. -Enter the total Federal share of expenditures claimed for FFP (sum of Columns (b) - (e) for each line item). For expenditures reported on Line 9, for which 100 percent FFP is claimed, enter in Column (f) the amount of expenditures claimed in Column (a).

Line 1 - Family Planning. -Enter in Column (a) the total computable administrative expenditures for family planning.

Enter in Columns (b) and (f) 90 percent of the amount reported in Column (a).

Line 2 - Design, Development Or Installation of MMIS.

Line 2.A - Costs Of In-house Activities Plus Other State Agencies And Institutions. -Enter in Column (a) the total computable amount of expenditures directly attributable to the design, development, installation, or enhancement of the MMIS.

Enter in Columns (b) and (f) 90 percent of the amount reported in Column (a).

Line 2.B - Costs Of Private Sector Contractors. -Enter in Column (a) the total computable amount of expenditures for the costs of private sector contractors directly attributable to the design, development, installation, or enhancement of the MMIS.

Enter in Columns (b) and (f) 90 percent of the amount reported in Column (a).

Line 2.C - Drug Claims System. -Enter in Column (a) the total computable amount of expenditures for the State acquisition of electronic point-of-sale claims management systems.

Enter in Columns (b) and (f) 90 percent of the amount reported in Column (a).

Line 3 - Skilled Professional Medical Personnel. -Enter in Column (a) the total computable amount of salaries and training for skilled professional medical personnel and directly supporting staff of the SA or other public agencies.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

Line 4 - Operation Of An Approved MMIS

Line 4.A - Costs Of In-house Activities Plus Other State Agencies And Institutions. -Enter in Column (a) the total computable amount of expenditures directly attributable to the operation of the MMIS.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

NOTE: If subject to a §1903(r) penalty, show FFP at the appropriate reduced rate in Column (e), not in Column (c).

Line 4.B - Costs Of Private Sector Contractors. -Enter in Column 9(a) the total computable amount of expenditures for the costs of private sector contractors directly attributable to the operation of the MMIS.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

NOTE: If you are subject to a §1903(r) penalty, show FFP at the appropriate reduced rate in Column (e), not Column (c).

Where your fiscal agent performs MMIS and other functions (e.g., provider audits), report the payments to the fiscal agent attributable to the non-MMIS functions on Line 7 (Other Financial Participation).

Line 5 - Mechanized Systems, Not Approved Under MMIS Procedures.

Line 5.A - Costs Of In-house Activities Plus Other State Agencies And Institutions. -Enter in Column (a) the total computable amount of expenditures directly attributable to the design, development, installation, improvement, or operation of a mechanized claims processing and information retrieval system not approved under MMIS procedures.

Enter in Columns (d) and (f) 50 percent of the amount reported in Column (a).

Line 5.B - Costs Of Private Sector Contractors. -Enter in Column (a) the total computable amount of expenditures for the costs of private sector contractors directly attributable to the design, development, installation, improvement, or operation of a mechanized claims processing and information retrieval system not approved under MMIS procedures.

Enter in Columns (d) and (f) 50 percent of the amount reported in Column (a).

Line 6 - Peer Review Organizations (PRO). -Enter in Column (a) the total computable amount of expenditures associated with medical and utilization reviews performed by a PRO under a contract entered into under §1902(d).

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

Line 7 - Other Financial Participation. -Enter in Column (a) the total computable amount of other administrative expenditures necessary for the proper and efficient administration of the State plan, and the total computable amount of training cost of personnel other than skilled professional medical personnel and their direct supporting staff, personnel involved in the operation of an approved MMIS, and personnel involved in family planning.

Enter in Columns (d) and (f) 50 percent of the amount reported in Column (a).

Line 8.A - Third Party Liability Recovery Procedure - Billing Offset. -Enter in Column (a) the total computable amount of the billing for the third party liability recovery procedure.

Enter in Columns (d) and (f) 50 percent of the amount reported in Column (a).

NOTE: HCFA recognizes your claim on the finalization of expenditures on the next grant award and makes a funding adjustment to collect your share of the billing. For example, SSA bills HCFA \$10,000 for you. The Federal share claimed by you is \$5,000. HCFA approves the \$5,000 claim but enters a negative \$10,000 funding adjustment, in effect recovering your share of the billing. (See §2500.) If you pay the bill, the recovery procedure is not used. Report payments on Line 7 of Form HCFA-64.10.

Line 8.B - Assignment of Rights-Billing Offset. -Enter in Column (a) the total computable amount of the billing for the assignment of rights.

Enter in Columns (d) and (f) 50 percent of the amount reported in Column (a). See note for Line 8.A.

Line 9 - Immigration Status Verification System Costs. -Enter in Column (a) the total computable amount of the reasonable and necessary expenditures directly attributable to the immigration status verification system described in §1137 of the Act in accordance with the allocation methodology approved by the RO. Only reasonable and necessary, direct and indirect, costs of activities directly related to the exchange of information necessary to verify Immigration and Naturalization Service (INS) is reimbursed at 100 percent. Enter in Column (f) the amount reported in Column (a).

NOTE: Reimbursement at 100 percent FFP is available only for expenditures incurred on or after October 1, 1987.

Line 10 - Nurse Aide Training and Competency Evaluation Programs Costs. - Enter in Column (a) the total computable amount of expenditures for nurse aide training and competency evaluation program costs.

Enter in Columns (e) and (f) the Federal percentage times the amount reported in Column (a).

NOTE: The Federal matching rate is 50 percent for nurse aide training and competency evaluation programs. However, from July 1, 1988 through September 30, 1990, the matching rate is your Federal medical assistance percentage plus 25 percentage points, but not to exceed 90 percent.

Line 11 - Preadmission Screening Costs. -Enter in Column (a) the total computable amount of expenditures for preadmission screening costs.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

Line 12 - Resident Review Activities Costs. -Enter in Column (a) the total computable amount of expenditures for resident review activities costs.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

Line 13 - Drug Use Review Program. -Enter in Column (a) the total computable amount of expenditures for drug use review program costs.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

Line 14 - Drug Implementation Costs. -Enter in Column (a) the total computable amount of expenditures for drug implementation costs.

Enter in Columns (c) and (f) 75 percent of the amount reported in Column (a).

Line 15 - Total. -Enter the total amounts from Lines 1 through 14 for the amounts reported in Columns (a) through (f).

Enter the amount reported on Line 15, Column (a) on Line 6, Column (c) of the Form HCFA-64, Summary Sheet. Enter the amount reported on Line 15, Column (f) on Line 6, Column (d) of the Form HCFA-64 Summary Sheet.

C. Preparation of the Quarterly Statement of Expenditures For State And Local Administration For The Medical Assistance Program Prior Period Adjustments, Form HCFA-64.10p. -Use the Form HCFA-64.10p to report prior period expenditures for State and Local Administration made in accordance with a State plan approved under title XIX of the Act. Complete the heading sections of the report by entering the name of the State, title of the SA, the ending date of the quarter reported, and the FY for the prior period adjustment. Check the appropriate box for Line 7, 8, 10.A or 10.B.

If the Form HCFA-64.10p reports prior period expenditures under a waiver, enter the type of waiver and complete waiver number in the space provided.

Column (a) - Total Computable. -Enter the total computable expenditures for prior periods made during the quarter reported for State and Local Administration expenditures of the Medical Assistance Program.

Columns (b), (c), and (d) - Rates of Federal Sharing. -Enter in Columns (b), (c), and/or (d), the Federal share of expenditures included in Column (a) for which 90, 75 and/or 50 percent FFP, respectively, is claimed.

Column (e) - Percent. -Enter in Column (e) the appropriate FMAP rate and the Federal share of expenditures other than 90, 75 or 50 percent on its respective line. For example, report MMIS costs matchable at a reduced FFP rate due to imposition of a penalty under §1903(r) with the reduced FFP rate entered at the top.

Column (f) - Total Federal Share. -Enter the total of Columns (b) - (e) by category. For expenditures reported on Line 9, for which 100 percent FFP is claimed, enter in Column (f) the amount of expenditures claimed in Column (a).

Column (g) - Deferral, Disallowance or CIN NO.. -Enter the deferral, disallowance and/or CIN.

Lines 1 Through 14. -Follow instructions for Form HCFA-64.10. (See §2500.5.B.)

Line 15. -Enter the total amounts from Line 1 through Line 14 for the amounts reported in Columns (a) through (f).

Enter the total amounts in Columns (a) and (f) on Form HCFA-64 Summary Sheet Line 7, 8, 10.A or 10.B, Column (c) and (d), as appropriate.

THIS PAGE RESERVED FOR
EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION
FOR THE MEDICAL ASSISTANCE PROGRAM
EXPENDITURES IN THIS QUARTER CHART
FORM HCFA-64.10 (LINE 6((4-91))

THIS PAGE RESERVED FOR
EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION
FOR THE MEDICAL ASSISTANCE PROGRAM
PRIOR PERIOD ADJUSTMENTS CHART

2500.6 Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program - Reference. -

A. Overpayments. -Overpayments are not considered payments made in accordance with your approved State plan and, therefore, are not allowable for FFP. An overpayment is any amount in excess of the amount that should have been paid and is refunded as required under §1903 of the Act. Examples of overpayment are:

- o Duplicate payments;
- o Payments for noncovered services;
- o Payments to the wrong provider;
- o Excessive provider reimbursement attributable to reimbursement rate setting methods or aggregate payments that are higher than the upper payment limit, and
- o Payments made at incorrect rates.

Situations involving fraud or abuse constitute overpayments, as do excess payments to institutional providers which you seek to recover in lump sum, by installments or by withholding a portion of future payments. However, excess payments to institutional providers which you recover solely through adjustment to the per diem rate for a subsequent period are overpayments, but not subject to these reporting guidelines.

Likewise, incorrect payments involving TPL, probate collections, administrative costs or errors in recipient eligibility do not constitute overpayments for these reporting purposes. Cases involving TPL represent payments that would be allowable had another payer not been responsible for them. In providing that a refund to the Federal Government is not due until the State has been reimbursed by a liable third party, §1903(d)(2)(B) of the Act further distinguishes TPL cases from the refund requirements of §1903(d)(2)(C) of the Act. Likewise, probate collections from the estates of deceased Medicaid recipients represent the recovery of payments properly made from resources later determined to be available to the State and are not subject to these regulations. As COBRA §9512 addressed only provider overpayments, overpayments involving administrative costs must be refunded immediately following discovery as required under §1903(d)(2)(A) of the Act. The Federal government recoups recipient overpayment dollars exclusively on the basis of Medicaid Eligibility Quality Control (MEQC) penalties for periods during which MEQC systems are in effect. The Federal share of overpayment involving recipients must be refunded immediately following discovery, as required under §1903(d)(2)(A) of the Act, only if the overpayment occurred during a period for which MEQC systems were not in effect.

Section 9512 of COBRA does not require you to refund the Federal share of overpayments which occurred on or after October 1, 1985, if this constitutes debts discharged in bankruptcy or involve out of business providers, where no collection is possible.

Refund the Federal share of any overpayment which occurred before October 1, 1985 on the next Form HCFA-64 submission following discovery, regardless of whether you have made complete recovery from the provider. For an overpayment which occurred on or after October 1, 1985, the Federal statute allows up to 60 days to pursue recovery after which the Federal share must be credited to HCFA regardless of whether you have completed recovery. The date upon which an overpayment occurs is the date you make the payment involving unallowable

costs to a provider, using your normal method of reimbursement for a particular class of provider, e.g., interfund transfer, check. These refunds must be made on the Form HCFA-64 for the quarter no later than that in which the 60-day period following overpayment discovery ends. (See §2853.)

B. Return of the Federal Share of Recoveries and Collections. -Form HCFA-64 also shows the Federal share of recoveries from any source of expenditures claimed in prior quarters.

Include refunds from overpaid Medicaid providers or recipients, cancelled, uncashed or voided checks and vouchers (see 42 CFR 433.40), or settlements from liable third parties such as private insurance and casualty related court settlements.

Upon receipt of such funds, determine the date or period of the expenditure for which the refund is made to establish the FMAP at which the original expenditure was matched by the Federal government. Make refunds of the Federal share at the FMAP for which you were reimbursed. When recoveries cannot be related to a specific period, compute the Federal share at the FMAP rate in effect at the time the refund was received. Make adjustments to prior periods in subsequent HCFA-64 forms to reflect the correct FMAP rate.

C. Civil Monetary Penalties (CMP). -Section 1128A of the Act authorizes the imposition of CMPs and assessments against persons who have submitted certain prohibited claims under the Medicaid program. This authority provides that legal action may be taken to obtain the return of State and Federal funds disbursed on the prohibited claims, as well as additional penalty and assessment amounts.

When the State and Federal share of these funds are recovered, an adjustment of reported expenditures is necessary. Reduce the amount of prohibited claims from your total computable amount of expenditures and the Federal share from Federal expenditures.

Penalty and assessment amounts do not change either the State or Federal expenditures. Collections from the provider are made by the DHHS and deposited into the proper Federal accounts. A check is issued to you for any State funds collected. You are informed as to the amount of State and Federal expenditures to adjust on your Form HCFA-64.

If you receive the entire overpayment (both State and Federal share) from the provider, report on Line 9.C of Form HCFA-64 Summary Sheet both the total computable amount and the Federal share and footnote the action. No further action on your part is necessary. If you receive only your share, report on Line 9.C of the Form HCFA-64 Summary Sheet the total computable amount and the Federal share. The Federal share is not used in the grant award computation and, therefore, does not affect your award authority.

P.L. 100-93, enacted on September 11, 1987, allows you to share in the penalties and assessments collected under CMP to the extent of the FMAP(s) in affect during the period of overpayment. The law effects settlement agreements made on or after September 1, 1987. The order of collection is interest first, overpayment, and then penalty and assessment.

D. Cash Holding Accounts. -Collections and refunds are often held by a State in cash holding accounts while the appropriate periods to which they must be assigned are identified. Accounts such as these must be cleared at the end of each quarter and the Federal share of the funds returned along with the Federal share of any interest earned. Where the appropriate FMAP rate cannot be determined by the time the next quarterly Form HCFA-64 is prepared,

apply the current FMAP to compute the Federal share. Adjustments to reflect the correct FMAP rate may be made in subsequent HCFA-64 forms as adjustments to prior periods.

Even though all funds are properly reported to HCFA under these procedures and the grant award ultimately adjusted, this procedure only assures correct reporting. To assure proper cash management and preclude disallowances for interest earned in accordance with OMB Circular A-87 Attachment A(C)(1)(g) and (C)(3)(a) and (b) and Departmental Appeals Board Decision No. 361 and 588, implement the cash management procedure discussed in subsection E.

E. Reducing Cash Drawdowns to Reflect Recoveries. -Deposit Medicaid recoveries made during a quarter in the Medicaid disbursement account. Reduce subsequent drawdowns of Federal Medicaid funds accordingly. If for any reason you are unable to deposit recoveries in the disbursement account, reflect the recoveries in subsequent Medicaid drawdowns.

This insures that Federal funds are drawn only to meet net disbursement requirements. Show all recoveries and the interest earned on the recoveries on the expenditure report for that quarter.

When you refund an overpayment adjustment required under §9512 of COBRA of 1985, reduce your next draw against the Medicaid disbursement account by the amount of the overpayment. (See §2500.4.A.3 for further information.)

F. Interest Income on Grant Related Funds. -Report the Federal share of any interest received on Medicaid recoveries on the Form HCFA-64 Summary Sheet, Line 3.A.

G. Third Party Liability (TPL) Recovery Procedure - Billing Offset. -This is an administrative procedure to reimburse the Social Security Administration (SSA) for the cost of collecting TPL information by SSA field offices from Supplemental Security Income (SSI) applicants and recipients who are also eligible for Medicaid. States that have agreements with SSA to make Medicaid eligibility determinations under §1634 of the Act must also agree to have TPL information collected during SSI application and redetermination interviews. The health insurance information collected during the interviews is forwarded to the State Medicaid agencies for use in TPL recovery and cost avoidance systems to identify third party insurers and utilize third party health insurance coverage of SSI recipients instead of making Medicaid program payments. The collection of this information is authorized by §1902(a)(25) of the Act.

The §1634 States receive a quarterly invoice from HCFA showing the amount due for collecting and forwarding this information. The invoice shows the estimated cost for the upcoming quarter and any adjustments necessary to reflect the difference between the prior quarter's estimated and actual costs. Show any disputed amounts that have been resolved as an adjustment. Upon receipt of an invoice, either pay HCFA the amount invoiced or have the amount offset against your quarterly grant award authority.

If you fail to make a timely payment, the billed amount is offset against your quarterly grant award authority. Where you make a payment to HCFA, show the total computable amount and Federal share on Line 7 of Form HCFA-64.10. Where the amount invoiced is offset against your grant award authority, show the total computable amount and Federal share on Line 8.A. In these cases, HCFA recognizes the expenditures on the grant award for the expenditure report and deducts the invoiced amount from the funds to be reimbursed.

H. Assignment of Rights - Billing Offset. -Section 2367 of the Deficit Reduction Act of 1984 (P. L. 98-369), mandates that States require, as a condition of Medicaid eligibility, that a person assign his/her rights to payments for medical support and other medical care to the State. The person must also cooperate with the State in establishing paternity and obtaining third party payments. In addition, applicants and recipients must assign the rights of any other individual eligible under the Medicaid State Plan for whom he/she can legally make an assignment. SSA's revised regulations allow a State to have a §1634 agreement with SSA and also implement §2367. (See 20 CFR Part 416.) Under this procedure, SSA obtains assignments from new SSI/Medicaid eligible applicants only. The Medicaid State agency obtains assignments from all SSI/Medicaid recipients. To ensure all recipients are covered by this procedure, SSA provides each State a listing of all existing SSI/Medicaid recipients.

Each quarter, HCFA forwards an invoice showing the estimated SSA cost for collecting and reporting the assignment of rights for the upcoming quarter. The invoice includes any necessary adjustments for the difference between the prior quarter's estimated and actual costs and any disputed amounts that have been resolved. Upon receipt of any invoice, either pay HCFA the amount invoiced or have the amount offset against your Medicaid quarterly grant award authority. If you fail to make a timely payment, the billed amount is offset against your quarterly Medicaid grant award authority. When a payment is made to HCFA, show the total computable amount and Federal share shown on Line 7 of the Form HCFA-64.10. Where the amount invoiced is offset against your Medicaid quarterly grant award authority, show the total computable amount and Federal share on Line 8.B. In these cases, HCFA recognizes the expenditures on the grant award for that expenditure report and deducts the invoiced amount from the funds to be reimbursed.

For States participating in both the TPL recovery procedure and the assignment of rights, HCFA issues one invoice covering the costs incurred by SSA for providing the TPL information as well as costs incurred for obtaining the assignment of rights. The invoice details the costs separately for each category so that you can report each expenditure correctly.

I. Cost of Determining a State's Medicaid Eligibility Quality Control (MEQC) Error Rate. -Section 133 of the Tax Equity and Fiscal Responsibility Act of 1982 (P. L. 97-248) set the payment error rate tolerance level at 3 percent. It requires that this rate be achieved by the States in the third and fourth quarters of FY 1983 and in each succeeding fiscal year.

Regulations covering the implementation of §133 are in 42 CFR Part 431, Subpart P. If you fail to cooperate in completing a valid MEQC sample or individual reviews in a timely and appropriate fashion, under the authority of 42 CFR 431.804(c)(6), HCFA establishes your payment error rate. This is based on a special sample or audit, the Federal subsample, or on such other basis as the Administrator prescribes.

42 CFR 431.804(c)(7) provides that when it is necessary for HCFA to exercise the authority in 42 CFR 431.804(c)(6), the amount that would otherwise be payable under title XIX of the Act is reduced by the full costs incurred by HCFA in making the determinations. HCFA may make the determination directly or under contractual or other arrangements.

J. Contingency Fee Reimbursement for TPL Collections. -Contingency fees are based upon a percentage of the amounts recovered from, or identified as, liable third party resources. (See §2975.)

In practice, it is customary for contractors/attorneys to take their fee off

the top and to return the TPL recovery, less their fee. This simplifies and facilitates the cash flow for the administrative cost of the contract. However, administrative monies must be separately reported from program benefit dollars. Contract fees for identification and/or collection from liable third parties are administrative expenses. Consequently, for financial reporting, the amount recovered with respect to medical assistance is the total amount of the overpayment prior to the deduction of any collection fee expenses. Report this figure at the applicable FMAP rate on Form HCFA-64.9a. Any proper administrative expenses (attorney/contractor collection fees) incurred in making the recovery are eligible for reimbursement at a 50 percent FFP rate and reported on the Form HCFA-64.10.

Also, report on Form HCFA-64.9a. incentive payments or offsets made to a locality or to another State securing collections authorized under §1903(p)(1) which meet the requirements of §1912. (See 42 CFR 433.151-433.154.)

K. Prior Approval Requirements for State Agency Contracts. -Your contracts and subcontracts are subject to regulations in 42 CFR Parts 433, 434 and 462 and 45 CFR Parts 74 and 95. They generally allow you to enter into contracts without prior Federal approval unless prior approval requirements are specified. For example, 45 CFR 95.611 requires that you obtain prior written approval from DHHS for contracts for automatic data processing (ADP) equipment and services where the total estimated Federal and State funding for the acquisition equals:

- o \$200,000 or more over a twelve (12) month period,
- o \$300,000 or more for the total acquisition, or
- o \$25,000 where the equipment/services are acquired noncompetitively.

This applies not only to procurement of ADP equipment and services but to procurement of fiscal agents whose primary function is to provide mechanized claims processing and information retrieval systems and/or the ADP services required to operate such systems.

42 CFR 433.112 and Part 11 of the SMM require you to obtain prior written approval from HCFA for any Advance Planning Document (APD) involving a contract for the design, development, installation and/or improvement of Medicaid Management Information Systems (MMIS) where enhanced funding at the 90 percent rate is requested regardless of the funding amount.

45 CFR Part 74, Appendix G-6 requires prior written approval for proposed contracts where the procurement:

- o Is expected to exceed \$10,000 and be awarded without competition or only one bid or offer was received in response to solicitation,
- o Is expected to exceed \$10,000 and specifies a brand name product, or
- o Procedure or operation fails to comply with one or more significant aspects of 45 CFR Part 74, Appendix G.

45 CFR 74.171 (see OMB Circular No. A-87) requires prior approval for contracts for management studies performed by agencies other than the grants department or outside consultants.

While all requests for prior APD approval are submitted to the Assistant Secretary for Management and Budget (ASMB), DHHS, simultaneously submit requests which involve only title XIX funding to your servicing RO, attention of the Associate Regional Administrator. Include the:

- o APD,
- o Request for proposals,
- o Detailed implementation plan,
- o Proposal evaluation plan,
- o Final contending proposals,
- o Proposed contract,
- o Contract amendments, and
- o Extensions.

See §2080 for further information.

L. Claiming FFP for Certain Training Costs. -Treat costs associated with training an individual in the same manner as the individual's salary costs. Claim training costs associated with individuals whose salary is treated as a service cost as a service cost. They are reimbursed at the FMAP rate. Where their salaries are part of the cost pool used in calculating per diem rates, the training costs are included in the per diem rate calculation. Conversely, claim training costs associated with individuals whose basic salaries are properly claimed as a State or local administrative cost, as administration. The Federal matching rate for administration training costs is 50 percent unless a higher rate is warranted under 42 CFR 432.50 and related regulations.

M. Collection of Overdue Medicare Part B Premiums. -On September 30, 1985, in Federal Register, Volume 50, Number 189 at Page 39784, HCFA published its policy on collection of Medicare Part B premiums from States with buy-in agreements. It describes the assessment of interest on overdue premiums and offset against FFP if HCFA does not receive payments by the specified due dates.

Under §1843 of the Act, you may contractually agree with the Secretary to enroll in Medicare Part B (Supplemental Medicare Insurance) Medicaid beneficiaries who are also eligible for Medicare. These agreements are commonly referred to as buy-in agreements. States which have entered into buy-in agreements agree to enroll individuals eligible for both programs in the Part B program and to pay the premiums on their behalf. If a State fails to pay premiums due, it violates the terms of the contractual agreement.

The first day of the month to which the Part B premium applies is the due date from which interest accrues. There is a 25-day grace period for payment. Interest is waived for payments received by the 25th day of the month to which they apply. This allows approximately 45 days from the billing date for receipt of payment. On premiums which remain unpaid at the end of the grace period, interest is charged from the first day of the month to which the premiums apply.

For example, if the Part B premium payment is due on October 1, interest accrues beginning October 1 unless full payment is received by October 25. The

applicable interest rate is the SMI Trust fund rate as computed for new investments in accordance with §1841(c) of the Act, 42 U.S.C. 1395t(c).

Under the authority of the DHHS debt collection procedures in 45 CFR Part 30, an offset is made against monies due the State on its Medicaid grant award authority for premiums which are overdue beyond the grace period. Accrued interest on overdue premiums are assessed from the first day of the month to which the premiums apply to the date of offset. This is not a disallowance of FFP. Offset is an accounting adjustment, after the amount of FFP is determined, which reduces the amount of money paid to a State.

Report the total computable amount and Federal share on Line 17.B of Form HCFA-64.9 regardless of whether the payment is made by you or offset by HCFA. In these cases, HCFA recognizes the expenditures on the grant award for that expenditure report and deducts the invoiced amount from the funds you are reimbursed. Report interest charged on overdue premiums on Line 5 of HCFA-64 Summary Sheet.

The total computable amount to use for determining the Federal share is shown on the bottom of each monthly bill sent to you on the Summary Accounting Statement, Medicare Insurance Premiums (Form HCFA-1604). The amount shown represents the portion of the premium liability which qualifies for Federal sharing based on your identification of the title XIX Medical Assistance only recipients with buy-in coverage. Since this amount is calculated using your input of the buy-in eligibility codes, it is important that these codes be correctly reported to SSA. (See State Buy-In Manual, §225.)

N. Immigration Status Verification System Costs. -Section 121(a) of the Immigration Reform and Control Act (IRCA) of 1986 (P. L. 99-603) requires that, beginning October 1, 1988, an applicant for or recipient of Medicaid benefits must declare in writing that he/she is a citizen or national and present either alien registration documentation or other documents that you determine constitute evidence of satisfactory immigration status. Use this evidence to verify the individual's immigration status with the Immigration and Naturalization Services (INS).

Section 121(b) of IRCA amended §1903(a) to provide for 100 percent funding of the administrative costs of implementing and operating an immigration status verification system to verify evidence with INS. Section 121(c) of IRCA requires that INS make a verification system available to you by October 1, 1988. You may, at your option, choose to verify immigration status using the INS designated system prior to October 1, 1988 and receive 100 percent funding of the administrative costs of implementing and operating of an immigration status verification system in accordance with IRCA.

You are reimbursed only for those reasonable and necessary costs directly related to the implementation and operation of the INS designated system. You may claim those labor and non-labor activities directly related to the primary and secondary verification process with INS. Other functions that are integral to the eligibility determination process, but separate from the immigration status verification system requirements, continue to be reimbursed at the 50 percent matching rate.

O. Recovery of Unallowable Medicaid Expenditures When the State Agrees to the Adjustment. -When the RO or the Office of Inspector General (OIG), Office of Audit, issues a financial management review report or an audit report to you containing a recommended financial adjustment and you agree in writing to refund the amount in question, HCFA allows you to refund the unallowable expenditure by making a Line 10.A or 10.B adjustment on the next quarterly expenditure report (Form HCFA-64) submission following the date you agree

regardless if the HCFA-64 submitted is for a period that precedes the date of the agreement letter. However, if you do not make the adjustment on the next Form HCFA-64 submission, HCFA processes a negative grant award to recover the amount within 15 days of HCFA receipt of the Form HCFA-64 which should have included the refund. The basis for this recovery is the agreement letter received from you.

P. Case Management Services. -Claim case management as a Medicaid service only when it is provided:

- o As an integral and inseparable part of another covered Medicaid service,
- o In a waiver approved under §1915(c) as home and community-based services,
- o As an optional service under §1915(g) when included in the approved State plan, or
- o In a Freedom of Choice waiver approved under §1915(b) to implement a primary care case management system and the services are performed by a vendor.

When claiming case management as a Medicaid service in these instances, fully document your claim as you would for any other Medicaid service. If you pay for case management through a capitation or prepaid health plan arrangement, the requirements of 42 CFR Part 434 must be met. When you make other arrangements to provide the service, you must provide the following minimum documentation:

- o Date of service,
- o Name of recipient,
- o Medicaid identification number,
- o Name of provider agency and person providing the service,
- o Nature, extent, or units of service, and
- o The place of service.

Time studies, random moment sampling, cost allocation plans, and other methods which you use to support Medicaid administrative expenditures are not sufficient to support a claim for a Medicaid service. If these documentation requirements are not met, the expenditure is disallowed for lack of supporting documentation. These documentation requirements apply to both public and private providers. Remember that when you use public providers to provide the service, your expenditures cannot exceed actual cost as required by OMB Circular A-87.

Certain case management functions can be claimed as Medicaid administration as necessary for the proper and efficient administration of your approved State plan. (See §4302.)

Q. Preadmission Screening Costs. -Effective January 1, 1989, you must have a preadmission screening program for mentally ill and mentally retarded individuals who are admitted to nursing facilities on or after January 1, 1989. These costs are reimbursed as an administrative cost at 75 percent.

R. Resident Review Activities Cost. -As of April 1, 1990, provide a review for each resident who is mentally ill. You must review and determine based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority:

o Whether the resident, because of his/her physical and mental condition, requires the level of services provided by a nursing facility, by an inpatient psychiatric hospital for individuals under age 21 (as described in §1905(h)), or by an institution for mental diseases providing medical assistance to individuals 65 years of age or older, and

o Whether the resident requires active treatment for mental illness.

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, you must review and determine:

o Whether the resident, because of his/her physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility (ICF) described under §1905(d), and

o Whether the resident requires active treatment for mental retardation.

The reviews must be conducted annually. In the case of a resident subject to preadmission review, the review and determination need not be done until the resident has resided in the nursing facility for one year. For those not subject to preadmission review, the reviews must be conducted no later than April 1, 1990.

Your expenditures for nurse aide training and competence evaluation, preadmission screening and annual resident review, and the nurse aide registry are reported on the Form HCFA-64, not on the Form HCFA-2824.