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March 26, 1984

Joe Pappy, Rick Saul

Teleconference

SB 509 - Physical Therapists

SB 510 - Medicaid

Anchor

Dr. John Godfrey - Chiropractor.

In 1981, A.C. opinion on P.T. - feel they should have the right to use another licensed profession.

\* Rick - P.T.'s feel they need not treat only by referral, but independently.

Godfrey - question scope of practice for independent work.

Glennallen

Dr. Dallas Nelson - chiro

SB 509 - support.

SB 510 - support freedom of choice for low income people.

~~Walt in~~ Alvin

Anchor

Bill McCasoe - ATC

CS/SB 510 - support.

psychological and social services

Anchor

Gary McCarthy - P.T. private practice

Hal Ebert - P.T. / Endicover

In last 10 years change in P.T. 6 states allow practice w/o referral. 27 states allow consultation after initial visit for ind. practice.

delete all but last sentence

Therapist stretch & mobilize not that much manipulation

95% referrals from M.D.'s  
 Make it unlawful for P.T. not to refer pts.  
 or to other professionals.

Archa Gary McCarthy - PT

patient response good.  
 Chiropractor who testified from Kentucky  
 said he knows little about training for P.T.  
 so he questions what types of referrals  
 would be received.

FBKS

Dr. G.S. ~~Hulse~~ Khalsa - Chiro.

SB 510 - support freedom of choice of providers.

Archa

Pat Mladoo - P.T., Pres. P.T. Assoc.

SB 509 - feel strongly that they need to  
 be recognized as a profession and not tied  
 to lic. Calif. & Illinois, practice  
 independently - also in U.S. Army. Support  
 C.E.

mechanism → stringent regulation by State  
 board, ability to act quickly.

Archa

Susan Pettis - P.T.

specialty - orthopedics.

Very professional people - support  
 open referrals. M.D.'s refer w/ specific  
 procedures → maybe

Archa Donna Klakke - PT/Chair. of PT Board.

a person may financially profit  
 from referrals. Delaware does not allow  
 M.D.'s to have PT in their practice

Chiro. diagnostic work-up not appropriate  
to illness.

Met Em Alice Hallinger - P.T.

agree w/ testimony of other P.T.'s  
who had in appropriate referrals from  
MD's that could have had serious  
consequences if done.

difficult to refuse a referral from an M.D.  
may not be any different w/ chiro -> creates  
hard feelings etc.

Pt. aligned w/ traditional medical treatment.

Arch Diane Allen - P.T.

support practice w/ referral  
convenient for chiro. to hire a P.T. if no one  
will take referrals.

June Beth Hansen - Pt. All P.T. Assoc

philosophical difference between medical  
and chiropractic professions. The traditional  
medical approach. Chiro. diagnosis would  
not provide sufficient information for  
background for therapy.

Code of Ethics require treatment of other  
professionals with respect; and could see  
litigation over referral refusal. The professional  
association (nat'l) code of ethics does not  
allow chiropractic referrals.

June Rob Pettie - DHSS

SB 510

Medicaid only pay for - manual manipulation / x rays

CORF - AG opinion on ATC, do qualify as a  
CORF by Medicare. ATC offers services not  
covered under Medicaid - state cannot  
cover social worker/psychological services.

Clemellen Dr. Vicki Nelson - chiro.  
freedom of choice of providers.

Archa Marcia Wakeland - PT Eagle River

Archa Lisa Brooks - P.T.

Siddons Monica Lofgren - P.T.; on Board  
against broadening referrals.

Archa Susan Hutchinson - PT  
different philosophies.

Kim Busch - 3347

1. Transferring people from hosp. ~~and~~ <sup>to</sup> nursing home.
2. ATC - Comp. outpt. rehab. ~~unit~~ <sup>facility</sup>.

Presp. Reimb.

CORF

3 spec. services

- soc. & psych services

CORF - as def. under Fed Medicare Regulations.

3.

STATE OF ALASKA 1984 LEGISLATIVE SESSION  
FISCAL NOTE

Revision Date: \_\_\_\_\_

REQUEST

Bill/Resolution No.: HB 712  
 Title: "An Act relating to the pro-  
 vision of chiropractic & CORF services under Medicaid"  
 sponsor: \_\_\_\_\_  
 Requestor: House & Labor & Commerce Committee  
 Date of Request: 4/10/84

FISCAL DETAIL

Agency Affected: DHSS - D1A  
 Program Category Affected: Medicaid  
 BRU, Program or Subprogram(s) Affected: \_\_\_\_\_

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		44.0	25.9	28.0	30.2	32.6
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		809.3	1117.9	1206.5	1302.2	1405.5
800 MISCELLANEOUS						
TOTAL OPERATING		853.3	1143.8	1234.5	1332.4	1438.1
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		426.6	571.9	617.2	666.2	719.0
FEDERAL FUNDS		426.7	571.9	617.3	666.2	719.1
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

See Attached

ANALYSIS: Attach a separate page for analysis

Prepared By: Jeffrey Hubbard  
 Division: Medical Assistance

JCC  
 Phone: 465-3355  
 Date: 7/12/84

Approved by Commissioner: Robert Loden Smith  
 Agency: Department of Health & Social Services

Date: 4/17/84

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Cost Analysis  
CORF Services

	<u>FY85</u>	<u>FY86</u>
A. # of Total Annual Recipients (FY83)	2058	10,516
B. # of Recipients Needing Rehabilitation	253 Annually	368 Annually
C. Psych Evaluation (\$172 per evaluation C = \$172 (b)) Limit Once Annually	\$43,516	\$63,296
D. Social Work (80% of B for 30 Hours annually at \$72/hour or 2160 per recipient)	\$437,184	\$635,040
E. Psychology Services (50% (b) for 15 hours annually at \$92/hr or \$1,380 per recipient)	<u>\$174,570</u>	<u>\$253,920</u>
Subtotal	\$655,270	\$952,256
F. FY85 our Admin with B recipients at \$2.80 per claim and 5.7 claims/recipient	<u>\$4,037</u>	<u>\$5,873</u>
Yearly Cost	\$659,307	\$958,129
G. Enrollment, AMPS Modification for MARS, SURS and PBA	<u>\$20,000</u>	<u>\$20,000</u>
Total Operating	\$679,307	\$978,129
FY85 General Fund 50%	\$349,304	\$489,064
Federal 50%	\$349,304	\$489,065

The chief impact of this bill would be a) the expansion of providers who can be reimbursed by Medicaid for psychological services; and b) the inclusion of social services as a covered service in an outpatient clinic; and c) the increase in administrative costs for surveillance and utilization review.

FY85 costs were computed by estimating the cost of psychological and social services rendered at Alaska Treatment Center, which is the only certified CORF, for all medicaid recipients treated there (253 recipients). Psychological services consist of a 2 hour evaluation for all recipients followed by an average of 15 hours of therapy for 50% of the recipients. Social services are budgeted for 80% of the recipients for an average of 30 hours per recipient.

While Alaska currently has only one CORF, in FY86 it is expected the number of CORF's will be expanded. Especially given the proposed expansion by Humana and Providence Hospitals of inpatient rehabilitation beds of 15 each. These two facilities handle significant numbers of medicaid patients and referrals from all around the State. It is estimated that 3.5% would make use of the "new" CORF services.

## Cost Analysis for Chiropractic Services

### Contractual

Chiropractors will need to be added to the Alaska Medical Payments System (AMPS). The contractual costs include the following: provider manuals, training, a new claims form, tables included in the system for chiropractic services, computer programming, computer reports, the addition of collocation codes, the provision of notice to providers, provider relations, and a computer system test.

### Grants/Claims

These figures were adjusted by an inflation factor of 7.5%. This is the average percent increase experienced during the past two years in chiropractic services. These costs are for only manual manipulation of the spine and the x-rays necessary for diagnosis. Again, these are the only chiropractic services for which federal reimbursement is available. The federal match for Medicaid is 50%.

We did not develop a fiscal note for the full range of chiropractic services included in SB 510. We used the following formula to develop our cost estimates:

$$\left( \frac{\# \text{Recipients}}{\text{Month}} \times \frac{\# \text{Services}}{\text{Month}} \times \frac{\text{Cost/Service}}{\text{Month}} + \frac{\# \text{Recipients}}{\text{mth}} \times \frac{\# \text{X-Rays}}{\text{Month}} \times \frac{\text{Cost/X-Ray}}{\text{Month}} \right) \times 12 \text{mths}$$
$$[50 \times \$30 \times 2] + [\$65 \times 50 \times 3] \times 12 = \$154.0 + 1 \text{ time Administrative Cost } \$20 = \$174.00$$

### Assumption #1:

Alaska's ratio of recipients to eligibles is similar to the ratio of recipients to eligibles in Idaho.

Idaho averaged 75 chiropractic recipients and 30,000 eligibles per month. Therefore we would average 50 chiropractic recipients out of 20,000 eligibles per month.

### Assumption #2:

Services would be limited to 2 visits per month per recipient.

### Assumption #3:

X-rays would be limited to three x-rays per month per recipient.

### Assumption #4:

Manual manipulation of the spine costs \$30. An x-ray costs \$65.55.

Position Paper  
House Bill No. 712

"An act relating to provision of services under the Medical Assistance program."

I. Background

This bill would modify the Medicaid program to 1) add chiropractic services and 2) expand reimbursable services offered by a Comprehensive Outpatient Rehabilitative Facility (CORF). (A 1984 Attorney General's opinion stated CORF could participate in Medicaid for those services already added by the Legislature.)

II. Need for Chiropractic Services

Currently, 29 states recognize the value of chiropractic services by including them in their Medicaid program. In addition, the major private insurance programs also include chiropractic coverage. Generally, chiropractors and advocates of their services contend that chiropractic services are an alternative to other, potentially more costly medical treatments.

The chiropractic services should be limited to the two services for which we can claim federal financial participation. Specifically, these are manual manipulation of the spine and the x-rays necessary for this treatment. The Department would support this addition to the Medicaid program with this limited definition. Added FY85 costs is anticipated to be \$174.0 of which \$87.0 is State funds.

III. Need for Comprehensive Outpatient Rehabilitation Facility Services

Alaska's Medicaid program already provides coverage for most of the 13 services that can be provided by a CORF. Services covered include physician services, physical therapy, occupational therapy, prosthetic devices, orthotic devices and nursing care.

The services that are not currently covered but which would be added under this bill are:

1. Social services performed by a social worker with a B.A. who has had one year of experience in a health care setting.
2. Psychological services performed by a psychologist with a master's degree.
3. Drugs and biologicals which are currently reimbursed under the General Relief Medical Assistance Program.
4. Home environment evaluations for the purpose of assessing the potential impact of the home situation on the rehabilitation goals.

**POSITION PAPER/Department of Health & Social Services**

The Department does not support adding these additional services to Medicaid. Psychological services are already available under Medicaid if provided as inpatient hospital services, through a community mental health clinic, or by a physician. Addition of psychological and social worker services is not recommended as the FY85 added costs are expected to be \$679.3 of which \$339.6 is State funds.

Recommended By: Rod Betit  
Rod Betit, Director  
Division of Medical Assistance

Date: 4/12/84

Approved By: \_\_\_\_\_  
Robert London Smith, Ph.D.  
Commissioner  
Department of Health & Social  
Services

Date: \_\_\_\_\_

Position Paper  
CSSB No. 510

"An act relating to provision of services under the Medical Assistance program."

I. Background

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Date: 4/12/84

Approved By: Robert London Smith  
Robert London Smith, Ph.D.  
Commissioner  
Department of Health & Social  
Services

Date: 4/17/84

STATE OF ALASKA 1984 LEGISLATIVE SESSION  
FISCAL NOTE

Includes both chiropractic  
and CORF services as  
proposed in bill.

Revision Date: \_\_\_\_\_

**REQUEST**

Bill/Resolution No.: CSSB 510  
Title: "An Act relating to the pro-  
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Sponsor: \_\_\_\_\_  
Requestor: House & Labor & Commerce Committee  
Date of Request: 4/10/84

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See Attached

**ANALYSIS:** Attach a separate page for analysis

Prepared By: Jeffrey Hubbard

Division: Medical Assistance

Approved by Commissioner: Robert Gordon Smith

Agency: Department of Health & Social Services

Phone: 465-3355  
Date: 4/12/84  
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**Distribution (by Agency preparing fiscal note):**

- Legislative Finance
- Legislative Sponsor
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12/1/83

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# MEMORANDUM

# State of Alaska

TO: William O'Connor  
Executive Director  
Alaska Treatment Center

272-0586

DATE: February 17, 1984

FILE NO:

TELEPHONE NO:

FROM: Robert G. Ogden, Chief  
Medical Assistance

SUBJECT: Reimbursement of a CORF  
Under Medicaid

As you know, for some time we have been waiting for an Attorney General's interpretation of what CORF services are to be reimbursed under the Alaska Medicaid program, and how to handle what seems to me to be a conflict in statutes; i.e., AS 47.07.070 and AS 47.07.030.

As you will note in the attached opinion, Medicaid will set rates prospectively for those services included in AS 47.07.030, but may not pay for services not included in AS 47.07.030.

As you know, we have set Alaska Treatment Center's rates at 100 percent of charges for services covered by Medicaid.

I hope this opinion is of important reference.

RGO:hp

attachment

cc: Rod Betit

# MEMORANDUM

State of Alaska <sup>601</sup>

TO: Hon. Robert London Smith, Ph.D  
Commissioner  
Department of Health and  
Social Services

DATE: January 1984

FILE NO: 366-405-B3

TELEPHONE NO: 465-3603

FROM: Norman C. Gorsuch  
Attorney General

SUBJECT: CORF'S Expansion  
Services Under  
AS 47.07.030

RECEIVED  
JAN 30 1984

MEDICAL REVIEW  
SECTION

By: Elizabeth L. Shaw  
Assistant Attorney General  
Human Services - Juneau

You have asked whether a Comprehensive Outpatient Rehabilitation Facility may be included in the prospective rate determinations of the Medicaid Rate Commission.

We believe that those functions of a CORF which are reimbursable under Medicaid fall under the provisions of prospective rate determination but those functions which are not reimbursable may not be included in determining the prospective rate.

## Discussion

As "rehabilitation facility" is not defined in statute or regulation, the Department needs to use a reasonable standard in determining what is a rehabilitation facility. <sup>1/</sup> At this time it does not appear to be unreasonable to assume that a CORF is a rehabilitation facility. That assumption does not mean that all the services provided in a rehabilitation facility may be reimbursed under Medicaid.

AS 47.07.070 provides in part:

The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 -- 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section....

---

<sup>1/</sup> We suggest that the Department, either through regulations or statute, inform the public of that definition.

AS 47.07.900 defines a health care facility to include:

... a hospital skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic. 2/

Although the Medicaid Rate Commission may set prospective rates for a health care facility, which includes a rehabilitation facility, it does not have the authority to determine a rate for services which may not be reimbursed under Medicaid. Merely because a health care facility provides a service does not mean that that service is a medical service which is approved for payment.

AS 47.07.030 provides:

MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

---

2/ One may argue that the language of AS 47.07.900(5) does not contain an exhaustive list of facilities which may participate in the prospective rate scheme. The term "includes" generally is interpreted to mean "includes but is not limited to."

Hon. Robert London Smith, Ph.D.  
Commissioner  
366-405-83

January 18, 1984  
Page 3

Some of those services listed in AS 47.07.030 are provided in a CORF. A CORF, however, is also required by federal regulation to provide services such as social work services and psychological services, which are not covered under AS 47.07.030. 3/

In summary, a CORF may be considered a rehabilitation facility as it provides a range of medical rehabilitation services. As a health facility a rehabilitation facility is eligible for prospective rate determinations for those services reimbursable under Medicaid.

ELS:bap

---

3/ Services of a social worker or psychologist are currently reimbursed if provided in a community mental health clinic, a general hospital or a psychiatric hospital. This office has received no information which would make us believe that the CORF is a general medical or psychiatric hospital. See 7 AAC 43.130(b).

ANCHORAGE CENTER FOR CHIROPRACTIC, INC.  
KENNETH O. KETZ, D.C., AND ASSOCIATES  
3128 SEWARD HIGHWAY  
ANCHORAGE, ALASKA 99503  
PHONE 274-7621

To date there are twenty-eight states which have chiropractic care covered in their medicaid programs, and one state pending.

They are as follows:

- |               |                          |
|---------------|--------------------------|
| 1. Arkansas   | 15. New Hampshire        |
| 2. California | 16. New Nersey           |
| 3. Kentucky   | 17. North Carolina       |
| 4. Idaho      | 18. North Dakota         |
| 5. Illinois   | 19. Ohio                 |
| 6. Indiana    | 20. Oregon               |
| 7. Iowa       | 21. Pennsylvania         |
| 8. Kansas     | 22. South Carolina       |
| 9. Louisiana  | 23. South Dakota         |
| 10. Maine     | 24. Texas                |
| 11. Michigan  | 25. Utah                 |
| 12. Minnesota | 26. Washington           |
| 13. Nebraska  | 27. West Virginia        |
| 14. Nevada    | 28. Wisconson            |
|               | * 29. New York - Pending |

More information will be forwarded to you as I receive and segregate it.

Sincerely,

*Francis L. Corbin D.C.*

F. L. (Butch) Corbin, D.C.

FLC/dh

ANCHORAGE CENTER FOR CHIROPRACTIC, INC.  
KENNETH O. KETZ, D.C., AND ASSOCIATES  
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PHONE 274-7621

To date there are a total of thirty-four states which have an insurance equality act, they are as follows:

- |                   |                    |
|-------------------|--------------------|
| 1. Arkansas       | 18. Nevada         |
| 2. California     | 19. New Hampshire  |
| 3. Colorado       | 20. New Mexico     |
| 4. Connecticut    | 21. New York       |
| 5. Delaware       | 22. North Carolina |
| 6. Florida        | 23. Ohio           |
| 7. Illinois       | 24. Oklahoma       |
| 8. Indiana        | 25. Pennsylvania   |
| 9. Kansas         | 26. Rhode Island   |
| 10. Louisiana     | 27. South Dakota   |
| 11. Maryland      | 28. Utah           |
| 12. Massachusetts | 29. Virginia       |
| 13. Michigan      | 30. Washington     |
| 14. Minnesota     | 31. West Virginia  |
| 15. Missouri      | 32. Wisconsin      |
| 16. Montana       | 33. Wyoming        |
| 17. Nebraska      | 34. New Jersey     |

I'm still in the process of combining more information on insurance equality, when I have more I'll forward it on to you.

Sincerely,

*Francis L. Corbin D.C.*

F.L. (Butch) Corbin, D.C.

Note

pect to payments under section 1396b of s title for calendar q rters commencing er Dec. 31, 1973, see section 13(d) of Pub. 93-233, set out as an Effective Date of 73 Amendment note under section 1396a of s title.

Legislative History. For legislative history purpose of Pub.L. 89-97, see 1965 U.S. le Cong. and Adm.News, p. 1943 See, o, Pub.L. 93-233, 1973 U.S.Code Cong. l Adm.News, p. 3177.

Practice Manual

tion, see § 13904.

Regulations

41 seq.  
s, see 45 CFR 19.1 et seq.  
es, see 42 CFR 441.1 et seq.  
0 et seq.

Workers and Disability Insurance

Disabled, see 20 CFR 416.101 et seq., set

Amendments

7. Social Security and Public Welfare 126  
8. United States § 122

Provisions

Eligibility

one may directly apply for medical aid out first applying for a category of public ource. Perez v. Layme, D.C.N.Y.1976, 1 Supp. 1340, supplemented 422 F.Supp. 6.

though persons eligible for Aid to Fam- with Dependent Children are automati- eligible for medicaid, persons who do nally for welfare assistance may never- still qualify for medicaid. 11.

order for person to qualify for medicaid, person must be eligible, and to be eligible son must qualify under a state plan n agrees with all the statutes and regula- promulgated under this chapter. Flat- Health Center v. Flathead County, 598 P.2d 1111, 183 Mont. 211

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, ex-

cept that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (11) and (12) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this

## 42 § 1396c

### Note 8

mination would have on them, patients were entitled to a pretermination evidentiary hearing which would be governed by Department regulations providing for a hearing with respect to suspension, reduction, discontinuance, or termination of assistance to medicaid recipients. *Id.*

### 9. Findings

On reassessment of medicaid reimbursement given State, Social Rehabilitation Service Administrator's findings that sample of physicians' claims was not biased, that pricing of sample claims was accurately and consistently done by qualified medicare clerk, that medicare data used in pricing sample claims were consistent and that Medicare data necessary to screen physicians' claims were available to State, were not arbitrary and capricious. *State of Ga. By and Through Dept. of Human Resources v. Califano, D.C.Ga.1977, 446 F.Supp. 404.*

## PUBLIC HEALTH AND WELFARE

### 10. Injunction

Plaintiff was entitled to a preliminary injunction requiring the Secretary to commence proceedings to prevent the Commonwealth of Massachusetts from enforcing medicaid rule which violated this subchapter and, until such proceedings were completed, to withhold from the Commonwealth all federal contributions for medicaid payments to persons other than supplemental security income recipients unless, within 30 days, the invalid regulation was amended. *Robinson v. Pratt, D.C.Mass. 1980, 497 F.Supp. 116.*

### 11. Mandamus

Ordering of holding of compliance hearing by Secretary to determine whether state is complying with approved medicaid plan was not within mandamus power of the district court. *Arthur C. Logan Memorial Hospital v. Tona, D.C.N.Y.1977, 441 F.Supp. 26.*

## § 1396d. Definitions

For purposes of this subchapter—

### (a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, N, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter.



(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a)(3)(A) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in subsection (m) of this section) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and

(18) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clauses<sup>2</sup> (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well being of such individual.

**(b) Federal medical assistance percentage; State percentage;  
Indian health care percentage**

The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal

§ 436.1002 FFP for services.

(a) FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided, except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability.

[42 FR 45218, Sept. 29, 1978, as amended at 44 FR 17940, Mar. 23, 1979]

§ 436.1003 Recipients overcoming certain conditions of eligibility.

FFP is available for a temporary period specified in the State plan in expenditures for services provided to recipients who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

[45 FR 24000, Apr. 11, 1980]

§ 436.1004 Institutionalized individuals.

(a) Except as provided in paragraph (b) of this section, FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in § 435.1009; or

(2) Individuals under age 65 who are patients in an institution for tuberculosis or mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

(b) FFP is available in expenditures for services provided to eligible individuals during the month in which they become inmates of a public institution or patients in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is

considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

§ 436.1005 Definitions relating to institutional status.

For purposes of FFP, the definitions in § 435.1009 of this subchapter apply to this part.

**PART 440—SERVICES: GENERAL PROVISIONS**

**Subpart A—Definitions**

- Sec.
- 440.1 Basis and purpose.
- 440.2 Specific definitions; definitions of services for FFP purposes.
- 440.10 Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases.
- 440.20 Outpatient hospital services and rural health clinic services.
- 440.30 Other laboratory and X-ray services.
- 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases), EPSDT, and family planning services and supplies.
- 440.50 Physicians' services.
- 440.60 Medical or other remedial care provided by licensed practitioners.
- 440.70 Home health services.
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- 440.90 Clinic services.
- 440.100 Dental services.
- 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- 440.120 Prescribed drugs, dentures, prosthetic devices, and eyeglasses.
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- 440.140 Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases.
- 440.150 Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.
- 440.160 Inpatient psychiatric services for individuals under age 21.
- 440.165 Nurse-midwife services.
- 440.170 Any other medical or remedial care recognized under State law and specified by the Secretary.
- 440.180 Home or community-based services.

Sec.

**Subpart B—Requirements and Limits Applicable to All Services**

- 440.200 Basis, purpose, and scope.
- 440.210 Required services for the categorically needy.
- 440.220 Required services for the medically needy.
- 440.230 Sufficiency of amount, duration, and scope.
- 440.240 Comparability of services for groups.
- 440.250 Limits on comparability of services.
- 440.260 Methods and standards to assure quality of services.
- 440.270 Religious objections.

**AUTHORITY:** Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

**SOURCE:** 43 FR 45224, Sept. 29, 1978, unless otherwise noted.

**Subpart A—Definitions**

§ 440.1 Basis and purpose.

This subpart interprets section 1905(a) of the Act, which lists the services included in the term "medical assistance," sections 1905 (c), (d), (f)-(i), (j), and (m), which define some of those services, and section 1915(c), which lists as "medical assistance" certain home and community-based services provided under waivers under that section to individuals who would otherwise require institutionalization. It also implements sec. 1902(a)(43) with respect to laboratory services (see also §§ 447.10 and 447.342 for related provisions on laboratory services), and implements section 1913 of the Act with respect to "swing-bed" services (see related provisions in §§ 405.1041 and 447.280 of this chapter).

[47 FR 31532, July 20, 1982]

§ 440.2 Specific definitions; definitions of services for FFP purposes.

(a) *Specific definitions.* "Outpatient" means a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, which is not providing him with room and board and professional services on a continuous 24-hour-a-day basis.

"Patient" means an individual who is receiving needed professional services that are directed by a licensed

practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain. (See also § 435.1009 of this subchapter for definitions relating to institutional care.)

(b) *Definitions of services for FFP purposes.* Except as limited in Part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart.

§ 440.16 Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases.

(a) "Inpatient hospital services" means services that—

(1) Are ordinarily furnished in a hospital for the care and treatment of inpatients;

(2) Except in the case of nurse-midwife services, as specified in § 440.165, are furnished under the direction of a physician or dentist; and

(3) Are furnished in an institution that—

(i) Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;

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

(iii) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare; and

(iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 405.1035 of this chapter, unless a waiver has been granted by the Secretary.

(b) Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing-bed approval.

[47 FR 21050, May 17, 1982, as amended at 47 FR 31532, July 20, 1982]

§ 440.20 Outpatient hospital services and rural health clinic services.

(a) "Outpatient hospital services" means preventive, diagnostic, thera-

peutic, rehabilitative, or palliative services that—

- (1) Are furnished to outpatients;
- (2) Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and
- (3) Are furnished by an institution that—

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

(ii) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

(b) *Rural health clinic services.* If nurse practitioners or physician assistants (as defined in § 481.1 of this chapter) are not prohibited by State law from furnishing primary health care, "rural health clinic services" means the following services when furnished by a rural health clinic that has been certified in accordance with Part 481 of this chapter.

(1) Services furnished by a physician within the scope of practice of his profession under State law, if the physician performs the services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that he will be paid by it for such services.

(2) Services furnished by a physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner (as defined in §§ 405.2401 and 481.2 of this chapter) if the services are furnished in accordance with the requirements specified in § 405.2414(a) of this chapter.

(3) Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See §§ 405.2413 and 405.2415 of this chapter for the criteria for determining whether services and supplies are included under this paragraph.)

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

(i) The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see § 405.2417 of this chapter);

(ii) The services are furnished by a registered nurse or licensed practical nurse or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

(iii) 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, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

(iv) The services are furnished to a homebound recipient. For purposes of visiting nurse care, a "homebound" recipient means one who is permanently or temporarily confined to his place of residence because of a medical or health condition. He may be considered homebound if he leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or a skilled nursing facility.

(c) *Other ambulatory services furnished by a rural health clinic.* If the State plan covers rural health clinic services, other ambulatory services means ambulatory services other than rural health clinic services, as defined in paragraph (b) of this section, that are otherwise included in the plan and meet specific State plan requirements for furnishing those services. Other ambulatory services furnished by a rural health clinic are not subject to the physician supervision requirements specified in § 481.8(b) of this chapter, unless required by State law or the State plan.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 21050, May 17, 1982]

§ 440.30 Other laboratory and X-ray services.

"Other laboratory and X-ray services" means professional and technical laboratory and radiological services—

(a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory;

(b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and

(c) Provided by a laboratory that meets the requirements for participation in Medicare.

[46 FR 42672, Aug. 24, 1981]

§ 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases), EPSDT, and family planning services and supplies.

(a) *Skilled nursing facility services.* (1) "Skilled nursing facility services for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases," means services that are—

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§ 405.127, 405.128, and 405.128a of this chapter;

(ii) Provided by (A) a facility or distinct part of a facility that is certified to meet the requirements for participation under Subpart C of Part 442 of this subchapter, as evidenced by a valid agreement between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; or (B) if specified in the State plan, a swing-bed hospital that has an approval from HCFA to furnish skilled nursing facility services in the Medicare program; and

(iii) Ordered by and provided under the direction of a physician.

(2) Skilled nursing facility services includes services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of Subpart K of Part 405 of this chapter.

(b) *EPSDT.* "Early and periodic screening and diagnosis and treatment" means—

(1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and

(2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. (See Subpart B of Part 441 of this subchapter.)

(c) *Family planning services and supplies for individuals of child-bearing age.* [Reserved]

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

§ 440.50 Physicians' services.

"Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided—

(a) Within the scope of practice of medicine or osteopathy as defined by State law; and

(b) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

§ 440.60 Medical or other remedial care provided by licensed practitioners.

(a) "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.

(b) *Chiropractors' services* include only services that—

(1) Are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under § 405.232b of this chapter; and

(2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

§ 440.70 Home health services.

(a) "Home health services" means the services in paragraph (b) of this section that are provided to a recipient—

(1) At his place of residence, as specified in paragraph (c) of this section; and

(2) On his physician's orders as part of a written plan of care that the physician reviews every 60 days.

(b) Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.

(1) 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 as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who—

(i) Is currently licensed to practice in the State;

(ii) Receives written orders from the patient's physician;

(iii) Documents the care and services provided; and

(iv) Has had orientation to acceptable clinical and administrative record-keeping from a health department nurse.

(2) Home health aide service provided by a home health agency.

(3) Medical supplies, equipment, and appliances suitable for use in the home, and

(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See § 441.15 of this subchapter.)

(c) A recipient's place of residence, for home health services, does not include a hospital, skilled nursing facility, or intermediate care facility except for home health services in an intermediate care facility that are not required to be provided by the facility under Subparts F and G of Part 442 of this subchapter. For example, a registered nurse may provide short-term care for a recipient in an intermediate care facility during an acute illness to avoid the recipient's transfer to a skilled nursing facility.

(d) "Home health agency" means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare.

(e) A "facility licensed by the State to provide medical rehabilitation services" means a facility that—

(1) Provides therapy services for the primary purpose of assisting in the re-

habilitation of disabled individuals through an integrated program of—

(i) Medical evaluation and services; and

(ii) Psychological, social, or vocational evaluation and services; and

(2) Is operated under competent medical supervision either—

(i) In connection with a hospital; or

(ii) As a facility in which all medical and related health services are prescribed by or under the direction of individuals licensed to practice medicine or surgery in the State.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

#### § 440.80 Private duty nursing services.

"Private duty nursing services" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility, and that are provided—

(a) By a registered nurse or a licensed practical nurse;

(b) Under the direction of the recipient's physician; and

(c) To a recipient in his own home or in a hospital or skilled nursing facility.

#### § 440.90 Clinic services.

"Clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that—

(a) Are provided to outpatients;

(b) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

(c) Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist.

[47 FR 21050, May 17, 1982]

#### § 440.100 Dental services.

(a) "Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of—

(1) The teeth and associated structures of the oral cavity; and

(2) Disease, injury, or impairment that may affect the oral or general health of the recipient.

(b) "Dentist" means an individual licensed to practice dentistry or dental surgery.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy.* (1) "Physical therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

(b) *Occupational therapy.* (1) "Occupational therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A "qualified occupation therapist" is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

(c) *Services for individuals with speech, hearing, and language disorders.* (1) "Services for individuals with speech, hearing, and language disorders" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. It includes any necessary supplies and equipment.

(2) A "speech pathologist or audiologist" is an individual who—

(i) Has a certificate of clinical competence from the American Speech and Hearing Association;

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

#### § 440.120 Prescribed drugs, dentures, prosthetic devices, and eyeglasses.

(a) "Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are—

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

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

(3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

(b) "Dentures" are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

(c) "Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to—

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

(d) "Eyeglasses" means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.

§ 440.130 Diagnostic, screening, preventive, and rehabilitative services.

(a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

(b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

(c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

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

§ 440.140 Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases.

(a) *Inpatient hospital services.* (1) "Inpatient hospital services for individuals age 65 or older in institutions for tuberculosis or mental diseases" means services provided under the direction of a physician for the care and treatment of recipients in—

(i) An institution for tuberculosis that meets the requirements under

Medicare, § 405.1036 of this chapter; and

(ii) An institution for mental diseases that meets the requirements under Medicare, §§ 405.1035 and 405.1036 of this chapter, except the requirements for admission reviews under § 405.1035(f) of this chapter, or utilization review under § 405.1035 of this chapter if the institution has been granted a waiver under section 1903(i)(4) and Subpart II of Part 456 of this subchapter.

(2) "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.

(3) "Institution for tuberculosis" means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with tuberculosis, including medical attention, nursing care, and related services.

(b) *Skilled nursing facility services.* "Skilled nursing facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases" means skilled nursing facility services as defined in § 440.40 that are provided in institutions for tuberculosis or mental diseases, as defined in paragraph (a) of this section.

(c) *Intermediate care facility services.* "Intermediate care facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases" means intermediate care facility services as defined in § 440.150 of this subpart, that are provided to recipients who are—

(1) Determined under §§ 456.360-456.372 of this subchapter to be in need of services; and

(2) In institutions for tuberculosis and mental diseases, as defined in paragraph (a) of this section.

§ 440.150 Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.

(a) "Intermediate care facility services, other than in an institution for tuberculosis or mental diseases" means services provided in a facility that—

(1) Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services that—

(i) Are above the level of room and board; and

(ii) Can be made available only through institutional facilities;

(2) Has been certified to meet the requirements of Subpart C of Part 442 of this subchapter as evidenced by a valid agreement between the Medicaid agency and the facility for providing intermediate care facility services and making payments for services under the plan; and

(3) Meets the conditions of Subpart E of Part 442 of this subchapter.

(b) "Intermediate care facility services" include services—

(1) Considered appropriate by the State and provided by a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass.; or

(2) Provided by a facility located on an Indian reservation that—

(i) Furnishes, on a regular basis, health-related services; and

(ii) Is certified by the Secretary to meet the standards in Subpart E of Part 442 of this subchapter.

(c) "Intermediate care facility services" may include services in an institution for the mentally retarded or persons with related conditions if—

(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;

(2) The institution meets the standards in Subpart E of Part 442 of this subchapter; and

(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in § 435.1009.

(d) "Intermediate care facility services" may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part—

(i) Meets all requirements for an intermediate care facility;

(2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

(3) Consists of all beds and related facilities in the unit;

(4) Houses all recipients for whom payment is being made for intermediate care facility services, except as provided in paragraph (e) of this section;

(5) Is clearly identified; and

(6) Is approved in writing by the survey agency.

(e) If a State includes as intermediate care facility services those services provided by a distinct part of a facility other than an intermediate care facility, it may not require transfer of a recipient within or between facilities if, in the opinion of the attending physician, it might be harmful to the physical or mental health of the recipient.

(f) Intermediate care facility services may include services provided in a swing-bed hospital that has an approval to furnish intermediate care services.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

§ 440.160 Inpatient psychiatric services for individuals under age 21.

"Inpatient psychiatric services for individuals under age 21" means services that—

(a) Are provided under the direction of a physician;

(b) Are provided in a facility or program accredited by the Joint Commission on Accreditation of Hospitals; and

(c) Meet the requirements in Subpart D of Part 441.

§ 440.165 Nurse-midwife service.

(a) "Nurse-midwife services" means services that—

(1) Are concerned with management of the care of mothers and newborns throughout the maternity cycle;

(2) Are furnished by a nurse-midwife within the scope of practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse-midwife to the extent permitted by the facility; and

(3) Unless required by State law or regulations or a facility, are reimbursed.

bursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. (See § 441.21 of this chapter for provisions on independent provider agreements for nurse-midwives.)

(b) "Nurse-midwife" means a registered professional nurse who meets the following requirements:

(1) Is currently licensed to practice in the State as a registered professional nurse.

(2) Is legally authorized under State law or regulations to practice as a nurse-midwife.

(3) Except as provided in paragraph (b)(4) of this section, has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

(4) If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, meets one of the following conditions:

(i) Is currently certified as a nurse-midwife by the American College of Nurse-Midwives.

(ii) Has satisfactorily completed a formal educational program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives.

(iii) Has successfully completed a formal educational program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and was practicing as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976 to July 16, 1982.

(c) "Maternity cycle" means a period limited to—

(1) Pregnancy;

(2) Labor;

(3) Birth; and

(4) The immediate postpartum period, not to exceed six weeks.

[47 FR 21050, May 17, 1982; 47 FR 23448, May 20, 1982]

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

(2) Transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency. If other arrangements are made to assure transportation under § 431.53 of this subchapter, FFP is available as an administrative cost.

(3) "Travel expenses" include—

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging en route to and from medical care, and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary.

(b) *Services of Christian Science nurses.* "Services of Christian Science nurses" mean services provided by nurses who are listed and certified by the First Church of Christ, Scientist, Boston, Mass., if—

(1) The services have been requested by the recipient; and

(2) The services are provided—

(i) By or under the supervision of a Christian Science visiting nurse organization listed and certified by the First Church of Christ, Scientist, Boston, Mass.; or

(ii) As private duty services to a recipient in his own home or in a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., if the recipient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the sanatorium.

(c) *Services in Christian Science sanatoriums.* "Services in Christian Science sanatoriums" means services

provided in Christian Science sanatoriums that are operated by, or listed and certified by, the First Church of Christ, Scientist, Boston, Mass.

(d) *Skilled nursing facility services for individuals under age 21.* "Skilled nursing facility services for individuals under 21" means those services specified in § 440.40 that are provided to recipients under 21 years of age.

(e) *Emergency hospital services.* "Emergency hospital services" means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§ 440.10 and 440.20.

(f) *Personal care services in a recipient's home.* Unless defined differently by a State agency for purposes of a waiver granted under Part 441, Subpart G of this chapter, "personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

(1) Qualified to provide the services;

(2) Supervised by a registered nurse; and

(3) Not a member of the recipient's family.

[43 FR 45224, Sept. 20, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 46540, Oct. 1, 1981]

§ 440.180 Home or community-based services.

(a) "Home or community-based services" means services that are furnished under a waiver granted under the provisions of Part 441, Subpart G of this subchapter. The services may consist of any of the following services as defined by the agency (but not including room and board except as specifically provided for in paragraph (b) of this section):

(1) Case management services;

(2) Homemaker services;

(3) Home health aide services;

(4) Personal care services;

(5) Adult day health services;

(6) Habilitation services;

(7) Respite care services;

(8) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

(b) FFP for home community-based services described in paragraph (a) of this section is not available in expenditures for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

[46 FR 46540, Oct. 1, 1981]

#### Subpart B—Requirements and Limits Applicable to All Services

§ 440.200 Basis, purpose, and scope.

(a) This subpart implements—

(1) Section 1902(a)(10), regarding comparability of services for groups of recipients, and the amount, duration, and scope of services described in section 1905(e) of the Act that the State plan must provide for recipients;

(2) Section 1902(a)(22)(D), which provides for standards and methods to assure quality of services;

(3) Section 1907 on observance of religious beliefs; and

(4) Section 1915 on exceptions to section 1902(a)(10) and waivers of other requirements of section 1902 of the Act.

(b) The requirements and limits of this subpart apply for all services defined in Subpart A of this part.

[46 FR 46528, Oct. 1, 1981]

§ 440.210 Required services for the categorically needy.

A State plan must specify that, as a minimum, categorically needy recipients are provided the services as specified in §§ 440.10 through 440.50, 440.70, and (to the extent nurse-mid-

wives are authorized to practice under State law or regulation) 440.165.

147 FR 21050, May 17, 1982]

§ 440.220 Required services for the medically needy.

A State plan that includes the medically needy must specify that the medically needy are provided, as a minimum, the following services:

(a) Prenatal care and delivery services for pregnant women.

(b) Ambulatory services, as defined in the State plan, for—

- (1) Individuals under age 18; and
- (2) Individuals entitled to institutional services.

(c) Home health services (§ 440.70) to any individual entitled to skilled nursing facility services.

(d) If the State plan includes services in an institution for mental diseases (§ 440.140 or § 440.160) or in an intermediate care facility for the mentally retarded (§ 440.150(c)) for any group of medically needy, either of the following sets of services to each of the medically needy groups:

(1) The services contained in §§ 440.10 through 440.50 and (to the extent nurse-midwives are authorized to practice under State law or regulation) 440.165; or

(2) The services contained in any seven of the sections in §§ 440.10 through 440.165.

146 FR 47992, Sept. 30, 1981; 46 FR 54744, Nov. 4, 1981, as amended at 47 FR 21050, May 17, 1982]

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

- (1) The categorically needy; and
- (2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

146 FR 47993, Sept. 30, 1981]

§ 440.240 Comparability of services for groups.

Except as limited in § 440.250—

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

- (1) The categorically needy.
- (2) A covered medically needy group.

146 FR 47993, Sept. 30, 1981]

§ 440.250 Limits on comparability of services.

(a) Skilled nursing facility services (§ 440.40(a)) may be limited to recipients age 21 or older.

(b) Early and periodic screening, diagnosis, and treatment (§ 440.40(b)) must be limited to recipients under age 21.

(c) Family planning services and supplies must be limited to recipients of childbearing age, including minors who can be considered sexually active and who desire the services and supplies.

(d) If covered under the plan, services to recipients in institutions for tuberculosis or mental diseases (§ 440.140) must be limited to those age 65 or older.

(e) If covered under the plan, inpatient psychiatric services (§ 440.160) must be limited to recipients under age 22 as specified in § 441.151(e) of this subchapter.

(f) If Medicare benefits under Part B of title XVIII are made available to recipients through a buy-in agreement or payment of premiums, or part or all of the deductibles, cost sharing or similar charges, they may be limited to recipients who are covered by the agreement or payment.

(g) If services in addition to those offered under the plan are made available under a contract between the agency or political subdivision and an organization providing comprehensive health services, those additional services may be limited to recipients who reside in the geographic area served by the contracting organization and who elect to receive services from it.

(h) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

- (1) Individuals under age 18; and
- (2) Individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

143 FR 45224, Sept. 29, 1976, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48541, Oct. 1, 1981]

§ 440.260 Methods and standards to assure quality of services.

The plan must include a description of methods and standards used to assure that services are of high quality.

§ 440.270 Religious objections.

(a) Except as specified in paragraph (b) of this section, the agency may not require any individual to undergo any medical service, diagnosis, or treatment or to accept any other health service provided under the plan if the individual objects, or in the case of a child, a parent or guardian objects, on religious grounds.

(b) If a physical examination is necessary to establish eligibility based on disability or blindness, the agency may not find an individual eligible for Medicaid unless he undergoes the examination.

**PART 44.—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES**

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