AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   \[X\] Provided: \[\_\_\_] No limitations \[X\] With limitations*
   \[\_\_\_] Not provided.

2.a. Outpatient hospital services.
   \[X\] Provided: \[\_\_\_] No limitations \[X\] With limitations*
   \[\_\_\_] Not provided.

2.b. Rural health clinic services and other ambulatory services furnished by a rural health
    clinic (which are otherwise included in the State Plan).
    \[X\] Provided: \[\_\_\_] No limitations \[X\] With limitations*
    \[\_\_\_] Not provided.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are
    covered under the Plan and furnished by an FQHC in accordance with Section 4231 of
    the State Medicaid Manual (HCFA-Pub. 45-4).
    \[X\] Provided: \[\_\_\_] No limitations \[X\] With limitations*
    \[\_\_\_] Not provided.

3. Other laboratory and x-ray services.
   \[X\] Provided: \[X\] No limitations \[\_\_\_] With limitations*
   \[\_\_\_] Not provided.

*Description provided in Supplement to this Attachment.

TN No. 92-01
Supersedes Approval Date 2/26/92 Effective Date 1/01/92
TN No. 91-14
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

___X___ Provided: ___X___ No limitations _____With limitations*

_____Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

___X___ Provided: _____No limitations ___X___With limitations*

_____Not provided.

d. 1. Face-to-face tobacco cessation counseling services for pregnant women.

___X___ (i) Provided by or under supervision of a physician;

___X___ (ii) Provided by any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Provided by any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations.

(None are designated at this time.)

2. Face-to-face tobacco cessation counseling services benefit package for pregnant women.

___X___ Provided: ___X___ No limitations _____With limitations*

5.a. Physicians’ services whether furnished in the office, the patient’s home, a hospital, a nursing facility, or elsewhere.

___X___ Provided: _____No limitations ___X___With limitations*

_____Not provided.

b. Medical and surgical services furnished by a dentist (in accordance with Section 1905(a)(5)(B) of the Act).

___X___ Provided: _____No limitations ___X___With limitations*

_____Not provided.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists’ services.

___X___ Provided: _____No limitations ___X___With limitations*

_____Not provided.

*Description provided in Supplement to this Attachment.

TN No. 11-8
Supersedes Approval Date 11/10/11
TN No. 93-12 Effective Date 7/01/11
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORIAQLY NEEDY

b. Optometrists’ services.

  [X] Provided: _____No limitations  [X] With limitations*
  _____Not provided.

c. Chiropractors’ services.

  [X] Provided: _____No limitations  [X] With limitations*
  _____Not provided.

d. Other practitioners’ services.

  [X] Provided: Identified on attached sheet with description of limitations, if any.
  _____Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

  [X] Provided: _____No limitations  [X] With limitations*
  _____Not provided.

b. Home health aide services provided by a home health agency.

  [X] Provided: _____No limitations  [X] With limitations*
  _____Not provided.

c. Medical supplies, equipment, and appliances suitable for use in the home.

  [X] Provided: _____No limitations  [X] With limitations*
  _____Not provided.

*Description provided in Supplement to this Attachment.

TN No. 91-14 Supersedes Approval Date 1/27/92 Effective Date 7/01/92
TN No. 90-19
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

   X Provided: X No limitations  _____ With limitations*
   _____ Not provided.

8. Private duty nursing services.

   _____ Provided: _____ No limitations  _____ With limitations*
   X Not provided.

*Description provided in Supplement to this Attachment.

TN No. 06-2
Supersedes Approval Date 10/23/07 Effective Date 7/01/06
TN No. 91-14
9. Clinic services.

____X____Provided: _____No limitations _____X____With limitations*
_____Not provided.

10. Dental services.

____X____Provided: _____No limitations _____X____With limitations*
_____Not provided.

11. Physical therapy and related services.

a. Physical therapy.

____X____Provided: ____X____No limitations _____X____With limitations*
_____Not provided.

b. Occupational therapy.

____X____Provided: ____X____No limitations _____X____With limitations*
_____Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

____X____Provided: ____X____No limitations _____X____With limitations*
_____Not provided.

*Description provided in Supplement to this Attachment.

TN No. 06-2
Supersedes Approval Date 10/23/07 Effective Date 7/01/06
TN No. 86-6
AMOUNT, DURATION, AND SCOPE OF MEDICAL 
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

   a. Prescribed drugs.
      \[\checkmark\] Provided: _____ No limitations  \[\checkmark\] With limitations*
      _____ Not provided.

   b. Dentures.
      \[\checkmark\] Provided: _____ No limitations  \[\checkmark\] With limitations*
      _____ Not provided.

   c. Prosthetic devices.
      \[\checkmark\] Provided: _____ No limitations  \[\checkmark\] With limitations*
      _____ Not provided.

   d. Eyeglasses.
      \[\checkmark\] Provided: _____ No limitations  \[\checkmark\] With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the Plan.

   a. Diagnostic services.
      _____ Provided: _____ No limitations  _____ With limitations*
      \[\checkmark\] Not provided.

*Description provided in Supplement to this Attachment.

TN No. 92-14
Supersedes Approval Date 5/26/92 Effective Date 7/01/92
TN No. 85-12
b. Screening services.
   - Provided: No limitations
   - With limitations*
   - Not provided.

c. Preventive services.
   - Provided: No limitations
   - With limitations*
   - Not provided.

d. Rehabilitative services.
   - Provided: No limitations
   - With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.
   a. Inpatient hospital services.
      - Provided: No limitations
      - With limitations*
      - Not provided.
   b. Skilled nursing facility services.
      - Provided: No limitations
      - With limitations*
      - Not provided.
   c. Intermediate care facility services.
      - Provided: No limitations
      - With limitations*
      - Not provided.

*Description provided in Supplement to this Attachment.
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.

____ Provided: _____ No limitations _____ With limitations*

__X__ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

__X__ Provided: ___ No limitations _____ With limitations*

_____ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

__X__ Provided: _____ No limitations ____ X With limitations*

_____ Not provided.

17. Nurse-midwife services.

__X__ Provided: ___ No limitations _____ With limitations*

_____ Not provided.

18. Hospice care (in accordance with Section 1905(o) of the Act.

__X__ Provided: ___ No limitations _____ With limitations*

_____ Not provided.

*Description provided in Supplement to this Attachment.

TN No. 06-2
Supersedes Approval Date 10/23/07
TN No. 02-2 Effective Date 7/01/06
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis-related services.
   a. Case management services as defined in, and to the group specified in, Supplements 1 and 2 to Attachment 3.1-A (in accordance with Section 1905(a)(19) or Section 1915(g) of the Act).
      ___X__Provided: _____No limitations ___X__With limitations*
      _____Not provided.
   b. Special tuberculosis (TB) related services under Section 1902(z)(2)(F) of the Act.
      _____Provided: _____No limitations _____With limitations*
      ___X__Not provided.

20. Extended services for pregnant women.
   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
      _____Additional coverage++
   b. Services for any other medical conditions that may complicate pregnancy.
      ___X__Additional coverage++

++Attached is a description of increases in covered services beyond limitations for all groups described in this Attachment and/or any additional services provided to pregnant women only.

*Description provided in Supplement to this Attachment.

TN No. 99-10
Supersedes Approval Date 8/21/00 Effective Date 10/01/99
TN No. 98-5
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility
period by an eligible provider (in accordance with Section 1920 of the Act).

[ ] Provided: [ ] No limitations  [ ] With limitations*

[ ] Not provided.

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the
Act).

[ ] Provided: [ ] No limitations  [ ] With limitations*

[ ] Not provided.

23. Certified pediatric or family nurse practitioners’ services.

[ ] Provided: [ ] No limitations  [ ] With limitations*

[ ] Not provided.

*Description provided in Supplement to this Attachment.

TN No. 92-1
Supersedes Approval Date 2/26/92 Effective Date 1/01/92
TN No. 91-14
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

  X  Provided: _____ No limitations  X  With limitations*

  ____ Not provided.

b. Services provided in religious non-medical health care institutions.

  _____ Provided: ______ No limitations  _____ With limitations*

  X  Not provided.

c. Reserved.

d. Nursing facility services for patients under 21 years of age.

  X  Provided:  X  No limitations  X  With limitations*

  ____ Not provided.

e. Emergency hospital services.

  X  Provided:  X  No limitations  X  With limitations*

  ____ Not provided.

f. Personal care services in recipient’s home or recipient’s place of employment, authorized for the recipient in accordance with a service plan approved by the state and provided by a qualified person.

  X  Provided: _____ No limitations  X  With limitations*

  ____ Not provided.

*Description provided in Supplement to this Attachment.
25. Home and community care for functionally disabled elderly individuals, as defined,
described, and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to
Supplement 2 to Attachment 3.1-A.

______Provided: _______No limitations _______With limitations*

____X____Not provided.

*Description provided in Supplement to this Attachment.

TN No. 93-7
Supersedes Approval Date 4/08/93 Effective Date 1/01/93
TN No. NEW
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26.a. Licensed or otherwise State-approved freestanding birth centers.

__X__ Provided: __X__ No limitations _____ With limitations*

_____ Not provided.

26.b. Licensed or otherwise State-recognized, covered professionals providing services in the freestanding birth center.

__X__ Provided: __X__ No limitations _____ With limitations*

_____ Not provided.

*Description provided in Supplement to this Attachment.