ANALYSIS OF FEDERAL MEDICAID REQUIREMENTS

REQUIREMENT	SECTION OF FEDERAL LAW	FEDERAL REGULATION	DEFINITION
Statewideness	42 USC §1396a(a)(1)	42 CFR 431.50	Requires that a State plan for medical assistance "shall be in effect in all subdivisions of the state, and if administered by [political subdivisions], be mandatory upon them." The state plan must be continuously in operation throughout the state.
Freedom of Choice of Provider	42 USC §1396a(23)	42 CFR 431.51	Any individual eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them.
Comparability	42 USC §1396a(a)(2) and 42 USC §1396a(a)(10)(B)	42 CFR 440.230 and 42 CFR 440.240	A State plan must specify the amount, duration and scope of each service that it provides for eligible recipients. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 (Required Medicaid Services) to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition. The Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. The State 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 the plan must provide that the services available to any individual in the categorically needy and/or a covered medical needy group are equal in amount, duration and scope for all recipients within the group.
Reasonable Promptness	42 USC §1396a(a)(8)	42 CFR 435.911 and 42 CFR 435.930	The state agency must determine eligibility for Medicaid within specified time periods and must furnish Medicaid services promptly to recipients without any delay caused by the state agency's administrative procedures; continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and seven days a week.

REQUIREMENT	SECTION OF FEDERAL LAW	FEDERAL REGULATION	DEFINITION
Single State Medicaid Agency	42 USC §1396a(a)(5)	42 CFR 431.10	A State plan must specify a single State agency established or designated to administer or supervise the administration of the plan. That agency must have legal authority to administer or supervise the administration of the plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan. In order for an agency to qualify as the Medicaid agency, it must not delegate, to other than its own officials, authority to exercise administrative discretion in the administration or supervision of the plan, or issue policies, rules and regulations on program matters. The authority of the Medicaid agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the applications of policies, rules, and regulations issued by the Medicaid agency. In Ohio, the Ohio Department of Job and Family Services is the single State agency. (See R.C. §5111.01)
State matching Funds	42 USC §1396a(a)(2)	42 CFR 433.50 and 42 CFR 433.51 and 42 CFR 433.53	A state must provide matching funds for carrying out the State plan on a 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. Generally, public funds may be considered as the State's share in claiming Federal Financial Participation (FFP) if "the public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP." The public funds cannot be Federal funds, unless they are Federal funds authorized by Federal law to be used as match for other Federal funds. A State plan must provide that State (as distinguished from local) funds will be used both for medical assistance and administration; state funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; state and federal funds will be apportioned among the

REQUIREMENT	SECTION OF FEDERAL LAW	FEDERAL REGULATION	DEFINITION
State matching Funds (continued)	42 USC §1396a(a)(2) (continued)	42 CFR 433.50 and 42 CFR 433.51 and 42 CFR 433.53 (continued)	political subdivisions of the State on a basis that assures that 1) individuals in similar circumstances will be treated similarly throughout the State and 2) if there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope or quality of services or level of administration under the plan in any part of the State.
Out of state	42 USC 1396(a)(16)	42 CFR 431.52	Provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom.
Border Issues	42 USC 1396(a)(16)	42 CFR 431.52(b)(4)	A state plan must provide that the state will pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the service are furnished to a recipient who is a resident of the state and it is general practice for recipient in a particular locality to use medical resources in another state.
Utilization review requirements	42 USC 1396(a)(30)	42 CFR 456.3	Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.
Contracting (Provider Agreement)	42 USC 1396(a)(27)	42 CFR 431.107	Provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

REQUIREMENT	SECTION OF FEDERAL LAW	FEDERAL REGULATION	DEFINITION
Fair Hearing Requirements	42 USC 1396(a)(a)(3)	42 CFR 431.200	Provide for granting on 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 the reasonable promptness.