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Work Incentive Support Center

Policy and Practice Brief:

Medicaid and Persons with Disabilities

A Focus on Eligibility, Covered Services, and Program Structure

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This is one of a series of articles written for benefits specialists employed by Benefits Planning, Assistance and Outreach projects and attorneys and advocates employed by Protection and Advocacy for Beneficiaries of Social Security programs. Materials contained within this policy brief have been reviewed for accuracy by the Social Security Administration (SSA), Office of Employment Support Programs. However, the thoughts and opinions expressed in these materials are those of the authors and do not necessarily reflect the viewpoints or official policy positions of the SSA. The information, materials and technical assistance are intended solely as information guidance and are neither a determination of legal rights or responsibilities, nor binding on any agency with implementation and/or administrative responsibilities.

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This policy and practice brief is written for a primary audience of individuals who work for either a Benefits Planning, Assistance and Outreach (BPA&O) project or a Protection and Advocacy for Beneficiaries of Social Security (PABSS) program. The BPA&O and PABSS programs were created to serve beneficiaries of Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) as they transition from benefits to full or part-time work.

The subject of this brief, Medicaid, is an issue which most of the individuals with disabilities who are served by the BPA&O and PABSS programs will deal with constantly. For those beneficiaries, Medicaid will be the likely payment source, for example, to pay for their doctors, therapists, prescription drugs, home health care, replacement wheelchairs, or episodic hospital stays.

A many advocates know, Medicaid has, since its inception in 1965, been the most complicated of all public benefit programs. In fact, Medicaid, as it relates to individuals with disabilities, has become a much more complicated program in the past 20 years as we have witnessed tremendous increases by states in using a wide range of Medicaid waiver programs; the movement to a managed care model in many states; and the 1619(b) and Medicaid buy-in programs emerge as ways for individuals with disabilities to retain Medicaid while working.

Recognizing the importance and complexity of Medicaid, this policy and practice brief will provide the reader with a practical guide to understanding the program. In doing so, our focus will be on: the services covered or potentially covered by Medicaid; the many ways that individuals with disabilities can establish or retain eligibility; the way the program is typically structured; and the appeals system available when the Medicaid agency makes a decision that is adverse to the applicant or beneficiary.

I. What is Medicaid?

A. A Cooperative Federal-State Program

Medicaid, officially referred to in the federal law as “Medical Assistance,” is a cooperative federal-state program authorized by Title XIX of the Social Security Act.¹ Medicaid is designed as a fee-for-service program in which the state or local Medicaid agency provides payment for covered services, with the federal government reimbursing states for 50 to 83 percent of eligible costs, depending on the average per capita income of a state.²

Although Medicaid is designed to serve persons with limited income and resources, there are several special provisions which either allows a state’s Medicaid program to waive income and resource rules, or that permit eligibility at much higher levels of income. As explained below, Medicaid can pay for a wide range of health-related costs for both children and adults with disabilities.

¹ 42 U.S.C. §§ 1396 *et seq.*
² You can find the rate at which the federal government reimburses eligible Medicaid costs in your state at www.statehealthfacts.org (follow the links for your state, then the state Medicaid program).

Administration of Medicaid will occur at the state level, with the state Medicaid agency often delegating decision making either to other state agencies, or to county or local Medicaid units. In some states, the state Medicaid agency will delegate decision making to private managed care organizations.

B. Distinguish from Medicare

Medicare, a federal health insurance program authorized by Title XVIII of the Social Security Act, is most frequently associated with the receipt of Social Security benefits.³ Adults with disabilities can establish Medicare eligibility in three ways:

- After 24 months of eligibility for SSDI benefits; or
- After 24 months of eligibility for Railroad Retirement disability benefits⁴; or
- If diagnosed with kidney disease and not receiving SSDI benefits, upon entering end stage renal disease or developing a disability that requires regular dialysis or kidney transplantation to maintain life.⁵

There is also a class of Medicare-Qualified Federal Employees who can qualify for benefits.⁶

Medicare is, for a majority of persons with disabilities, an inferior health insurance plan compared to Medicaid. Compared to most state Medicaid programs: Medicare provides much more limited home health care benefits; it provides more limited coverage of community-based care; and typically, Medicare provides more limited coverage for the wide range of durable medical equipment (or assistive technology devices) compared to Medicaid. It is not clear whether Medicare's new prescription drug benefit, Medicare Part D, will provide the same scope of coverage that is currently available to Medicaid beneficiaries in most states. Medicare's new Part D benefit, which begins on January 1, 2006, is beyond the scope of this article but is expected to be covered in a future policy and practice brief. Readers must be aware that under the Part D program, as currently written, individuals who are dually eligible for Medicaid and Medicare will be required to obtain their prescription drugs through Medicare.

Medicare requires payment of premiums (for the optional Part B coverage), deductibles and co-payments that are either not typically required by Medicaid, or when imposed by a state Medicaid agency, may not be for more than a "nominal amount."⁷ In 2005, the Medicare Part B premium is \$78.20 per month. A state's Medicaid agency may, subject to income eligibility requirements, pay for the Part B premiums, deductibles and co-payments. This is generally done under the Qualified Medicare Beneficiaries (QMB) program or the Selected Low-Income Medicare Beneficiaries (SLMB) program, also known as Medicare Savings Programs.⁸ The QMB and SLMB programs can be extremely important to Medicaid beneficiaries who are also eligible for Medicare.

³ 42 U.S.C. §§ 1395 *et seq.*

⁴ 42 U.S.C. § 426(b).

⁵ 42 U.S.C. §§ 426-1, 1395c, 1399r; 42 C.F.R. § 406.13(b).

⁶ Social Security Administration (SSA) Program Operations Manual Systems (POMS) HI 00835.001.

⁷ See 42 U.S.C. §§ 1396o(a)(3), 1396o(B)(3). Under Medicaid buy-in program (see section III.E, below), states can charge monthly premiums subject to a formula adopted by the state.

⁸ For links to state websites related to QMB and SLMB, go to the federal Medicare website at: www.medicare.gov/Contacts/Related/MSPs.asp.

C. Why is Medicaid Important to Persons with Disabilities?

Medicaid is typically the only or primary health insurance plan for persons with disabilities who have limited income. Additionally, an increasing number of individuals with disabilities are looking to Medicaid as their primary health insurance plan, notwithstanding higher levels of income. Medicaid may be available to those individuals through state-specific Medicaid waivers, through optional Medicaid buy-in programs, or through the section 1619(b) provisions, all discussed below. A lack of adequate health insurance is often cited as a primary barrier to both the ability to live in the community and the ability to succeed in employment.

II. Services Covered by Medicaid

The extent of services covered by Medicaid will vary, state-by-state, as states are given great leeway on what optional categories of service to cover. States are also given total discretion in deciding whether or not to offer special services to selected populations under a federally-approved home and community-based services waiver. The waiver programs are often used to offer services that go beyond what is offered through the state’s Medicaid plan (see section IV, below).

Although participation in Medicaid is voluntary, once a state chooses to participate in the program (and every state does) it must comply with federal Medicaid requirements. One such requirement is that a state must offer each category of “required services.” Many of the required and optional services, listed in parts B. and C, below, are defined in the federal Medicaid regulations.⁹

A. Service Categories Must be Listed in the State Medicaid Plan

Each state must develop a state Medicaid plan that describes the administration of the program and the eligibility categories covered by the state. The state plan must identify the required and optional health care services that are available through the state Medicaid program. The state plan must describe how beneficiaries, advocates, and others can review and obtain copies of all current policies and rules governing the operation of the program.¹⁰

B. Required Services

All states must offer each of the required Medicaid services. The required services include:

- Inpatient Hospital Care
- Outpatient Hospital Care
- Physician’s Services
- Laboratories and X-Ray Services
- Nurse Midwife Services
- Rural Health Clinic Services

⁹ See 42 C.F.R. §§ 440.1-440.185.

¹⁰42 C.F.R. § 431.18.

- Prenatal Care
- Family Planning Services
- Skilled Nursing Facility Services for Persons Over Age 21
- Home Health Care Services to Persons Over 21, Eligible for Skilled Nursing Services (Includes Medical Supplies and Equipment)
- Pediatric and Family Nurse Practitioner Services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Persons Under Age 21
- Vaccines for Children
- Federally Qualified Health Center
- Transportation

C. Optional Services

The following are optional services that may be included in your state's Medicaid plan:

- Podiatrist Services
- Optometrist Services and Eyeglasses
- Chiropractor Services
- Private Duty Nursing
- Clinic Services
- Dental Services
- Physical Therapy
- Occupational Therapy
- Speech, Hearing and Language Therapy
- Prescribed Drugs
- Dentures
- Prosthetic Devices
- Diagnostic Services
- Screening Services
- Preventive Services
- Rehabilitative Services
- Transportation Services
- Services for Persons Age 65 or Older in Mental Institutions
- Intermediate Care Facility Services
- Intermediate Care Facility Services for Persons with Mental Retardation/ Developmental Disabilities and Related Conditions
- Inpatient Psychiatric Services for Persons under Age 22
- Christian Science Schools
- Nursing Facility Services for Persons under Age 21
- Emergency Hospital Services
- Personal Care Services
- Hospice Care
- Case Management Services
- Respiratory Care Services

D. Which of the Covered Services in a State Are Most Important to Persons with Disabilities?

The most important Medicaid-funded services tend to be those that are the most expensive and either not usually covered through employer-funded health insurance programs or covered with high deductible requirements. These include:

- Inpatient hospital care (required) – This is very important for persons who have predictable expenses for periodic hospitalization
- Home health care services (required) – Importantly, this required service includes “medical supplies and equipment,” the category typically used to fund a wide range of durable medical equipment and assistive technology.
- EPSDT (required) – for children under age 21. For children with severe disabilities, this opens the door to every optional service category under Medicaid (in all states), even when the optional service is not covered for adults. This ensures that any of the expensive services, potentially covered by Medicaid, will be covered for the child or young adult when such services are medically necessary.¹¹
- Prescription drugs (optional) – Many of the newer drugs, used to treat conditions like multiple sclerosis or depression may be extremely expensive. If covered by a private insurance plan, the coverage may come with high copayments.
- Private duty nursing (optional) – This very expensive service is seldom available on an ongoing basis through traditional health insurance plans.
- Physical therapy; occupational therapy; speech, hearing and language therapy (optional) – Each of these services can be expensive and, when needed on an ongoing basis, is not available through many traditional private insurance plans. Under each of these categories, funding is available for necessary equipment and supplies, providing potential funding for expensive durable medical equipment and assistive technology.¹²
- Prosthetic devices – This has also been used to fund expensive durable medical equipment and assistive technology, i.e., to the extent that the device replaces or replaces the functioning of a non-functioning part of the body.¹³
- Intermediate care facilities (optional) – These very expensive residential programs enable many persons with disabilities to move from institutions into more community-based living environments.
- Personal care services (optional) – This service provides for personal care aides and is what allows many individuals with disabilities to live independently in the community.

¹¹42 U.S.C. § 1396d(r)(5).

¹²42 C.F.R. § 440-110(c).

¹³42 C.F.R. § 440.120(c).

- Clinic services (optional) – To the extent that this category and other optional categories (e.g., case management services) are available to provide community-based mental health treatment, this allows persons with mental illness diagnoses to avoid the need for more segregated inpatient treatment.

E. Relationship Between Medicaid and Medicare or Private Health Insurance Plans

I. Medicaid is The Payer of Last Resort

Many Medicaid beneficiaries will also have coverage through Medicare or a private health insurance plan. When this is the case, Medicare or the private insurance plan will be the primary payer and Medicaid will be secondary.

For example, if a person who is covered by both Medicaid and Medicare sees a doctor who charges \$50, Medicare Part B will pay up to 80 percent of this charge with Medicaid picking up the copayment. Similarly, if a private insurance plan covers a \$100 prescription refill, subject to a \$35 copayment, Medicaid can pay the copayment (assuming prescription drugs are covered as an optional Medicaid service). One limitation is that the state Medicaid copayment will only be made to the extent that the combined Medicare (or private insurance) and Medicaid payments do not exceed Medicaid rates for the item.

Keep in mind that under the new Medicare prescription drug plan, Medicare Part D, individuals who are dually eligible for Medicaid and Medicare will be required to obtain their prescription drugs through Medicare. The Medicare Part D program will begin on January 1, 2006.

2. Medicaid Can Pay the Medicare or Private Insurance Premiums

We have already explained that the state Medicaid agency can pay for Medicare Part B premiums through the QMB or SLMB programs (see section I.B, above). The Medicaid agency is also authorized to pay for private insurance premiums when it determines that it is cost-effective to do so.

Recent health care trends find the employee responsible for an ever increasing share of the monthly health insurance premiums when health insurance is offered to employees. In some cases, the employee share of premiums may be so high that many employees might opt not to take the insurance. By picking up the employee's share of the premium, the Medicaid agency should save money as the private insurance plan will be the primary payer for health care that is covered by the plan. The employee will then have access to doctors and health care providers that are covered by the plan, some of whom may have opted not to participate in the Medicaid program.

3. Prior Medicaid Coverage Can Satisfy the Period of “Creditable Coverage” Requirements, Ensuring Private Insurance Coverage in Many Cases Without a Period of Exclusion for a Preexisting Condition

In our earlier policy and practice brief, *Expanding Health Insurance Options: A Framework for Advising Social Security Beneficiaries of Their Rights Under Private Insurance Contracts*,¹⁴ we discussed the federal Health Insurance Portability and Accountability Act (HIPAA) provisions governing preexisting conditions, provisions which generally apply to group health plans and health insurance issuers offering group health plans.¹⁵ HIPAA allows private insurance plans to exclude coverage of preexisting conditions for a period of up to 12 months after the enrollment date.¹⁶ That 12-month exclusion period can be shortened or eliminated if the beneficiary of the plan was covered by another third party insurance plan (or plans) during the year prior to enrollment, with a break of no more than 63 days during which the individual was not covered.¹⁷ This is referred to under HIPAA as a period of “creditable coverage”

Many SSI or SSDI beneficiaries will take a job with private health insurance, having not worked during the previous year and having been covered only by Medicaid during that time. Many are concerned that the employer-funded insurance plan will not cover their preexisting conditions. The good news, for health insurance plans covered by HIPAA, is that Medicaid coverage is considered creditable coverage. What this means is that a person who was covered by Medicaid during the previous 12 months (or by a combination of Medicaid and private insurance), with no break in coverage of more than 63 continuous days, cannot be subject to a preexisting conditions exclusion period upon enrolling with the private plan.

III. Establishing Medicaid Eligibility

This section details the many ways that persons with disabilities become eligible for Medicaid. During the past 25 years, many new ways to qualify for Medicaid have been added to the Medicaid Act. For example, the Act has been amended to create the optional, home and community-based services waiver and Medicaid buy-in programs. Additionally, the SSI provisions in Title XVI of the Social Security Act have been amended to make four separate classes of former SSI recipients eligible for continued Medicaid.

A. Using SSI to Establish Medicaid Eligibility

I. In Most States Medicaid Eligibility is Automatic for SSI Recipients

SSI is a cash benefit for individuals with disabilities who have limited income and resources. In 2005, the SSI federal benefit rate is \$579 for an individual. Individuals eligible for SSI automatically qualify for Medicaid in 39 states, the District of Columbia, and the

¹⁴Available on Cornell's website at: www.ilr.cornell.edu/ped/dep/PP_9.txt or www.ilr.cornell.edu/ped/dep/PP_9.pdf.

¹⁵29 C.F.R. § 2590.701-2.
¹⁶29 C.F.R. § 2590.701-3(a)(1)(ii).

¹⁷29 C.F.R. §§ 2590-701-4(a)(1), 4(b)(2).

Northern Mariana Islands. In most of these states, the SSI application also serves as a Medicaid application and no additional action is needed to establish Medicaid eligibility. However, the following states require a separate Medicaid application, even though the SSI status is enough to make them eligible: Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, and the Northern Mariana Islands.

In 11 states, known as section 209(b) states, Medicaid eligibility is not automatic for SSI recipients. These states use their own Medicaid eligibility criteria which differs from SSI eligibility criteria.¹⁸ States exercising the 209(b) option include Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.¹⁹

B. Working with SSI's Income and Resources Rules Can Enable the Individual to Retain or Obtain Medicaid

Working with SSI's income and resource rules to establish or retain SSI eligibility is a critical way of ensuring Medicaid eligibility in many cases. This section provides some illustrative examples of how this can work.

1. Lump Sums of Money Can be Used to Purchase Exempt Resources

An SSI recipient may receive a lump sum for retroactive SSI or SSDI benefits. The lump sum might also be for a personal injury settlement or it could be an inheritance. If this amount is for more than \$2,000 and it is retained in the bank, it will make the individual ineligible for SSI and automatic Medicaid in those states in which Medicaid is automatic for SSI recipients.

Many of our readers are familiar with SSI's list of exempt resources. These would include, for example, the residence of the SSI recipient (or responsible spouse or parent), a vehicle that is used for transportation by the recipient, or money set aside into an approved Plan for Achieving Self Support (PASS).²⁰ By using the lump sum for these purposes, the individual may be able to ensure SSI and Medicaid eligibility.

2. Parental Income and the Transition-Aged Student

If parental income is high enough, part of it is considered available (or "deemed") to their child under 18 who is seeking SSI. Parents can often organize their finances to ensure SSI and Medicaid eligibility.

For example, in a state that pays the 2005 SSI federal benefit rate of \$579, with no state supplement, a single parent living with two children, including one with a disability, would be able to maintain SSI eligibility for the child with a disability as long as the parent's gross monthly wages do not exceed \$2,731 (\$32,462 per year). If the parent's gross monthly wages are just above this limit, SSI eligibility for the child with a disability could be accomplished by: accepting extra health benefits in lieu of wages; putting earnings into a flexible spending account, if available²¹; or by going to a part-time schedule. If the

¹⁸42 U.S.C. § 1396a(f).

¹⁹SSA Program Operations Manual System (POMS) SI 01715.020.

²⁰For a complete list of exempt resources, see 20 C.F.R. § 416.1210.

²¹The flexible spending account (FSA), authorized by Internal Revenue Code § 125, allows a wage earner to use pre-tax dollars to pay for items like uncompensated medical costs, co-payments, premiums, child care, public transportation, and parking. See POMS SI 00820.102, referring to the FSA as a "cafeteria plan" and excluding FSA contributions in determining countable income for the SSI program.

child is old enough to have a viable vocational goal (generally age 14 or older) the parent could also consider putting part of their income (i.e., that which is deemed to the child) into a PASS to save toward expenses like college tuition or a computer. Of course, in most states the child's eligibility for SSI will mean that he or she is also eligible for Medicaid.

3. Using the SSI Work Incentives Can Ensure SSI and Medicaid Eligibility

This brief will not attempt to summarize the many work incentives that are available to SSI recipients, as these are summarized in many other materials, including Cornell's two-volume manual, other policy and practice briefs, and numerous SSA publications. We will, instead, provide a few examples of how work incentives could be used to establish or retain SSI and, presumably, Medicaid in most states.

SSI's PASS can be used in any case in which the individual is disabled, needs money to pay for items or services to support a vocational goal, and has excess income or resources that would affect eligibility for SSI or the benefit amount.²² For example, an individual with a monthly SSDI check of \$900, who lives in a state that pays the 2005 SSI federal benefit rate of \$579, could put \$400 per month into an approved PASS and qualify for an SSI check of \$99 per month and Medicaid in most states. With the \$20 general income exclusion and a \$400 PASS exclusion, countable income is reduced to \$480 ($\$900 - 20 - 400 = \480). The SSI check is then calculated by subtracting \$480 from the \$579 SSI rate ($\$579 - 480 = \99).

An individual might also use blind work expense to qualify for SSI despite earnings that would ordinarily be too high to qualify for a monthly check. For example, an individual who earns \$18,000 gross per year (\$1,500 per month) and lives in a state that pays the 2005 SSI federal benefit rate (\$579) would not ordinarily qualify for SSI because their countable income, \$707.50, is more than the monthly SSI rate. If we assume that the individual has \$500 in monthly blind work expenses, covering expenses such as income tax withholding, Social Security and Medicare taxes, union dues, transportation, guide dog expenses, lunches, readers, Braille paper, cassette tapes, and computer discs,²³ then countable income is reduced to \$207.50 and the individual will qualify for an SSI check of \$371.50 and automatic Medicaid in most states.

C. Four Provisions Allow Former SSI Recipients to Retain Medicaid Eligibility²⁴

I. Recipients of Social Security Widow's/Widower's Benefits

If a person loses SSI when he or she becomes eligible for Social Security widow's or widower's benefits, the person remains automatically eligible for Medicaid if SSI eligibility would continue in the absence of the widow's or widower's benefits. Eligibility for Medicaid, however, continues only so long as the person remains ineligible for Medicare, a period of 24 months following the first month of Social Security eligibility.²⁵

²²A very comprehensive discussion of the PASS appears in our policy and practice brief, *PASS: SSI's Plan for Achieving Self-Support*, available on the Cornell website at www.ilr.cornell.edu/ped/dep/PP_12.txt or www.ilr.cornell.edu/ped/PP_12.pdf.

²³POMS SI 00820.535 - .565.

²⁴See CMS's Publication, *Groups Deemed to be Receiving SSI for Medicaid Purposes* (Disability and Aging TA Series # 01), available at www.cms.hhs.gov/medicaid/eligibility/ssideem.pdf.

²⁵42 U.S.C. § 1383c(d).

Example: Harriet Simmons, age 53, was receiving \$579 in SSI benefits and Medicaid until her husband died. Now she has been approved for SSDI Widow's Benefits at the rate of \$650 per month, making her ineligible for SSI. She will continue her right to automatic Medicaid, under this provision, during the 24-month waiting period for Medicare.

2. Recipients of Social Security Disabled Adult Child's Benefits

A recipient of Social Security Childhood Disability Benefits, typically referred to as Disabled Adult Child's (DAC) benefits, can continue eligibility for automatic Medicaid if, after July 1, 1987, the person lost SSI due to entitlement to or an increase in SSDI/DAC benefits.²⁶ DAC benefits are available to adult children of individuals who paid sufficient amounts into the Social Security trust fund and now are disabled, retired, or deceased.

Example: Chad Armstrong, age 27, was receiving \$579 in monthly SSI benefits and Medicaid. Upon his father's death, he applies for and is approved for DAC benefits of \$720 per month and then loses his SSI benefit. So long as Mr. Armstrong remains "otherwise eligible" for SSI (i.e., if we ignored his DAC benefits or the most recent increase in DAC benefits, he would continue to be eligible for SSI), he continues to be eligible for Medicaid.²⁷

3. The Pickle Amendment

Individuals who lost SSI because of cost-of-living or other increases in Social Security benefits may have their automatic Medicaid eligibility re-established if the person would be presently eligible for SSI if Social Security cost-of-living increases, since the last month of dual eligibility for SSI and SSDI, are disregarded.²⁸

4. Section 1619(b): Continued Medicaid for Persons Who Lose SSI Due to Wages

This very important work incentive provides Medicaid for individuals who lose SSI when earnings are too high to qualify for the SSI cash benefit.²⁹ Under section 1619(b), which is applicable in all states, automatic Medicaid continues if the person would be eligible for SSI if his or her wages were ignored and annual income is less than a specified income threshold. The 2005 state eligibility thresholds range from \$21,000 to \$45,000 in annual wages, as the threshold is based on a combination of state-specific SSI payment rates and per capita Medicaid expenditures.³⁰

Example, general 1619(b) threshold: Mary was getting SSI benefits of \$579 and Medicaid until July 2005 when she started working a job that pays \$18,000 per year. She will lose her cash benefits, but should be able to keep her Medicaid benefits in all states under the 1619(b) program so long as other criteria are met.

Example, individualized 1619(b) threshold: A higher, individualized eligibility threshold can be established based on such factors as very high health-related costs.³¹ For example, assume that Mary in the preceding example resides in Utah where the 2005 general threshold for 1619(b) is \$26,326 in annual gross wages. Mary gets a promotion and will now be earning \$28,000 in gross annual wages, just above Utah's general threshold for 1619(b). Assume that Mary has \$15,000 per year in Medicaid-funded expenses.

²⁶42 U.S.C. § 1383c(c).

²⁷For a further explanation of this provision and the litigation it took in two states to enforce it, see Munger, J., *Categorical Medicaid Eligibility for Recipients of Disabled Adult Child Social Security Benefits*, 29 CLEARINGHOUSE REV. (March 1996).

²⁸For an excellent resource on this topic, see Bonnyman, G., *A Quick and Easy Method of Screening for Medicaid Eligibility Under the Pickle Amendment* (updated annually), available at: www.healthlaw.org/pubs/200411.2005Picklechart.pdf.

²⁹42 U.S.C. § 1382h; 20 C.F.R. §§ 416.264 et seq.; POMS SI 02302.010 B.

³⁰See POMS SI 02303.200 N, listing state-by-state eligibility thresholds for 2005.

³¹POMS SI 02302.050.

Mary will be eligible for Medicaid under an individualized threshold. This threshold for her will be determined by taking the base amount from the 1619(b) chart available in SSA’s POMS manual³² (\$14,916 for Utah) and adding the annual amount that would be paid by Medicaid (\$15,000). Adding those two figures together provides you with Mary’s individualized eligibility threshold, \$29,916 per year. Since Mary’s new annual gross wage amount, \$28,000, is less than her individualized threshold of \$29,916 she remains eligible for Medicaid under 1619(b).

D. Obtaining Medicaid Through the “Medically Needy” or “Spend Down” Program

I. The Medically Needy Program is an Option Exercised by Two Thirds of the States

Medically needy individuals include individuals with disabilities or blindness, who would qualify for SSI, but have income or resources above the SSI limits set by their state.³³ Since disability and blindness are two optional coverage groups under the medically needy program, not all states will cover them.³⁴ Thirty-four states, the District of Columbia, and Puerto Rico have established a medically needy program for individuals with disabilities or blindness, including Alaska, Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Maryland, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.³⁵ Since Medicaid agencies often do not explain the spend down (or “share of cost”) program to applicants or recipients, you should find out if your state offers this option and take steps to educate yourself and your clients on how it works.

2. How the Spend Down Works

Each state sets its medically needy income levels based on family size. For example, New York set its 2005 level at \$667 per month for a household of one. All individuals meeting the federal SSI definition of disability or blindness, who have income or resources below the medically needy level, automatically qualify for Medicaid. Individuals with income above the medically needy level must first meet a “spend down” or “share of cost” test. The spend down is the amount by which countable income exceeds the state’s medically needy level after subtracting allowable deductions.

For individuals in states in which Medicaid is automatic for SSI recipients, the Medicaid agency must follow SSI’s rules (or rules that are more liberal than the SSI rules) for counting of income and resources.³⁶ In these states, the rules (or “methodologies”) used in determining eligibility for persons who are blind or disabled can be no more restrictive than those employed by the SSI program.³⁷ In states using more restrictive income and resource rules than those of SSI (i.e., section 209(b) states), those rules can be no more restrictive than those used under the state’s Medicaid plan in effect on January 1, 1972.³⁸

³²See note 30 above.
³³42 U.S.C. § 1396a(a)(10)(C).

³⁴CMS State Medicaid Manual § 3612.

³⁵See *CMS’s Medicaid At-a-Glance 2003: A Medicaid Information Source*, www.cms.hhs.gov/states/maag2003.pdf.

³⁶See 42 U.S.C. § 1396(a)(10)(C)(i); 42 C.F.R. §§ 435.831 (income) (requiring, at § 435.831(b)(2) that “the agency must deduct amounts that would be deducted in determining eligibility under SSI”), 435.601 and 435.845 (resources); CMS State Medicaid Manual § 3620 C.

³⁷See *Addis v. Whitburn*, 153 F.2d 836 (7th Cir. 1998); *Camacho v. Perales*, 786 F.2d 32 (2d Cir. 1986).

³⁸See, e.g., 42 C.F.R. § 435.831(b)(3) (regarding income determinations).

In the states that are required to follow the SSI rules for determining countable income and resources, the implications are very significant for those Medicaid applicants and beneficiaries who are working or have vocational plans. This is because all of the SSI work incentives must be available to reduce what would otherwise be countable income and resources.³⁹ For example, the following monthly income disregards must be allowed when determining income eligibility or the amount of an individual's spend down:

- The \$1,410 student earned income exclusion for students under age 22;
- The \$20 general income exclusion;
- The \$65 earned income exclusion;
- Impairment related work expenses;
- One-half of remaining earned income;
- Blind work expenses; and
- Amounts set aside in a Plan for Achieving Self Support (PASS).⁴⁰

Additionally, since these states must follow SSI's rules for counting of income and resources, any of the strategies for preserving SSI and Medicaid, discussed above, are applicable here.⁴¹

3. What Bills or Expenses Will Be Counted Toward the Spend Down?

Nearly any medical expense that is paid or incurred can be used to meet a Medicaid spend down requirement, even if it is for goods or services not covered by the Medicaid state plan.⁴² However, the Medicaid applicant/beneficiary will need to keep good records. The following is a list of typical expenses that may be used:

- Health insurance premiums and co-payments
- Doctor bills
- Mental health bills (including a psychiatrist's services and mental health counseling services)
- Dental bills
- Home health care
- Prescriptions drugs
- Eyeglasses and optometry bills
- Over-the-counter drugs or purchases related to health care

Medical expenses of the beneficiary, incurred or paid by a program of the state or a political subdivision (i.e., county, city, school district), must be counted as medical expenses under the spend down provisions.⁴³ Examples of such expenses include services provided by a state agency serving a specific disability population, such as the office of mental health or developmental disabilities. Services like physical or occupational therapy, provided by special education programs, may also qualify under these provisions.

Example: Consider the case of Kevin, age 29, who has a diagnosis of major depression and receives \$887 in Social Security Disabled Adult Child's benefits. He is not eligible for SSI (and never had been) and is eligible for Medicaid with an \$200 per month spend down (i.e., the spend down in a state with a one-person monthly eligibility threshold of

³⁹See note 37, above.

⁴⁰For a comprehensive discussion of the various work incentive rules, see Sheldon, J., *Work Incentives for Persons with Disabilities Under the Social Security and SSI Programs* (2002), available at www.nls.org/work_incentives.htm or www.nls.org/pdf/work_incentives.pdf.

⁴¹See section III.B, above.

⁴²See, generally, CMS State Medicaid Manual §§ 3628 et seq.

⁴³42 U.S.C. § 1396a(a)(17)(D); CMS State Medicaid Manual § 3628.

\$667). Kevin receives free mental health counseling through a program sponsored by his county office of mental health, at a cost of \$175 per month to the county. This \$175 in county-funded medical expenses will reduce the spend down to \$25 per month. This means that for \$25 per month, Kevin can obtain Medicaid coverage. This will now provide a payment source for prescription drugs, doctor visits, and a range of other services.

E. The Optional Medicaid Buy-In

The optional Medicaid buy-in program is an important way for individuals with disabilities to obtain or retain Medicaid coverage when they are working. It is designed to provide health insurance to working people with disabilities who, because of relatively high earnings, cannot qualify for Medicaid under other eligibility categories. The buy-in was originally made available as part of the federal Balanced Budget Act of 1997. The enhancements to this optional program have been touted as some of the more important provisions of the Ticket to Work and Work Incentives Improvement Act of 1999.⁴⁴

At the time of publication, 26 states had adopted and were implementing a buy-in program, with an additional three states awaiting CMS approval to implement this program. Many other states were in the process of developing buy-in programs that would need to be approved by CMS prior to implementation.

The states currently implementing a buy-in program include: Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, Wisconsin, and Wyoming. Additionally, Massachusetts is implementing a Medicaid waiver program very similar to the buy-in program.⁴⁵

The buy-in program is most important to those individuals with disabilities who have significant health care needs that cannot be met through employer-sponsored health insurance plans and have no other means to obtain or retain Medicaid when working for significant wages. Often, the group that will benefit most are recipients of SSDI, who are not simultaneously eligible for SSI and, thus, cannot qualify for Medicaid under the section 1619(b) program. Many of these individuals currently receive Medicaid through medically needy programs and could not afford to work if it meant giving up Medicaid as the source of payment for expensive items like prescription drugs, personal care services, and durable medical equipment. In those states that have implemented buy-in programs, eligibility for Medicaid can continue in many cases at annual wage levels exceeding \$40,000. In a few of the states, Medicaid eligibility can continue at annual wage levels exceeding \$70,000.⁴⁶

Subject to federal criteria, a state can choose to structure the buy-in as it sees fit. Largely due to fears of rising Medicaid costs, only five or six states had initiated buy-in programs when the Ticket to Work and Work Incentives Improvement Act (TWWIIA) was signed into law in December 1999. TWWIIA sought to make the program more attractive to states.

⁴⁴42 U.S.C. §§ 1396a(a)(10)(A)(ii) and 1396o.

⁴⁵See the SSA website at: www.ssa.gov/work/ResourcesToolkit/Health/states.html.

⁴⁶A very comprehensive discussion of the different buy-in criteria and different buy-in experiences, in several states, is contained in *The Effectiveness of the Medicaid Buy-In Program in Promoting Employment of People with Disabilities: A Briefing Paper for the Ticket to Work and Work Incentives Advisory Panel* (Cornell University Institute for Policy Research, July 2004), available at www.socialsecurity.gov/work/panel (then follow links for “panel documents,” then “briefing papers”).

The key eligibility criteria for buy-in programs established since 1999 are:

- States can set income eligibility levels between 250 and 450 percent of the federal poverty level. (Since income is “net,” i.e., after SSI-related disregards, including earned income disregards, individuals can earn well over \$40,000 per year and keep Medicaid even in states with the more modest 250 percent of poverty level guideline.)
- A person can perform substantial gainful activity (i.e., earn more than \$830 per month in 2005) and still qualify for the buy-in.
- Individuals need not ever have been eligible for SSI in the past.
- States can increase Medicaid resource limits to as high as \$14,000.
- States can charge premiums or other cost-sharing charges, on a sliding scale, based on income.
- States can require some individuals to pay the full premium as long as the premiums do not exceed 7.5 percent of the individual’s total income.
- States must require a 100 percent premium payment for individuals with adjusted gross incomes greater than \$75,000 unless states choose to subsidize the premium using their own funds.

Example of individual using buy-in. Anna, age 46, is single, has multiple sclerosis and receives SSDI benefits of \$1,020 per month. She lives in a state that has the optional medically needy program, with a monthly income eligibility threshold of \$600 for a household of one. Since the Medicaid program will disregard the first \$20 of her unearned income, her countable income is \$1,000 per month and she pays a \$400 per month spend down to qualify for Medicaid. She uses Medicaid to pay for doctor’s visits, medication, and her power wheelchair, among other things.

Anna lives in a state that has implemented a buy-in program, with eligibility based on 250 percent of the federal poverty level. This means her countable monthly income, after all SSI-related exclusions, must be below \$1,994. Her state’s buy-in program allows her to have non-exempt resources of up to \$14,000. If approved for the buy-in, she must pay a premium based on 3 percent of her countable earned income and 7.5 percent of her countable unearned income.

Anna goes to work at a part-time job paying \$665 gross per month. Using SSI-related earned income disregards, her gross earned income is reduced by \$65, then by one half of the remainder ($\$665 - 65 - 300 = \300). Since her gross wages are less than the 2005 substantial gainful activity (SGA) figure of \$830 per month, she will keep her SSDI checks of \$1,020 per month. Combining her countable earned and unearned income, Anna now has \$1,300 in countable income ($\$300 + \$1,000$). She will also now qualify for her state’s Medicaid buy-in program as she:

- meets the disability test based on her receipt of SSDI;
- is engaged in paid work;
- we'll assume has well below \$14,000 in non-exempt resources; and
- has countable income of \$1,300, well below the 2005 eligibility threshold of \$1,994 per month.

Anna will also be required to pay a monthly premium of \$84, i.e., 3 percent of countable earned income (.03 x \$300 = \$9) plus 7.5 percent of countable unearned income (.075 x \$1,000 = \$75). If Anna's rate of pay increases to more than the \$830 per month SGA level and she loses her SSDI benefits, she can retain Medicaid through the buy-in as there is no SGA test for eligibility.

F. Obtaining Medicaid Through The Federal Adoption Assistance Program

Federally funded adoptions are governed by the federal Adoption Assistance and Child Welfare Act of 1980.⁴⁷ States are authorized to enter into adoption assistance agreements with parents “who adopt a child with special needs.”⁴⁸

For children with disabilities, the child is held to meet the criteria as a child with special needs if the child meets all the eligibility requirements for SSI.⁴⁹ For such children, the state “may make adoption assistance payments to such [adoptive] parents directly through the State agency or through another public or nonprofit agency, in amounts to be determined.”⁵⁰ These payments are commonly referred to as “adoption subsidy payments.”

States have leeway to make adoption assistance payments based on individual circumstances, but they cannot be higher than foster care payments would have been if the child had remained in or entered a foster home.⁵¹ In the case of adopted children with disabilities, states may continue the adoption assistance payments until the child is 21.⁵²

The law provides that a child with a disability will not be considered a child with special needs unless: (a) the state has determined that the child cannot or should not return to the home of his or her natural parents; (b) the state has determined that because of the child's disability (or other special factors, such as ethnic background) it is reasonable to conclude that the child cannot be adopted without providing adoption assistance; and (c) a reasonable but unsuccessful effort has been made to place the child without providing adoption assistance or Medicaid.⁵³

Automatic Medicaid eligibility. If the following criteria are met, the adopted child with a disability is automatically eligible for Medicaid⁵⁴:

- The child meets the criteria of “child with special needs” by meeting the eligibility requirements for SSI.
- There must be an adoption assistance agreement in effect, even if adoption assistance payments are not being made pursuant to that agreement.

⁴⁷42 U.S.C. §§ 620-28, 670-676.

⁴⁸42 U.S.C. §§ 673(a)(1)(B), 675(3).

⁴⁹42 U.S.C. § 673(a)(2)(A)(ii).

⁵⁰42 U.S.C. § 673(a)(1)(B)(ii).

⁵¹42 U.S.C. § 673(a)(3).

⁵²42 U.S.C. § 673(a)(4).

⁵³42 U.S.C. § 673(c).

⁵⁴42 U.S.C. § 673(b)(1).

Automatic Medicaid eligibility is also available at state option. States may choose to provide Medicaid coverage for children who are receiving benefits from state or local (non-federal) adoption assistance programs.⁵⁵

IV. Medicaid Waivers: Allowing for Expanded Eligibility and Services for Specific Disability Groups

A. The Concept of a CMS-Approved Waiver

As the previous sections of this brief make clear, Medicaid is a program that is subject to very extensive federal mandates. A CMS-approved waiver allows a state to operate outside the confines of specified federal mandates, often to test innovative approaches to delivery of services or to extend or expand coverage for a targeted population.

B. Some Examples of Waivers that CMS Can Approve

Three of the more common waivers that states have used include:

- The “freedom of choice” waiver, often called a section 1915(b) waiver,⁵⁶ is typically used to create a managed care model to serve Medicaid recipients. A key provision waived in a managed care model is that provision that would ordinarily allow recipients to get services from the provider they choose.
- The “home and community-based services” (HCBS) waiver allows Medicaid agencies to serve individuals who would be eligible for Medicaid if institutionalized. These are often called 1915(c) waivers⁵⁷ and can be used to offer a broader range of services than are offered to Medicaid recipients under the general state plan.
- The “demonstration waiver” is often called the 1115 waiver⁵⁸ and can be used to implement demonstration projects which are “likely to assist in promoting the objectives” of the Medicaid Act. Massachusetts is implementing its Medicaid buy-in program through an approved 1115 waiver.

In the next section, we will discuss the HCBS waiver at greater length as those waivers are very likely to be encountered by individuals with disabilities.

C. How the Home and Community-Based Services Waiver Can Be Used for Individuals With Disabilities

These waivers have been available to states since 1981. Although they are optional, every state has implemented one or more HCBS waivers.⁵⁹ These waivers can be used to extend eligibility to individuals who would not otherwise be eligible for Medicaid or to provide services not available to the Medicaid population generally.

⁵⁵42 U.S.C. §§ 1396a(a)(10)(A)(ii), 1396d(a)(1).

⁵⁶42 U.S.C. § 1396n(b).

⁵⁷42 U.S.C. §§ 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e).

⁵⁸42 U.S.C. § 1315(a).

⁵⁹Information on the HCBS waivers available in your state can be obtained through the Kaiser Family Foundation’s website at www.statehealthfacts.org (follow the links for your state, then the state Medicaid program).

The HCBS waiver can be used to waive three key federal Medicaid requirements:

- Waiver of statewidedness: Ordinarily, the state’s Medicaid plan must offer comparable coverage in all regions of a state. A waiver could be approved that will offer a level of Medicaid coverage in one or more sections of the state that is not available to recipients statewide.
- Waiver of comparability: Ordinarily, the state’s Medicaid plan must treat all similarly situated recipients equally. A waiver could select a targeted group of Medicaid recipients (such as persons with traumatic brain injury, for example) and offer them a scope of services not available to persons who have different disabilities but similar needs.
- Waiver of certain income and resource rules: A waiver can be implemented which exempts certain populations from the general income and resource requirements. For example, many states operate waiver programs that make certain children with very severe disabilities eligible for Medicaid without regard to parental income and resources.

The expanded scope of services, potentially available through an HCBS waiver, can be very important to individuals with disabilities who are pursuing vocational goals. An HCBS waiver can offer optional services to a specific disability group that are not otherwise offered to adult Medicaid recipients. These could include optional services such as private duty nursing or prosthetic devices. The HCBS waiver can also offer services that are not currently authorized by the Medicaid Act, including some that are not strictly medical in nature.

Under federal HCBS waiver regulations a very wide range of services can be provided, including:

- Case management
- Homemaker services
- Home health aide services
- Personal care services
- Adult day health
- Habilitation
- Respite
- Partial hospitalization and psychosocial rehabilitation for persons with psychiatric diagnoses.
- Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.⁶⁰

States have apparently used this “other services” category to approve things like home modifications and even modifications to vehicles.⁶¹

In 1997, the HCBS regulations were amended to allow for “expanded habilitation services,” which include “prevocational services” and “educational services.”⁶² Under the prevocational and educational services categories, CMS would allow an approved waiver to provide a wide range of services that would prepare an individual with a very severe disability to eventually move to either competitive employment, long term supported employment, or a more traditional vocational rehabilitation program.



⁶⁰42 C.F.R. § 440.180.

⁶¹See N.Y. State Department of Health, Administrative Directive, Transmittal #00 OMM/ADM-4 (May 22, 2000), available at www.wnylc.net/pdf/2000-adms/00ommadm-4.pdf, explaining the criteria for approving home adaptations and vehicle modifications under the state’s Care at Home I and Care at Home II waiver programs.

⁶²42 C.F.R. § 440.180(c)(2) (i) & (ii).

Services available through the expanded habilitation services category include:

- teaching an individual such concepts as compliance, attendance, task completion, problem solving, and safety;
- supported employment services (which presumably includes job coaching) that are provided in integrated work settings with an assumption that the individual is not receiving a competitive wage (at or above minimum wage) during the period they receive services;
- any combination of special supervisory services, training, transportation, and adaptive equipment that the state demonstrates are essential for engaging in paid employment.

V. Due Process: The Right to a Hearing When Medicaid Eligibility or Medicaid Services are Denied

A. When is the Opportunity for a Hearing Required?

The federal Medicaid regulations require that an individual is entitled to a written notice and right to an administrative fair hearing at any time the Medicaid agency takes an adverse action or fails to act with reasonable promptness on an application or other request for services.⁶³ An action is considered adverse, for example, if an application is denied or approved subject to a spend down, or if the agency plans to terminate, suspend, or reduce a previously-approved service.⁶⁴

The written notice of proposed action must explain the action that is intended, the reasons for the action, the legal basis for the action, and the right to request a fair hearing to challenge the action. The notice must also explain that the individual has a right to continued benefits pending a final hearing decision.⁶⁵

The federal regulations give states some leeway for setting their own time limits for requesting a hearing, mandating only that the individual be allowed a reasonable time to request a hearing, not to exceed 90 days from the date that the notice of adverse action is mailed.⁶⁶ If you are working with an individual who has received a notice of adverse action by a Medicaid agency, it is critical to read the notice to determine the time limits for requesting a hearing and the separate time limit if “aid continuing” is going to be requested.

B. What Medicaid Hearing Issues Would Be Appropriate for a PABSS Attorney or Advocate to Handle?

BPA&O advocates and PABSS attorneys and advocates are limited to working with beneficiaries of SSI or SSDI, including former cash beneficiaries who retain Medicaid eligibility through 1619(b) or Medicare eligibility through the extended Medicare provisions. So long as the beneficiary status is verified BPA&O and PABSS staff may work on Medicaid issue if to do so could help the beneficiary overcome a barrier to work. BPA&O staff will only be involved in Medicaid issues from a benefits planning perspective, while PABSS staff may represent the beneficiary on Medicaid issues that go to a hearing or litigation.

⁶³The federal regulations governing due process rights are found at 42 C.F.R. §§ 431.200-431.250.

⁶⁴42 C.F.R. § 431.201.

⁶⁵42 C.F.R. §§ 431.206, 431.210.

⁶⁶42 C.F.R. § 431.221(d).

There are a number of Medicaid issues discussed in this brief that would be appropriate for involvement by a PABSS advocate or attorney if the matter went to a hearing:

- in the medically needy program, enforcing the individual’s right to reduce countable income (thereby reducing or eliminating a spend down) by using the SSI work incentives if required to be followed in your state⁶⁷;
- in that same state with a medically needy program, appealing the denial of a proposed Plan for Achieving Self Support, which proposed to exclude income in order to support a vocational goal, thereby reducing or eliminating a Medicaid spend down;
- in a state which has implemented a Medicaid buy-in program, appealing from a denial of eligibility or challenging the amount of premium required to maintain the benefit;
- appealing the denial of prior approval for an item of durable medical equipment, such as a power wheelchair or augmentative communication device;
- appealing a reduction in the amount of personal care services or private duty nursing services approved;
- appealing the denial of funding for a new medical procedure or medicine that promises to restore functioning and make the individual more employable;
- challenging the agency’s imposition of a spend down when it appears that the individual lost SSI due to the receipt of Social Security DAC benefits and should be eligible for continued Medicaid without a spend down.

In keeping with the PABSS eligibility criteria, any appeal must have as its purpose overcoming a barrier to employment.

C. Appealing an Adverse Fair Hearing Decision Into Court

Following the hearing, the state Medicaid agency must issue a written decision. If the decision is in any way adverse to the individual — i.e., the decision either affirms the original denial, suspension, or termination, or provides less than the full benefits the individual was seeking — there is a right to pursue the matter in either state or federal court. We will very briefly explore each option.

In every state but Texas, state law provides for a procedure to review (or appeal) the fair hearing decision in state court. Generally, this review will be based on the record that was made at the hearing. The reviewing court will usually consider whether the decision was correct based on the law, regulations, and policy and/or whether the decision was based on substantial evidence in the record.

⁶⁷The SSI rules for excluding income must be followed in medically needy programs in those states in which SSI recipients are automatically eligible for Medicaid. See note 36 above.

Alternatively, the matter can be taken into federal court. Generally, this review will be pursuant to 42 U.S.C. § 1983 to enforce a provision of the federal Medicaid Act. Although beyond the scope of this brief, readers must be aware that not every provision of the Medicaid Act has been held to be enforceable under section 1983 and the courts are split on whether section 1983 can be used to enforce some provisions. Section 1983 can also be used, without first pursuing a hearing, to challenge actions of a state Medicaid agency that are systemic in nature, such as where the agency is not enforcing a particular requirement of the Medicaid Act. Again, it will be important to first research whether the provision you want to enforce has been addressed by the courts, particularly the federal courts in your state or appeals circuit.⁶⁸

In selected cases, attorneys have used the Americans with Disabilities Act (ADA) to challenge the actions of a state Medicaid agency when it appeared that the federal courts would not entertain a claim under section 1983. Here again, a discussion of how this is done is beyond the scope of this brief.

VI. Conclusion

This policy and practice brief has presented a comprehensive, practical guide on the Medicaid program for use by individuals who work for BPA&O or PABSS programs. It has laid out the basic federal requirements covering both eligibility and available services, pointing out those many areas where states have individual discretion.

Attorneys or advocates who are involved with specific Medicaid provisions that have been covered in these pages may need to dig much more deeply to determine how those provisions apply in your state and to your individual client or consumer. What we have presented to you is based on the federal law, regulations, and policy. As a practical matter, however, the decisions made by state and local Medicaid staff in your state will most likely be based on state law, regulation, and policy. It is incumbent on the reader, then, to become familiar with state law or develop contacts with other attorneys or advocates in your state who have that expertise. Often, the attorneys and advocates with the most Medicaid expertise will come from the legal services and legal aid agencies in your state.

Finally, as this article goes to press the Medicaid program is being closely scrutinized at both the federal level and in every state in the country. The federal government and many states are looking to make changes to contain what is seen as the ever increasing burden on taxpayers for this comprehensive health care program. It is important for the reader, therefore, to keep abreast as changes are made at the federal and state levels.

⁶⁸The National Health Law Project maintains great resource materials on what the courts have said about using 42 U.S.C. § 1983 to enforce provisions of the Medicaid Act. You can call them at 310-204-6010 or check out their website at www.healthlaw.org.

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