

# Medicaid

**By Jane Perkins**

Medicaid, established by Title XIX of the Social Security Act, is the program of medical assistance for individuals with limited incomes.<sup>1</sup> Medicaid covers one in seven people, more than any other public or private insurer in America.<sup>2</sup> This article covers the following topics:

- Administration of the Medicaid program.
- Medicaid eligibility.
- Scope of covered benefits.
- Provider participation and managed care.
- Key issues confronting legal services programs and resources for dealing with them.

## Administration of the Medicaid Program

Since its enactment in 1965, Medicaid has been an “entitlement” program. This means

that individuals who meet Medicaid eligibility requirements have a *legal right* to have payments made to their providers for the covered services they need.

While state participation in Medicaid is voluntary, all states participate. States also have an entitlement—to receive federal matching payments for all state spending on covered services. Federal payments do not come without strings attached, however, as states must adhere to minimum federal requirements when implementing their Medicaid programs.<sup>3</sup>

Administration of the Medicaid program at the federal level is the responsibility of the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services.<sup>4</sup> In addition to promulgating Medicaid regulations, CMS publishes the *State Medicaid Manual* and *Dear State Medicaid Director* letters that announce federal Medicaid policy.

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<sup>1</sup> See 42 U.S.C. §§ 1396 *et seq.*; 42 C.F.R. §§ 430 *et seq.*

<sup>2</sup> See KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER 2 (2001), available at [www.kff.org](http://www.kff.org).

<sup>3</sup> See, e.g., *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502 (1990) (“Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Medicaid Act . . . and regulations promulgated by the Secretary of Health and Human Services.”); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36–37 (1981) (Clearinghouse No. 21,452) (“An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives. State Medicaid plans must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services.”).

<sup>4</sup> Until June 2001 the Centers for Medicare and Medicaid Services (CMS) were known as the Health Care Financing Administration (HCFA).

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### Sources of Information on Medicaid

- Medicaid Act, 42 U.S.C. §§ 1396 *et seq.*
- Medicaid Regulations, 42 C.F.R. §§ 430 *et seq.*
- CENTERS FOR MEDICARE AND MEDICAID SERVICES, STATE MEDICAID MANUAL, *available at* [www.hcfa.gov/pub-forms/45\\_smm/pub45toc.htm](http://www.hcfa.gov/pub-forms/45_smm/pub45toc.htm).
- Centers for Medicare and Medicaid Services, Dear State Medicaid Director Letters, *available at* [www.cms.hhs.gov/states/letters](http://www.cms.hhs.gov/states/letters).
- Centers for Medicare and Medicaid Services transmittals, *at* [www.nhelp.org/publications.shtml](http://www.nhelp.org/publications.shtml).
- Federal and state court cases.
- State statutes and regulations, health plan and provider contracts, and policy letters.
- State Medicaid Plan, *at* [www.hcfa.gov/medicaid/stateplan/map.asp](http://www.hcfa.gov/medicaid/stateplan/map.asp).
- State caseworker and provider manuals.

Federal law requires each state to designate a “single state agency” to administer its Medicaid program.<sup>5</sup> This means that each state must have in effect a written state Medicaid plan that the federal government has approved.<sup>6</sup> The state plan describes who is eligible for Medicaid, what services are covered, and how the program is administered. In general, the state’s Medicaid program must

- conform to all requirements of federal law<sup>7</sup> and
- operate statewide.<sup>8</sup>

States must provide that all individuals wishing to apply for Medicaid can apply without delay, and states must ensure reasonably prompt assistance.<sup>9</sup> States must also establish a medical care advisory committee, which includes Medicaid beneficiaries and knowledgeable providers, to advise the single state agency on policy development and program administration and to review marketing materials of Medicaid-participating managed care organizations.<sup>10</sup>

Through matching payments, the federal and state governments fund the Medicaid program. In some states, counties or local governments also contribute toward the state costs. Federal matching payments can vary from 50 percent to 83 percent of the total expenditures, with poorer per-capita income states receiving higher federal payments.<sup>11</sup> In the 1999 fiscal year, Medicaid was the single largest source of federal funding to the states; it accounted for nearly 40 percent of all federal grants to the states.<sup>12</sup>

#### Medicaid Eligibility— Fitting into a Category

One is not eligible for Medicaid simply because one has a low income. Rather, individuals must successfully pass through four separate screens before being awarded a Medicaid card. A Medicaid applicant must

- fit into a recognized eligibility category;

<sup>5</sup> See 42 U.S.C. § 1396a(a)(5) (Supp. 2001); 42 C.F.R. § 431.10 (2000).

<sup>6</sup> See 42 U.S.C. § 1396a (Supp. 2001); 42 C.F.R. § 430.10 (2000).

<sup>7</sup> See 42 U.S.C. § 1396a (Supp. 2001) (setting forth requirements that states must meet).

<sup>8</sup> See 42 U.S.C. § 1396a(a)(1) (Supp. 2001); 42 C.F.R. § 431.50 (2000).

<sup>9</sup> See 42 U.S.C. § 1396a(a)(8) (Supp. 2001); 42 C.F.R. § 435.906 (2000).

<sup>10</sup> See 42 U.S.C. § 1396a(a)(4) (Supp. 2001); 42 C.F.R. § 431.12 (2000).

<sup>11</sup> See 42 U.S.C. §§ 1396d(a), 1396d(b) (Supp. 2001).

<sup>12</sup> See MEDICAID: A PRIMER, *supra* note 2, at 6.

- meet financial criteria by having limited income and resources;<sup>13</sup>
- have appropriate immigration status—have U.S. citizenship or be a “qualified alien”;<sup>14</sup> and
- be a resident of the state where one applies for Medicaid benefits.<sup>15</sup>

The first screen, fitting into an eligibility category, requires additional discussion. Of about sixty Medicaid eligibility categories currently, some are mandatory while others may be offered at state option.<sup>16</sup> The categories focus on four groups: children and their caretakers, pregnant women, the elderly, and people with disabilities. For example, states must cover

- children under 6 whose family incomes are at or below 133 percent of the federal poverty level<sup>17</sup> and
- children and adolescents, 6–19, whose

family incomes are at or below the federal poverty level.<sup>18</sup>

In most states, individuals who are receiving Supplemental Security Income (SSI) on the basis of disability automatically qualify for Medicaid.<sup>19</sup> States must also use Medicaid to cover the Medicare Part A and Part B premiums, deductibles, and coinsurance of certain elderly or disabled individuals.<sup>20</sup> For example, states must provide Part A and Part B coverage to aged and disabled individuals who are entitled to receive Medicare Part A and who have incomes at or below the federal poverty level.<sup>21</sup>

States have the option to cover a number of other groups, including

- infants and pregnant women with incomes up to 185 percent of the federal poverty level,<sup>22</sup>
- noninstitutionalized disabled children,<sup>23</sup>

<sup>13</sup> See 42 U.S.C. § 1396a(a)(17) (2000). E.g., possession of a car with an equity value of \$1,500, or less at state option, makes an applicant ineligible for Medicaid. See, e.g., *Hazard v. Shalala*, 44 F.3d 399 (6th Cir. 1995) (Clearinghouse No. 47,792) (upholding \$1,500 limit on automobile exclusion). Special financial eligibility rules apply when one spouse is in an institution, such as a nursing home, and the other still lives in the community; see 42 U.S.C. § 1396r-5 (Supp. 2001).

<sup>14</sup> Most immigrants who arrive in the United States lawfully after August 22, 1996, are barred from receiving full-scope Medicaid benefits for at least five years, and Medicaid covers only treatment of emergency medical conditions for these persons and other unqualified immigrants. See 8 U.S.C. §§ 1601 *et seq.* (2000); 42 U.S.C. §§ 1320b-7, 1396b(v) (2000).

<sup>15</sup> See 42 C.F.R. § 435.403 (2000).

<sup>16</sup> See 42 U.S.C. § 1396a(a)(10) (Supp. 2001).

<sup>17</sup> See *id.* §§ 1396a(a)(10)(A)(I)(IV), (VI), 1396a(l)(A)–(C). The 2002 federal poverty level for a family of three in the forty-eight contiguous states and the District of Columbia is \$15,020. See 67 Fed. Reg. 6931 (Feb. 14, 2002). Federal poverty level figures are published annually in the *Federal Register*, usually during the month of February.

<sup>18</sup> See 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D) (Supp. 2001).

<sup>19</sup> See *id.* § 1396a(a)(10)(A)(i)(II). Supplemental Security Income (SSI) was created in 1972 to provide cash assistance to the aged, blind, and disabled who have limited income and resources. Some states do not provide Medicaid automatically to persons receiving SSI. Under section 1902(f) of the Social Security Act, these states use their 1972 state assistance eligibility rules in determining Medicaid eligibility. See 1972 Social Security Amendments Act, Pub. L. No. 92-603, § 209(b), 86 Stat. 1381 (1972). These states, referred to as “209(b) states” after the provision of the Social Security Act enacting the option, are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

<sup>20</sup> Medicare Part A, called hospital insurance, includes inpatient hospital services, skilled nursing, home health services, and hospice care, while Part B, called medical insurance, includes outpatient hospital services, physician services, ambulances, and medical equipment and devices. See 42 U.S.C. §§ 1395 *et seq.*

<sup>21</sup> See *id.* §§ 1396a(a)(10)(E), 1396d(p) (2000).

<sup>22</sup> See *id.* §§ 1396a(a)(10)(A)(ii)(IX), 1396a(l)(A), (B) (Supp. 2001).

<sup>23</sup> See *id.* § 1396a(a)(e)(3).

- working disabled individuals,<sup>24</sup> and
- elderly and disabled persons with incomes below the federal poverty level.<sup>25</sup>

States also may cover the medically needy—persons who fit into a federal public benefit program category, such as SSI or families with children, but whose income or resources are above the eligibility levels for the benefit program.<sup>26</sup> Such individuals qualify for Medicaid once their income, minus incurred medical expenses, is less than the state’s medically needy income level.<sup>27</sup> For example, assume that (a) the state’s medically needy income level is \$500 per month; (b) the budget period is three months (states may use a one-to-six-month budget period); and (c) the applicant has income of \$700 per month. In this example the applicant must incur a total of \$600 in medical expenses over a three-month budget period before Medicaid coverage begins (\$200 income exceeding the medically needy income level X 3-month budget period = \$600 spend-down).

Not surprisingly, given the strict eligibility requirements, not all poor people qualify for Medicaid. In 1999 Medicaid

covered only 37 percent of nonelderly Americans with incomes below the federal poverty level.<sup>28</sup> Nonetheless, Medicaid is a crucial source of coverage for people with disabilities. In fact, Medicaid is the single largest source of insurance—public or private—for people with disabilities.<sup>29</sup>

### Medicaid Scope of Benefits

Under federal law, states must cover certain services and may choose to cover other types of services when program beneficiaries need them. Included in the mandatory benefit package available to most beneficiaries are

- inpatient and outpatient hospital services,<sup>30</sup>
- physician services,<sup>31</sup>
- laboratory and x-ray services,<sup>32</sup>
- family planning services,<sup>33</sup> and
- nurse midwife services.<sup>34</sup>

States must cover home health services for any individual who is eligible to receive nursing facility services.<sup>35</sup> States must also cover Early and Periodic Screen-

<sup>24</sup> See *id.* § 1396a(a)(10)(A)(ii)(XV). States may impose premiums and cost-sharing requirements on this covered group. *Id.* § 1396o(g).

<sup>25</sup> See *id.* § 1396a(a)(10)(ii)(XIII).

<sup>26</sup> See *id.* § 1396a(a)(10)(C) (Supp. 2001). The following jurisdictions have medically needy programs: California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. States electing the 209(b) option (*see supra* note 19) must have a medically needy program for the aged, blind, and disabled. *Id.* § 1396a(f).

<sup>27</sup> See *id.* § 1396a(a)(17). While states have a great deal of flexibility in how they operate their medically needy programs, states choosing this option must include prenatal and delivery services for pregnant women and ambulatory services for children under 18. *Id.* § 1396a(a)(10)(C)(ii), (iii).

<sup>28</sup> See KAISER COMM’N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE COVERAGE IN AMERICA: 1999 DATA UPDATE 6 (2000), *available at* www.kff.org. The 2001 federal poverty level for a family of three in the forty-eight contiguous states and the District of Columbia is \$14,630; in Alaska, \$18,290; and in Hawaii, \$16,830. See 66 Fed. Reg. 10695–97 (Feb. 16, 2001).

<sup>29</sup> Medicaid covers about seven million people under 65 with disabilities. See KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID’S ROLE FOR THE DISABLED POPULATION UNDER AGE 65 (2001), *available at* www.kff.org.

<sup>30</sup> See 42 U.S.C. § 1396d(a)(1) (Supp. 2001); 42 C.F.R. § 440.10(a) (2000).

<sup>31</sup> See 42 U.S.C. § 1396d(a)(5)(A) (Supp. 2001); 42 C.F.R. § 440.50 (2000).

<sup>32</sup> See 42 U.S.C. § 1396d(a)(3) (Supp. 2001); 42 C.F.R. § 440.30 (2000).

<sup>33</sup> See 42 U.S.C. § 1396d(a)(4)(C) (Supp. 2001); 42 C.F.R. § 441.20 (2000).

<sup>34</sup> See 42 U.S.C. § 1396d(a)(17) (Supp. 2001); 42 C.F.R. § 440.165 (2000).

<sup>35</sup> See 42 U.S.C. § 1396a(a)(10)(D) (Supp. 2001); 42 C.F.R. § 440.70 (2000).

ing, Diagnosis, and Treatment (EPSDT) for children and adolescents under 21.<sup>36</sup> EPSDT includes periodic medical, vision, hearing, and dental examinations, age-appropriate health education, and treatment services to “correct or ameliorate” physical or mental problems, including case management.<sup>37</sup>

For adults, states may choose whether to cover twenty-three optional services, including

- prescription drugs,<sup>38</sup>
- dental services,<sup>39</sup>
- physical and related therapies,<sup>40</sup>
- home health services,<sup>41</sup>
- intermediate care facility services for the mentally retarded,<sup>42</sup> and
- personal care services.<sup>43</sup>

States may provide transportation as an optional Medicaid service, which includes expenses for transportation and “travel-related expenses” necessary to secure medical examinations and treatment.<sup>44</sup> Notably EPSDT requires these optional services for adults to be provided to children and adolescents when they need them to correct or ameliorate a health problem.

Each service must be “sufficient in amount, duration and scope to reasonably achieve its purpose.”<sup>45</sup> Thus, while a state may limit coverage of inpatient

hospital days to, for example, twenty-one days per year, it may not limit these services to one day per year.<sup>46</sup> States may not arbitrarily deny or reduce the amount, duration, or scope of services to an otherwise eligible individual solely because of the diagnosis, illness, or condition.<sup>47</sup> For example, a state may not exclude drugs that they need because they are suffering from HIV (human immunodeficiency virus) or AIDS (autoimmune deficiency syndrome).<sup>48</sup>

States may impose “nominal” cost sharing on beneficiaries by, for example, requiring beneficiaries to pay a small amount (called a “copayment”) to the provider, up front, before they receive services.<sup>49</sup> Given Medicaid’s poverty linkage, many beneficiaries and services—including children and youth, pregnant women, nursing home residents, emergency services, family planning services, and hospice services—are exempt from cost sharing.<sup>50</sup>

### Provider Participation and Managed Care

States have much flexibility to decide how they deliver services to Medicaid beneficiaries and how they pay providers. However, the federal law requires states to assure that Medicaid payments to providers are sufficient to attract enough providers so that services are available to the Medicaid population at least to the

<sup>36</sup> See 42 U.S.C. § 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (Supp. 2001).

<sup>37</sup> *Id.*

<sup>38</sup> See 42 U.S.C. § 1396d(a)(12) (Supp. 2001); 42 C.F.R. § 440.120 (2000).

<sup>39</sup> See 42 U.S.C. § 1396d(a)(10) (Supp. 2001); 42 C.F.R. § 440.100 (2000).

<sup>40</sup> See 42 U.S.C. § 1396d(a)(11) (Supp. 2001); 42 C.F.R. § 440.110 (2000).

<sup>41</sup> See 42 U.S.C. § 1396d(a)(7) (Supp. 2001); 42 C.F.R. § 440.70 (2000).

<sup>42</sup> See 42 U.S.C. § 1396d(a)(15) (Supp. 2001); 42 C.F.R. § 483.400 *et seq.* (2000).

<sup>43</sup> See 42 U.S.C. § 1396d(a)(24) (Supp. 2001); 42 C.F.R. § 440.167 (2000).

<sup>44</sup> See 42 U.S.C. § 1396d(a)(27) (Supp. 2001); 42 C.F.R. § 440.170(a) (2000). Transportation is also included as an administrative obligation of states. State Medicaid plans must describe how states ensure necessary transportation for beneficiaries to and from providers. See 42 U.S.C. § 1396a(a)(4)(A) (Supp. 2001); 42 C.F.R. § 431.53 (2000).

<sup>45</sup> See 42 C.F.R. § 440.230(b) (2000).

<sup>46</sup> See, e.g., *Charleston Mem’l Hosp. v. Conrad*, 693 F.2d 324 (4th Cir. 1982) (upholding twelve-day annual limit on inpatient hospital services).

<sup>47</sup> See 42 C.F.R. § 440.230(c) (2000).

<sup>48</sup> See *Weaver v. Reagan*, 886 F.2d 194 (8th Cir. 1989) (Clearinghouse No. 44,533) (discussing impermissible exclusion of AZT (azidothymidine) for individuals with AIDS-related condition).

<sup>49</sup> See 42 U.S.C. § 1396o (Supp. 2001); 42 C.F.R. § 447.50 *et seq.* (2000).

<sup>50</sup> See 42 U.S.C. § 1396o (Supp. 2001); 42 C.F.R. § 447.50 *et seq.* (2000).

### Medicaid Resources on the World Wide Web

1. The National Health Law Program, [www.healthlaw.org](http://www.healthlaw.org), updates and analyzes federal legislation and policy developments, federal and state case law, major state activities, and academic research; offers access to model pleadings' and extensive links to other organizations working on Medicaid issues.
2. Kaiser Commission on Medicaid and the Uninsured, [www.kff.org](http://www.kff.org), has Medicaid facts and figures, nationally and by state; publishes extensive analysis on Medicaid trends.
3. The Center on Budget and Policy Priorities, [www.cbpp.org](http://www.cbpp.org), has information on federal and state budgetary issues and how they affect the Medicaid program.

extent that they are available to the general population in the service area.<sup>51</sup> Medicaid-participating providers must accept Medicaid payment as payment in full.<sup>52</sup> In other words, they must agree not to seek payment from Medicaid beneficiaries.

States traditionally paid a fee, called "fee-for-service" reimbursement, to providers for each service rendered. Over the last twenty years, however, Medicaid has shifted toward managed care delivery that emphasizes prepaid or discounted services and utilization controls, such as prior authorization requirements before providers may render services. In many managed care programs, beneficiaries select or are assigned to a specific managed care plan and, except in emergencies, must obtain all of the services included in the managed care program from this managed care plan. If the beneficiary obtains services "out of plan," the beneficiary may be billed for them. Over half of all Medicaid beneficiaries are enrolled in managed care.<sup>53</sup> In 1998 about one-fourth of Medicaid beneficiaries with disabilities were enrolled in managed care.<sup>54</sup>

Managed care brings significant changes in the care-seeking patterns of Medicaid beneficiaries. Rather than dealing directly with state and local eligibility workers, beneficiaries are directed to the managed care plan (often to consumer services) when questions arise regarding providers and services. The contract between the managed care plan and the state Medicaid agency becomes a critical document because it provides for the details of the plan's obligations to enrolled beneficiaries. The payment dynamics (in particular, prospective, preset payments) create an incentive for managed care plans and providers to limit services. These limitations should not go so far as to prevent the beneficiary from obtaining services that are medically necessary. Moreover, managed care plans that previously served only commercial markets may not adhere to the Medicaid requirements for coverage. For example, the plan may provide, to Medicaid children and adolescents, checkups that do not include all of the required components of the EPSDT screens.<sup>55</sup>

### Key Issues Confronting Legal Services Programs

The National Health Law Program responds to hundreds of requests for assistance on Medicaid issues each year. According to a review of technical assistance and training requests over time, the problems that are likely to confront legal services practitioners include

- termination of Medicaid benefits when cash assistance is terminated;
- billing of Medicaid patients;
- denials, terminations, delays of needed services, particularly in managed care settings; and

<sup>51</sup> See 42 U.S.C. § 1396a(a)(30)(A) (Supp. 2001).

<sup>52</sup> See *id.* § 1396a(a)(25); 42 C.F.R. § 447.15.

<sup>53</sup> See KAISER COMM'N ON MEDICAID & THE UNINSURED, *THE MEDICAID PROGRAM AT A GLANCE* (2001), available at <http://www.kff.org>.

<sup>54</sup> *Id.*

<sup>55</sup> The Early and Periodic Screening, Diagnosis, and Treatment medical screen must include five components: an unclothed physical examination, developmental assessment, appropriate immunizations, laboratory testing (including lead blood tests for children at 12 and 24 months of age and otherwise for children at high risk), and health education. See 42 U.S.C. § 1396d(f)(1) (Supp. 2001).

■ failure to give adequate notice and hearing rights when eligibility or services or both are denied, reduced, terminated, or delayed.

Each of these issues is outlined below and resources to assist with follow-up research are cited.

### Improper Termination of Medicaid Benefits

The financial and family situations of Medicaid beneficiaries often change. This change in circumstances can cause individuals to lose cash benefits, such as SSI. The problem arises when Medicaid coverage is also terminated.

In most cases, Medicaid laws protect beneficiaries from the automatic termination of Medicaid benefits. For example, the Medicaid Act requires automatic redetermination of eligibility for certain children with disabilities and families making the transition from cash assistance to work.<sup>56</sup> Medicaid regulations also require the state to continue to provide Medicaid to eligible individuals until they make a finding that the individuals are ineligible.<sup>57</sup> Courts have applied these provisions to require the state agency to make an automatic, *ex parte* redetermination to see if the recipient might be eligible for Medicaid on some other basis.<sup>58</sup> During redetermination, Medicaid benefits should continue.

If you have a client whose Medicaid is automatically terminated when cash assistance benefits are lost, the following resources may be helpful:

1. CMS/HCFA, Dear State Medicaid Director Letters, available at [www.hcfa.gov/Medicaid/letters](http://www.hcfa.gov/Medicaid/letters). For example:

■ HCFA, Dear State Medicaid Director (Apr. 7, 2000) (discussing redetermination when Temporary Assistance to Needy Families is lost), [www.hcfa.gov/medicaid/smd40700.htm](http://www.hcfa.gov/medicaid/smd40700.htm).

■ HCFA, Dear State Medicaid Director

(Dec. 4, 2000) (discussing redetermination when beneficiary moves from one county to another), [www.hcfa.gov/medicaid/smd12400.htm](http://www.hcfa.gov/medicaid/smd12400.htm).

2. NATIONAL HEALTH LAW PROGRAM, An Advocate's Guide to the Medicaid Program 2.12–2.13 (June 2001) (available from National Health Law Program, Los Angeles, Cal.)

### Improper Billing

Legal services advocates across the country assist people who are dealing with overwhelming bills from hospitals and other health care providers. Indeed, hospitals billing Medicaid beneficiaries are not at all uncommon. Medicaid beneficiaries who have limited English proficiency may have particular problems because hospital billing and collection departments are not sufficiently bilingual or accommodating of non-English speakers. Moreover, with increasing frequency physicians require beneficiaries to make up-front payments that are not associated with and exceed state-sanctioned cost-sharing amounts. In many of these cases, Medicaid provides a defense to the collection actions. This is because, as noted above, Medicaid payment is payment in full. This means that a provider who accepts a patient as a Medicaid patient should not bill the patient before, during, or after the course of treatment. If you have a Medicaid collection case, consult the following resources:

■ NATIONAL HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM 4.9 (2001) (available from National Health Law Program, Los Angeles, Cal.).

■ NATIONAL HEALTH LAW PROGRAM, STRATEGIES TO ADDRESS HEALTH CARE DEBT OF THOSE WITH LOW INCOME (1999) (available from National Health Law Program, Los Angeles, Cal.).

<sup>56</sup> See *id.* §§ 1396a(e)(10)(B), 1396r-6(a)(3)(C), 1396r-6(b)(3)(C).

<sup>57</sup> See 42 C.F.R. § 435.930.

<sup>58</sup> See, e.g., *Crippen v. Kheder*, 741 F.2d 102 (6th Cir. 1984) (Clearinghouse No. 37,196); *Mass. Ass'n of Older Americans v. Sharp*, 700 F.2d 749 (1st Cir. 1983) (Clearinghouse No. 42,293); *Salazar v. Dist. of Columbia*, 954 F. Supp. 278 (D.D.C. 1996) (Clearinghouse No. 51,628).

■ Michael A. Dowell & Michael C. Parks, *Defending Against Suits by Medical Providers: Medicaid, Hill-Burton, and Beyond*, 20 CLEARINGHOUSE REV. 454 (Special Issue 1986) (although dated, this article is an excellent discussion of the history of the full-payment requirement and early case law).

See also

■ NATIONAL CONSUMER LAW CENTER, IN SICKNESS AND IN DEBT: USING CONSUMER LAW TO HELP ELDERS FACING OVERWHELMING MEDICAL BILLS (2001) (discusses non-Medicaid strategies and legal responses to collection actions) (available from National Consumer Law Center, Boston, Mass.).

■ ALLAN ALOP, DEFENDING HOSPITAL COLLECTION CASES (2001) (discusses non-Medicaid responses and includes sample pleadings) (Clearinghouse No. 49,090, available from National Center on Poverty Law, Chicago, Ill.).

### Denials, Terminations, Delays of Needed Children's Services

Medicaid covers one in every five children in the United States.<sup>59</sup> Problems arise when these children are denied the services they need. Moreover, in some instances, the family may not know what type of service the child needs. For example, all Medicaid-eligible children should be tested for lead blood poisoning, but unless the family receives specific information about this service, the family is unlikely to obtain the test. Other challenges arise when children with disabling and chronic conditions need services, such as physical therapy services, durable medical equipment, and home health aids, that the state may not cover or may limit for adults.

The federal EPSDT laws also require the state to conduct effective outreach to notify children and their families of EPSDT services, and the importance of preventive

care, and to offer appointment scheduling and transportation assistance.<sup>60</sup> The notification should be oral and in writing at routine intervals, at targeted intervals for certain populations (including pregnant women and children in out-of-home placement), and in formats that individuals can understand.<sup>61</sup>

The Medicaid EPSDT service solves many of these problems. The treatment component of EPSDT must include any necessary health care, diagnostic services, treatment, and other measures described in the Medicaid Act to correct or ameliorate physical and mental illnesses and conditions, whether or not the state's Medicaid program covers such services for adults.<sup>62</sup> This means that a child should be able to obtain Medicaid coverage of physical therapy services even if the state limits the number of visits for adult beneficiaries or does not cover physical therapy services at all for adults. For additional assistance with EPSDT cases, consult the following publications:

■ CENTERS FOR MEDICARE AND MEDICAID SERVICES, STATE MEDICAID MANUAL, Part 5, *available at* [www.hcfa.gov/pubforms/pub45pdf/smmtoc.htm](http://www.hcfa.gov/pubforms/pub45pdf/smmtoc.htm).

■ NATIONAL HEALTH LAW PROGRAM, REPRESENTING CLIENTS WHO NEED MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (2001) (available from National Health Law Program, Los Angeles, Cal.).

■ NATIONAL HEALTH LAW PROGRAM, TOWARD A HEALTHY FUTURE: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT FOR POOR CHILDREN (2002) (available from National Health Law Program, Los Angeles, Cal.).

■ NATIONAL HEALTH LAW PROGRAM, CHILDREN'S HEALTH UNDER MEDICAID: A NATIONAL REVIEW OF EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (rev. ed., 2002) (available from National Health Law Program, Los Angeles, Cal.).

<sup>59</sup> See KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE COVERAGE IN AMERICA: 2000 DATA UPDATE (2002), *available at* [www.kff.org/content/2002/4007/4007.pdf](http://www.kff.org/content/2002/4007/4007.pdf).

<sup>60</sup> See 42 U.S.C. § 1396a(a)(43); 42 C.F.R. §§ 441.50 *et seq.*

<sup>61</sup> See 42 U.S.C. § 1396a(a)(43); 42 C.F.R. §§ 441.50 *et seq.*

<sup>62</sup> See 42 U.S.C. § 1396d(r)(5).

■ National Health Law Program, EPSDT: Annotated Federal Documents (Jan. 6, 2000), *at* [www.nhelp.org/pubs/200001EPSDTtrans.html](http://www.nhelp.org/pubs/200001EPSDTtrans.html).

■ National Health Law Program, EPSDT Case Docket (updated regularly), *at* [www.healthlaw.org/children/shtml#EPSDT](http://www.healthlaw.org/children/shtml#EPSDT).

For resources addressing Medicaid managed care, see

■ National Health Law Program, Medicaid Managed Care Docket (updated regularly), *at* [www.healthlaw.org/pubs/MgdCareDocket.html](http://www.healthlaw.org/pubs/MgdCareDocket.html).

■ National Health Law Program, Fact Sheets: Getting the Best Out of Managed Care (2001), *at* [www.healthlaw.org/pubs/FS/managedcarefacts.shtml](http://www.healthlaw.org/pubs/FS/managedcarefacts.shtml).

■ NATIONAL HEALTH LAW PROGRAM & CENTER FOR HEALTH CARE RIGHTS, MAKING SENSE OF MANAGED CARE QUALITY INFORMATION (1999), *available at* [www.healthlaw.org/pubs/19990120qualguide.html](http://www.healthlaw.org/pubs/19990120qualguide.html).

■ NATIONAL ASSOCIATION OF CHILD ADVOCATES & NATIONAL HEALTH LAW PROGRAM, MEDICAID MANAGED CARE: AN ADVOCATE'S GUIDE FOR PROTECTING CHILDREN (1996) (available from National Association of Child Advocates, Washington, D.C.).

### Failure to Give Adequate Notice and Hearing Rights

At some point, the legal services practitioner is likely to handle a case where the client was terminated from Medicaid eligibility or services without having received the required adequate notice and opportunity to be heard. Individuals in Medicaid managed care programs particularly have been frustrated in this area, and problems with denials, terminations, or changes involving prescription drugs are increasing. The individual may be notified orally about the denial of the drug or be given a preprinted, generic notice

that does not explain the denial or how to challenge it. The individual may be steered to an internal grievance procedure, which does not provide due process protections.

Medicaid applicants and recipients have notice and administrative fair hearing rights when their claims for assistance are denied or not acted on with reasonable promptness.<sup>63</sup> If the Medicaid agency or its agents intend to take action that is adverse to an individual, then the agency or its agents must give an adequate and timely written notice. The notice should inform the individual about the intended action, reasons for the action, and legal support for the action and explain the individual's hearing rights.<sup>64</sup> If the action involves termination or reduction of services, then the notice should be sent to the beneficiary ten days before the intended action.<sup>65</sup> The administrative hearing must be conducted at a reasonable time, date, and place by an impartial hearing official and result in timely a decision, generally within ninety days of the request to be heard.<sup>66</sup> Where the action involves the termination or reduction of services, the individual has the right to continue to receive the benefits (called "continued benefits" or "aid paid pending") in question up through the final hearing decision.<sup>67</sup>

Resources to help advocates deal, in depth, with notice and fair hearing issues may be found at

■ NATIONAL HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM 2.16–2.17 (2001).

■ Maureen O'Connell & Sidney Watson, Medicaid Due Process Issues—Notice and Hearings (Mar. 2001), *at* [www.nls.org/conf/dueprocess.htm](http://www.nls.org/conf/dueprocess.htm).

■ CENTER FOR HEALTH CARE STRATEGIES, MEDICAID MANAGED CARE AND DUE PROCESS: THE LAW, ITS IMPLICATIONS AND RECOMMENDATIONS (2000) (prepared by Jane Perkins

<sup>63</sup> See U.S. CONST. amend. XIV, § 1; *Goldberg v. Kelly*, 397 U.S. 254 (1970) (Clearinghouse No. 1,799). See 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200 *et seq.*

<sup>64</sup> See 42 C.F.R. § 431.206, 431.210.

<sup>65</sup> *Id.* § 431.206, 431.211, 431.214.

<sup>66</sup> *Id.* § 431.240, 431.244.

<sup>67</sup> *Id.* § 431.210(e), 431.230.

and Kristi Olson, National Health Law Program), *available at* [www.chcs.org/publications/pdf/cas/NHELPDue\\_Process\\_Legal.pdf](http://www.chcs.org/publications/pdf/cas/NHELPDue_Process_Legal.pdf).

- CENTER FOR HEALTH CARE STRATEGIES, MEDICAID MANAGED CARE AND DUE PROCESS (2000) (prepared by Jane Perkins and Kristi Olson, National Health Law Program), *available at* [www.chcs.org/publications/pdf/cas/NHELPDueProcess.pdf](http://www.chcs.org/publications/pdf/cas/NHELPDueProcess.pdf).

- NATIONAL HEALTH LAW PROGRAM, MODEL MANAGED CARE COMPLAINT PROCESS (1999), *available at* [www.healthlaw.org/pubs/19980814grievance.html](http://www.healthlaw.org/pubs/19980814grievance.html).

THE LEGAL SERVICES PRACTITIONER MUST DEAL with a range of pressing issues, often concerning such basic necessities as food and housing. While appropriate health care is also a necessity, clients may not seek legal assistance until well into an illness or medical condition or when the client is facing an aggressive collection action. This makes the practice of health care law particularly challenging but always gratifying. Just as new clients are retained, so do new health issues arise. The practice, then, is a varied and exciting one.

### Adolescent Health: Consent and Confidentiality

Medical care requires the consent of the patient or a legally authorized representative. In the case of minors, the consent of one or both parents usually is required to authorize medical care. However, there are numerous exceptions to this rule: in every state, minor adolescents are authorized to give their own consent for health care under certain circumstances—based on the adolescents’ status or on the services that they are seeking or both. These state statutes—commonly known as “minor consent statutes”—vary widely among states.

**Status.** The categories of minors who may consent to their medical care include, among others, emancipated minors, married minors, minors in the armed forces, mature minors, minors living apart from their parents, minors over a certain age, high school graduates, pregnant minors, and minor parents.

**Services.** As with the status exceptions, statutes that authorize minors to consent to their own health care based on the type of service vary widely among states. Most common, the services in question are so-called sensitive services: pregnancy-related care, contraception, services for sexually transmitted infections, mental health care, or drug and alcohol services, or all of such services. Emergency care also is frequently included.

In many cases, service and status provisions coexist in the same law: California, for example, authorizes minors 12 and over to consent to treatment of sexually transmitted diseases (or other infectious, contagious, or communicable diseases) (Cal. Fam. Code § 6926). Other provisions of minor consent laws also vary significantly from state to state. Some statutes specifically include confidentiality provisions, and others specify that parents are not financially liable for care to which they do not give consent.

While a number of states specifically permit minors to consent to abortion services, a majority of states do the opposite: more than half the states enforce laws requiring parental consent or parental notification before a pregnant minor may receive this service. Details on state laws related to abortion are available from the Center on Reproductive Law and Policy, [www.crlp.org](http://www.crlp.org), or from the National Abortion and Reproductive Rights Action League, [www.narral.org](http://www.narral.org).

You need to be familiar with your state’s minor consent laws for better representation of children who live with their families. Also, these laws are essential gateways to health care for minors in foster care, in the juvenile justice system, and living on their own. For details on each state’s laws, contact your state medical associations or the Center for Adolescent Health and the Law, 211 N. Columbia St., Chapel Hill, NC 27514; 919.968.8850; [www.cahl.org](http://www.cahl.org). For a comprehensive listing of state minor consent statutes, see Abigail English et al., *State Minor Consent Statutes: A Summary* (Center for Continuing Education in Adolescent Health, Children’s Hospital Medical Center, Cincinnati, 1995); an updated version will be published by the Center for Adolescent Health and the Law in 2002.

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## Medicaid and the Elderly Poor

Poor elderly people are eligible for Medicaid coverage of their health care needs when they fit within specific income and resource eligibility rules. Many middle-income people are eligible for Medicaid coverage of long-term care. Medicaid is the major source of payment for nursing home coverage because Medicare, the federal health insurance program for the elderly and disabled, covers limited days for long-term care, and few people have private long-term care insurance. Because the cost of nursing home care is so high, many middle-income people become Medicaid-eligible after several months of long-term care. Special protections for the spouses of nursing home residents allow them to keep reasonable amounts of income and resources when their spouses are institutionalized.

The National Senior Citizens Law Center provides technical assistance to attorneys and other advocates on Medicaid issues affecting the elderly. Common problems and issues that new attorneys address include rules on spousal impoverishment and transfer of assets, special eligibility groups such as Pickle people and Kennelly widows, home health care, trusts, estate recovery, and liens. For further assistance, see [www.nslc.org](http://www.nslc.org).

**Spousal Impoverishment Protections.** Congress enacted special protections for spouses of nursing home residents so that one spouse can become eligible for Medicaid long-term care without first spending down all of the couple's income and resources.<sup>1</sup> The spouse at home is allowed to keep a minimum amount of resources, from \$17,856.00 to \$89,280.00, depending upon the state, and have a minimum monthly income allowance, from \$1,454.25 to \$2,232.00, at state option, for the spouse's use in the community. States have some discretion in setting these amounts. But the federal statute sets the minimum and maximum amount, and the levels are increased every year.<sup>2</sup>

**Transfer of Assets.** People who give away income or assets may be penalized by the Medicaid rules on transfer of assets. Transfers for less than fair market value within thirty-six months (sixty months for trusts) of an application for Medicaid long-term care are subject to a potential penalty period of ineligibility.<sup>3</sup> The period is calculated by dividing the uncompensated value of the asset by the average private pay rate for nursing home care in the state.<sup>4</sup> This determines the number of months that one is ineligible for Medicaid long-term care.

**Pickle People and Kennelly Widows.** A few groups of elderly people are eligible for Medicaid as a result of specific congressional enactments. One group, called Pickle people, not after the deli food but after the legislator who introduced the amendment to the Social Security Act, are people who received Supplemental Security Income (SSI) but lost it as a result of cost-of-living increases on their social security checks.<sup>5</sup> Another group is the Kennelly widows, who lost their SSI due to eligibility for early widow's benefits under the social security survivors program.<sup>6</sup>

**Home Health Care.** Medicaid is available for home health services under

- the mandatory home health services program,<sup>7</sup>
- or, at state option, under several home and community-based waiver programs,<sup>8</sup> or
- other optional programs.<sup>9</sup>

Ironically most of the Medicaid home health care in the country is provided through the waiver, rather than the mandatory programs. The most common waiver program serving the elderly is the waiver for elderly people who, but for the services, would be institutionalized.<sup>10</sup> Under a waiver program, certain requirements of

<sup>1</sup> 42 U.S.C. § 1396r-5.

<sup>2</sup> *Id.*

<sup>3</sup> 42 U.S.C. § 1396p(c).

<sup>4</sup> *Id.*

<sup>5</sup> See also *Questions You Always Wanted to Ask*, in this manual.

<sup>6</sup> 42 U.S.C. § 1383(c).

<sup>7</sup> *Id.* § 1396a(a)(10)(E).

<sup>8</sup> *Id.* § 1396n.

<sup>9</sup> *Id.* § 1396d(a).

<sup>10</sup> *Id.* § 1396n(c); 42 C.F.R. § 441 subpart G.

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### Medicaid and the Elderly Poor (Continued)

the Medicaid program, such as statewideness or comparability, are waived, but the state must prove that the program will be cost effective.<sup>11</sup>

**Trusts.** As a general rule trusts, except those created by will, may not be used to protect assets to qualify for Medicaid.<sup>12</sup> Limited exceptions to the trust rules allow for

- certain trusts for disabled people under 65,<sup>13</sup>
- income-only trusts in states without medically needy programs,<sup>14</sup> and
- pooled trusts serving people with disabilities.<sup>15</sup>

**Estate Recovery and Liens.** States are now required to recover from the estates of deceased beneficiaries benefits paid for nursing facility services, home and community-based services, as well as related hospital and prescription drug benefits.<sup>16</sup> They are permitted to recover other Medicaid benefits as well. Recovery is made from the probate estate as defined by state law, but this can be defined expansively.<sup>17</sup> No recovery may be made until after the death of a surviving spouse or a dependent or disabled child.<sup>18</sup> Liens may be placed on property for benefits that were incorrectly paid, or on the real property of a permanently institutionalized person.<sup>19</sup> But numerous exceptions apply, protecting surviving relatives.<sup>20</sup>

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<sup>11</sup> 42 U.S.C. § 1396n(c); 42 C.F.R. § 441 subpart G.

<sup>12</sup> 42 U.S.C. § 1396p(d).

<sup>13</sup> *Id.* § 1396p(d)(4)(A).

<sup>14</sup> *Id.* § 1396p(d)(4)(B).

<sup>15</sup> *Id.* § 1396p(d)(4)(C).

<sup>16</sup> *Id.* § 1396p(b).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* § 1396p(a).

<sup>20</sup> *Id.*