

Medicaid for New Attorneys

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National Health Law Program

December 2006

<http://www.heathlaw.org>



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This paper provides the new attorney with an overview of the Medicaid program—its administration, eligibility and service rules. While each state must adhere to the federal Medicaid Act’s minimum requirements, there is much room for flexibility. Therefore, it is important to become familiar not only with the federal rules but also with the policies guiding the program at the state level.

Medicaid can be complex. For in-depth information about the program, please consult our *Advocate’s Guide to the Medicaid Program*. We are also available to consult with you on any question that you have about the program’s operation federally or in your state. Please do not hesitate to contact us.

Introduction

Medicaid is the program of medical assistance for individuals with limited incomes established by Title XIX of the Social Security Act.² Medicaid covers one in six people.³ It is the largest source of insurance for children, covering nearly one in four.⁴ This paper covers the following topics:

- Administration of the Medicaid program
- Medicaid eligibility
- The scope of covered benefits
- Provider participation and managed care
- Key issues and resources for dealing with them

¹Updated and revised from the original publication: National Center on Poverty Law, *Poverty Law Manual for the New Lawyer* (2002), Ch. 5, pp. 61-70.

² See 42 U.S.C. §§ 1396 *et seq.* 42 C.F.R. §§ 430 *et seq.*

³ See THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER i (July 2005), available at <http://www.kff.org>. [hereinafter MEDICAID: A PRIMER]; U.S. Bureau of the Census, www.census.gov.

⁴*Id.* at 3.

Sources of Information on Medicaid

- Medicaid Act – 42 U.S.C. §§ 1396 *et seq.*
- Medicaid Regulations – 42 C.F.R. §§ 430 *et seq.*
- CMS, State Medicaid Manual, *available at* http://www.cms.hhs.gov/Manuals/01_Overview.
- CMS, Dear State Medicaid Director Letters, *available at* <http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage> and www.healthlaw.org
- CMS transmittals, *see* www.healthlaw.org
- Federal and state court cases
- State statutes and regulations, health plan and provider contracts, and policy letters
- State Medicaid Plan, link through <http://www.cms.hhs.gov/medicaid/stateplans/>
- State case worker and provider manuals

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.⁵

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.⁶ In addition to promulgating Medicaid regulations, CMS publishes the *State Medicaid Manual* and *Dear State Medicaid Director* letters that announce federal Medicaid policy.

Federal law requires each state to designate a “single state agency” to administer its Medicaid program.⁷ This means that each state must have in effect a written state Medicaid plan that has been approved by the federal government.⁸ 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 law⁹ and operate statewide.¹⁰

States must provide that all individuals wishing to apply for Medicaid can do so without delay and ensure that assistance will be furnished with reasonable promptness.¹¹ States must also establish a Medical Care Advisory Committee,

⁵*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 (Act) and regulations promulgated by the Secretary of Health and Human Services.”); Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981) (“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.”).

⁶Until June 2001, CMS was known as the Health Care Financing Administration or HCFA.

⁷*See* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

⁸*See* 42 U.S.C. § 1396a ; 42 C.F.R. § 430.10.

⁹*See* 42 U.S.C. § 1396a (setting forth requirements states must meet).

¹⁰*See* 42 U.S.C. § 1396a(a)(1); 42 C.F.R. § 431.50.

¹¹*See* 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.

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.¹²

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 fifty percent to eighty-three percent of the total expenditures, with poorer per capita income states receiving higher federal payments.¹³ Federal spending accounts for 57 percent of all Medicaid spending.¹⁴

Medicaid Eligibility – Fitting into a category

An individual is not eligible for Medicaid simply because he or she 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.
- Meet financial criteria by having limited income and resources.¹⁵
- Have appropriate immigration status—have United States citizenship or be a “qualified alien.”¹⁶

¹²See 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.12.

¹³See 42 U.S.C. §§ 1396d(a), 1396d(b).

¹⁴See MEDICAID: A PRIMER, *supra* at 11.

¹⁵See 42 U.S.C. § 1396a(a)(17). For example, possession of a car with an equity value of \$1500, or less at state option, makes an applicant ineligible for Medicaid. *See, e.g.* Hazard v. Sullivan, 44 F.3d 399 (6th Cir. 1995) (upholding \$1500 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.

¹⁶Most 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 will only cover treatment of emergency medical conditions for these

- Be a resident of the state where the individual applies for Medicaid benefits.¹⁷

The first screen, fitting into an eligibility category, requires additional discussion. Of about 60 Medicaid eligibility categories currently, some are mandatory while others may be offered at state option.¹⁸ 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 age six whose family incomes are at or below 133 percent of the federal poverty level,¹⁹ and children and adolescents between ages six and nineteen whose family incomes are at or below the federal poverty level.²⁰ In most states, individuals who are receiving Supplemental Security Income (SSI) on the basis of disability automatically qualify for Medicaid.²¹ States must also use Medicaid to cover the Medicare Part A and Part B premiums, deductibles, and coinsurance of certain

persons and other unqualified immigrants. *See* 8 U.S.C. § 1601 *et seq.*; 42 U.S.C. §§ 1320b-7, 1396b(v).

¹⁷*See* 42 C.F.R. § 435.403.

¹⁸*See* 42 U.S.C. § 1396a(a)(10).

¹⁹*See* 42 U.S.C. §§ 1396a(a)(10)(A)(I)(IV) and (VI), 1396a(l)(A)-(C) (Supp. 2001). The 2006 federal poverty level for a family of four is in the forty-eight contiguous states and the District of Columbia is \$20,000. *See* 71 Fed. Reg. 3848 (Jan. 24, 2006). Federal poverty level figures are published annually in the Federal Register, usually during the month of February.

²⁰*See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D).

²¹*See* 42 U.S.C. § 1396a(a)(10)(A)(i)(II). 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.

elderly or disabled individuals.²² 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.²³

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,²⁴ noninstitutionalized disabled children,²⁵ working disabled individuals,²⁶ and elderly and disabled persons with incomes below the federal poverty level.²⁷ States can also 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.²⁸ Such individuals qualify for Medicaid once their income, minus incurred medical

²²Medicare 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.*

²³*See* 42 U.S.C §§ 1396a(a)(10)(E), 1396d(p).

²⁴*See id.* at §§ 1396a(a)(10)(A)(ii)(IX), 1396a(l)(A), (B).

²⁵*See id.* at § 1396a(a)(e)(3).

²⁶*See id.* at § 1396a(a)(10)(A)(ii)(XV). States may impose premiums and cost-sharing requirements on this covered group. *Id.* at § 1396o(g).

²⁷*See id.* at § 1396a(a)(10)(ii)(XIII).

²⁸*See* 42 U.S.C. § 1396a(a)(10)(C). 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 21, must have a medically needy program for the aged, blind, and disabled. *Id.* at § 1396a(f).

expenses, is less than the state's medically needy income level.²⁹ For example, assume that: (a) the state's medically needy income level is \$500 per month; (b) the budget period is three months (states can 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).

Given the strict eligibility requirements, it is not surprising that not all poor people qualify for Medicaid. In 2003, Medicaid covered only forty two percent of non-elderly Americans with incomes below the federal poverty level.³⁰ 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.³¹

The citizenship requirement also requires additional discussion. In February 2006, President Bush signed the Deficit Reduction Act, which addresses a wide range of issues including Medicaid.³² Previously, states were permitted to grant eligibility to individuals who declared that they were citizens, without

²⁹See 42 U.S.C. § 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 age 18. *Id.* at § 1396a(a)(10)(C)(ii), (iii).

³⁰See THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE at 2 (May 2006), *available at* <http://www.kff.org>. The 2006 federal poverty level for a family of three is in the forty-eight contiguous states and the District of Columbia is \$16,600; in Alaska, \$20,750 and in Hawaii, \$19,090. 71 Fed. Reg. 3849-3849 (Jan. 24, 2006).

³¹Medicaid covers about eight million people under age 65 with disabilities. See THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID'S ROLE FOR PEOPLE WITH DISABILITIES at i, 10 (Aug. 2003), *available at* <http://www.kff.org>.

³²Pub. L. No. 109-171. For a detailed discussion of the Medicaid, Medicare and State Children's Health Insurance Program provisions of the DRA, see National Health Law Program, *Health Advocate* (Spring 2006), *available at* www.healthlaw.org.

requiring additional documentation.³³ The DRA requires that states document U.S. citizenship and identity or be denied federal funding for providing services to individuals for whom documentation is required.³⁴ The implementing interim regulations promulgated by CMS provide a closed-end list of documents that may be used to verify identity and require a hierarchical approach to verification.³⁵ For example, a passport can be used to prove both U.S. citizenship and identity. If the individual does not have a passport, a birth certificate may be used to verify citizenship, but another document must be used to prove identity, such as a driver's license.³⁶ If, and only if, an individual does not have a birth certificate, he may produce a document from the next category, such as a hospital record.³⁷ Moreover, copies are not acceptable – even notarized copies.³⁸

The following recipients are not subject to these requirements: Individuals who are on Medicare, individuals who receive social security benefits based on disability and are in the two-year waiting period for Medicare eligibility, children who are receiving foster care or adoption assistance through either title IV-B or IV-E, and individuals who receive Supplemental Security Income (SSI) in states that grant automatic eligibility to SSI recipients.³⁹

Even so, it is likely that this requirement will cause serious difficulties for the many individuals who will have trouble locating birth certificates or another document from the prescribed lists.⁴⁰ For a detailed discussion of these

³³42 U.S.C. § 1320b-7(d).

³⁴42 U.S.C. § 1396b(i)(22).

³⁵Centers for Medicare and Medicaid Services, “Medicaid Program; Citizenship Documentation Requirements,” 71 Fed. Reg. 39214 (July 12, 2006).

³⁶71 Fed. Reg. at 39222 – 39224.

³⁷71 Fed. Reg. at 39223.

³⁸71 Fed. Reg. at 39216.

³⁹*Id.*

⁴⁰At the time this was written, final regulations had not been issued. Moreover, a challenge to the documentation requirements, filed by a nationwide class of

citizenship documentation requirements, including all of the individuals who are exempted, *see* NHeLP, *Health Advocate* (Spring 2006) at 26.

Medicaid Scope of Benefits

Under federal law, states must provide coverage for certain services and may choose to cover other types of services when needed by program beneficiaries. Included in the mandatory benefit package that is available to most beneficiaries are: inpatient and outpatient hospital services,⁴¹ physician services,⁴² laboratory and x-ray services,⁴³ family planning services,⁴⁴ and nurse midwife services.⁴⁵ States must cover home health services for any individual who is eligible to receive nursing facility services.⁴⁶ States must also cover Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and adolescents under age twenty-one.⁴⁷ 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.⁴⁸

States can choose whether or not to cover for adults, twenty-three optional

applicants and beneficiaries, was ongoing in the Federal District Court for the Northern District of Illinois. *Bell v. Leavitt*, No. 06 C-3520 (N.D. Ill.).

⁴¹*See* 42 U.S.C. § 1396d(a)(1); 42 C.F.R. § 440.10(a).

⁴²*See* 42 U.S.C. § 1396d(a)(5)(A); 42 C.F.R. § 440.50.

⁴³*See* 42 U.S.C. § 1396d(a)(3); 42 C.F.R. § 440.30.

⁴⁴*See* 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20.

⁴⁵*See* 42 U.S.C. § 1396d(a)(17); 42 C.F.R. § 440.165.

⁴⁶*See* 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.70.

⁴⁷*See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

⁴⁸*Id.*

services, including prescription drugs,⁴⁹ dental services,⁵⁰ physical and related therapies,⁵¹ home health services,⁵² intermediate care facility services for the mentally retarded,⁵³ and personal care services.⁵⁴ States can also provide transportation as an optional Medicaid service, which includes expenses for transportation and “travel related expenses” necessary to secure medical examinations and treatment.⁵⁵ Notably, EPSDT requires these optional services for adults to be provided to children and adolescents when needed to correct or ameliorate a health problem.

Each service must be covered according to “reasonable standards” and “sufficient in amount, duration and scope to reasonably achieve its purpose.”⁵⁶ Thus, while a state can limit coverage of inpatient hospital days to, for example,

⁴⁹*See* 42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120.

⁵⁰*See* 42 U.S.C. § 1396d(a)(10); 42 C.F.R. § 440.100.

⁵¹*See* 42 U.S.C. § 1396d(a)(11); 42 C.F.R. § 440.110.

⁵²*See* 42 U.S.C. § 1396d(a)(7); 42 C.F.R. § 440.70.

⁵³*See* 42 U.S.C. § 1396d(a)(15); 42 C.F.R. § 483.400 *et seq.*

⁵⁴*See* 42 U.S.C. § 1396d(a)(24); 42 C.F.R. § 440.167.

⁵⁵*See* 42 U.S.C. § 1396d(a)(27); 42 C.F.R. § 440.170(a). The Deficit Reduction Act authorizes states to establish non-emergency medical transportation brokerage programs. Pub. L. No. 109-171, § 6083 (adding 42 U.S.C. § 1396a(a)(70)). Transportation is also included as an administrative obligation of states. State Medicaid plans must describe how states will ensure necessary transportation for beneficiaries to and from providers. *See* 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53.

⁵⁶*See* 42 U.S.C. § 1396a(a)(17) (requiring states to use “reasonable standards”); 42 U.S.C. § 1396b(i) (requiring sufficient amount, duration and scope); 42 C.F.R. § 440.230(b) (same). *See, e.g.* Lankford v. Sherman, 451 F.3d 496, 511 (8th Cir. 2006) (finding that state’s failure to provide Medicaid coverage for non-experimental, medically-necessary services within a coverage Medicaid category is both “per se unreasonable and inconsistent with the stated goals of Medicaid.”).

twenty-one days per year, it should not be able to limit these services to one day per year.⁵⁷ States cannot arbitrarily deny or reduce the amount, duration or scope of services to an otherwise eligible individual solely because of the diagnosis, illness or condition.⁵⁸ For example, a state should not be able to exclude drugs needed by people because they are suffering from HIV/AIDS.⁵⁹

The DRA offers states the option of providing Medicaid to certain groups by enrolling them in pre-existing health insurance plans.⁶⁰ This would enable the state to ignore traditional rules requiring coverage of mandatory and optional services, statewideness, freedom of choice and comparability. These groups must receive coverage through a “benchmark” or “benchmark equivalent” plan. The benchmark plans are (1) the standard Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefit Plan; (2) the HMO plan with the largest commercial, non-Medicaid enrollment in the state; (3) any generally available state employee plan; (4) any plan that the Secretary of HHS determined to be appropriate.⁶¹ States are not permitted to require certain individuals to obtain benefits through this option, including pregnant women with incomes less than 133 percent of poverty and many individuals with disabilities.⁶²

While some children can be required to enroll in these benchmark plans, the DRA also requires states to provide for “any children under 19 years of age [other than the medically needy] wrap around benefits to the benchmark coverage that consist of early and periodic diagnosis and treatment services.”⁶³ For a detailed discussion of the benchmark requirements, including all of the individuals who are exempted, *see* NHeLP, *Health Advocate* (Spring 2006) at 26.

⁵⁷*See, e.g.,* Charleston Memorial Hosp. v. Conrad, 693 F.2d 324 (5th Cir. 1982) (upholding 12 day annual limit on inpatient hospital services).

⁵⁸*See*. 42 C.F.R. § 440.230(c).

⁵⁹*See* Weaver v. Reagan, 886 F.2d 194 (8th Cir. 1989) (discussing impermissible exclusion of AZT for individuals with AIDS-related condition).

⁶⁰ DRA, § 6044.

⁶¹ DRA § 6044.

⁶² DRA, § 6044(a).

⁶³ *Id.*

Medicaid Cost Sharing

The Medicaid Act has authorized states to impose cost sharing on some Medicaid beneficiaries. The DRA of 2005 added an entirely new section to the Medicaid Act, 42 U.S.C. § 1396oA, that vastly expands the states' options to impose cost sharing on Medicaid beneficiaries. See DRA, § 6041. This new provision leaves the existing premium and cost sharing provision, § 1396o, on the books untouched, but, in effect, largely repealed.⁶⁴ Children, the elderly, and persons with disabilities are all affected by the changes.

The DRA allows states to generally increase beneficiary cost sharing and establishes separate options for prescription drugs and non-emergency use of the emergency room. However, whether using the new DRA option or the previous cost sharing authorization, states may not impose copayments on certain beneficiaries, including children and youth with incomes below the federal poverty level and nursing home residents, or on certain services, including pregnancy-related services for pregnant women, emergency services, family planning services, and hospice services.

These DRA provisions became effective on March 31, 2006, except for the emergency room provisions, which are effective on January 1, 2007. For a discussion of the new cost sharing rules, see NHeLP, *Health Advocate* (Spring 2006) at 21-25.

Provider participation and managed care

States have much flexibility to decide how they will deliver services to Medicaid beneficiaries and how providers will be paid. 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 extent they are available to the general population in the service

⁶⁴Before the DRA, states could only impose “nominal” cost sharing on beneficiaries by, for example, requiring beneficiaries to pay a small amount to the provider, up front, before services are received (called a “copayment”). See 42 U.S.C. § 1396o (Supp. 2001); 42 C.F.R. § 447.50 *et seq.* (2000)..

area.⁶⁵ In addition, Medicaid participating providers must accept Medicaid payment as payment in full.⁶⁶ In other words, they must agree not to seek payment from Medicaid beneficiaries.

Traditionally, states paid a fee to providers for each service rendered, called “fee-for-service” reimbursement. 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 can 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 services are obtained “out of plan,” the beneficiary may be billed for them. Over half of all Medicaid beneficiaries are enrolled in managed care.⁶⁷

Managed care will bring significant changes to the care seeking patterns of Medicaid beneficiaries. Rather than dealing directly with state and local eligibility workers, beneficiaries will be 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 the details of the plan’s obligations to enrolled beneficiaries. The payment dynamics (in particular, prospective, pre-set 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 have previously served only commercial markets may not adhere to the Medicaid requirements for coverage. For example, the plan may provide check ups to Medicaid children and adolescents that do not include all of the required components of the EPSDT screens.⁶⁸

⁶⁵See 42 U.S.C. § 1396a(a)(30)(A).

⁶⁶See *id.* at § 1396a(a)(25); 42 C.F.R. § 447.15.

⁶⁷CMS, “Medicaid Managed Care: Overview,” <http://www.cms.hhs.gov/MedicaidManagCare/> (May 19, 2006)

⁶⁸The EPSDT medical screen must include five components: an unclothed physical exam, developmental assessment, appropriate immunizations, laboratory testing (including lead blood tests for children at 12 and 24 months and otherwise

Medicaid Resources on the World Wide Web

The National Health Law Program

- <http://www.healthlaw.org>
- Provides updates and analysis on federal legislation and policy developments, federal and state case law, major state activities, and academic research; provides access to model pleadings' provides extensive links to other organizations working on Medicaid issues

The Kaiser Commission on Medicaid and the Uninsured

- <http://www.kff.org>
- Provides extensive Medicaid facts and figures, nationally and by state; publishes extensive analysis on Medicaid trends

Center on Budget and Policy Priorities

- <http://www.cbpp.org>
- Provides research and advocacy support on Medicaid issues

for children at high risk), and health education. *See* 42 U.S.C. § 1396d(r)(1) (Supp. 2001).