

(3) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided as defined in 45 CFR 228.1; and

(b) A publicly operated community residence does not include the following facilities, even though they accommodate 16 or fewer residents:

(1) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.

(2) Educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there.

(3) Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

(4) Hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

**.01 Source:**

As redesignated, 43 FR 45175 (Sept. 29, 1978, effective Oct. 1, 1978), and amended at 47 FR 28652 (July 1, 1982, effective Sept. 29, 1982), and at 47 FR 31518 (July 20, 1982), and at 51 FR 19177 (May 28, 1986, effective June 27, 1986), and at 52 FR 47926 (Dec. 17, 1987, effective Jan. 19, 1988), and corrected at 53 FR 657 (Jan. 11, 1988), and amended at 56 FR 8832 (Mar. 1, 1991, effective Apr. 1, 1991), and corrected at 56 FR 23021 (May 20, 1991), and as amended at 59 FR 56116 (Nov. 10, 1994, effective July 1, 1995).

**Requirements for State Supplements**

[¶ 21,441]

**§ 435.1010 Requirement for mandatory State supplements.**

(a) Except as specified in paragraph (b) of this section, FFP is not available in Medicaid expenditures in any quarter in which the State does not have in effect an agreement with the Secretary under section 212 of Pub. L. 93-66 (July 9, 1973) for minimum mandatory State supplements of the basic SSI benefit.

(b) This section does not apply to any State that meets the conditions of section 212(f) of Pub. L. 93-66.

**.01 Source:**

As redesignated, 43 FR 45175 (Sept. 29, 1978, effective Oct. 1, 1978):

**¶ 21,441 Reg. § 435.1010**

[¶ 21,442]

**§ 435.1011 Requirement for maintenance of optional State supplement expenditures.**

(a) This section applies to States that make optional State supplement payments under section 1616(a) of the Act and mandatory supplement payments under section 212(a) of Pub. L. 93-66.

(b) FFP in Medicaid expenditures is not available during any period in which the State does not have in effect an agreement with the Secretary under section 1618 of the Act to maintain its supplementary payments.

**.01 Source:**

As redesignated, 43 FR 45175 (Sept. 29, 1978, effective Oct. 1, 1978), and amended at 51 FR 19177 (May 28, 1986, effective June 27, 1986).

**Subpart L—Option for Coverage of Special Groups**

[¶ 21,443.1100]

**§ 435.1100 Basis and scope.**

(a) *Statutory basis.* Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) *Scope.* This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

**Source:**

As adopted, 66 FR 2490 (Jan. 11, 2001, effective Apr. 11, 2001), effective date changed to June 11, 2001 at 66 FR 11547 (Feb. 26, 2001), effective date changed to June 25, 2001 at 66 FR 31178 (June 11, 2001), effective date changed to Aug. 24, 2001 at 66 FR 33810 (June 25, 2001).

**Presumptive Eligibility for Children**

[¶ 21,443.1101]

**§ 435.1101 Definitions related to presumptive eligibility for children.**

*Application form* means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(l) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

*Period of presumptive eligibility* means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day

on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

*Presumptive income standard* means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

*Qualified entity* means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

(6) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(7) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(8) Is a State or Tribal child support enforcement agency;

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(ii) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under

the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); and

(10) Any other entity the State so deems, as approved by the Secretary.

*Services* means all services covered under the plan including EPSDT (see part 440 of this chapter).

**Source:**

As adopted, 66 FR 2490 (Jan. 11, 2001, effective Apr. 11, 2001), effective date changed to June 11, 2001 at 66 FR 11547 (Feb. 26, 2001), effective date changed to June 25, 2001 at 66 FR 31178 (June 11, 2001), amended and effective date changed to Aug. 24, 2001 at 66 FR 33810 (June 25, 2001).

**[¶ 21,443.1102]**

**§ 435.1102 General rules.**

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency;

(3) Provide all services covered under the plan, including EPSDT; and

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

**Source:**

As adopted, 66 FR 2490 (Jan. 11, 2001, effective Apr. 11, 2001), effective date changed to June 11, 2001 at 66 FR 11547 (Feb. 26, 2001), effective date changed to June 25, 2001 at 66 FR 31178 (June 11, 2001), effective date changed to Aug. 24, 2001 at 66 FR 33810 (June 25, 2001).

[The next page is 18,601.]

payment, notification of the consequences of non-payment, and the waiver of payment procedure;

- a statement as to whether state or local funds under other than the Medicaid program are used to pay for premiums; and

- a definition of undue hardship for purposes of granting waivers under subsection E.

3571.3 *Postpartum Period*.—A woman may become newly eligible during the 60-day period beginning on the last day of her pregnancy during which time she is considered part of the group of poverty level pregnant women.

The state must provide services for 60 days post partum, and the remaining days of the month in which the 60th day falls, to all women who during pregnancy:

- applied for medical assistance;
- were eligible; and
- received services.

3571.4 *Mandatory Continuation of Assistance to [Infants]*.—If an infant's . . . eligibility ends because the maximum age with respect to which the state provides coverage has been reached, but the [infant] continues to meet all other eligibility criteria, and is receiving inpatient services provided under the state's plan on the date that eligibility should end, the [infant's] eligibility continues until the end of his or her inpatient stay.

3571.5 *Premium Option*.—Section 4101(d) of OBRA 87, which amended §1916(c) of the Act, authorizes states to impose premium payments on poor pregnant women and infants under age one whose family income equals or exceeds 150 percent of the federal poverty income level.

A. *General*.—States may provide for imposing a monthly premium, not to exceed the limits set forth in subsection B, on a pregnant woman or infant under age one described in §1902(l) of the Act, who receives Medicaid on the basis of §1902(a)(10)(A)(ii)(IX), and whose family income equals or exceeds 150 percent of the federal poverty income level. Family income is determined in accordance with §3571.1B.

The person responsible for payment of the premium for a minor is determined in accordance with state law.

B. *Premium Limits*.—In no case may the premium charged under this section be more than 10 percent of the amount by which family income (as determined in accordance with §3571.1B.) after deducting expenses for the care of dependent children, exceeds 150 percent of the federal poverty income level. Since income eligibility of this optional categorically needy group (like the cash programs) must be determined on a monthly basis, the premium is also determined on a monthly basis. If the state

elects to provide continuous eligibility without regard to changes in family income, it must determine income on a monthly basis in order to ensure conformance with the limits.

C. *Prepayment Requirement Prohibited*.—The state may not require prepayment of the premium imposed under this section.

D. *Termination for Nonpayment of Premium*.—The state may terminate the eligibility of the individual for nonpayment of the premium. However, it cannot terminate eligibility until the premium has been unpaid for a period of 60 calendar days from the date due. The termination action must be in compliance with the requirements in 42 CFR 431, Subpart E.

E. *Waiver of Payment*.—The state may waive payment of a premium imposed under this section if it determines that requiring the payment would create an undue hardship. Undue hardship is determined in accordance with the guidelines in the state's approved state plan for waiver of the premium payment.

F. *Use of State or Local Funds to Pay Premium*.—The state may use state or local funds available under other programs to pay for a premium imposed under this section.

The amount paid with state or local funds is not counted as income to the individual with respect to whom the payment is made.

G. *State Plan Requirements*.—The imposition of a premium under this section is authorized only under a state plan amendment approved by HCFA.

The State must include the following information in its state plan:

- A description of the method by which premium amounts are determined;
- A description of the billing method the state employs, including the due date for the premium payment, notification of the consequences of non-payment, and the waiver of payment procedure;
- A statement as to whether state or local funds under other than the Medicaid program are used to pay for premiums; and
- A definition of undue hardship for purposes of granting waivers under subsection E.

*State Medicaid Manual*, HCFA Pub. 45-3, §3571—§3571.5, Transmittal No. 45 (June 1990).

47 *Pregnant women during presumptive eligibility period*.—The following guidelines have been issued in HCFA's *State Medicaid Manual* concerning optional Medicaid coverage of pregnant women during a period of presumptive eligibility:

#### GUIDELINES

3570. OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PREGNANT WOMEN

14,251.47

A. *General Policy.*—States have the option to provide ambulatory prenatal care to pregnant women during a single limited period of presumptive eligibility. The period of presumptive eligibility begins on the day a pregnant woman is determined presumptively eligible. *If a presumptively eligible woman files a Medicaid application* by the last day of the month following the month in which she is determined presumptively eligible, she remains presumptively eligible until a determination is made on that application. *If a presumptively eligible woman does not file an application* for Medicaid by the last day of the month following the month in which she is determined presumptively eligible, her presumptive eligibility ends on that last day.

Presumptive eligibility must be determined by a qualified provider.

A woman is presumptively eligible if she is pregnant and if a qualified provider determines, based on preliminary information, that her gross family income does not exceed the highest income standard under which she might be eligible (i.e., the higher of poverty level or medically needy standard).

After a woman is determined presumptively eligible by a qualified provider, she may receive services from any provider that is eligible (subject to the requirements of § 1903(i)(14) of the Act) for payment for services under the state's plan.

NOTE: FFP is available to states for payments made on behalf of a woman who is correctly determined to be presumptively eligible. If she does not file a Medicaid application, or files an application and is determined ineligible, payments made on her behalf for covered ambulatory prenatal care during the period of presumptive eligibility are not included in the state's total amount of erroneous excess payments.

B. *Definition.*—A *qualified provider* is a provider that:

- is eligible to receive payments under an approved State plan; and
- provides services of the type provided by: (1) outpatient hospitals (see § 1905(a)(2)(A) of the Act); (2) rural health clinics under the state's plan (see § 1905(a)(2)(B) of the Act); or (3) clinics furnished by, or under, the direction of a physician, without regard to whether the clinic itself is administered by a physician (see § 1905(a)(9) of the Act); and
- has been designated by the state, in writing, as a qualified provider on the basis of the state's determination that the provider is capable of making determinations of presumptive eligibility; and
- receives funds under one of the following:

—the Migrant Health Centers, Community Health Centers, or Public Health Service primary

care research and demonstration projects (see §§ 329, 330 and 340 of the Public Health Service Act); or

—the Maternal and Child Health Services Block Grant Program (see Title V of the Act); or

—Health Services for Urban Indians (see Title V of the Indian Health Care Improvement Act); or

● participates in a program established under:

—the Special Supplemental Food Program for Women, Infants and Children (see § 17 of the Child Nutrition Act of 1966); or

—the Commodity Supplemental Food Program (see § 4(a) of the Agriculture and Consumer Protection Act of 1973); or

● participates in a state perinatal program; or

● is itself the Indian Health Service or a health program or facility operated by the tribe or tribal organization under the Indian Self Determination Act.

NOTE: States may determine whether a program is a state perinatal program. In making this determination, a state must take into account the overall intent of the presumptive eligibility provision as well as the nature and purpose of the program involved.

C. *Responsibilities of a Qualified Provider.*—A qualified provider must:

- make determinations of presumptive eligibility;
- notify the state of any determination that a woman is presumptively eligible within five working days after the determination is made;
- provide Medicaid applications to pregnant women who are determined presumptively eligible or who wish to apply; and
- assist pregnant women in completing and filing their applications for Medicaid.

NOTE: States are required to provide application forms to qualified providers and to give them information on how to assist the pregnant women in completing and filing the forms.

If a woman is determined to be presumptively eligible, the qualified provider must inform the woman in writing, at the time the determination is made, that:

- if she *does not* file an application for Medicaid by the last day of the next month, her presumptive eligibility ends; and
- if she *does* file an application for Medicaid by the last day of the next month, her presumptive eligibility continues until a determination of her eligibility based on that application is made.

NOTE: The qualified provider need not inform the woman of the consequences of not filing an

application for Medicaid if the provider knows that the woman has already completed such an application (e.g., if the same form is used to screen for presumptive eligibility and to apply for Medicaid.)

If a woman is determined not to be presumptively eligible, the qualified provider must inform the woman of the following, in writing:

- the reason for the determination; and
  - that she may file an application for Medicaid if she wishes to have a formal determination; and
- where she can apply for Medicaid; or
- that she has not been determined presumptively eligible but that her application for Medicaid has been received and she will be informed later of the formal determination made on the basis of that application.

**D. Forms.**—States may use a single form as both a screening form for presumptive eligibility and as a regular application for Medicaid (including a shortened application used for low income pregnant women described in § 1902(l)(1) whose eligibility is related to the poverty level). *However, states may not require that a pregnant woman provide information on a combined form which is not needed to determine if she is presumptively eligible.*

If the state uses a separate screening form and application, the application which the qualified provider gives to the pregnant woman may be the state's shortened application used to determine the eligibility of low income pregnant women described in § 1902(l)(1) of the Act whose eligibility is related to the poverty level.

**E. Notice and Appeal Rights.**—

● *If a presumptively eligible woman fails to file a regular Medicaid application, the state does not need to take any action when her presumptive eligibility ends. In this case, the recipient was covered under a special time-limited status. Because she was never actually determined eligible for Medicaid, the notice and appeal rights of the Medicaid program do not apply.*

● *If a presumptively eligible woman files a regular Medicaid application, the standard notice and appeal rights apply.*

*State Medicaid Manual, HCFA-Pub. 45-3, § 3570, Transmittal No. 55 (June 1991).*

**.49 TB-infected individuals.**—CCH issued a summary of the provisions of the Omnibus Budget Reconciliation Act of 1993 (PubLNo 103-66) affecting the Medicare and Medicaid programs. The text of the law can be found at Report No. 759 Extra Edition. Included is information regarding optional Medicaid coverage of tuberculosis-related services for certain tuberculosis-infected individuals.

*Summary of the Provisions of the Omnibus Budget Reconciliation Act of 1993 (PubLNo 103-66) affecting*

Medicare and Medicaid Guide

*Medicare and Medicaid Programs, Jan. 1, 1993. [This summary originally was reported at NEW DEVELOPMENTS ¶ 41,604.]*

**.50 The medically needy.**—The following guidelines and rulings have been issued concerning optional Medicaid coverage of the medically needy:

**GUIDELINES**

Guidelines in HCFA's *STATE MEDICAID MANUAL* are reproduced below in the following order:

3600 INTRODUCTION

3600.1 Changes Due to Welfare Reform

3601 BACKGROUND

3610 ELIGIBLE GROUPS

3611 REQUIRED GROUPS

3611.1 Individuals Under Age 18 and Pregnant Women

3611.2 Newborn Children and Extended Coverage of Pregnant Women

3611.3 Grandfathered Groups

3612 OPTIONAL ELIGIBLE GROUPS

3613 CRITERIA FOR DETERMINING CATEGORICALLY NEEDY AND MEDICALLY NEEDY

3613.1 General Requirements

3613.2 Exceptions

3613.3 States Which Use More Restrictive Requirements of Eligibility for Aged, Blind, or Disabled Than SSI

3600. INTRODUCTION

This chapter describes the medically needy and the related requirements of determining eligibility. The policies set forth in this chapter related to the medically needy reflect self-implementing amendments contained in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 98-248), amendments contained in the Deficit Reduction Act of 1984 (P.L. 98-369), and the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

**3600.1 Changes Due To Welfare Reform.**—The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). States may begin their TANF programs between August 22, 1996 and July 1, 1997. This law established a new Medicaid eligibility group for low income families with children which is described in Sec. 3301. After the TANF program is in effect in your State, all references to AFDC (or title IV-A) in this chapter are references to AFDC under the AFDC State plan in effect on July 16, 1996. The income standard under the July 16, 1996 AFDC State plan may be increased by any subsequent increases in the consumer price index (CPI) for all urban consumers (all items; U.S. city average) or lowered to a level no lower than the level in the AFDC State plan in effect on May 1, 1988.

**A. Limitation of Federal Financial Participation (FFP).**—If you choose to raise your AFDC income standard for purposes of determining eligibility under the mandatory group of low income families

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with children (see Sec. 3301), the FFP limitation explained in Sec. 3624 is raised accordingly. However, if you choose to lower your income standard for that group below the July 16, 1996 level, the FFP limitation remains based on the July 16, 1996 level.

**B. Medically Needy Income Level.**—The medically needy income level (MNIL) may be no higher than the FFP limitation. If you choose to lower your income standard for the mandatory group of low income families with children (see Sec. 3301), you may lower the MNIL to a level no lower than the income standard used for the low income families with children group. (If you choose to raise your income standard for the mandatory group of low income families with children, you are not required to raise your MNIL.)

**C. Income and Resource Methodologies.**—Less restrictive income and resource methodologies adopted under Sec. 3301 do not carry over to references to AFDC in this chapter. All references to AFDC in this chapter include only the income and resource methodologies under your AFDC State plan in effect on July 16, 1996.

*State Medicaid Manual*, HCFA Pub. 45-3, §3600—§3600.1, Transmittal No. 67 (Feb. 1997).

### 3601. BACKGROUND

The "medically needy" option allows states to provide Medicaid to individuals and families who have more income and, in some instances, more countable resources than allowed for Medicaid eligibility under the mandatory or optional categorically needy groups described in §1902(a)(10)(A) of the Social Security Act (the Act). A feature of this option is that an individual or family having income in excess of a state's prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses and establish Medicaid eligibility. This method used for determining eligibility is referred to as *spenddown*.

Prior to October 1981, states electing to provide Medicaid to the medically needy were required to include the same types of individuals defined by states' or territories' Medicaid plans as categorically needy (with certain specified exceptions). States were also required to follow financial methodologies and standards used in the cash-assistance programs of Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) for determining eligibility for the medically needy (with certain specified exceptions).

The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) (OBRA) amended §1902(a)(10)(C) of the Act to allow states more flexibility in defining the medically needy, and permitted states to vary Medicaid services by group. Regulations implementing OBRA permitted states to determine eligibility of the medically needy by varying financial requirements used for each medically needy group. They also permitted states to use financial methodologies

that were more or less restrictive than the cash-assistance programs.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 98-248) (TEFRA) again amended §1902(a)(10)(C) of the Act. These amendments were retroactive to the effective date of the OBRA changes. Under the TEFRA amendments, states are required to use a single income-and-resource standard (i.e., the standards used could not vary by group). The income-and-resource methodologies of the most closely related cash-assistance program are to be used to determine eligibility. Section 1902(a)(10)(C) of the Act was also amended to clarify who states and territories must include if they elect to provide Medicaid to the medically needy and who may be covered at their option. These changes were self-implementing.

Section 2373 of the Deficit Reduction Act of 1984 (P.L. 98-861) (DRA) imposes a moratorium on Health and Human Services (HHS) actions arising from states' or territories' use of certain standards or methodologies in their medically needy programs.

Section 9501 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272) amended section 1902(e) of the Act, effective April 7, 1986, to provide that pregnant women who, while pregnant, applied for and received Medicaid on the date pregnancy ended are eligible for pregnancy-related and postpartum services under the state plan for a 60-day period beginning on the date pregnancy ends.

Sections 1902(a)(10)(C) and 1902(e)(5) of the Act define who states and territories *must* include if they provide Medicaid to the medically needy, and establishes financial eligibility requirements. Section 1902(a)(10)(C) and 1905(a) of the Act describes who states *may* cover under the medically needy option.

Section 1902(a)(17) of the Act sets forth provisions for establishing reasonable income and resource standards. Section 1903(f) of the Act establishes the federal financial participation (FFP) limit for the income level used to determine eligibility.

*State Medicaid Manual*, HCFA Pub. 45-3, §3601, Transmittal No. 67 (Feb. 1997).

### 3610. ELIGIBLE GROUPS

Under §1902(a)(10)(C) of the Act, the medically needy are defined as—

Any group of individuals described in §1905(a) who are not described in subparagraph (A).

Therefore, individuals who are described in subparagraph (A) of §1902(a)(10), (which includes both the required categorically needy and the optional categorically needy groups) cannot be medically needy individuals. Whether the state has elected to cover a particular optional categorically needy group has no bearing on the issue of who can be medically needy.

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