



# *What Makes Medicaid, Medicaid?*

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Wayne Turner



## What Makes Medicaid, Medicaid? Five Reasons Why Medicaid is Essential to Low-Income People

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### Introduction

With the enactment of the Affordable Care Act (ACA) in 2010, and the implementation of Medicaid expansions and Marketplaces in 2014, the United States significantly expanded access to health insurance coverage.

Architects of the ACA rightly viewed Medicaid as an essential piece as we move toward universal coverage. Medicaid has proven to be an essential lifeline during the COVID-19 pandemic and downturn, enrolling more than 85 million people.<sup>1</sup> Even some policy experts analyzing the ACA fail to realize that Medicaid is not just a way to cover one more groups of people, it is the coverage program specifically designed to meet the needs of low-income individuals, who have disproportionate medical needs and health challenges. Simply providing Medicaid enrollees with Marketplace coverage would not meet their health care needs – they need Medicaid coverage. Ultimately, this means that Medicaid cuts, or shifting enrollees to private, Marketplace coverage, would harm people who receive care through Medicaid. This paper explains why it is essential for health coverage in the United States to maintain what makes Medicaid, Medicaid.

The five reasons Medicaid is essential to low-income people are:

- [Medicaid Services Are Specifically Designed to Meet the Needs of Low-Income People](#)
- [Medicaid Provider Network Rules Maximize Access for Low-Income People](#)
- [Medicaid is the Only Insurance Program That is Affordable for Low-Income People](#)
- [Medicaid Is the Only Insurance That Can Protect the Rights of Low-Income People](#)
- [Medicaid Provides Low-Income People with the Access and Continuity They Need](#)



## Medicaid Services Are Specifically Designed to Meet the Needs of Low-Income People

Medicaid enrollees, by definition, have low-income and often minimal savings and other resources. They are also more likely to have serious health problems and almost certainly are lacking in any resources to address those health problems on their own.<sup>2</sup> Therefore, a robust benefits package meeting the unique needs of these enrollees is a cornerstone of the Medicaid program. Without Medicaid, enrollees would simply go without care they need. They do not have any other way to pay for the care they need.

Medicaid includes a strong set of “**mandatory**” **benefits** for enrollees, which every participating state (all states participate) must provide to its Medicaid population.<sup>3</sup> This establishes a guaranteed minimum level of coverage to meet the special needs of Medicaid enrollees. Mandatory Medicaid benefits include: inpatient and outpatient hospital services, physician services, and laboratory and x-ray services, among others. Medicaid is also the primary long-term care program in the United States, covering both institutional and community-based services. This guaranteed package of benefits ensures that low-income Medicaid enrollees have a strong baseline coverage for their health care needs. The mandatory benefits also address the special needs of the covered populations, for example:

- Children living in poverty have unique health care needs. These children face a number of challenges to their health and development – such as malnourishment and exposure to environmental toxins – that result in regular developmental drop-offs in the population. Without aggressive intervention and case management, many of these children would never “catch-up” or attain their best possible function. To address this deficit, children in Medicaid receive a special benefit known as **Early and Periodic Screening, Diagnostic and Treatment**, or “EPSDT.” EPSDT ensures that low-income children are periodically screened for health and developmental problems and referred for further diagnosis and treatment as needed. EPSDT also guarantees that children will receive access to all Medicaid services when needed to correct or ameliorate the conditions, irrespective of any limits in the coverage package for adults or the package offered by a contractor.
- Medicaid also provides strong benefits and protections for people in need of **family planning services and supplies** (FPSS). Without these benefits and protections, many would be unable to guarantee their reproductive health and freedom.<sup>4</sup>

Medicaid incentivizes states to provide the services with generous federal funding.<sup>5</sup> Medicaid also includes protections to ensure access to the benefit. For example, in Medicaid, people have freedom of choice to seek FPSS from any provider, which protects low-income persons who may have very specific providers that are available to them or whom they trust with their reproductive health.<sup>6</sup> Medicaid also prohibits cost-sharing for all FPSS, meaning low-income persons have unrestricted access to the services.<sup>7</sup> (These protections are discussed further below).

In addition to mandatory benefits, states also can receive federal matching funds for providing Medicaid enrollees with any one of a long list of **"optional" services**.<sup>8</sup> The broad range of optional services provides states with funding to expand the Medicaid benefits package to further address the specific needs of the Medicaid population.

Examples of services that are generally optional include outpatient prescription drug coverage (all states cover these), dental coverage, physical therapy, and case management services, among many others.

Optional services also include flexibility for states to add critical support services for older adults and persons with disabilities. These populations often have functional limitations that result in lower quality of life, worsened health and forced institutionalization. For example, an individual with a disability may be unable to bathe without adequate supports and forced to either forego basic hygiene or accept placement in an isolated institution to receive that basic support. Low-income individuals without Medicaid simply have no means to pay for those supports on their own. However, Medicaid allows states to fund **home and community-based service programs** (HCBS), which provide these supports to individuals in their home settings, such as a home attendant to help an individual bathe, dress, and eat.<sup>9</sup> (Note: It also saves taxpayers money, as institutional placements are extremely expensive).<sup>10</sup>

Low-income individuals often cannot afford to own a car or pay for public transportation at the moment they need health care. Particularly in rural areas, providers may not be accessible by public transportation. In other cases, individuals with disabilities may not be able to access public transit. In these situations, having coverage is not enough to have access to care. Medicaid solves this problem by offering a **transportation** benefit to ensure the Medicaid population can access their coverage.<sup>11</sup> This benefit is specifically for non-emergency transportation and can include reimbursement for fuel or public transportation costs, and special accessible transportation systems for persons with disabilities. This is yet another way that Medicaid provides special coverage to meet the needs of vulnerable low-income enrollees.



While states (and their contractors) have some flexibility to limit utilization of services, ultimately all services (both mandatory and optional) must be provided in sufficient **"amount, duration and scope** to reasonably achieve its purpose."<sup>12</sup> This standard, when properly followed, guarantees that states do not set arbitrary limits on services that will fail Medicaid enrollees who have no other recourse to obtain services. Arbitrary service limits with no clinical basis add frustrating hurdles and costs to coverage for many individuals with private employment-based coverage, but they completely block access to treatment for low-income individuals.

## **Medicaid Provider Network Rules Maximize Access for Low-Income People**

Medicaid's service package is a critical component to effective coverage for low-income people. However, health coverage is only as good as the individual's access to health care providers.

Medicaid law requires states to set payment rates sufficient "to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."<sup>13</sup> In addition, Medicaid law requires that payment rates for Medicaid managed care be actuarially sound.<sup>14</sup> Medicaid managed care also includes requirements that each managed care plan "[m]aintain[s] a **network of providers** that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."<sup>15</sup> These requirements, when properly implemented, help ensure Medicaid enrollees have access to an adequate network of medical providers. To the extent that Medicaid does have some provider access problems, it is a function of the state's low level of funding for the program, which in turn necessitates low provider rates. Medicaid is extremely efficient with the dollars actually allocated to the program, maximizing coverage for a very large population of vulnerable individuals, with low levels of funding. While Medicaid's funding has been weak, Medicaid's provider access requirements are in fact strong.

Additionally, Medicaid includes further protections to specifically promote access to providers for the underserved populations that depend on it. For example, low-income individuals depend disproportionately on care from federally qualified health centers (FQHCs) and rural health clinics (RHCs) in their communities.<sup>16</sup> Medicaid requires states to cover FQHCs and RHC services and "any other ambulatory services which are offered" by such clinics.<sup>17</sup> These

requirements are also specifically applied to the alternative benefits plan package that individuals receive in the Medicaid expansion.<sup>18</sup> State managed care programs are also supposed to include federally qualified health center services.<sup>19</sup> To protect FQHCs and RHCs and secure access for beneficiaries, Medicaid law guarantees fair minimum payment rates for these providers including a requirement that managed care companies also pay them fair rates.<sup>20</sup>

Medicaid managed care also includes requirements that specifically require each managed care plan [m]aintain[s] a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number.

Medicaid's emphasis on promoting access to FQHC and RHC services is a unique and critical component of the program, specifically designed to improve care for low-income individuals.

## Medicaid is the Only Insurance Program That is Affordable for Low-Income People

Health insurers commonly implement a variety of premium and cost-sharing mechanisms, including premiums, deductibles, copayments and co-insurance. Premiums are intended to generate revenue, while the other cost-sharing mechanisms are intended to reduce utilization of unnecessary medical care, though there is a wide gap between intent and reality.<sup>21</sup> The general effectiveness of these mechanisms for incentivizing more efficient use of health care is debatable, even for the middle to high-income individuals who may have employment-based coverage, Marketplace coverage, or other individual coverage.<sup>22</sup> However, these common health insurance mechanisms are clearly bad health policy for low-income individuals, who, when faced with even small costs, forego essential health care due to the financial burden.<sup>23</sup> Low-income individuals with health care costs would be forced to choose food and rent instead of medicine. For this reason, Medicaid has been specially designed to keep care affordable for low-income individuals.

Low-income individuals cannot afford to make a monthly **premium** payment for their health coverage and certainly won't be able to do so every month over the course of a year. The evidence shows that when these individuals are subject to a premium, large numbers of them fall off coverage sooner rather than later.<sup>24</sup> Medicaid thus prohibits premiums on all individuals below 150% of the federal poverty level (FPL).<sup>25</sup> (See NHeLP's series on Medicaid affordability [here](#)).



Medicaid allows states to impose some **cost-sharing** on services. Deductibles are not allowed, but copayments and coinsurance are allowed subject to special limits that apply depending on the service and income level of the individual. In general, the lowest-income individuals, those living in poverty, can only be charged “nominal” copayments – for example, \$4 for a doctor visit or a preferred prescription drug.<sup>26</sup>

States can charge these individuals higher amounts for some other services, such as \$8 for a non-emergency Emergency Department visit or a non-preferred prescription drug.<sup>27</sup> (Higher-income individuals, namely those above the poverty line, have higher limits applicable to them.) All of these limits are critical because, when low-income individuals are subject to high cost-sharing, they forego care.<sup>28</sup> (In fact, there is evidence that even at Medicaid’s “nominal” level, cost-sharing is detrimental to health outcomes.)<sup>29</sup> In any event, these low limits are unique to Medicaid, and an essential part of Medicaid’s design, intended to preserve access to care for low-income individuals.

"[Cost-sharing and premiums] are clearly bad health policy for low-income individuals, who, when faced with even small costs, forego essential medical care due to the financial burden."

Furthermore, Medicaid also includes three additional extraordinary affordability protections to ensure access to care for the lowest-income populations. First, Medicaid law requires that anyone who is living at or below the federal poverty level cannot be denied treatment for the inability to pay the copayment.<sup>30</sup>

Therefore, low-income people can always get the care they need. Second, Medicaid law specifically allows providers the standing right to waive copays for their patients, a flexibility providers are often able to use when a patient is clearly destitute or desperately needs a service for which she cannot afford the copay.<sup>31</sup> Third, Medicaid law requires that no individual in poverty can be charged cost-sharing in excess of an aggregate cap based on 5% of their income in a month or quarter.<sup>32</sup> This means that no matter how many clinician visits and treatments a patient needs, there is a set maximum above which they will have no further costs. Taken together, these unique Medicaid protections dramatically improve the affordability of care for individuals in poverty, meaning they can actually afford to use their insurance and get treatment.

## Medicaid Is the Only Insurance That Can Protect the Rights of Low-Income People

As the Supreme Court noted over fifty years ago in the landmark case *Goldberg v. Kelly*, individuals eligible for a program like Medicaid face a “brutal need” for their public benefits.<sup>33</sup> It is therefore critical that Medicaid benefits never be terminated without a proper basis for doing so. As the Court noted, incorrectly terminating the benefits of an individual may “deprive an eligible recipient of the very means by which to live while he waits” for the error to be corrected.<sup>34</sup> Furthermore, the Court observed that once terminated, such an individual faces “immediately desperate” circumstances that “adversely affect his ability to seek redress from the welfare bureaucracy.”<sup>35</sup> In short, the brutal need of Medicaid recipients admits no error in terminating or reducing their benefits.

For this reason, Medicaid includes strong **notice and appeals rights** that the Supreme Court has required under the Due Process Clause of the United States Constitution, and which are a cornerstone of the Medicaid statute and regulations. Prior to terminating or reducing an enrollee’s benefits, Medicaid law requires that the enrollee must be provided with a full administrative review of the proposed termination or reduction.<sup>36</sup> This means, first and foremost, that an enrollee’s benefits cannot be altered by a state (or its contractors) without providing the beneficiary with a hearing prior to implementing the proposed change. In simple terms: the state cannot shoot first, and ask questions later. This **pre-termination review** itself includes numerous requirements which, if omitted, would be “fatal to the constitutional adequacy of the procedures.”<sup>37</sup>

For example, under Medicaid law, the state must: provide a timely notice informing the enrollee of the intended action; include specific content in the notice such as the reasons for the intended action, the specific regulations that support the action, and the enrollee’s hearing rights; allow the enrollee to attend a hearing where she can present evidence orally and cross-examine adverse witnesses; allow the enrollee to be represented by an attorney; have the case decided by an impartial decision maker; and ultimately, have an explanation of the decision including the evidence relied upon to make the decision.<sup>38</sup>

The due process protections required under Medicaid law protect vulnerable Medicaid enrollees who lack alternative resources to obtain medical care or the resources to lobby to have their case fixed after the fact. The consequences of these legal requirements, in practical terms, are significant. For example, the parent of a Medicaid-enrolled child whose insurance company wants to stop covering the child’s behavioral health services has the right to file an appeal and dispute this change *prior* to having the services reduced; this “**aid paid pending appeal**”



allows the enrollee to continue to receive their treatment for the duration of time required to have a hearing and receive a decision. Medicaid's protection allows individuals to maintain essential coverage while justice is pursued. For Medicaid enrollees, no other health coverage would be acceptable.

## Medicaid Provides Low-Income People with the Access and Continuity They Need

Low-income individuals often face urgent health care problems and have no manner to quickly access care without special enrollment policies. In other circumstances, vulnerable low-income individuals may face serious risks when their coverage status changes and leaves them one emergency away from tragedy. Medicaid includes a series of special protections to promote health care access and continuity for low-income enrollees to solve these problems. If low-income individuals were required to use enrollment systems such as annual enrollment periods – currently used by Marketplaces and Medicare – terrible health outcomes would result. Only Medicaid utilizes an application and enrollment system which ensures access for low-income people.

Medicaid law requires that “all individuals wishing to make application for medical assistance” have the “opportunity to apply for Medicaid without delay.”<sup>39</sup> Furthermore, the law requires that “such assistance shall be furnished with **reasonable promptness** to all eligible individuals.”<sup>40</sup> Individuals must be able to apply and enroll quickly at any time of the year, subject to no annual enrollment periods. Since Medicaid enrollees lack the resources to pay for care through any other means, this requirement is critical.

Medicaid also includes additional unique protections to ensure access. The Marketplace, like many commercial insurances, effectuates enrollment on a date one to two months subsequent to application.<sup>41</sup> Medicaid enrollees often have urgent medical needs and cannot afford to wait for months, and also lack the means to pay for their care in the interim. To solve this, Medicaid uses a unique “**point-in-time**” **eligibility** system which makes enrollment retroactive to the date of application.<sup>42</sup> For example, if an individual applies on November 15th, and is found eligible on December 10th, their Medicaid effective date is November 15th, meaning Medicaid considers her enrolled as of that date and any medical bills since that date can be covered. Medicaid enrollees thus have immediate access to coverage if they are ultimately eligible.

Medicaid's unique point-in-time and retroactive coverage rules provide critical and unique protection for low-income individuals (and health care providers).

Furthermore, since a medical event may render an individual unable to apply for some amount of time, in most circumstances Medicaid generally offers coverage for the three months prior to the month of application if the individual has any bills for treatment in that time period.<sup>43</sup> An individual with unpaid bills filing a Medicaid application on November 15th, therefore, could receive coverage for bills from August, September and October (assuming they met Medicaid eligibility criteria for all of the months and their state has not gotten federal approval to eliminate this coverage). This **retroactive eligibility** provision is vital to Medicaid recipients because it helps ensure they receive care and protects them from overwhelming medical bills. Also important, this provision protects the entire health care system, as providers and health systems have a source of payment for care that otherwise would be uncompensated. Medicaid's unique point-in-time and retroactive coverage rules provide critical and unique protection for low-income individuals (and health care providers).

Medicaid also includes special eligibility provisions to ensure continuity for underserved populations. For example, out of recognition of the extreme vulnerability of low-income pregnant women, they are protected in at least two special ways.<sup>44</sup> First, Medicaid coverage automatically extends until the end of the month in which a pregnant person's **60-day postpartum period** (beginning on the last day of the pregnancy) ends.<sup>45</sup> Second, eligibility during this time period remains intact regardless of any changes in household income which might make the person otherwise ineligible for Medicaid.<sup>46</sup> Acknowledging that people whose pregnancies in 2022 Congress permanently extended a state option to cover postpartum individuals for twelve months after the end of the pregnancy.<sup>47</sup> Over thirty states have taken that option so far with more are expected in the future.<sup>48</sup>

As another example, newborn children are afforded a similar continuity guarantees. First, children born to mothers receiving Medicaid on their date of birth are **automatically deemed eligible** and enrolled in Medicaid as of that date, meaning there is no administrative obligation for families or delay in starting a newborn's coverage.<sup>49</sup> Second, the baby automatically remains eligible for Medicaid for a full year as long as the mother's income does not exceed the Medicaid pregnancy limit (which may be higher than normal limits).<sup>50</sup> These provisions protecting special vulnerable populations are unique to Medicaid, and Medicaid is the only way to meet the health care needs of such populations.

Finally, while Medicaid law creates many rules to support continue health coverage eligibility of low-income individuals, it does not allow states to add arbitrary eligibility rules that would hamper access to care for low-income individuals. Extraneous eligibility requirements are **illegal conditions of eligibility** in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.<sup>51</sup> Although states have flexibility in designing and administering



their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law, and courts have held additional eligibility requirements to be illegal.<sup>52</sup> States seeking to promote other state objectives – such as encouraging employment or reducing use of illegal drugs – cannot use Medicaid dollars to achieve those objectives or complicate Medicaid eligibility with barriers such as work search requirements or drug tests. Medicaid is a medical assistance program, designed to efficiently provide coverage to low-income individuals who may not survive arbitrary rules coming between them and the care they need.

Medicaid law does not allow states to add arbitrary eligibility rules that would hamper access to care for low-income individuals.

## **Conclusion**

Low-income and underserved individuals have specialized health care needs, and only Medicaid is specifically designed and effective in meeting those needs. Numerous features of the Medicaid program help guarantee that low-income individuals can get covered, stay covered, and most importantly, use the health care services they need. No matter how the health care system evolves, Medicaid's unique protections must be preserved for the vulnerable populations that depend on this program. Health care coverage should not mean one-size-fits all coverage for low-income individuals who can only live healthy with Medicaid coverage.

## **Additional Resources**

- For information on other aspects of Medicaid, see our entire series on [What Makes Medicaid, Medicaid](#).

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ENDNOTES

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<sup>1</sup> Ctrs. for Medicaid and CHIP Srvs., *December 2022 Medicaid & CHIP Enrollment Data Highlights* (Apr. 4, 2023), <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=92%2C340%2C585%20individuals%20were%20enrolled%20in,enrollment%20data%20for%20December%202022.>

<sup>2</sup> Benjamin D. Sommers, *Low-Income Americans and Health Reform: Unmet Needs, Significant Opportunities*, The Commonwealth Fund (Oct. 8, 2014), <https://www.commonwealthfund.org/blog/2014/low-income-americans-and-health-reform-unmet-needs-significant-opportunities>.

<sup>3</sup> 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a)(1)-(5), (17), (21) (28); 42 C.F.R. § 440.210.

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

<sup>5</sup> 42 U.S.C. § 1396b(a)(5).

<sup>6</sup> 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(3).

<sup>7</sup> 42 U.S.C. § 1396o(a)(2)(D), (b)(2)(D); 42 C.F.R. § 447.56(a)(2)(ii).

<sup>8</sup> 42 U.S.C. § 1396d(a); 42 C.F.R. § 440.225.

<sup>9</sup> HCBS state plan options and waivers are available under 42 U.S.C. § 1396n(c), (d), (e), (i), (k); 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI); 42 C.F.R. § 435.217.

<sup>10</sup> Wendy Fox-Grage and Jenna Walls, *State Studies Find Home and Community-Based Services to Be Cost-Effective* (Mar. 2013), <https://www.aarp.org/health/medicare-insurance/info-03-2013/state-studies-find-hcbs-to-be-cost-effective-AARP-ppi-ltc.html>.

<sup>11</sup> See 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53.

<sup>12</sup> 42 C.F.R. § 440.230(b).

<sup>13</sup> 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204.

<sup>14</sup> 42 U.S.C. § 1396b(m)(2)(A)(iii).

<sup>15</sup> 42 C.F.R. § 438.207(b)(2).

<sup>16</sup> Health centers provide services to one in three people living in poverty, and seventy-two percent of all health center patients are living in poverty. See National Association of Community Health Centers, *A Sketch of Community Health Centers* (2016), <http://nachc.org/wp-content/uploads/2016/08/Chartbook16.pdf>.

<sup>17</sup> 42 U.S.C. § 1396d (a)(2)(B),(C).

<sup>18</sup> 42 U.S.C. § 1396u-7(b)(4).

<sup>19</sup> 42 U.S.C. § 1396n(b).

<sup>20</sup> 42 U.S.C. § 1396a(bb); 42 U.S.C. § 1396b(m)(2)(A)(ix).

<sup>21</sup> David Machledt and Jane Perkins, Nat'l Health Law Program, *Medicaid Premiums and Cost Sharing* (Mar. 2014), <http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#>.

<sup>22</sup> *Id.* at notes 10, 27.

<sup>23</sup> *Id.* at note 9.

<sup>24</sup> Salam Abdus et al., *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFF. 1353 (2014);

Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999); Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106 (2005); Samantha Artiga & Molly O'Malley, Henry J. Kaiser Fam. Found., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005), <https://www.kff.org/wp-content/uploads/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf>.

<sup>25</sup> 42 U.S.C. § 1396o(c). Although Medicaid law is very clear about this premium policy, HHS has recently given a few states special permission (based on a misuse of § 1115 demonstration authority) to apply premiums below 150% FPL – the states have been allowed to apply mandatory premiums for individuals from 100-150% FPL and voluntary premiums for individuals below 100%. Both of these policies fly in the face of clear evidence that such premiums are harmful, and represent a serious departure from the carefully calculated design of Medicaid, which prohibits premiums for individuals that the evidence clearly shows cannot afford to pay those premiums. Medicaid law on premiums, if correctly applied, is uniquely designed to protect the needs of Medicaid beneficiaries.

<sup>26</sup> 42 U.S.C. § 1396o(a)(3), (b)(3), § 1396o-1(c)(2); 42 C.F.R. §§ 447.52(b)(1) and 447.53(b). *See also* further restrictions at 42 C.F.R. § 447.56(a).

<sup>27</sup> 42 U.S.C. §§ 1396o(a)(3), (b)(3), 1396o-1(c)(2)(A); 42 C.F.R. §§ 447.53(b), 447.54(b).

<sup>28</sup> David Machledt and Jane Perkins, *supra* note 21 at note 13.

<sup>29</sup> David Machledt and Jane Perkins, *supra* note 21 at notes 9, 62.

<sup>30</sup> 42 U.S.C. § 1396o(e); 42 U.S.C. § 1396o-1(d)(2); 42 C.F.R. § 447.52(e).

<sup>31</sup> 42 U.S.C. § 1396o-1(d)(2); 42 C.F.R. § 447.52(e)(3).

<sup>32</sup> 42 U.S.C. § 1396o-1(b)(1)(B)(ii) and (b)(2)(A); 42 C.F.R. § 447.56(f).

<sup>33</sup> *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970).

<sup>34</sup> *Id.* at 264.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* at 266-67. Medicaid regulations explicitly apply all of the *Goldberg* due process protections to Medicaid hearings at 42 C.F.R. § 431.205(d).

<sup>37</sup> *Id.* at 268.

<sup>38</sup> These examples are all set out in *Goldberg* and are found in regulations at 42 C.F.R. §§ 431.206, 431.210, 431.240, 431.242, 431.244.

<sup>39</sup> 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.

<sup>40</sup> 42 U.S.C. § 1396a(a)(8).

<sup>41</sup> 45 C.F.R. § 155.410(f).

<sup>42</sup> 42 U.S.C. § 1396o(a)(34); 42 C.F.R. § 435.915.

<sup>43</sup> *Id.*

<sup>44</sup> The National Health Law Program recognizes that pregnancy can occur in people other than cisgender women, including transgender and non-binary persons. We use the term “pregnant women” here tracking the language in the statute.

<sup>45</sup> 42 U.S.C. § 1396a (e)(5).

<sup>46</sup> 42 U.S.C. § 1396a (e)(6).



<sup>47</sup> Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, § 5113 (2022).

<sup>48</sup> Maggie Clark, Georgetown Univ. Health Policy Inst. Ctr. For Children and Families, *Permanent Medicaid Postpartum Coverage Option, Maternal Health Infrastructure Investments in 2022 Year-End Omnibus Bill* (Jan. 4, 2023), <https://ccf.georgetown.edu/2023/01/04/permanent-medicaid-postpartum-coverage-option-maternal-health-infrastructure-investments-in-2022-year-end-omnibus-bill/>.

<sup>49</sup> 42 U.S.C. § 1396a (e)(4); 42 C.F.R. § 435.117.

<sup>50</sup> *Id.*

<sup>51</sup> See generally 42 U.S.C. § 1396a.

<sup>52</sup> *Camacho v. Texas Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005), *aff'g*, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not “add additional requirements for Medicaid eligibility”). See generally *Carleson v. Remillard*, 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).