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Representing Immigrant Families

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When medical facilities provide emergency services to noncitizens, the federal government reimburses them through a program known as emergency Medicaid. Officials in ten states recently surveyed by the U.S. General Accounting Office reported that most of the $2 billion those states spent on emergency Medicaid services in the 2002 fiscal year was attributable to undocumented aliens, particularly pregnant women’s labor and delivery services. These states also reported that emergency Medicaid expenditures, while a small portion of total Medicaid spending, have increased over the past several years.

In this article I discuss Medicaid coverage of emergency medical conditions for noncitizens. I trace the legislative history of coverage, describe the current legal authority for coverage, and address commonly raised coverage issues, including residency requirements, requests for verification of eligibility, coverage of pregnancy-related services, duration of emergency medical conditions, and relief for disproportionate providers.


As enacted in 1965, the Medicaid Act did not address the availability of Medicaid to noncitizens, but the U.S. Department of Health, Education and Welfare (the Department of Health and Human Services’ predecessor) interpreted the statute to allow coverage. Then, in 1973, Congress amended the Social Security Act to deny social security benefits to noncitizens. Following suit, the Department of Health, Education and Welfare issued a regulation that also denied any Medicaid eligibility to any noncitizen who was not a permanent resident or otherwise permanently residing in the United States under color of law.

In 1986 a federal district court in New York held that the regulation violated the Medicaid statute. Congress responded by amending the Medicaid Act to exclude certain “aliens” from receiving full-scope Medicaid assistance. However, Congress

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2. Id. at 11.


also required that Medicaid payments “shall be made” if

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the state plan ... and

(C) such care and services are not related to an organ transplant procedure. 8

At present the Medicaid Act defines the term “emergency medical condition” to mean a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in

(A) placing the patient’s health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part. 9

The definition in the implementing federal regulation tracks the statute, with one important addition—services are limited to those required “after the sudden onset” of a medical condition. 10

One final legislative action is worth noting. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 denies full-scope Medicaid benefits to most immigrants. 11 The welfare law divides noncitizens into two groups: qualified and nonqualified aliens. Qualified aliens are further divided into two groups: those lawfully residing in the United States before August 22, 1996, and those arriving in the country after August 22, 1996. Those falling within the former group are eligible for full-scope Medicaid benefits while those in the latter group are ineligible for Medicaid for a period of at least five years. 12 Persons who enter the United States without the proper documentation, that is, “nonqualified aliens,” are also ineligible for full-scope Medicaid benefits. Notwithstanding these disqualifications, both nonqualified aliens and qualified aliens, during the ineligibility period, are eligible for Medicaid coverage of emergency medical conditions. The welfare law did not amend the definition of the term “emergency medical condition” that Congress added to the Medicaid Act in 1986. 13 However, the welfare law House conferees stated their intent that this coverage was to be limited:


9 42 U.S.C. § 1396b(v)(3)(A)–(C) (2004). This same definition is used in the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2004), which requires each Medicare-participating hospital to conduct a medical examination of any patient who comes to the emergency room to determine if the patient has an emergency medical condition, to stabilize the patient, and to transfer or discharge the patient only if stabilized.


11 See 8 U.S.C. §§ 1611(a), (b)(1)(A) (stating that an “alien who is not a qualified alien … is not eligible for any Federal public benefit” with an exception for Medicaid coverage of emergencies), (c)(2)(B) (listing qualified alien categories) (2004).

12 See id. §§ 1612(b), 1613(a). States may expand the period of ineligibility beyond five years. Id. § 1612b(1).

13 See id. § 1611(b)(1)(A).
The allowance for emergency medical services under Medicaid is very narrow. The conferees intend that it only apply to medical care that is strictly of an emergency nature, such as medical treatment administered in an emergency room, critical care unit, or intensive care unit. The conferees do not intend that emergency medical services include prenatal or delivery care assistance that is not strictly of an emergency nature.14

Thus, while greatly reducing the number of persons who are eligible for full Medicaid benefits, the welfare law expanded the number of persons who may qualify for Medicaid coverage of their emergency conditions.15

II. Issues Surrounding Medicaid and Emergency Medical Conditions

Advocates have raised a number of questions about the extent to which Medicaid programs must cover noncitizens who may be experiencing an emergency medical condition.16 In the sections that follow, I discuss some of the most frequently raised issues in this area, including residency requirements, requests for verification of eligibility, coverage of pregnancy-related services, duration of emergency medical conditions, and relief for disproportionate providers.

A. Application of State Residency Requirements

Under the Medicaid Act, emergency Medicaid is available to any aliens, regardless of immigration status, provided they “otherwise meet the eligibility requirements for medical assistance under the State plan.”17 This means that the recipients must belong to a Medicaid-eligible category, such as pregnant women or children under 19, and must meet income and residency requirements. The federal rules require recipients to be residents of the state where they are applying for benefits.18 For most individuals over 21, “residency” means the state where the individual is “[l]iving with the intention to remain there permanently or for an indefinite period of time.”19 For an individual who is under 21 and not institutionalized or emancipated, residency is that of the parent.20

Regarding residency, the primary federal guidance document on Medicaid, the State Medicaid Manual, provides that “in some cases an alien in a currently valid non-immigrant classification may meet the State residence rules” and thus qualify for emergency Medicaid coverage.21 This exception appears to be limited to noncitizens who hold certain employment authorization documents.22 The State Medicaid Manual further provides that “[a]mong otherwise ineligible aliens” are visitors, tourists, foreign students, members of the foreign press and their families, some workers, and diplomats and their “families and servants” who are currently lawfully admitted as legal nonimmigrants.23

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15This change in the Medicaid program can be confusing because the Medicaid Act continues to allow full-scope Medicaid coverage for persons “lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.” 42 U.S.C. § 1396b(v)(1) (2004).
19Id. § 435.403(j)(1)).
20Id. § 435.403(h)(3). For background discussion, see Medicaid Program; Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36813–14 (Sept. 7, 1990) (comparing alien and homeless residency requirements).
21STATE MEDICAID MANUAL, supra note 10, § 3211.10.
22Id. (listing Form I-688B or Form I-766).
23Id. (listing the various types of Immigration and Naturalization Service documentation).
Despite the guidance of the State Medicaid Manual, some states have used residency provisions to deny Medicaid coverage of emergency medical conditions. Courts generally affirm such states’ refusals to cover emergency conditions based on the nonresident status of the noncitizen. For example, in Okale v. North Carolina Department of Health and Human Services, the Medicaid agency refused to recognize the costs associated with a noncitizen’s childbirth. At the time of her child’s birth, the noncitizen had entered into a lease agreement, opened a checking account, and obtained an identification card and driver’s license. The North Carolina Court of Appeals, affirming the denial of coverage, found that the noncitizen was lawfully in the United States on an unexpired tourist visa at the time of the request for Medicaid payment and thus neither she nor her son met the test for state residency. Rejecting the evidence of her intent to remain in North Carolina, the court found that the “unexpired tourist temporary visa creates the verification to doubt Okale’s asserted intent to remain in the state. To hold otherwise, we must presume that Okale will violate the law and attempt to illegally stay beyond her latest declared date of departure from this state and country.”

B. Application of Eligibility Verification Requirements

Noncitizens complain that they are being asked to submit social security numbers and other verification of eligibility when emergency medical services are needed. This adds to the fear of being discovered by immigration authorities—already a significant barrier to care for many noncitizens.

According to federal law, noncitizens who are eligible only for emergency Medicaid need not present documentation to establish satisfactory immigration status or furnish social security numbers. Thus the application process should not include requests for this information, and emergency care providers should not attempt to verify an alien’s immigration status as a condition of receiving emergency services. Nevertheless, in 1994 a California court allowed that state to require all applicants, including those for restricted benefits, to declare under penalty of perjury whether they were citizens or aliens with satisfactory immigration status and, unless they declared that they were neither citizens nor aliens with satisfactory immigration status, to have their social security numbers.

According to Crespin v. Coye, “[n]othing in these provisions precludes the state …

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25 Okale, 570 S.E.2d at 741.

26 Id. at 744.

27 Id. at 745.

28 See, e.g., UNDOCUMENTED ALIENS, supra note 1, at 12 (noting that state Medicaid offices and hospital associations attributed fear of being discovered by immigration authorities as a reason noncitizens do not obtain Medicaid).


30 Crespin v. Coye, 34 Cal. Rptr. 2d 10, 17 (1994). In county offices, noncitizens complete an application that asks them to declare citizenship or satisfactory immigration status and whether the applicant has a social security number. See DEPARTMENT OF HEALTH SERVICES, CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY, FORM NO. MC 13, STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS (1999), available at www.dhs.ca.gov/publications/forms/pdf/mc013.pdf.
from requiring an applicant to affirmatively deny that he or she has satisfactory immigration status in order to be excused from providing a Social Security number.\footnote{Crespin, 34 Cal. Rptr. 2d at 17 (emphasis in original).}

Although the federal Medicaid agency does not require them to do so, states such as California, Massachusetts, and Washington avoid the confusion that can surround eligibility questions at the time of an emergency by allowing noncitizens to prequalify for emergency Medicaid.\footnote{See DEPARTMENT OF HEALTH SERVICES, CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY, MEDI-CAL NEW MAIL-IN APPLICATION AND INSTRUCTIONS § 5 (2001), available at www.dhs.ca.gov/mcs/medi-calhome/MD210.htm. Massachusetts allows individuals to apply annually for emergency Medicaid by using a uniform application form. Nonqualified immigrants receive the MassHealth card that the provider swipes to determine the scope of coverage. E-mail from Vicky Pulos, Massachusetts Law Reform Institute, to Jane Perkins, National Health Law Program (June 15, 2004) (on file with Jane Perkins). At least one state allows undocumented women to enroll in Medicaid during their third trimester of pregnancy. Undocumented Aliens, supra note 1, at 12 n.15. Such processes are consistent with the federal agency’s acknowledgment that these individuals are in a “special eligibility group” that is eligible for Medicaid with services limited to those specified in 42 U.S.C. § 1396b(v). See Medicaid Program: Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36813, 36816 (Sept. 7, 1990).}

For example, Washington has an Alien Emergency Medical Program that allows individuals to qualify for restricted Medicaid coverage for three-month periods so long as they continue to meet the Medicaid eligibility requirements (except for presenting social security number, citizenship status, or alien status).\footnote{See WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES, ELIGIBILITY A-Z MANUAL § F (describing W.A.C. 388-438-0110, alien emergency medical program) (2004), available at www1.dshs.wa.gov/esa/EAZManual/Sections/EA_AlienMedical.htm.}

**C. Pregnancy-Related Services Coverage**

The Medicaid Act’s definition of “emergency medical condition” limits the term to “medical condition[s] (including emergency labor and delivery).”\footnote{42 U.S.C. § 1396b(v)(3) (2004).} Pregnant women have questioned the extent to which the emergency benefit for labor and delivery includes pregnancy-related services, such as prenatal and postpartum care. In *Lewis v. Thompson* the Circuit found that Medicaid coverage of emergency medical conditions was narrow and did not include conventional prenatal care.\footnote{Lewis v. Thompson, 252 F.3d 567, 580 (2d Cir. 2001).} The court also found that the citizen children of excluded pregnant women must be accorded automatic eligibility on terms as favorable as those available to the children of citizen mothers.\footnote{Id. at 591. See also Doe v. Wilson, 67 Cal. Rptr. 2d 187 (Cal. Ct. App. 1997) (allowing state to terminate coverage of routine prenatal care of illegal immigrants); Doe v. Wilson, No. C-97-2427, 1997 U.S. Dist. LEXIS 21137 (N.D. Cal. Dec. 15, 1997) (finding state termination of coverage for routine prenatal care of undocumented immigrants did not violate Tenth Amendment or guarantee clause of the U.S. Constitution).}

Pregnant women also have raised questions regarding the coverage of scheduled cesarean deliveries. A recent statement from the Centers for Medicare and Medicaid Services regional office allows states to deny payment for this service.\footnote{Letter from Andrew A. Fredrickson, Associate Regional Administrator, Division of Medicaid, Dallas Regional Office (Region VI [Arkansas, Louisiana, New Mexico, Oklahoma, Texas]), Centers for Medicare and Medicaid Services, to Don Hearn, Medical Advocacy Services for Healthcare, Fort Worth, Tex. (Dec. 9, 2002) (on file with Jane Perkins). The letter says that states are allowed to define emergency “as they deem appropriate” to include scheduled cesareans. Id.}

The position is also based upon the federal regulatory requirement for “sudden onset” of the condition.\footnote{See supra note 15 and accompanying text.} However, unlike its regulations, the Medicaid Act itself does not...
require “sudden onset.” Rather, it requires “acute symptoms of sufficient severity (including severe pain)” such that absence of immediate attention could result in placing the patient’s health in serious jeopardy, serious dysfunction of any body part, or serious impairment of bodily function.40 Congress used this same statutory definition of emergency medical condition for purposes of the Emergency Medical Treatment and Active Labor Act.41 Interestingly, while the Medicaid regulation includes the “sudden onset” requirement, the Emergency Medical Treatment and Active Labor Act regulation does not.42

The addition of a “sudden onset” requirement is not inconsequential. As noted by one court, the requirement draws a distinction between two classes of patients in need of emergency care—(1) trauma victims whose symptoms have a very rapid onset and (2) those who have suffered symptoms for a period of time before they evidence the need for immediate medical attention to preserve health, life, or limb—and can eliminate coverage for the second class.43

D. Duration of an Emergency Medical Condition

When an emergency medical condition ends is a complex issue. Federal guidance regarding the issue has refused to be definitive. According to an eligibility expert at the Centers for Medicare and Medicaid Services, the agency’s position is that “each case needs to be evaluated on its own merits, and the determination of what constitutes an emergency medical service is left to the state Medicaid agency and its medical advisors.”44 With respect to optional Medicaid coverage of women with breast or cervical cancer, the centers note that these cancers may be identified at various stages and thus may or may not qualify as emergencies:

Some women in need of treatment for breast or cervical cancer will have an emergency condition. As with other examples of emergency medical conditions, medical judgment and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.45

Over the years plaintiffs have asked a handful of courts to decide whether a noncitizen’s medical condition qualified as an emergency. In most of these cases, there was no question that the patient entered a medical facility because of an emergency. However, at some point in these cases the Medicaid agency denied additional coverage usually because the patient’s condition stabilized or was chronic. Such cases most frequently have involved patients who need treatment for

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41 Id. § 1395dd(e)(1)(A).
43 See Arizona Health Care Cost Containment System v. Carondelet, 935 P.2d 844, 848 (Ariz. Ct. App. 1996) (holding that the government agency “has created a sudden onset requirement which improperly restricts the legislature’s intended scope of coverage for medical emergencies”).
44 UNDOCUMENTED ALIENS, supra note 1, at 13, 31–32. See also Medicaid Program: Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36813, 36816 (1990) (preamble) (“The significant variety of potential emergencies and the unique combination of physical conditions and the patients’ response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions.”).
45 Letter from Timothy M. Westmoreland, Director, Centers for Medicare and Medicaid Services, to State Health Officials (Jan. 4, 2001) (on file with Jane Perkins).
Medicaid Coverage of Emergency Medical Conditions

When faced with questions of duration, courts differ in their interpretations of coverage requirements. In Scottsdale Healthcare v. Arizona Health Care Cost Containment System, 887 P.2d 625 (Ariz. Ct. App. 1994); Montez v. Martin Memorial Medical Center, No. 4D03-2638 (Fla. Dist. Ct. App. May 5, 2004), finding that Medicare discharge planning laws, 42 U.S.C. § 1395xix and 42 C.F.R. § 482.32, require patients to be transferred only to an identified “appropriate facility” and holding these laws were violated when the hospital, despite a pending motion before the court, flew the patient to Guatemala, where appropriate treatment for the patient’s traumatic brain injury was not available. On renal failure see, e.g., Quinonez v. Department of Social Services, 728 A.2d 553 (Conn. Super. Ct. 1999) (dialysis); Gaddam v. Rowe, 684 A.2d 286 (Conn. Super. Ct. 1995) (dialysis); Norwood Hospital v. Commissioner of Public Welfare, 627 N.E.2d 914 (Mass. 1994) (alcoholic liver disease and renal failure); Padilla v. Biedess, No. CV 02-176-TUC-WOB (D. Ariz. Sept. 25, 2002) (class certification and preliminary injunction) (dialysis). On cancer treatment see, e.g., Luna v. Division of Social Services, 589 S.E.2d 917 (N.C. Ct. App. 2004); Szewczyk v. Department of Social Services, 822 A.2d 957 (Conn. App. Ct. 2003) (on appeal); Rosales v. Department of Social Services, No. CV-0105063-825, 2001 Conn. Super. LEXIS 3642 (Conn. Super. Ct. Dec. 21, 2001); Yale-New Haven Hospital v. Department of Social Services, No. CV-9904955-485, 2000 Conn. Super. LEXIS 2177 (Conn. Super. Ct. July 31, 2000). The Scottsdale reasoning was accepted by the North Carolina Court of Appeals in Luna v. Division of Social Services. In Luna the patient arrived at the hospital in an emergency, experiencing weakness and numbness in the lower extremities, and tests revealed a spinal cord tumor. Medicaid covered the first few days of initial hospitalization but refused to cover subsequent surgery and treatment, which included high doses of chemotherapy, and the circuit court affirmed the denial of Medicaid coverage. The appellate court reversed the circuit court and emphasized physician testimony that the services in question were part of the same finite course of treatment addressing the rapid, life-threatening progression of the patient’s cancer, and not part of the patient’s condition stabilized. 75 P.3d at 97 n.6.


47 Scottsdale Healthcare, 75 P.3d at 91.

48 Id. at 94.

49 Id. at 97.

50 Id. The court contrasted the Medicaid Act provisions with those contained in the federal antidumping statute, the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §§ 1395dd(c), (e)(1), (e)(3)(B) (2002), which do focus on whether the patient’s condition is stabilized. 75 P.3d at 97 n.6.

51 Scottsdale Healthcare, 75 P.3d at 97. The court said that such coverage would amount to long-term care and noted that a previous Arizona case had already found that coverage of long-term care was not contemplated by the statute. Id. at 97–98 (citing Mercy Healthcare Arizona v. Arizona Health Care Cost Containment System, 887 P.2d 625, 628 (Ariz. Ct. App. 1994)).

52 Luna v. Division of Social Services, 589 S.E.2d 917 (N.C. Ct. App. 2004).

53 Id. at 919.
of long-term care. As in Scottsdale, the court remanded the case for a determination of whether the medical condition was manifesting itself by an acute symptom and whether the absence of immediate medical treatment could reasonably be expected to result in one of the three consequences defined by the statute.

Both Luna and Scottsdale distinguished Greenery Rehabilitation Group v. Hammon, in which the Second Circuit found that an emergency medical condition existed only when an unstable patient required constant care. Greenery involved undocumented aliens who suffered sudden and serious head injuries, leaving them with debilitating conditions that required ongoing care. One plaintiff suffered severe brain damage and was a quadriplegic as a result of a car accident. She was tube-fed and totally dependent on nursing staff for eating, bathing, mobility, and monitoring. Another plaintiff experienced severe brain injury from a gunshot wound and was wheelchair bound, unable to speak, incontinent, and in need of constant monitoring of his medications.

Despite the plaintiffs’ ongoing needs, the Second Circuit held that coverage of emergency medical conditions for sudden traumatic brain injuries ended after the initial injury was stabilized and did not include the continuous and regimented treatment of the patients’ subsequent symptoms. In reaching its decision, the court read the statute’s requirements for “acute symptoms” and “immediate medical attention” to require the condition to exhibit severity, temporality, and urgency. According to Greenery, the care at issue in the case did not need to be covered by Medicaid because “the statutory language unambiguously conveys the meaning that emergency medical conditions are sudden, severe and short-lived physical injuries or illnesses that require immediate treatment to prevent further harm.”

Connecticut state courts have been particularly influenced by Greenery. For example, Connecticut courts have cited the case to deny Medicaid payment, finding:

- that coverage for an emergency medical condition lasted only until the direct harm that brought the plaintiff to the emergency room due to leukemia had been eliminated;
- that the “fatal consequences of the discontinuance of ... ongoing [dialysis] care does not transform into emergency medical care”; and
- that neither inpatient chemotherapy treatment nor surgery to remove a tumor would be covered because the patients’ conditions did not evidence the required “severity, temporality, and urgency.”

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54 Id. at 921–22.
55 Id. at 925. For a similar, earlier holding, see Gaddam v. Rowe, 684 A.2d 286, 288 (Conn. Super. Ct. 1995) (refusing to allow the “medical Russian roulette’ that the state agency position requires; i.e., stop the [dialysis] payment, wait a short time for symptoms to recur and then hope there is time to get the patient to the hospital to restart the treatment before the patient dies”).
57 Id. at 232.
58 Id.
60 Quiceno, 728 A.2d at 553.
61 Szewczyk, 822 A.2d 957 (Conn. App. Ct. 2003) (noting that whether the patient would have died if inpatient chemotherapy treatment had not started on the day he was admitted was not proven) (on appeal); Rosales, No. CV-0105063-82S, 2001 Conn. Super. LEXIS at 3642 (noting that, while the plaintiff was extremely ill, her medical condition was not an emergency because she could survive three days until tumor surgery could take place; remanding to determine whether plaintiff’s postsurgical abscess was a discrete emergency medical condition). For a similar, earlier case, see Norwood Hospital v. Commissioner of Public Welfare, 627 N.E.2d 514 (Mass. 1994) (holding “emergency medical condition” did not include treatment for liver disease brought on by chronic alcoholism, finding that it did not matter whether patient came to the hospital that day or a week later because the outcome would probably have been the same).
E. Relief for Disproportionate Health Care Providers

Some states’ Medicaid programs serve a disproportionate number of noncitizens. Recent federal legislation has provided some redress to selected states; however, these enactments are time-limited and do not guarantee continued relief.

The Balanced Budget Act of 1997 first acknowledged the disproportionate amount of emergency care for noncitizens from some states by providing for distribution of additional federal funding of $25 million for each fiscal year from 1998 through 2001 among the twelve states having the greatest number of undocumented aliens.62 States were allowed use these funds toward the emergency expenses of any undocumented aliens, but the majority of states reported using their entire payment to recover a portion of what the state had already paid for undocumented aliens as emergency Medicaid.63

Similarly the recent Medicare drug coverage legislation includes funding for providers who serve undocumented aliens unable to pay for care required by the Emergency Medical Treatment and Active Labor Act.64 The Medicare drug coverage legislation provides $250 million per year for the 2005–2008 fiscal years for payments to eligible providers for emergency health services to undocumented aliens. Two-thirds of the funds are to be divided among all fifty states and the District of Columbia based on their relative percentages of undocumented aliens. One-third are to be divided among the six states with the largest number of undocumented aliens. The amount of money set aside for each state is to be paid directly to eligible hospitals, physicians, and ambulance providers. Payment amounts are to be the lesser of (1) the amount the provider shows was incurred for emergency services or (2) amounts determined by using a methodology developed by the secretary of health and human services. The secretary is to develop the payment process by September 1, 2004.65

Medicaid coverage of most noncitizens is limited to emergency medical conditions. Given the demand for this coverage, disputes arise not surprisingly as to whether a given condition qualifies as an emergency. Among the various statements of the legal standard, the application that tracks the Medicaid Act results in a two-step process for determining whether a condition is a covered emergency: (1) the presenting condition (including labor and delivery) must initially manifest itself by “acute symptoms (including severe pain),” and (2) absence of immediate treatment of that condition reasonably could be expected to result in placing the patient’s health in serious jeopardy, causing serious impairment to bodily function, or causing serious dysfunction of any bodily organ or part. In applying this test, decision makers must assess the facts of each case and defer to the statements of the treating health care providers.


63See UNDOCUMENTED ALIENS, supra note 1, at 14.


65Section 1011, 117 Stat. at 2432.