An Advocate's Guide to **Reproductive Health in the Medicaid Program**

NHeLP
NATIONAL HEALTH LAW PROGRAM

Table of Contents

I. Forward

An Advocate's Guide to Reproductive Health in the Medicaid Program will familiarize readers with the basics of the Medicaid program and highlight features that support women's reproductive health. The first half of this Guide includes a brief history and the administrative structure of the Medicaid program. It also discusses the program's eligibility standards. The second half describes the health and support services available through the program in general, and the services critical to the reproductive health of women and adolescent girls in particular.

State Medicaid programs vary from state to state but under federal law each state Medicaid program must meet certain requirements. There are examples throughout this Guide of how different state programs assist or hinder access to reproductive services, as well as statistics highlighting the need for improved access to care. Medicaid programs may be amended to expand or curtail enrollment and/or services, so advocates should follow developments in their states closely.

As this publication goes to print, the United States Congress is considering health care system reform. Passage of a bill is likely to mean substantial changes to Medicaid eligibility. However, even if health reform legislation is passed in 2010, most changes likely will not take effect until 2013. Until that time, the information contained in this Guide reflects current law and the state of the Medicaid Program. NHeLP will monitor developments in the law and implementation of any health reform legislation that impacts Medicaid, and will update *An Advocate's Guide to Reproductive Health in the Medicaid Program* as necessary to keep it a timely and relevant tool.

> *Reproductive health is a state of complete physical, mental and social well-being and ... not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*
>
> —World Health Organization: United Nations 1995 Fourth World Conference on Women, Beijing.

This Guide may be used in conjunction with NHeLP's *An Advocate's Guide to the Medicaid Program* and other NHeLP publications.

An Advocate's Guide to Reproductive Health in the Medicaid Program is the product of a collaborative process among NHeLP's Los Angeles, CA, Chapel Hill, NC, and Washington, D.C., offices, and is comprised of contributions from NHeLP attorneys: Manjusha Kulkarni, Doreena Wong, Steve Hitov, Mara Youdelman, Deborah Reid, Sarah Somers, and Sarah Spector-Lichtman. Law clerks Anthony Gomez of USC Gould School of Law, and Annie Hsu of Loyola Law School, provided diligent cite-checking.

Special acknowledgement and thanks are extended to NHeLP's Legal Director, Jane Perkins; Director of NHeLP's Reproductive Rights Project, Susan Berke Fogel; and Managing Attorney Randy Boyle, for their editorial contributions, exhaustive reviews, invaluable insights, and untiring support and encouragement through the many months of the Guide's incubation.

An Advocate's Guide to Reproductive Health in the Medicaid Program would not have been possible without the generous support of the Ford Foundation, The Educational Foundation of America, the General Service Foundation, and The Moriah Fund. In particular we would like to thank our Program Officer from the Ford Foundation's Sexuality and Reproductive Health and Rights Unit, Lourdes Rivera, who inspired the creation the Guide when she was an attorney with NHeLP. The opinions expressed in this Guide are those of NHeLP and do not necessarily reflect the views of NHeLP's donors.

Amber Hartgens
Staff Attorney, Editor
National Health Law Program, February 2010

II. Introduction

A woman's reproductive health is central to her overall health. The average American woman spends approximately 30 years of her life avoiding pregnancy.[1] Moreover, regardless of her ability or desire to have children, many conditions that affect a woman's overall health will also affect a pregnancy and the health of her children. Providing women and adolescent girls with adequate comprehensive health care is a necessity if women are to be equal, participating and productive members of society.

Medicaid and Low-income Women's Health

The Medicaid program is the largest public health insurance program for low-income people in the U.S. At some point during 2007, 61.9 million people (about one of every five people in the U.S.), were enrolled in Medicaid.[2] Medicaid plays a particularly important role for low-income women. Women tend to be poorer than men and are more likely to be employed in low wage or part-time jobs that do not offer insurance. Health disparities in the U.S. impact women at all income levels, but low-income women and women of color face a disproportionate burden of illness. In 2005, one in five low-income women received basic and/or long-term health coverage through Medicaid. At all ages, women make up the majority of beneficiaries receiving Medicaid.[3]

- *Seven of ten Medicaid beneficiaries older than age 14 are women.*
- *Women comprise sixty-nine percent of adult beneficiaries.*
- *Thirty-seven percent of women of reproductive age in families with incomes below the federal poverty level were enrolled in Medicaid in 2006.*

Many services essential to women's reproductive health are covered through Medicaid including physician visits, hospital care, preventive screenings, family planning services and supplies, maternity care, and mental health services. However, accessing services can be difficult. This Guide highlights the opportunities and avenues through which low-income women can obtain these vital services through Medicaid.

III. Overview of the Medicaid Program

The Medicaid program was established in 1965 as part of President Lyndon Johnson's War on Poverty. It is the primary health safety net for low-income families with dependent children, elderly people, and people with disabilities.[4] The majority of Medicaid recipients are members of working poor families who do not have access to health insurance through employment, or who are not able to afford to pay out-of-pocket costs such as premiums and deductibles. Medicaid however, does not cover all poor people. To be eligible, a person must meet very specific financial and other criteria.

Medicaid covers 45% of Americans who live below the federal poverty level (FPL) and 24% of those who are considered near poor with incomes between 100% and 200% of FPL.[5] The FPL is revised each year by the federal government and increases with each additional family member. In 2009, the FPL was $22,050 for a family of four.

A. ADMINISTRATION

Medicaid is a cooperative federal and state program.[6] State participation is voluntary. All fifty states, the District of Columbia and the U.S. territories participate. Participating states receive federal payments and, in return, agree to follow federal Medicaid rules. Within certain federal parameters, states are afforded a great deal of flexibility in administering Medicaid. For example, they can determine income levels for eligibility, what income to count, and what benefits to cover. State Medicaid programs also must comply with federal anti-discrimination laws, including Title VI of the Civil Rights Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act.[7]

1. Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for administering Medicaid. CMS is part of the U.S. Department of Health and Human Services (HHS). CMS promulgates regulations and guidelines that implement the Medicaid statute and govern the administration of the program. Each CMS regional office is regularly in contact with the state Medicaid agencies in its region. Appendix D lists the addresses of regional offices, along with the states within each region.

2. Single State Agency

In each state, a single state agency is responsible for the administration and effective operation of the Medicaid program.[8] In many states, county offices play a role in administering Medicaid. Some of those counties also contribute to the cost of providing Medicaid coverage. The single state Medicaid agency may also contract with private entities and other state agencies, such as the mental health department, to assist with operating Medicaid. The state agency must stay informed of its agents' and contractors' activities and ensure they comply with the Medicaid rules.

Every state has a statute or budget item that authorizes the state to spend money on its Medicaid program. Most of these statutes also contain substantive provisions that may add additional rights beyond those found in the federal Medicaid laws. Most states also issue their own Medicaid regulations and guidelines, which must comply with federal law and regulations. The single state agency will likely provide worker handbooks, provider manuals and other materials that contain detailed instructions for the front-line workers who interact with Medicaid applicants and beneficiaries.

ADVOCACY TIP:
When advocating with a state Medicaid agency about what it should do to help your client, first look at the Medicaid worker handbook. That is the document the workers will be most familiar with. If it helps your client, rely on it. If the worker manual does not help, move on to the state regulation. If that is of no help, check the state statute. If that affords no relief, move on to the federal regulation and then, if necessary, to the federal Medicaid Act itself.

3. State Medicaid Plan

Once a state has decided whom it will serve, what benefits it will provide, and the rules for qualifying for the program, it must record those decisions in a state Medicaid plan. The plan is then submitted to CMS for approval. The state plan must be amended whenever necessary to reflect changes in federal statute, regulation, or court decisions, and material changes in state law, policy, organization, or operation of the program. If the state plan is not approved, or if the state is not following its approved state plan, federal payments for Medicaid can be negatively affected.

4. Federal Financial Participation (FFP)

The federal government shares the cost of each state's Medicaid program by reimbursing a substantial portion of the Medicaid costs. The federal payment is called the "federal financial participation" (FFP). The reimbursement rate each state receives for Medicaid services is called the "federal medical assistance percentage" (FMAP). The FMAP varies from state to state and is based on the per capita income of the state. Poorer states get higher FMAP. Generally, the federal government pays at least 50% of a state's costs for the program, up to a maximum of 78%. For family planning services and supplies, states are reimbursed at a 90% FMAP.[9] States also receive federal payments for the administrative cost of operating their Medicaid programs, typically set at a 50% FMAP, although some administrative activities receive higher federal payments.

5. Service Delivery

Medicaid is a "vendor payment program." This means that health care providers provide Medicaid services directly to beneficiaries and are paid through the state Medicaid program. Medicaid providers are not employees of the Medicaid program, nor do Medicaid agencies directly provide services.[10] In establishing Medicaid as a vendor payment program, Medicaid's founders wanted to avoid a two-track system of health care by enabling Medicaid patients to see private health care providers who also serve privately insured patients.

a. Traditional Fee-for-Service Medicaid

Like other insurance models, Medicaid has traditionally operated using "fee-for-service" payments. Each provider contracts separately with the state to furnish services to Medicaid beneficiaries. After the provider furnishes the covered service to the patient, he or she submits a claim to the state. The state then pays the provider a fee for that particular claim. Health care providers who voluntarily participate in Medicaid must accept Medicaid payment as payment in full.[11] In fee-for-service Medicaid, a beneficiary may obtain services from any health care provider who participates in the Medicaid program. As of 2007, every state, except Tennessee, still covered at least some of their Medicaid services through fee-for-service arrangements.[12]

b. Medicaid Managed Care

State Medicaid programs also make extensive use of managed care programs. Under these arrangements, states contract with managed care organizations (MCOs), such as health maintenance organizations (HMOs), to provide services to beneficiaries. The contracts can cover a comprehensive range of services or be more limited, for example covering only mental health or dental services. Unlike fee-for-service, managed care programs typically involve "capitation." This means that the state pays the MCO a set amount of money per member, per month—regardless of how much or how little care the beneficiary member receives. MCOs can be either for-profit or not-for-profit entities.[13]

Participating MCOs assemble "networks" of providers to provide services to the MCO's patient members. Generally, beneficiaries enrolled in the MCO must obtain the covered services through a network provider, or the MCO/Medicaid will not pay for the service. Beneficiaries usually are required to choose a primary care provider (PCP) and, if a choice is not made, a PCP is assigned. The PCP is the main doctor for all of

the beneficiary's health care. For most non-emergency services, the beneficiary must first go to the PCP, and if the primary care provider thinks that a specialist is needed, he/she makes a referral to a specialist.

(i) Women's Health in Managed Care—Direct Access

In the managed care system, a beneficiary usually cannot refer herself to a specialist. However, under federal rules, women enrolled in Medicaid must be able to access women's health specialists within the MCO directly.[14] This means that MCOs must permit women to make appointments directly with OB/GYNs and other women's health specialists without a referral from her PCP. In addition, women enrolled in managed care plans are not limited to the family planning providers in their MCO network.[15] Family planning services received out-of-network cannot cost more to the beneficiary than if she had obtained the services in-network.[16]

(ii) Emergency Care

In a medical emergency, a beneficiary is not limited to the MCO network's emergency rooms.[17] The person may, and should, go to the nearest emergency room. The MCO must pay for the emergency care if a "prudent layperson" would have thought she was having a medical emergency, even if it later turns out not to have required emergency treatment.[18] States must inform Medicaid managed care enrollees of what constitutes an "emergency" and how to obtain emergency services.[19]

The sudden onset of labor is considered an emergency. In an emergency a woman is not restricted to delivering her child in the hospital assigned to her through the MCO, but rather should go to the nearest hospital with an emergency room.

(iii) Medicaid Services Not Included in Managed Care

In some states, the MCO provides most of the day-to-day health care for its Medicaid members but does not contract to pay for more complicated, specialty, or unusually expensive care. This additional care is said to be "carved out" of the MCO's contract. Dental and mental health care are examples of services that are often carved out. Several states have entered into Medicaid managed care contracts that allow religiously controlled plans to "carve out" the reproductive health services to which they object.[20] In such cases, Medicaid beneficiaries must obtain the necessary care outside of the MCO network. Thus, the restrictions necessitate extra steps to obtain reproductive care and can result in barriers to such care. The state is required to inform beneficiaries that "carved out" services are available outside of the MCO network, as well as how and where they may obtain that care.[21]

B. MEDICAID ELIGIBILITY[22]

To be eligible for Medicaid, a woman must fit into an eligibility group, meet certain citizenship or immigration requirements, be low-income with limited resources, and be a resident of the state in which she is applying. States must cover certain population groups and have the option to cover others.[23] Medicaid benefits may differ between eligibility groups.

Four general groups of individuals qualify for Medicaid services: 1) children, 2) parents, including pregnant women, 3) the elderly, and 4) people with disabilities. Although some states have received special permission to cover them, couples and single adults under the age of 65 who are not pregnant, have no children and are not disabled, generally do not qualify for Medicaid, even if they are destitute.

1. Eligibility Categories

a. Mandatory Categorically Needy

All states that participate in Medicaid must include certain groups within their programs. There are a number of mandatory populations groups, and the rules for deciding whether an individual falls within a covered group can be complicated.

Historically, Medicaid was automatically provided to recipients of welfare assistance, such as Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI).[24] In more recent years, Congress has "de-linked" Medicaid from welfare programs and, for some groups, tied eligibility to poverty-level status. Thus, for example, pregnant women and low-income children qualify for Medicaid if their family incomes are below 133% of the federal poverty level. Other mandatory eligibility groups include families transitioning off public welfare assistance due to increased earnings or child/spousal support, certain working disabled individuals, and in most states, recipients of SSI. Notably, Congress repealed AFDC in 1996. When it did so, mandatory Medicaid was extended to individuals and families who would have qualified for AFDC based on the rules that were in effect in the state in 1996. This means that state Medicaid programs need to know the AFDC eligibility rules that were in place in 1996.

b. Optional Categorically Needy

States have the option to cover a number of other groups. Individuals within these groups are people with limited-incomes who cannot afford to pay for a health care crisis. As with the mandatory covered populations, states' coverage options reflect an attempt to offer a safety net to society's most vulnerable people, such as children and pregnant women, and those suffering from particular diseases. For instance, pregnant women and children whose family incomes are below certain percentages of the federal poverty level (e.g., 185% of FPL) may be covered, as well as adolescents who are in foster care under the responsibility of the state on their 18th birthday.[25] Other individuals that states may choose to cover include: women with breast or cervical cancer, individuals with tuberculosis or sickle cell anemia, elderly and disabled individuals whose income is below the federal poverty level, and individuals who are receiving home and community-based care services.

c. Medically Needy

The medically needy category is an additional optional coverage group consisting of individuals who fall within a federal eligibility category, but whose income or resources are too high to meet the categorical income limitations. These individuals qualify for Medicaid by "spending down" their excess income on health care to the point where they meet the income eligibility level. States have much flexibility to decide which population groups to include in this category; however, states choosing the medically needy option must at least include pregnant women and children under age 18 who, but for income and resources, would be covered as categorically needy.[26] The medically needy option is important because it often provides coverage to people who are in the midst of a health care crisis and have accumulated large medical bills.

ADVOCACY TIP:
Many states employ streamlined application procedures to encourage pregnant women to apply. Check to see if your state offers mail-in applications, on-line applications, outstationed eligibility workers to process applications, or simplified applications.

2. Some Specifics on Eligibility for Pregnant Women

Pregnant women are a major Medicaid beneficiary group. Medicaid pays for over 41% of births in the U.S., and in some states Medicaid pays for over half of the births.[27] Federal Medicaid law sets more generous income eligibility levels for pregnant women. At a minimum, states must cover pregnant women with family incomes at or below 133% of the FPL.[28] States have the option to expand eligibility for pregnant women above the minimum threshold in two additional ways: 1) they can cover those with incomes up to 185% of the FPL,[29] and 2) they can choose to cover women with incomes above 185% of the FPL by disregarding a certain amount of their income to bring it within coverage range.[30] For purposes of deciding eligibility, a pregnant woman is treated as a family of two.[31]

Women who applied for, qualified for, and received Medicaid benefits while pregnant are entitled to coverage of pregnancy-related and postpartum medical assistance through the end of the month following the 60-day period after the last day of their pregnancy.[32] Even if a woman experiences a change in income that would otherwise make her ineligible during this period, she remains eligible until the end of the month in which the 60th day after the end of the pregnancy falls.[33]

States also have the option of providing pregnant women immediate access to medical care related to pregnancy if a "qualified provider" finds that a woman is pregnant and it appears, based on preliminary information, that her family income is below the state's Medicaid income eligibility levels. This is called presumptive eligibility (see discussion below).

3. Financial Eligibility: Income and Resources

To qualify for Medicaid, a person or a family must not only meet the personal characteristics described above, but she must also be low-income and have few assets. Upon application and at periodic redeterminations, individuals generally must present proof of income and assets. Within certain federally required constraints, each state may establish its own rules for determining financial eligibility.

Determination of an applicant's income eligibility will include consideration of: pre-tax income (in-kind, cash or cash equivalent) that is available to her, whether earned by her or someone legally responsible for her, and (ii) cash and non-cash resources that are available to her. A beneficiary or a beneficiary's family must maintain income and resources below legally required limits in order to continue to qualify for Medicaid. States must have procedures for periodically reviewing whether a beneficiary remains financially eligible for Medicaid.[34]

a. What income counts toward eligibility?

When determining whether a person or family is eligible for Medicaid, a state Medicaid agency will look at the family's "countable gross income." Countable gross income includes:

(i) Pre-tax income only: A family's "gross income" is pre-tax income.

(ii) Income of responsible parties: Only income from someone who is legally responsible for the applicant may be counted.[35] This is referred to as "deeming" because part or all of the income of one person is automatically counted as income for another family member. For example, if the person for whom benefits are being requested is living with a legal spouse, the spouse's income will count; in a family with children, the parents' income counts toward determining whether the children are eligible. By contrast, a minor child's income is not counted when determining a parent's Mdicaid eligibility (because the child is not legally responsible for the parent).

ADVOCACY TIP:
If two unmarried people are living together, the live-in partner's income cannot be counted for Medicaid eligibility purposes,[36] or, if a married couple is not living together, then only the income of the spouse who is present in the home will count—not the income of the spouse who lives elsewhere.[37]

(iii) Available income: Only income that is actually available to the applicant or beneficiary, may be counted[38] If the person does not have access to the money, it cannot be used to determine eligibility. For example, if a woman earns $100 by working in February, but she is not paid until March, the income does not get counted in February, but rather is counted in March when it is actually available to her. Similarly, money that a person may later receive that is currently unavailable, such as an inheritance or settlement, should not be counted. States must require applicants and beneficiaries to apply for any public benefits, disability benefits, and/or retirement benefits to which the person may be entitled before the applicant's/beneficiary's income can be adequately assessed. [39]

(iv) In-kind income: In-kind income is something of value that a person receives other than cash or cash equivalent (e.g., a check). It is often in the form of goods. For example, if a person who is not legally responsible for the applicant provides groceries or pays the applicant's rent or child care, the value may count as income when deciding eligibility.

(v) Earned and Unearned Income: Income generally includes wages, salary, tips, public benefits, monetary inheritances, royalties, interest on bank accounts and investments, tax refunds, alimony and child support, and many other types of income. Earned income is generally that which is paid in exchange for work provided. Unearned income is that which is not earned through work (e.g., interest on a bank account, public benefits).

b. What income is disregarded (exempt) or deductible from countable income?

The federal Medicaid Act provides that not all income gets counted when determining Medicaid eligibility. Certain income may be disregarded and not counted towards an applicant's/beneficiary's income eligibility. Income that may be disregarded includes:

(i) Exempt Income: Some income does not count at all for Medicaid eligibility purposes. For example, most types of public benefits, some tax refunds or rebates, federal housing assistance payments, federal student loan payments and disaster or relocation assistance payments, are usually entirely exempt from consideration.

(ii) Deductible Income: States allow for deductions from earned income for work-related expenses and child care expenses in order to enable beneficiaries to work. In Medicaid programs for people with disabilities, states often have special deductions that allow people with disabilities to return to work. Income deductions will vary from state to state.

c. Resources

To be eligible for Medicaid, an applicant or family must have few assets or "resources" that can be used to pay for health care coverage. The term "resources" refers to both cash and property that can be sold or converted to cash. Resources include real estate, personal belongings, money in bank accounts or under a mattress, stocks, bonds, automobiles, life insurance policies, business interests and licenses that can be sold, livestock, family jewelry and heirlooms, and musical instruments. Only resources that are countable, non-exempt, and available to the applicant/beneficiary are considered in the determination of whether the person meets the Medicaid program's resource limit.

ADVOCACY TIP:
More and more states are allowing beneficiaries to self-certify the amount of assets they own or to declare that they have assets under the Medicaid threshold. Check to see if your state has implemented a streamlined eligibility process that eliminates burdensome verification procedures. For pregnant women and children whose incomes are below a percentage of the FPL, states have the option not to look at resources.

(i) Available Resources: A resource will be countable for eligibility purposes if an individual owns the resource and the resource is available to her.[40] In other words, the applicant has the resource in hand or it is under her control and can be liquidated. Thus, stocks or bonds that can be sold, even at a loss, are considered available. A plot of land that can be sold is available. However, if a beneficiary has made a bona fide effort to sell the plot of land and has been unable to find a buyer, it becomes unavailable.

(ii) Exempt Resources: Certain resources are exempt from consideration in determining Medicaid eligibility. A person's principal residence, be it a house, a multiunit dwelling, a mobile home, a boat, or a car is exempt. Other exempt resources include a car (up to a certain value), clothing, household possessions, family heirlooms, tools necessary for carrying out a trade, livestock, and burial plots. The rules will vary from state to state and between Medicaid eligibility categories.

4. State Residency

To receive Medicaid in a particular state, a person must be a resident of that state. The rules for determining a person's residency can be complex, but the basic rule for an adult or an emancipated or married minor is that her state of residency is where she "is living with the intention to remain there permanently or for an indefinite period…"[41] It should be noted that "indefinite" really just means the person has no present intention to leave. The state of residency for a person under 21 years of age who is living with a caretaker relative is generally determined based on the caretaker's state of residency.[42]

Federal guidance provides that, for Medicaid eligibility purposes, a person is a resident of the state where she "is living and is legally present under any recognized federal immigration status. The child of a non-citizen parent is a resident of the state in which the custodial parent is living, regardless of the parent's immigration status."[43] Some states have taken the position that citizen children who have immigrant parents who are undocumented, or legally present but with an immigration status that does not confer resident status (e.g., holder of a tourist Visa), are not residents because the parent's immigration documents do not evidence intent to remain in the state.

5. Citizenship and Immigration Status

Individuals seeking to enroll in Medicaid must be U.S. citizens or have qualifying immigration status.[44]

a. Citizenship Documentation

Most Medicaid applicants and beneficiaries who are U.S. citizens or U.S. nationals must provide satisfactory documentation of citizenship and identity at the time of application or renewal.[45] U.S. citizens are people born in the 50 states, District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the Northern Marianna Islands. U.S. nationals are people who are born in the "outlying possessions" of the U.S. or a foreign-born child of such a person.[46] Applicants within the following categories are exempt from this requirement:

- people receiving Supplemental Security Income (SSI) benefits (current and former),
- people receiving Social Security Disability Insurance (SSDI) benefits,
- people entitled to or enrolled in any part of Medicare, and
- children who are in federally funded foster care, or who are receiving federal adoption or foster care assistance.[47]

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gives states the option of allowing verification through the Social Security Administration (SSA). Effective January 1, 2010, states can allow an applicant to provide her name and social security number, which will then be sent to the SSA.[48] If the state gets a positive response from the SSA that the applicant has appropriate citizenship status, the applicant will have met the Medicaid citizenship documentation requirement. If not, the applicant will have to submit additional documentation.

ADVOCACY TIP:
Social Security Administration verification eases the applicants burden to prove citizenship. Advocate in your state to adopt this process.

Documents that Medicaid applicants and beneficiaries must provide to prove citizenship and identity, such as U.S. passports and naturalization certificates, must be originals or certified copies.[49] States can accept original documents in person, by mail, or through an authorized representative such as state or local health officials or staff at federally qualified health centers, disproportionate share hospitals, or additional outstation locations.[50]

ADVOCACY TIP:
Original documents should not be mailed if at all possible. They can get lost. Ideally, these documents should be delivered by hand, and applicants should retain certified copies for their records. Original documents should be returned.

States are required to initiate coverage for otherwise eligible applicants while affording them a "reasonable opportunity" period to secure their citizenship documents.[51] If satisfactory documentation is not provided, the applicant will receive a notice of termination of benefits. If a timely appeal is filed, she can maintain benefits pending a final administrative decision.

States that choose the new social security number citizenship verification procedure must cover full Medicaid benefits for otherwise eligible applicants while the SSA determines whether there is a match. If the number does not match the SSA's records, benefits continue until the state Medicaid agency has made a "reasonable effort to identify and address" the inconsistency by contacting the beneficiary and verifying citizenship with other documentation.[52]

b. Immigration Status

Certain immigrants are eligible for Medicaid benefits. Non-citizen immigrants are divided into two groups, "qualified" and "not qualified" immigrants. Certain "qualified" immigrants may receive full Medicaid benefits while "not qualified" immigrants can receive only emergency Medicaid services. Qualified immigrants are further divided into two groups: those lawfully residing in the U.S. before August 22, 1996 and those arriving in the country after August 22, 1996. Immigrants who were lawfully residing in the U.S. before August 22, 1996, if otherwise eligible, may receive full Medicaid benefits, but immigrants who arrived after August 22, 1996

are barred from receiving Medicaid for a period of at least five years.[53] Some states use state-only funds to cover health care for certain not qualified immigrants and for qualified immigrants who are not yet eligible for Medicaid under the federal rules due to the five year bar.[54]

CHIPRA of 2009 amended the Medicaid Act to give states the option to provide Medicaid to otherwise eligible "qualified" immigrant children and pregnant women who are "lawfully residing" in the U.S. without the five-year waiting period.[55] CHIPRA defines "child" as anyone less than 21 years of age, and the definition of "pregnant woman" includes a woman who is in the 60-day postpartum period. [56]

(i) Qualified Immigrants

Qualified immigrants are eligible for Medicaid, as long as they meet the financial, residential, and categorical requirements of the Medicaid program.[57] However, the period of Medicaid eligibility for certain qualified immigrants may be limited.[58]

ADVOCACY TIP:
Title X supported clinics and similar agencies receiving federal funding serve clients seeking family planning services regardless of immigration status.

Qualified immigrants include:

- legal permanent residents (LPR)(those with "green cards"),
- asylees or refugees,
- Cuban and Haitian entrants,
- honorably discharged veterans,
- certain individuals who have been battered or subjected to extreme cruelty, and their children and/or parents (if there is a substantial connection between the battery or cruelty and the need for Medicaid),[59]
- individuals granted conditional entry,
- individuals granted withholding of deportation/removal,
- individuals paroled into the U.S. for at least one year, and
- individuals born in Canada who have 50% blood of the American Indian race or those who are members of certain Indian tribes.

(ii) Not-qualified Immigrants

All other immigrants are "not qualified" and are not eligible to receive full Medicaid benefits but may receive emergency Medicaid. Not-qualified immigrants include:

- individuals permanently residing under color of law (PRUCOL), [60]
- non-immigrants, such as students and tourists in the U.S. temporarily, and
- persons without proper documentation or undocumented immigrants.

Non-citizens applying for Medicaid must have their immigration status verified through the Systematic Alien Verification for Entitlements (SAVE).[61] Applicants must submit evidence of their satisfactory immigration status which, is sent to the Department of Homeland Security (DHS) for verification.[62] These individuals have a "reasonable opportunity" period to gather proof of immigration status, and until DHS responds with an immigration status determination, applicants are eligible to receive full Medicaid.[63] DHS cannot use the SAVE inquiry to deport an applicant.[64]

(iii) Emergency Medicaid for Immigrants

Not qualified immigrants, as well as qualified immigrants who arrived in the U.S. after August 22, 1996 and who have been in the country less than five years, are eligible for care and services "necessary for the treatment of an emergency medical condition if they fit into one of the Medicaid eligibility categories and meet the financial and state residency requirements."[65]

The Medicaid Act defines emergency medical condition as "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:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily function, and/or
- serious dysfunction of any bodily organ or part."[66]

CMS has determined that emergency medical care for immigrants does not extend to pregnancy-related services such as prenatal and post-partum care. [67] The CMS position rests in part on a House of Representatives Conferees' statement that coverage of emergencies is to be "very narrow," and is not intended to include "prenatal or delivery care assistance that is not strictly of an emergency nature…"[68]

The question of when an emergency condition ends is also not clearly defined, thus making the determination of how much care a patient is entitled to receive as a result of an emergency condition difficult. According to an eligibility expert at CMS, 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."[69]

INNOVATIVE APPROACH: *California has avoided the confusion that can surround eligibility questions at the time of an emergency by allowing non-citizens to pre-qualify for emergency Medicaid. Immigrants in California eligible for restricted Medicaid benefits receive a card that entitles them to care for emergencies.*[70]

6. Medicaid Eligibility Expansion Programs

Under certain circumstances, the Health and Human Services Secretary can approve demonstration projects under Section 1115 of the Social Security Act to allow states to implement experimental, pilot, or demonstration projects likely to promote the objectives of the Medicaid statute. Using Section 1115, states have expanded coverage to individuals who would not otherwise be eligible to receive Medicaid and/or to cover services that are not typically covered under a state's Medicaid plan. Of particular interest here are Section 1115 family planning demonstration projects (also referred to as family planning waivers). These demonstration projects typically extend family planning services to women (and in some states, men) whose income would otherwise exceed the Medicaid eligibility cutoffs.

Another Medicaid expansion program that is important for women is the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA). The BCCPTA allows full Medicaid coverage for women diagnosed with breast and cervical cancer who would not otherwise be eligible.

C. APPLYING FOR MEDICAID

Anyone can apply for Medicaid by submitting a written application. States should help people apply for Medicaid and applicants must be allowed to have someone of their choice assist them during the application process.[71] This person is often called a representative. State Medicaid agencies must tell applicants about the benefits that Medicaid offers. There are special informing requirements for pregnant, post-partum, and breastfeeding women and for caregivers of children under age five. State agencies must notify these individuals in writing about the nutrition education and benefits available through the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provide for referring these individuals to the local WIC agency.[72] These notices must be given as soon as the woman or young child is identified as eligible for Medicaid. The state agency must effectively inform individuals who are blind, deaf, or who cannot read or understand the English language.[73] States must also inform applicants about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children and youth under age 21.

Applicants can be eligible for Medicaid under more than one category, and they must be informed of the choices and allowed to choose the category under which they apply.[79] This can be an important decision. For example, a low-income woman might be eligible for certain benefits because she is pregnant, but she may also qualify for full Medicaid benefits because she is receiving cash assistance such as Temporary Assistance for Needy Families (TANF). Depending on the circumstances, this woman might choose to obtain her benefits through the latter category because she will be entitled to receive health services in addition to those related to the pregnancy.

ADVOCACY TIP:
When using a mail-in application, avoid possible delays by making sure the application is legible, submitted to the correct office, signed by the applicant or her representative, and includes the name, date of birth, gender and address of each person who is requesting Medicaid.

1. How to Apply

There are different ways to apply for Medicaid.

Applications are generally taken at local social services offices. An applicant must be permitted to apply the day she appears at the local office.[74] In addition, many states allow mail-in applications. Some of these states allow people to request applications by mail or phone, while other states require individuals to obtain mail-in applications at social services offices or other locations designated by the state. Once a complete mail-in application is received, a Medicaid eligibility worker may follow up to interview the applicant.

States must ensure that children and pregnant women can apply for Medicaid at locations in addition to a local social services office.[75] This application process is called "outstationing." Short-form, Medicaid-only applications that are straightforward and easy to complete are accepted and processed without applicants ever having to go to a social services office. [76] Outstationing sites include federally-qualified health centers and hospitals that serve large numbers of low-income and uninsured people.

Finally, in most states, low-income people with disabilities who have been found eligible for Supplemental Security Income (SSI) are automatically eligible for and enrolled into Medicaid.[77] These states have contracted with the Social Security Administration to determine Medicaid eligibility, and a separate Medicaid application is unnecessary.

ADVOCACY TIP:
Some states have shorter time frames for deciding Medicaid eligibility. Check your state's laws to find out whether shorter time frames apply.

2. Applicant Responsibilities

A woman applying for Medicaid will need to provide her name, address, date of birth, citizenship status, and social security number. If she does not have a social security number she should explain that she is applying for one. She will also need to provide information about her income and property and other individuals in her household. Others in the household not applying for Medicaid do not need to provide a social security number and should not be asked for one.[78]

3. Time Frames [79]

The Medicaid Act requires eligibility to be determined with "reasonable promptness." [80] Except in unusual circumstances, applications for Medicaid must be decided within 90 days in cases involving disability determinations, and in 45 days in all other cases.[81] The Medicaid determination must be in writing and must be mailed to the applicant or her representative.

ADVOCACY TIP:
Some states re-determine Medicaid eligibility more frequently—for example, every six months. Each time someone must have her Medicaid eligibility re-determined is a potential barrier to coverage. Encourage your state to re-determine eligibility no more than once per year.

Depending on the state, persons who are found eligible for Medicaid will be provided with a Medicaid card, coupon or other evidence of eligibility. States need to have a method of making Medicaid available to individuals who are homeless or do not have a fixed mailing address.[82]

4. Re-determinations of Eligibility

Once a person is found eligible, the state agency should continue to provide Medicaid benefits until she is determined to be ineligible.[83] The state agency will periodically confirm that a Medicaid beneficiary continues to be eligible and must re-determine eligibility at least once a year with respect to conditions that may change.[84] In cases where an individual appears to have lost eligibility, the state agency should make an automatic review, sometimes referred to as an ex parte re-determination, to see if the beneficiary might be eligible for Medicaid on some other basis. A beneficiary remains Medicaid eligible until the re-determination process is completed.[85]

5. Presumptive Eligibility

Federal law allows states to offer "presumptive eligibility" to pregnant women, women with breast or cervical cancer, and/or children.[86] Based on preliminary information, these individuals can be presumed

to qualify for Medicaid before they submit a full application. Presumptive eligibility is designed to allow individuals to begin receiving necessary health care services immediately while the Medicaid application is being processed.

a. Presumptive eligibility period

Presumptive eligibility coverage begins on the day a qualified provider or qualified entity (such as a clinic) makes the preliminary decision that a woman or child qualifies for Medicaid. Presumptive eligibility continues until the earlier of: (i) the day on which the Medicaid agency makes an eligibility determination or, (ii) if the individual or someone on her behalf does not file an application, the last day of the month following the month during which the qualified provider or qualified entity made the preliminary eligibility determination.

b. Presumptive eligibility for pregnant women

For pregnant women, presumptive eligibility covers only ambulatory prenatal care, which is outpatient prenatal care.[87] "Qualified providers" determine presumptive eligibility by finding that a woman is pregnant and that her family income is probably below the state's Medicaid income eligibility levels. Qualified providers include outpatient hospital sites and clinics.

As of January 2008, 29 states and the District of Columbia made presumptive eligibility available to pregnant women. These states are: Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Wisconsin, and Wyoming.[88]

c. Presumptive eligibility for Women with Breast and/or Cervical Cancer

For women with breast or cervical cancer, presumptive eligibility covers full Medicaid benefits. States designate "qualified entities" that make the presumptive eligibility determinations based on results of a qualifying breast or cervical cancer screening and whether the woman has any other health insurance.

As of December 2008, 23 states had decided to offer presumptive eligibility to women diagnosed with breast or cervical cancer. These states are: California, Colorado, Connecticut, Delaware, Georgia, Idaho, Indiana, Iowa, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Tennessee, Texas, West Virginia, and Wisconsin.[89]

d. Presumptive eligibility for children

For children and adolescents, presumptive eligibility covers full Medicaid benefits. "Qualified entities" determine presumptive eligibility by finding that a child is under age 19 and her family income is probably below the state's Medicaid income eligibility levels. States can recognize a wide variety of providers as "qualified entities," including any entity eligible for Medicaid payments, entities authorized to determine a child's eligibility to participate in Head Start and/or WIC, elementary or secondary schools, and entities that decide eligibility for benefits for federally assisted housing.

As of January 2008, the following 14 states had adopted presumptive eligibility for children: California, Colorado, Connecticut, Illinois, Kansas, Louisiana, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, New Mexico, New York, and Wisconsin.[90]

6. Retroactive Eligibility

States must pay for Medicaid-covered services provided during the three month period prior to the month of application if the applicant would have been eligible for Medicaid had she applied for coverage at the time the services were rendered.[91] The three month retroactive coverage period runs backwards from the month the applicant applies and includes covered services provided in or after the third month before the month of application.[92]

ADVOCACY TIP:

If eligibility is being terminated or suspended, or services are terminated, suspended, or reduced, notice must go out at least ten days before the proposed date of the action. If a hearing is requested, the state must continue eligibility or coverage of the service until there is a hearing decision.[94] This is called "aid paid pending" or "continuing benefits," depending on the state. The deadline to request a hearing can vary from state to state, but the state must allow a "reasonable time" of not more than 90 days to request a hearing.[95] Most states allow between 30 and 60 days.

7. Due Process

Medicaid applicants and beneficiaries have the right to notice and the opportunity for an administrative hearing when their claims for assistance are denied or not acted on within a reasonable time.[93] These rights are triggered when the Medicaid agency or managed care organization takes "adverse action," which includes decisions to deny, modify, or terminate eligibility or services. The notice must be in writing and contain: a statement of the action the state is planning to take; reasons for the action; citation to the law supporting the action; explanation of the right to a hearing; explanation of the right to continued benefits if the notice is a termination or suspension of coverage; and a statement that the individual has the right to be represented by a personal representative or attorney (at the individual's expense).[94]

There is no right to a hearing when a federal or state law implements an automatic change that affects some or all recipients. Beneficiaries must, however, still receive written notice of the change.

Administrative hearings must be conducted at a reasonable time, date, and place by an impartial hearing official who was not involved in the original decision. Before the hearing, the applicant/beneficiary must be allowed to review the record upon which the agency will rely. At the hearing, the applicant/beneficiary must be allowed to present witnesses, present arguments without interference from the other side, and cross-examine witnesses.

Hearing decisions must be in writing and can only be based upon the evidence submitted at the hearing. Generally, a decision must be issued within 90 days of the request for a hearing. If the hearing decision is favorable, corrective payments must be made retroactive to the date that the incorrect action was taken. If the state's decision is upheld, the state is allowed to recover the costs of any continued benefits from the applicant/beneficiary. In all states, individuals may appeal a final agency decision to state court.

Beneficiaries receiving services through a managed care system are entitled to all of the "due process" protections described above. Additionally, they must have access to a plan-level grievance procedure to challenge the denial of coverage or payment.

IV. Services

Medicaid covers a broad range of health services which, taken together, should provide comprehensive health care. Yet, one-third of women on Medicaid rate their health as fair or poor, compared to only ten percent of low-income women with employer-sponsored coverage.[96] Accessing Medicaid services can be difficult, and as a result, health care can be fragmented and reactive as opposed to preventive and continuous. The Medicaid Act mandates coverage of certain services and gives states the option of whether or not to choose to cover other services.[97] Generally, federal Medicaid law sets forth broad categories of coverage, such as "laboratory and X-ray services" and "doctor visits" and does not describe in detail which specific services will be covered. Therefore, to find out the extent to which a particular service is covered, one must usually look to state law.

Moreover, under Medicaid, a health service will be covered only if a Medicaid-participating health care professional, generally a physician, has determined that the beneficiary's medical condition would benefit from the service. [98] In other words, the services must be "medically necessary." Each state has the authority to determine its own definition of "medical necessity" as it relates to adults. As a result, the definition of "medically necessity" varies by state. Medical necessity for beneficiaries under age 21 is determined by the requirements of EPSDT (discussed in section 3D below).[99]

A. SERVICES CATEGORIES

1. Mandatory Services for Categorically Needy Beneficiaries[100]

The Medicaid Act requires states to cover a broad array of services for all categorically needy beneficiaries, including:

- inpatient hospital services (other than services in an institution for mental diseases)
- outpatient hospital services
- rural health clinic services, including ambulatory services offered by a rural health clinic and otherwise included in the state's Medicaid plan
- federally-qualified health center services
- laboratory and X-ray services
- nursing facility services (other than in an institution for mental diseases) for individuals 21 or older
- early and periodic screening, diagnostic, and treatment (EPSDT) services for recipients under age 21
- pregnancy-related services and services for conditions that might complicate pregnancy[101]
- family planning services and supplies[102]
- physician services
- services furnished by a nurse-midwife who is legally authorized under state law to render the care[103]

2. Optional Services for Categorically Needy Beneficiaries[104]

The Medicaid Act provides that states may cover additional services. Once a state chooses to provide an optional service, it must fully adhere to the applicable requirements of federal law and regulations. Optional services include, but are not limited to, the following:

- clinic services furnished by or under the direction of a physician, including such services furnished outside the clinic by clinic personnel to beneficiaries who do not reside in a permanent dwelling or have a fixed mailing address
- physical therapy and related services
- prescribed drugs, dentures, prosthetic devices, and eyeglasses
- other diagnostic, screening, preventive, and rehabilitative services
- nursing facilities for persons under 21 years of age
- intermediate care facility services for the developmentally disabled (other than institutions for mental diseases)
- necessary transportation to providers

3. Services for Medically Needy Beneficiaries

States with medically needy Medicaid programs can offer this optional group the same or a more limited package of services than it offers the categorically needy. At a minimum, if a state chooses to cover the medically needy, it must provide prenatal and delivery services.[105] The state must also cover ambulatory services for children under age 18 and for individuals entitled to institutional services, as well as home health services to anyone entitled to nursing facility services.[106] Additionally, in instances where a state chooses to cover services in

institutions for mental diseases or in intermediate care facilities for the mentally retarded for any group of medically needy beneficiaries,[107] it must cover for all medically necessary beneficiaries, either (i) the mandatory services available to the categorically needy (except for nurse practitioner services), or (ii) any combination of seven mandatory and/or optional services available to the categorically needy.

B. REQUIREMENTS FOR SERVICES

The Medicaid Act mandates that covered services must be available to beneficiaries consistent with the objectives of the Medicaid Act.[108] The Act requires states to establish "reasonable standards" for determining which services will be available.[109] States may not "arbitrarily deny or reduce the amount, duration, or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness, or condition." [110] There is no concrete rule as to what constitutes a "sufficient amount, duration or scope of service" for adult beneficiaries, so states have some flexibility in determining the limits of the available services.[111] States must also ensure that beneficiaries can obtain covered medical services within a reasonable amount of time.

ADVOCACY TIP:
When a state is considering limitations on Medicaid services, look to see if those services are still reasonable under the proposed limitations. For example, if the number of permissible physical therapy visits is too low to do any real good, then it may be unreasonable and, therefore, illegal.

C. UTILIZATION CONTROLS

States may impose utilization controls on the delivery of services.[112] Utilization controls are limits and procedures designed to provide additional oversight over how services and supplies are dispensed. The stated aims are to ensure that beneficiaries receive the most cost-effective, medically necessary services and to avoid unnecessary program costs. Permissible utilization controls include: (i) medical necessity requirements, (ii) prior authorization for health services,[113] (iii) second surgical opinions, (iv) lock-in programs requiring a beneficiary to receive services from particular providers, and (v) for adults, limits on the number or frequency of services.

States frequently implement utilization controls to reduce Medicaid costs by cutting back on services, potentially putting patients' health at risk. Many states have imposed limitations on services for adults, such as a maximum number of hospital days per year, a maximum number of physician visits per month, or limitations on the quantity of prescriptions per month.

D. ADOLESCENT HEALTH: EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT)

"[American College of Obstetricians and Gynecologists (ACOG)] recommends that a teen first visit an ob-gyn between the ages of 13 and 15. Getting acquainted with an ob-gyn in the early teens facilitates the development of a trusting relationship between a teen and her doctor. This age is an excellent time to discuss pregnancy prevention and sexually transmitted infections, whether a teen has started having sex or not. The goal is to boost a teen's comfort level, so if she starts having sex, has questions about her reproductive health and development, needs advice on birth control, or has any other kind of problem, there is a reliable and knowledgeable source that she can consult." ACOG President Douglas H. Kirkpatrick, MD., chair of ACOG's Committee on Adolescent Health Care quoted in: Teens Need Comprehensive Reproductive Health Care, Sex Ed, ACOG Supports National Day to Prevent Teen Pregnancy on May 6, 2009 Press Release."

—American College of Obstetricians and Gynecologists President Douglas H. Kirkpatrick, MD., chair of ACOG's Committee on Adolescent Health Care, quoted in: Teens Need Comprehensive Reproductive Health Care, Sex Ed, ACOG Supports National Day to Prevent Teen Pregnancy on May 6, 2009 Press Release.

- Forty-six percent of 15 to 19 year olds in the U.S. have had sex at least once.
- Ninety-one million new cases of sexually transmitted infections (STIs) occur in people 15 to 24 years old, accounting for nearly half of new STIs each year.
- Each year almost 750,000 young women age 15 to 19 become pregnant; 82% of such pregnancies are unplanned.[114]

Approximately one in five adolescents— 7.2 million people aged 12 to 20 years old—are enrolled in Medicaid.[115] Adolescents as a group have low rates of primary care use in the U.S. and this holds true for those enrolled in Medicaid.[116] However, because extreme poverty is a risk factor for early sexual behavior, it is critical for adolescents who live in high poverty areas to have access to reproductive health services and supplies to help ensure their overall health into adulthood.[117]

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a comprehensive set of health care benefits for children and youth under age 21 who are enrolled in Medicaid.[118] All state Medicaid programs must cover EPSDT. EPSDT screening is important to adolescents' and young women's reproductive health because services include STI screening, HPV vaccines, nutritional assessments, pregnancy testing, HIV testing, lead testing, cholesterol screening, mental health assessments, as well as health education that includes family planning and sexuality counseling geared to the age of the beneficiary.[119]

Whether adolescents access the full range of reproductive services available through EPSDT depends on several factors, one being their concern that interactions with the provider will be kept private. Providers who treat minors need to be aware of the federal and state laws related to minor consent and confidentiality. State laws vary from state to state and may depend on the services provided and the adolescent's particular circumstances. Some states allow adolescents to consent to certain medical services without notifying their parents.

ADVOCACY TIP:
EPSDT providers of reproductive health care to adolescents should be aware of ways to protect confidentiality, such as asking them where they want their test results sent (to avoid sending test results to the adolescent's home address) and not including the services provided to adolescents on billing or insurance statements.

Sometimes, states will call EPSDT by another name, such as "Health Check." Often, states will offer EPSDT through managed care organizations like HMOs. Regardless of what the program is called or who is responsible for providing the benefits, Medicaid-eligible children and youth are entitled to EPSDT's comprehensive screening and treatment services.[120]

EPSDT is designed to ensure early and comprehensive preventive services. Benefits include regular medical, dental, vision and hearing check-ups, immunizations, laboratory tests, and health education. States are required to have set intervals for age appropriate health screens, referred to as periodicity schedules.

A broad package of diagnostic and treatment services is available for both new conditions and conditions that existed prior to Medicaid eligibility. In other words, pre-existing conditions are not excluded from coverage. Treatment must include care and services that are necessary to "correct or ameliorate" the child's health problems.[121] As a result, state Medicaid programs need to cover services for children and adolescents whether or not those services are covered for adult Medicaid recipients. Covered services include inpatient and outpatient hospital care, physician services, clinic services, outpatient prescription drugs, and other preventive and treatment services such as contraceptives and treatment for STIs. Young women are also covered for the full range of prenatal, pregnancy, and post-partum services.

Federal law requires states to inform all Medicaid-eligible families with children about EPSDT using a combination of written and oral means of communication.[122] States must also offer transportation and appointment scheduling assistance upon request. If the child or family has trouble reading or understanding English, then the information needs to be provided in a language that can be understood. Federal guidelines call on states to provide special outreach to make sure that "at risk" groups get EPSDT. At risk groups include new mothers and adolescents. Finally, EPSDT should be coordinated with other programs, such as WIC and Head Start, and outreach needs to include information about how women can obtain the benefits of each of these programs.[123]

ACTION PLAN:

- *Review your state's EPSDT outreach materials and work with the state to make sure they highlight coverage of reproductive health services.*
- *Find out what your state calls its EPSDT program. If the state uses a name like "Health Check," investigate to make sure that the program is covering more than just check ups. In other words, make sure that the state is implementing the "T" (treatment) in EPSDT.*
- *If your state offers EPSDT through HMOs or some other sort of managed care plan, monitor these plans to make sure they include the reproductive services EPSDT requires and that they maintain adequate provider networks for women and adolescents.*
- *Check to make sure that your state's periodicity schedules for screening services are up to date. Up-to-date schedules will reflect annual screening for adolescents and highlight psycho-social concerns.*

V. Women's Health Services[124]

Medicaid is of paramount importance to low-income women's health and well-being from infancy to end of life. Women's health is intricately linked to reproductive health, making reproductive services in Medicaid vital, primary care services for women.

A. FAMILY PLANNING SERVICES AND SUPPLIES

- In 2006, there were 66.4 million U.S. women of reproductive age (13-44).[125] Over half of them (36.2 million) were in need of contraceptive services and supplies because they did not want to be pregnant.[126]
- Nearly half (17.5 million) of women needing contraceptive services and supplies were also in need of publicly funded contraceptive services and supplies because they were under 20 years old and had incomes below 250% of the federal poverty level.[127]
- 7.3 million women between the ages of 15 and 44 requiring publicly-funded contraceptive services looked to Medicaid (and related public programs) for their care.

Medicaid is the single largest source of public funding for family planning services and supplies.[128] When Medicaid was first enacted in 1965, each state could decide whether or not to cover family planning. However, in 1976 Congress amended the Medicaid Act to establish a legal entitlement to family planning for Medicaid beneficiaries by requiring that any state that chooses to participate in Medicaid must cover "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies."[129] States cannot impose cost sharing, such as co-payments on family planning services, but they can impose cost sharing on certain prescription drugs. Cost-sharing for family planning supplies must be "nominal" and apply only to drugs that are not included on the state's "preferred" drug listing.[130]

> *Many states are not taking full advantage of the opportunity to receive the enhanced federal matching rate for family planning service — many [states] do not cover all the services that may be classified as family planning, and some do not report using the coding category of "family planning" to receive a 90% matching rate.*
>
> Medicaid Coverage of Family Planning Services: Results of a National Survey, The Henry J. Kaiser Family Foundation, 2001

To encourage states to promote family planning services within their programs, the federal financial participation (FFP) for costs associated with providing family planning services is 90%.[131] The state pays the remaining 10%.[132] In addition, administrative costs related to offering, arranging, and furnishing family planning services and supplies are also covered by an enhanced FFP of 90%.[133]

ADVOCACY TIP:
Find out if your state receives the maximum family planning FFP and, if not, educate providers and women's groups about proper reimbursement coding and encourage them to initiate outreach to beneficiaries to increase access to family planning services.

1. Eligibility for Family Planning Services

States are mandated to cover family planning services for all Medicaid beneficiaries except those who qualify as medically needy.[134] This includes minors who can be considered sexually active.[135] States have the option of covering medically needy beneficiaries, and can further extend coverage through Section 1115 "demonstration projects," sometimes referred to as "waivers," to individuals who would not otherwise qualify for Medicaid (see discussion below). States are required to establish procedures for identifying individuals who are sexually active and thus eligible for family planning services.[136]

States may use state funds to expand coverage of family planning services to individuals who do not meet any of the federal eligibility requirements.[137] If states choose to cover these individuals, the eligibility criteria and scope of services are governed by state law.

2. Access to Family Planning Providers

Freedom of choice is a critical aspect of women's reproductive health. Due to the intimate nature of family planning services and the prolonged period of time that women require such services, it is important that a woman has ready access to a family planning provider with whom she is comfortable and who is familiar with her health history. In recognition of these facts, the federal Medicaid Act provides women enrolled in Medicaid with the right to choose their family planning providers regardless of whether they obtain health care through a fee-for-service or a managed care organization (MCO) system.[138] This principle is referred to as "freedom of choice" because the beneficiary is free to choose her own health care providers so long as those providers are willing to accept Medicaid payment for their services.[139]

Medicaid's freedom of choice provision allows women to maintain relationships with family planning providers even when enrolled in managed care networks, helps to promote continuity of care and confidentiality.

—Medicaid's Role in Family Planning, Guttmacher Institute/ The Henry J. Kaiser Family Foundation, October 2007

Freedom of choice, however, can be difficult to fulfill when a state uses MCOs to provide Medicaid benefits and an MCOs does not have in-network providers who offer comprehensive women's health services. In this instance, women have the right to go out-of-network to obtain family planning services. However, this fact may not be made clear to them and/or, outside providers may not be readily available. Family planning services received out-of-network cannot cost more to the beneficiary than if she had obtained the services in-network.[140] Women's freedom of choice may also be curtailed when a state's Section 1115 demonstration project requires that beneficiaries be enrolled in an MCO and the state has obtained permission from the Secretary of HHS to waive the freedom of choice requirement.[141] So, while Medicaid protects a woman's right to choose her family planning provider in general, there are some limits to the right, and it can be denied altogether to women who receive only limited health services through a Section 1115 demonstration project.

3. Covered Services

As with most other Medicaid services, states have discretion to determine what family planning services and supplies will be covered in their state plans[142] as long as they "are in sufficient amount, duration, and scope to reasonably achieve their purpose."[143] But unlike other covered Medicaid services, there is no requirement that "medical necessity" exist for a beneficiary to be entitled to receive family planning services. There is widespread variation state to state as to which family planning benefits are covered. However, abortions and hysterectomies are specifically excluded from coverage as family planning services.[144]

Family planning services may include:[145]

- counseling services and patient education,
- examination and treatment by medical professionals in accordance with applicable state requirements,
- laboratory examinations and tests (e.g., STI testing),
- medically approved methods, procedures, and devices to prevent conception,
- medically approved pharmaceutical supplies to prevent conception,
- limited infertility services, including sterilization reversals, and
- sterilizations performed primarily for contraceptive purposes.

States are required to ensure that Medicaid beneficiaries are "free from coercion and mental pressure and free to choose the method of family planning to be used."[146] However, if the range of family planning services and supplies available in a particular state is not sufficient to offer beneficiaries meaningful alternatives, the effect may in fact be coercive, causing beneficiaries to use methods that may not be ideal for their needs.

Most Medicaid programs place a great emphasis on prevention of pregnancy. By contrast, conception and infertility services intended to promote childbearing are not included as family planning services in the majority of states. In fact, the Medicaid Act explicitly allows states to exclude fertility drugs from plan coverage.[147] Infertility testing is covered by only nine states and the District of Columbia and, as of 2006, only five states covered some sort of infertility service while thirty-seven states specifically excluded coverage of infertility services.

Notably, the treatment of STIs and the removal of birth control devices (such as an intrauterine device due to infection) are often not covered as family planning services.[148] These services are covered as medically necessary procedures for women with full scope Medicaid. However, women who receive only family planning services through a Section 1115 demonstration project may not be able to access these

services. Failing to remove an intrauterine device when an infection is present, or not treating an STI, may jeopardize a woman's long-term reproductive health.

a. Contraceptive Supplies

Forty-three states and the District of Columbia cover Food and Drug Administration (FDA) approved prescription methods of contraception, including oral contraceptives, intrauterine devices, contraceptive implants, contraceptive injections, and diaphragms, although only thirty-one states always cover them as family planning services[149] Forty-three states and the District of Columbia cover certain over-the-counter methods and supplies, such as condoms, spermicides, and sponges, but require a prescription to get them.[150]

Emergency contraception (EC) is a safe, effective method for preventing unintended pregnancies.[151] Emergency contraception is most effective if taken within 72 hours after unprotected sexual intercourse or contraceptive failure, but can be used up to 105 hours after intercourse. [152]

In 2006, the FDA announced that emergency contraception known as Plan B® would be sold over-the-counter (OTC) to women age 18 and older. In 2009, the age requirement was lowered to 17, and the FDA was ordered to reconsider whether an age restriction was necessary at all.[153] Also in 2009, Next Step®, a generic version of EC, became available for women 18 and older, while women 17 years old and younger, need a prescription.[154]

Despite EC's OTC status, most state Medicaid programs require a prescription for EC OTC in order for it to be covered. A few states do not cover the drug at all, and some states limit the number of EC prescriptions they will cover over a specific period of time. [155] Because of these requirements, women on Medicaid may be prevented from getting EC in a timely manner.

A handful of states have addressed the prescription requirement by using state funding to cover EC without a prescription. Pharmacists in these states submit claims for reimbursement for Plan B® without the need to reference a prescription or physician code. These states include: Hawaii, Illinois, Maryland, New York, New Jersey, New Mexico, Oklahoma, Oregon, and Washington.[156]

Innovative Approach: *Some states authorize specially trained pharmacists to prescribe EC directly from the pharmacy, eliminating a trip to a physician. This is referred to as "pharmacy access,"[157] (also called "Collaborative Agreements"). Currently Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Vermont, and Washington allow pharmacy access to all women regardless of their age.*

ADVOCACY TIP:
Be familiar with how your state Medicaid plan covers EC. Advocates should be mindful of developing administrative, legislative, or federal opportunities that might create expanded access to EC OTC.

b. Sterilization Services

Sterilization is any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing.[158] Medicaid-covered methods of sterilization include tubal ligation and vasectomy.[159] Federal Medicaid funds may be used to pay for sterilizations only when the following conditions have been met:

- the individual is at least 21 years old at the time of consent,
- the individual is not mentally incompetent,
- the individual has voluntarily given informed consent, and
- at least 30 days, but not more than 180 days, have passed between informed consent and date of sterilization. [160]

Tubal ligations are covered in cases of premature delivery or emergency abdominal surgery, provided the woman has given advance informed consent at least 72 hours before the surgery or, in the case of premature delivery, consent was given at least 30 days prior to the estimated delivery due date. [161] Informed consent for tubal ligation may not be obtained when a woman is in labor, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that may affect her state of awareness.[162]

48 states cover vasectomies in their Medicaid programs.[163] However, only Colorado, New Jersey and the District of Columbia cover the reversal of vasectomy.[164]

Hysterectomy is not considered a family planning service.[165] If a hysterectomy is performed for the sole purpose of rendering a woman permanently incapable of reproducing, it will not be covered by Medicaid.[166] If a hysterectomy is medically necessary, for example, to remove a cancerous uterus, then it will be covered at the state's regular FMAP rate.[167]

ADVOCACY TIP:
Encourage women who are considering enrolling in managed care to ask state representatives, MCOs and providers if they provide a full range of reproductive information, services and supplies. Share information about providers or MCOs that do not offer a full range of family planning services. [168]

4. Family Planning in Managed Care Organizations

Family planning services must be covered regardless of whether a beneficiary accesses Medicaid benefits through fee-for-service or managed care. However, women enrolled in managed care plans may face particular obstacles accessing family planning services and supplies if their managed care plan either does not provide the services or if the plan arranges for the provision of family planning services and supplies through a third party because of religious objections to contraception.

The Medicaid Act contains a broad refusal clause that allows managed care organizations (MCO's) to opt out of reimbursing or providing coverage for a counseling or referral service if the organization objects to such service on moral or religious grounds.[168] This is the only exception to the broad patient protections that prohibit "gag" rules that restrict the ability of providers to discuss all relevant treatment options with their patients regardless of whether the plan covers those treatments. This Medicaid provision allows religiously controlled MCOs to impose gag rules on their network providers prohibiting them from giving patients all the information necessary to make informed decisions about their care.

There are protections for Medicaid beneficiaries in these situations, including the right to disenroll from a managed care plan "for cause" at any time if the plan or provider cannot meet the beneficiary's health needs because of moral or religious objections.[170] However, beneficiaries are not always adequately informed of their rights, either by the state or the MCO. In addition, the right to disenroll is useless if there is no geographically accessible alternate provider.

ADVOCACY TIP:
Check with your state Medicaid agency to ensure that the state is informing beneficiaries of their option to disenroll for cause when a managed care organization is not meeting their reproductive health needs. Work with your state Medicaid agency to ensure that women are receiving current and understandable information about where and how to access the reproductive health services they need.

States are required to provide all new managed care enrollees with information about what family planning services are available under the state Medicaid plan, and if an MCO does not provide those services, how to obtain them from out-of-network providers.[171] MCOs have a duty to inform their patients or members about the services they do not provide, but this information may be hidden and difficult for beneficiaries to find,[172] and MCOs themselves are not required to inform their enrollees about how to access excluded services.[173]

B. FAMILY PLANNING DEMONSTRATION PROJECTS *(also known as "family planning waivers")*

Reproductive health care in the Medicaid program has been significantly expanded by the implementation of Section 1115 family planning demonstration projects, also known as "family planning waivers." Section 1115 of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services (HHS) to waive certain provisions of the Medicaid Act at the request of a state in connection with its application to implement a "research and demonstration" project. [174] Demonstration projects must, in the judgment of the Secretary, be "likely to further the objectives" of the Medicaid program.[175] Demonstration projects must be cost neutral, meaning that the amount of money the federal government contributes to the state's Medicaid program may not increase as a result of the project. A project's cost neutrality is calculated over the life of the demonstration period.

According to a 2007 report, Section 1115 demonstration projects provide family planning services to two million enrollees annually.[176] To date, 27 states have extended coverage of family planning services and supplies to women, and in some cases men, who otherwise would be ineligible for Medicaid.[177] Most Section 1115 family planning demonstration projects will cover individuals at any point in their reproductive lives; however nine states require a beneficiary to be at least 18 or 19 years old.[178] If unmarried teens are covered under a Section 1115 demonstration project, only their income, not their parents', is counted in determining eligibility. Family planning services provided through Section 1115 demonstration projects are matched by the federal government at an FFP of 90%.

There are generally two types of Section 1115 family planning demonstration projects. Most family planning demonstration projects base eligibility solely on income and make family planning coverage available to individuals who do not meet Medicaid's income eligibility criteria. [179] The other model covers Medicaid family planning services for women leaving Medicaid because they no longer qualify under any Medicaid eligibility category. Two states extend this coverage to women leaving the program for any reason, and six states limit coverage to women losing Medicaid when their 60-day post-partum period ends. The extended coverage period varies from one year in Missouri to five years in Maryland.[180]

Family Planning Section 1115 demonstration projects are considered single benefit coverage, meaning that demonstration beneficiaries receive only family planning services and supplies; primary care is not a covered benefit. However, as a result of a requirement instituted in 2001, and perhaps as a nod to the importance of reproductive health to a woman's overall health, family planning demonstration projects must help beneficiaries access primary care providers by developing written materials explaining how beneficiaries can obtain primary care services. [181]

As with family planning services provided in regular Medicaid, there is no required set of family planning services that Section 1115 family planning demonstration projects must cover and the scope of services is negotiated with HHS during the waiver application process. Thus, some states cover services solely related to contraception, while others include more comprehensive services, including office visits, basic health screens including STI screening and pap tests, laboratory tests, and contraceptive supplies whose "primary purpose" is family planning.[182]

One very important difference between family planning services available as part of a state's standard Medicaid plan and those a state may make available through a Section 1115 family planning demonstration project is that the state may require beneficiaries of a demonstration project to obtain family planning services through a managed care plan and an in-network provider, thus limiting participants' freedom of choice of family planning providers.[183]

C. SERVICES FOR PREGNANT WOMEN

Federal Medicaid laws are designed to accommodate pregnant women's heightened need for services and to encourage states to cover prenatal care. The range of services that states are allowed to cover for pregnant women is comprehensive, and states have some latitude to decide what services are covered and for whom.

1. Covered Services

Medicaid covers "pregnancy-related services." The State Medicaid Manual defines pregnancy-related services as "services necessary to treat conditions or complications that exist or are exacerbated because of the pregnancy."[184] The actual range of available services varies from state to state and can be broader than the services provided under the state's Medicaid program to non-pregnant beneficiaries.[185] Pregnancy-related services may include prenatal visits, laboratory tests, prenatal vitamins, ultrasound, amniocentesis, chorionic villus sampling, genetic counseling, vaginal and cesarean delivery, anesthesia, case management, nutritional counseling, educational services such as childbirth education and infant care education, delivery, post-partum care, post-partum family planning, and breastfeeding support.[186]

States cannot impose deductibles or co-payments on most pregnancy-related services such as routine prenatal care, labor and delivery, and post-partum care. Nor can states impose cost sharing on services necessary to treat medical conditions that might complicate pregnancy or delivery, such as hypertension, diabetes, and/or urinary tract infections. States can, however, impose nominal cost sharing on certain prescription drugs if the drug is not listed on the state's "preferred" drug listing.[187] Additionally, pregnant women with incomes above 150% of the federal poverty level may be charged monthly premiums for Medicaid coverage.[188]

ADVOCACY TIP:

Due to the February 2009 reauthorization of CHIP, states now have the option of covering pregnant women with incomes too high to qualify for Medicaid under a state's CHIP program.

Medicaid covers:

a. Prenatal Care:

These are services provided during pregnancy that are directed at protecting and ensuring the health of the woman and the fetus.[189]

b. Delivery Services:

These services include those necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery.[190] All states cover basic delivery services including vaginal and cesarean births and anesthesia.[191] Access to alternative, non-hospital birthing settings varies from state to state, as does coverage for birthing support personnel such as doulas or labor coaches.[192]

c. Post-Partum Services:

These are services rendered to an eligible woman following a pregnancy for any health condition or complication that is pregnancy-related.[193] These services are typically available through the last day of the month of the 60-day period following the end of the pregnancy.

d. Services for Other Conditions that Might Complicate the Pregnancy:

These are additional services necessary to treat non-pregnancy conditions that might cause pregnancy complications. They include services to diagnose or treat illnesses or medical conditions that might threaten carrying the fetus to full term or the safe delivery of the fetus.[194] Examples are dental care, smoking cessation services, or psycho-social counseling.

2. Eligibility for Pregnancy Services

The federal Medicaid statute and regulations establish requirements and options for states' coverage of services for pregnant women. Some of the major coverage categories are described below:

- States *must* provide coverage to women who meet the income and family composition rules that applied to the state's AFDC program on July 16, 1996.[195] Women receiving this coverage are entitled to the full scope of Medicaid benefits, including family planning services, pregnancy and post-partum services, and any other service that is covered by the state program. [196]

- States *must* cover pregnant women with family incomes at or below 133% of the poverty federal.[197] These women qualify for pregnancy-related services, including family planning, pregnancy and post partum services, and services related to conditions that could complicate the pregnancy.[198]

- States *may* cover pregnant women with family incomes between 133-185% of the federal poverty level.[199] These women qualify for pregnancy-related services, including family planning, pregnancy and post partum services, and services related to conditions that could complicate the pregnancy.[200]

- States *may* cover medically needy women whose incomes are below the medically needy income level. States choosing to provide coverage for the medically needy must include pregnant women and, at a minimum, cover their prenatal, delivery and post partum care.[201]

- Qualified immigrants are entitled to prenatal care, delivery and routine post-partum services. The five-year ban on eligibility *does not* apply.[202]

- Not qualified immigrants *only* qualify for emergency labor and delivery services.

Innovative Approach: *In California, not qualified immigrants who would otherwise be eligible for Medicaid can be pre-certified to receive restricted Medicaid benefits including pregnancy-related services.[203]*

D. ABORTION UNDER MEDICAID

Of the roughly 3.1 million unintended pregnancies in the U.S. each year, 42% end in abortion.[204] Approximately one-third of American women from every socio-economic, racial, ethnic and religious group will have an abortion during their lifetimes.[205] Abortion rates are higher among low-income women.[206] Yet poor women, and a disproportionate number of women of color, face the greatest barriers to obtaining abortions because many are dependent on government-sponsored health services, including Medicaid.

1. Restrictions on Federal Funding for Abortion: The Hyde Amendment

After the Supreme Court's 1973 *Roe v. Wade* decision legalized abortion, Medicaid covered abortion services in the same way it covered other physician and hospital services. In 1979, as a result of an amendment to the Labor/Health and Human Services Appropriations Act sponsored by Rep. Henry Hyde (referred to as the "Hyde Amendment"), federal funding of abortion came to an abrupt halt, and the use of federal funds to pay for any abortion was prohibited.[207] In 1981, the Hyde Amendment was revised to allow Medicaid to cover abortions that were deemed necessary to save the life of the woman, and in 1993 the law was further relaxed to allow federally funded abortions in cases of rape and incest.[208] These restrictions on federally funded abortions remain in place and have been reauthorized every year since 1979.[209] If not for Hyde Amendment restrictions, abortions would again be covered under Medicaid in the same way that other medically necessary physician and hospital services are covered.[210]

a. Life of the Woman Exception

To obtain a Medicaid-funded abortion under the life of the woman exception, the treating physician must certify in writing to the state Medicaid agency that, in his/her professional judgment, the life of the woman would be endangered if the fetus were carried to term. In these cases, the woman must suffer

ADVOCACY TIP:
The Hyde Amendment restrictions affect only federal spending. Seventeen states and the District of Columbia cover abortions with state-only money.[214] In addition, many family planning clinics and non-profit abortion funds can provide referrals and additional resources to women

from "a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by, or arising from the pregnancy itself that would place [her] in danger of death unless the abortion is performed."[211] Notably, the definition of life endangerment does not take into account any potentially life-threatening psychological or emotional harm that may result when a woman is forced to continue a pregnancy she does not want.

ADVOCACY TIP:
State Medicaid programs cannot impose reporting or documentation requirements that deny or impede coverage for abortions in cases of rape or incest. Thus, reporting requirements must be waived and the procedure considered reimbursable if the treating physician certifies that in his or her professional opinion the patient was unable, for physical or psychological reasons, to comply with the reporting requirement.[215]

b. Rape or Incest Exception

At least 9,100 U.S. abortions each year are attributed to pregnancies that occur because of forced sexual intercourse.[212] Yet, few states report Medicaid payments to medical providers for performing abortions to end pregnancies that are the result of rape or incest.

Rape and incest are defined by each state's statutes. In order for an abortion to be federally funded under Medicaid, the pregnancy must be the result of an act the state defines as rape or incest. Moreover, each state Medicaid agency decides whether a rape or act of incest must be reported as a condition to obtaining a federally funded Medicaid abortion and, if so, when and to whom the reporting must occur.[213]

2. Abortion-related Covered Services

While abortion is not a federally funded Medicaid service except in the instances set forth above, prenatal care prior to an abortion, treatment of complications resulting from a medically unsupervised abortion (someone other than a doctor has induced the abortion), and treatment of ectopic pregnancies are covered Medicaid services.[216] States may use federal matching funds for specific services commonly provided to pregnant women in the usual course of care under Medicaid, regardless of whether the woman is seeking an abortion.[217] So, if a pregnant, Medicaid-eligible woman thinks she may, or knows she wants an abortion, she can still access pre-abortion pregnancy care through Medicaid including transportation to doctor appointments. Covered services include tests to identify sexually transmitted infections and other laboratory tests performed on pregnant patients. Post abortion tests and procedures performed to remedy complications resulting from a non-federally funded abortion are covered, including extended hospital stays.[218] However, if a woman is eligible for Medicaid through a pregnancy expansion program, once she is no longer pregnant, either because she has miscarried or because she has had an abortion, post pregnancy care will not be covered.

E. REFUSAL CLAUSES

Despite Medicaid coverage for reproductive health services, low-income women may face barriers to care when providers rely on refusal clauses or so-called "conscience clauses," which are state and federal statutes or regulations that shield individuals and institutions from liability for failing to provide health services, counseling and/or referrals that patients would normally expect as part of their care. Refusal clauses permit a provider's personal or religious belief, or an institution's ideological or religious fidelity, to trump patient need, evidence, or medical conditions. In fact, refusals often directly contradict medical practice guidelines and standards of care.[219] And, while women of all socio-economic levels are negatively impacted by refusals to provide reproductive services or supplies, low-income women in particular are disproportionately harmed because they may be unable to access alternative sources of care due to the cost of the care, access to transportation, availability of child care, or time off from work necessary to travel to another location where care might be available.

1. Federal Refusal Clauses

The first major refusal clauses were adopted in the 1970's shortly after the Supreme Court decision, *Roe v. Wade.*[220] A federal law commonly known as the Church Amendment (named after its author, Senator Frank Church) allows individuals and institutions that receive federal funding to opt out of providing abortions or sterilizations.[221] Almost all states have similar refusal clauses pertaining to abortion and/or sterilization. The Church Amendment also allows individuals to refuse to "perform or assist in

the performance" of a health care service program or research activity to which they have a religious or personal moral objection.[222]

In addition, the Weldon Amendment is an annual rider that was first attached to the 2005 Federal Appropriations Act that prohibits "discrimination" by any federal agency or state or local government against an entity or individual who refuses to provide, pay for, provide coverage for, or provide referrals for abortion services.[223]

In December 2008, the Department of Health and Human Services issued final regulations that would expand the legal protections afforded to a wide range of participants in the health care workforce, including volunteers, framing any limitation on refusals as "discrimination."[224] The regulation applies to over 584,000 health care entities and state or local governments that are either recipients or sub-recipients of HHS funding. It prohibits "discrimination" against any "health care entity" (which includes any institution or individual member of the health care workforce, whether paid or unpaid) who refuses to "assist in the performance" of a "health program or health service" which is "contrary to his religious beliefs or moral convictions." In addition, the regulations require that covered institutions "certify" in writing to HHS that they do not discriminate as described in the regulations. These regulations fail to define "discrimination," fail to define "abortion," and go far beyond the underlying statutes in terms of the broad definition of who is covered by the regulations and what activities are considered "participation" in a particular service.

In February 2009, President Barack Obama issued a proposed regulation to rescind the 2008 HHS regulations.[225] As of this printing, no decision has been made on the rescission.

2. State Refusal Clauses

States have also enacted refusal clauses. In addition to state refusal clauses that allow health providers to refuse to perform or participate in abortion or sterilization services, some states also allow pharmacists to refuse to fill prescriptions for birth control, nurses to refuse to provide information or referrals to patients, and emergency rooms to refuse to provide emergency contraception to victims of sexual assault.[226] A few states have very broad refusal clauses that allow virtually anyone in the health care system to refuse to participate in any service to which they have an objection. In Mississippi, for example, an admitting clerk can refuse to admit a patient into a hospital if the clerk objects to the service the patient is going to receive.[227]

Some refusal clauses also allow providers to opt out of providing counseling, information, and referrals.[228] These refusals shield providers from complying with legal and ethical mandates regarding informed consent and the requirement to inform patients of all reasonable treatment options.

ADVOCACY TIP:
Familiarize yourself with the policies and practices of the hospitals in your area. Educate your clients to ask their clinics and providers about whether they offer a full range of reproductive health services, and if not, where they can get the services they need.

3. Institutional Restrictions

The largest group of restrictions, and the ones that have the greatest impact on access to care, are imposed by institutions controlled by some religious entities.[229] These institutions prohibit the delivery of many reproductive health services on their premises. The impact is that they interfere with the ability of health care providers to deliver care that meets accepted medical practice guidelines. The broadest religiously based health care restrictions are those imposed by Catholic Health Systems. According to the Catholic Health Association, "The Catholic health ministry is present in all 50 states and comprises the nation's largest group of not-for-profit health care sponsors, systems and facilities."[230] Catholic hospitals control more than 16% of the hospital beds in the U.S.[231]

Catholic health facilities are governed by the Ethical and Religious Directives for Catholic Health Care Services (the Directives).[232] The Directives specify a range of services that are prohibited, including family planning (even to prevent pregnancy as a result of a rape), sterilization, abortion, assisted reproductive

technology, the distribution of condoms even when intended to prevent HIV/AIDS or other sexually transmitted infections, and some end of life decisions. The prohibition on abortion applies to the direct termination of any pregnancy; there are no exceptions for rape, incest, the health or life of the woman, or the condition of the fetus.

Under the Directives, treatment options are not subject to patient control or physician recommendation. Physicians must agree to abide by the Directives in order to obtain admitting privileges, and other health care workers are contractually bound by them as a condition of employment.

Institutional restrictions are all the more problematic because the health facilities are not required to inform patients of their religious affiliation and often they fail to provide accurate information about the services that are restricted. Avoiding facilities that have such restrictions can be difficult as the names of hospitals may not indicate a religious affiliation, such as with West Suburban Medical Center in Chicago or Santa Rosa Memorial Hospital in California.

ADVOCACY TIP:
If a woman does not meet federal BCCPT eligibility criteria, check to see if the state in which she lives has a state-only program. State programs may have more relaxed immigration requirements, may not have an age limitation, or may supplement a woman's existing health insurance.

F. MEDICAID COVERAGE FOR BREAST AND CERVICAL CANCER TREATMENT

Breast cancer is the second most commonly diagnosed cancer among women in the U.S. after skin cancer, and the second most common cause of cancer death after lung cancer.[233] The American Cancer Society estimated that 192,370 women in the U.S. will be diagnosed with breast cancer in 2009, and 40,170 women will die from the disease.[234] An estimated 11,270 women will be diagnosed with cervical cancer this year, and 4,070 will perish as a result of the disease.[235]

Deaths from breast and cervical cancer occur disproportionately among women of color and low-income women.[236] According to the Institute of Medicine, low-income women have lower breast cancer screening rates, are 41% more likely to be diagnosed with late-stage breast cancer, and are three times more likely to die from breast cancer. Advanced stage breast cancer is also more commonly diagnosed in African-American and Latina women, compared to Caucasian women.[237] Although Caucasians have the highest incidence of breast cancer, mortality among that group is among the lowest. Conversely, African-Americans, have one of the lowest breast cancer incidence rates, but the highest mortality rate. Breast cancer is the most common cancer diagnosis for Latinas.[238] Latinas have the highest rates of new cases of cervical cancer and the second highest death rate from cervical cancer after African-American women.[239] Breast and cervical cancer are most easily treated when detected early and cervical cancer is preventable if precancerous cells are identified through regular PAP tests.

Low-income women can obtain free or low-cost breast and cervical cancer screenings at Title X family planning clinics and through programs supported by the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).[240] To be eligible for NBCCEDP screening, a woman's income may not exceed 250% of the Federal Poverty Level, and she must be between the ages of 18 and 64 to be screened for cervical cancer, or between the ages of 40 and 64 for breast cancer screening.[241] States that receive NBCCEDP grants agree to provide low-income women priority in receiving preventive screenings as well as referrals for medical treatment to ensure the appropriate follow-up and support services.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA), gives states the option of extending full Medicaid benefits to women diagnosed with breast and/or cervical cancer, who are not otherwise eligible for Medicaid. [242] All fifty states and the District of Columbia offer coverage under a Breast and Cervical Cancer Prevention and Treatment (BCCPT) program. States receive an enhanced FMAP from the federal government, equal to its Children's Health Insurance Program match, which funds 65%-83% of the total program cost.[243] Other than "nominal" charges for non-preferred prescription drugs, states cannot impose cost sharing or premiums on women covered under a BCCPT program.[244]

1. **Eligibility: Medicaid coverage for Breast and Cervical Cancer Treatment is available to women who:**
   - obtain a qualifying breast and/or cervical cancer screening that is provided in conjunction with the NBCCEDP that is (i) paid in whole or in part with CDC Title XV funds, (ii) performed by a provider/entity that is funded in part by CDC Title XV funds, or (iii) provided by a provider otherwise deemed qualified by a state CDC Title XV grantee,[245]
   - have been found to have breast and/or cervical cancer **and** are in need of treatment,[246]
   - are under age 65,
   - do not have any other creditable health insurance,[247] and
   - are citizens or qualified immigrants of the U.S., or have satisfactory immigration status.[248]

   American Indian and Alaskan Native women are eligible for the BCCPT Medicaid option even though medical care programs of the Indian Health Service or of a tribal organization are defined as creditable coverage under the Public Health Service Act.[249]

   States have flexibility in how they implement the BCCPT program. Each state determines which of the three levels of CDC Title XV screenings it will accept as sufficient for eligibility purposes,[249] as well as whether to offer presumptive eligibility to women who are determined by a qualified entity to be eligible.[250]

2. **Breast and Cervical Cancer Treatment Services**
   Women enrolled in Medicaid through a BCCPT program are entitled not only to services related to cancer treatment, but to the full range of covered services consistent with optimal standards of practice. At states' option, available services may include experimental treatments.[251]

3. **Breast and Cervical Cancer Treatment Coverage Period**
   Eligible women receive three-month retroactive coverage, counting back from the month of application, with coverage continuing throughout the duration of the applicable cancer treatment. When a woman is no longer in need of cancer treatment or she no longer meets any of the other eligibility criteria, Medicaid coverage under a BCCPT program will end. If the cancer recurs, or the woman needs additional breast or cervical cancer treatment, she can enroll for coverage again through a BCCPT program if she meets all of the eligibility requirements discussed above.[252]

ADVOCACY TIP:
Be aware of which CDC Title XV related screens your state accepts to satisfying the threshold eligibility criteria. Encourage state acceptance of all three levels of CDC Title XV-related screens to minimize the instances in which women must get a second screen because the first does not qualify.

G. MENTAL HEALTH SERVICES

In 2006, an estimated 28 million U.S. adults reported receiving mental health treatment in the previous year. Women represented two-thirds of users of mental health services. [253] Approximately one in ten new mothers suffers from maternal depression (also known as post partum depression) in the first year after giving birth.[254] Further, studies have shown that poor people have an increased likelihood of having mental health problems due to poverty-related stress and heightened levels of adversity caused by living in poverty[255]

As the largest payer for mental health services in the U.S., Medicaid is vitally important to women. Coverage of specific services varies somewhat depending on the state, and there may be limits on services for adults (such as the number of visits to a psychiatrist or number of prescriptions). Covered services can include:

- psychiatrist, psychologist and other counseling services, such as treatment for post-partum depression,
- prescription drugs, including anti-depressants and other psychotropic medication,
- clinic or mental health center services, and
- in-patient psychiatric hospital care for youth and children under age 21 and older people age 65 or over.

Coverage of mental health services for individuals under age 21 is broader under Medicaid's EPSDT requirements. Further, the EPSDT medical screening includes mandatory developmental screening.

Innovative Approach: *On December 1, 2004, the Illinois Medicaid program began a policy of allowing providers to receive Medicaid reimbursement for maternal depression screening of pregnant women and women with children under age one. The program covers two different populations: 1) pregnant and post-partum women who are covered by Medicaid and 2) women who are not themselves enrolled in Medicaid, but whose infants (under age one) are eligible for the program. For pregnant and post-partum women (up to one year after delivery) who are enrolled in Medicaid, the screening can be billed under the woman's Medicaid number. If the post-partum screening occurs during a well-child or acute care visit for a child covered by Medicaid, providers bill under the infant's Medicaid number. To help counsel pregnant and post-partum women identified in need of mental health services, providers can access a statewide Perinatal Mental Health Consultation Service and receive free consultation by a team of experts.*[256]

ADVOCACY TIP:
Advocates can work to encourage their states to take advantage of the federal match to increase language access. NHeLP tracks state practices in this area and periodically releases updated issue briefs on this topic. For more information, see www.healthlaw.org.

H. Language Services for Limited English Proficient Patients[257]

Studies have shown that in states with large populations of non-English speakers, language access is a major obstacle to accessing health care in general, and family planning in particular.[258] Title VI of the Civil Rights Act of 1964 provides that "no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."[259] The Department of Health and Human Services (HHS) and the courts have applied this statute to protect national origin minorities who do not speak English well or at all. Programs that receive federal funding – including Medicaid, CHIP and Title X family planning clinics – must take reasonable steps to ensure that people with limited English proficiency (LEP) have meaningful access to their programs and services. As of 2006, 19 states had enacted one or more laws that address women's health services for LEP individuals.[260]

Federal Medicaid law requires that information about the Medicaid program, long term care services, and childhood preventive care in particular, are rendered in a language that applicants and beneficiaries can understand, as well as in a culturally appropriate manner.[261] Federal guidelines require that state Medicaid agencies and contractors such as Medicaid MCO's provide both oral and written communication to LEP applicants to ensure that those entitled to receive Medicaid are not denied due to language barriers.[262]

State Medicaid programs should inform LEP beneficiaries that they are entitled to have Medicaid provide an interpreter without charge. Beneficiaries may designate family or friends to interpret; however, HHS guidance provides that "extra caution" should be taken when a LEP beneficiary chooses to use a minor to interpret.

In order to comply with the federal guidelines regarding written materials, state Medicaid programs should, at a minimum, cover written translations of "vital" documents (e.g., intake forms, consent and complaint forms, eligibility and service notices) into the languages spoken by significant LEP populations in the state.[263] However, state Medicaid agencies do not have to actually pay for interpreters (although the state itself must provide language services in its Medicaid offices). And even though states can receive matching federal funds if they opt to pay for language services, only 12 states and the District of Columbia have opted to pay for these services.[264] States can designate language services as an "administrative service" and receive 50% of their costs from the federal government, or as a "covered service" and receive a higher match, depending on their state's FMAP (federal medical assistance percentage). In the absence of the state paying for language services, the financial burden of doing so falls to providers. The additional cost lowers providers' return on reimbursement rates received from the state and may work as a disincentive for participation in the Medicaid program.

I. MEDICAID TRANSPORTATION

Transportation is a critical component to health care access. In rural and urban areas with limited public transportation or where certain specialists are scarce, women may forgo important health care services simply because they lack transportation to and from care. A recent study of pregnant immigrant women and women of color found that forty-two percent cited transportation as a serious barrier to attending prenatal education classes.[265] Lack of geographical access is of particular concern in areas where there are limited family planning or abortion providers. Eighty-eight percent of counties in the U.S. do not have an abortion provider, forcing women to travel for abortion services. Medicaid transportation services are an important and underutilized tool for helping women access medical services, including covered abortion services and post-abortion complications.[266]

Medicaid law mandates that a state plan cover necessary transportation for beneficiaries to and from medical providers.[267] Teens, children, and their families are entitled to scheduling assistance, information about transportation services, and transportation services under the EPSDT program.[268] In order to claim federal matching funds, states may cover "necessary" transportation either as an administrative expense, an optional medical service, or as both. The nature and extent of coverage for transportation varies from state to state.

1. Non-Emergency Medical Transportation (NEMT)

States electing to cover transportation as a Medicaid service (and to obtain federal payments for the service as opposed to the administrative matching rate) must specify that the Medicaid agency will ensure necessary transportation and must describe the methods the state will use.[269] "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the state agency to secure medical examinations and treatment for a recipient."[270]

States are obligated to find the least expensive, appropriate mode of travel. This can include utilizing volunteers, providing bus or other public transportation tokens, gas vouchers, mileage reimbursement for family and friends, taxis, shared vans, or other arrangements. As with other Medicaid services, states can impose utilization controls on transportation services such as requiring prior authorization, limits on how many times a beneficiary can use the transportation services, and the available forms of transportation.[271]

Related travel services are also covered and may include:

- the cost of transportation by ambulance, taxicab, common carrier, or other appropriate means,
- the costs of meals and lodging to and from medical care and while receiving medical care, and
- the expenses of an attendant when a woman's medical condition does not allow her to travel alone and the attendant's salary if she is not a relative.[272]

A woman's transportation options may be limited if her state Medicaid program establishes a transportation brokerage service, where the state contracts with a company to arrange for provision of transportation services to Medicaid beneficiaries.[273] In such states, beneficiaries must utilize the contract brokers if the transportation is to be a covered service.[274]

Innovative Approach: *Innovative transportation plans have increased utilization of prenatal care and reduced rates of infant mortality and low-birth weight babies. In North Carolina, the Baby Love Program combines transportation to and from prenatal visits with counseling and other support services. Utah's Baby Your Baby program issues debit cards that can be used for public transportation. Special bus services and door-to-door services are available when a physician documents that other services are not adequate for the woman or an urgent care need.* [275]

ADVOCACY TIP:
When advocating for scope of benefits and coverage for pregnant women, the stage of pregnancy and the condition of the woman should be considered in determining transportation options.

ADVOCACY TIP:
Understanding state transportation rules in advance will enable advocates to better support their clients. Every state handles Medicaid transportation differently. The fact that states have great leeway can make it more complicated for advocates to access transportation for their clients. For example, the Women's Law Project in Philadelphia found that each of Pennsylvania's 67 counties had different rules for accessing transportation services.[272] *Information about transportation services is generally available on the State Medicaid agency website.*

2. Emergency Transportation

The requirement to cover transportation "necessary to ensure examination and treatment" extends to emergency ambulance services to a hospital. In addition to general emergencies, emergent conditions for women include labor, abdominal pain that could indicate ectopic pregnancy, or excessive bleeding post abortion care.[276]

ADVOCACY TIP:

Encourage your state to refrain from imposing cost-sharing on non-preferred drugs prescribed to pregnant women and women receiving cancer treatment under BCCPT, and on drugs prescribed for family planning purposes. Also advocate for reducing imposed charges below nominal amounts.[284]

J. PRESCRIPTION DRUG COVERAGE

1. Outpatient Drugs in the Medicaid Program

States may cover outpatient drugs as an optional service for adults under the Medicaid Act.[277] All 50 states and the District of Columbia include this coverage. Once states have opted to include coverage of outpatient drugs, they must comply with federal requirements including Medicaid requirements of amount, duration and scope, comparability, and freedom of choice.

States may exclude over-the-counter drugs to treat the following conditions: anorexia, weight loss or gain, hair growth for cosmetic purposes, infertility, erectile dysfunction. States may also exclude smoking cessation supplies, nonprescription drugs, and prescription vitamins and minerals except prenatal vitamins.[278]

For their drugs to be included in the state's Medicaid program, drug manufacturers must enter into a drug rebate agreement for their products.[279] This means they must give a discount to the state Medicaid program in accordance with a federally mandated formula. States must cover all FDA-approved prescription drugs of the manufacturers who have entered into drug rebate programs, if the drug is prescribed for a medically accepted indication.[280]

As with other Medicaid services, states can impose utilization controls. Some of the controls include: [281]

- Preferred drug lists (PDL): Only drugs on the formulary are covered without prior authorization. The formulary must be developed by a committee of physicians, pharmacists and other appropriate individuals.
- Nominal cost-sharing or co-payments: States can charge premiums and co-payments tied to a person's poverty level and the cost of the drug **but they can only impose "nominal" charges for non-preferred drugs prescribed for family planning purposes, pregnancy-related conditions, or to women receiving Medicaid under a Breast and Cervical Cancer Prevention and Treatment program (BCCPT).**[282]
- Prior authorization: States can require prior authorization of a prescription, but only if there is a system for (i) providing a response by telephone or other telecommunications device within 24 hours of the request, and (ii) dispensing of at least a 72-hour supply in an emergency situation.[283]
- Minimum and maximum quantity per prescription and the number of refills: These restrictions are allowed if necessary to discourage waste. These limits are often imposed on contraceptives.[284] Most states allow only 30-day supplies of oral contraceptive pills.[285]

Managed care plans generally have their own drug formularies and prior authorization requirements. Covered outpatient drugs dispensed by health maintenance organizations, including Medicaid managed care organizations, are not subject to the utilization control provisions discussed above.[286] For example, an MCO's formulary may be more restrictive; fewer pharmacies may be included in the network.[287] Note, however, that access to family planning services and supplies is protected, and individuals seeking Medicaid family planning services still can access any available provider for care.

2. Over-the-Counter Drugs

States have the option of refusing to cover over-the-counter drugs in their Medicaid programs; however, most states do cover some over-the-counter drugs. In these states, federal Medicaid law provides that over-the-counter drugs are regarded as a covered outpatient drug "if they are prescribed by a physician (or other person authorized to prescribe under state law)."[288]

The prescription requirement is undoubtedly a barrier for women covered by Medicaid accessing family planning supplies.[289] A survey by the Pharmacy Access Partnership found that half of uninsured women (47%) and low-income women (40%) not using the pill, patch, or ring say they would start using those methods if available without a prescription.[290] And, as new methods of family planning come on the over-the-counter market (such as emergency contraception in 2006), Medicaid beneficiaries are often shut out of the benefits of these advances because in most states they still need a prescription in order for Medicaid to cover the cost.[291]

3. Tamper Resistant Prescribing

As of March 31, 2008, all Medicaid prescriptions must be written on what are called "tamper resistant pads."[292] These pads must meet certain characteristics designed to prevent counterfeiting and improperly altering prescriptions. The tamper resistant requirement "applies to all outpatient drugs, including over-the-counter drugs in states that reimburse for prescriptions for such items."[293]

4. Pharmacy Refusals

Women at all income levels experience pharmacy/pharmacist refusals when pharmacists refuse to fill prescriptions for drugs to which they have a religious or moral objection. A pharmacy refusal can be an insurmountable barrier to a woman who cannot find or travel to another pharmacy. Pharmacists have been documented refusing to fill prescriptions for birth control pills, emergency contraception, drugs to help complete a miscarriage, and drugs for pain management.[294] In response to these concerns, some states have enacted laws to ensure that pharmacies are responsible for having a pharmacist on duty who will fill a prescription.[295]

ACTION PLAN: *If a pharmacy refuses to seek prior authorization for a prescribed drug, do the following:*

- *Write down the name of the pharmacy and the pharmacist.*
- *Make a complaint to the state Medicaid Program.*
- *Ask the prescribing physician to call the pharmacy. The pharmacy is most likely to cooperate if the doctor frequently sends patients to the particular pharmacy. If the physician cannot or will not help the beneficiary with the pharmacy, ask the physician to recommend another pharmacy.*
- *If the pharmacy is part of a chain—that is, there are other pharmacies owned by the same parent company—the refusal may be contrary to company policy. Call the chain's headquarters and ask to speak with someone about a pharmacy problem.*

VI. APPENDIX A

OTHER REPRODUCTIVE HEALTH PROGRAMS

A. TITLE X FAMILY PLANNING CLINICS[296]

The Title X Family Planning Program (Population Research and Voluntary Family Planning Programs) was created in 1970 to assist individuals in determining the number and spacing of their children and to promote healthy birth outcomes and families.[297] Other goals of the program are reducing the incidence of teen birth, lowering the rates of sexually transmitted infections (STIs), and reducing the incidence of unintended pregnancy. Title X provides federal grants for a broad range of family planning programs and services, data collection and family planning research, guidelines for service delivery, community based outreach and education, funding for family planning providers, and contraceptives for little or no cost to low-income patients.[298]

ADVOCACY TIP:
Local Title X-funded family planning clinics can be found on the website for the HHS Office of Population Affairs by entering a specific city, state, and/or zip code: http://www.opaclearinghouse.or/dbsearch.asp

Programs that serve individuals from low-income families, the uninsured, and communities of color get priority status for Title X grants.[299] The program is administered within the U.S. Department of Health and Human Services, throught the offices of Public Health and Science, Population Affairs, and Family Planning (OFP).

Some of the services provided in Title X funded clinics include: contraceptive services and related counseling, [300] preventive health services such as patient education and counseling, screening services for hypertension, breast and pelvic examinations, breast and cervical cancer screening, STI and HIV prevention education, counseling, testing and referral, sterilizations, and pregnancy diagnosis and counseling. Title X programs cannot use their funding to provide abortions services.

Individuals utilizing Title X services are charged a sliding fee that is based upon their family size and income according to federal poverty guidelines. More than two-thirds of the individuals served in Title X funded programs are below the federal poverty level.[301] Title X funds more than 4,500 community-based clinics, and at least one family planning service provider in 75% of U.S. counties. Title X provides family planning services to over five million people each year.[302]

ADVOCACY TIP:
To locate a CHC in a particular area, use the following link to search by a designated address or by city and state: http://findahealthcenter.hrsa.gov. To locate medically underserved areas and populations, use the following link to search by county and state: http://muafind.hrsa.gov/.

Although family planning services are publicly funded through other federal sources, Title X still exists as the only federal grant program with the sole purpose of providing individuals with comprehensive family planning services and supplies, information, and other preventive health services.[303] Title X supported clinics have proven to be a critical and life-saving source of reproductive screenings, treatment, and services for millions of low-income women.

B. COMMUNITY HEALTH CENTERS

The Economic Opportunity Amendments Act of 1966 authorized the Neighborhood Health Center Program, which created 50 community health centers (CHC) to address the critical health needs of homeless individuals, minority populations, low-income populations, the chronically ill, and the uninsured. [304] In 2008, 1200 CHCs provided primary health care to 18 million individuals.[305]

CHCs are required to be located in a medically underserved area (MUA), or to serve a medically underserved population (MUP) as indicated by the Health Resources and Services Administration.[306] MUAs and MUPs have shortages of primary care providers, significant rates of infant mortality and poverty, and/or a large

number of elderly persons.[307] CHCs are staffed with clinical professionals including physicians, nurses, dentists, and mental health and substance abuse counselors. They also provide ancillary services (such as radiology and laboratory testing) as well as services that assist patients with getting access to health care (e.g., language interpretation and transportation).[308]

A recent review of the population served in Community and Migrant Health Centers (C/MHCs) shows that:

- 41% of women under age 20, and 20% of young women under age 13 use C/MHCs;
- Women of child bearing age comprise 29% of C/MHC patients;
- Almost one-fifth of patients using C/MHCs need an interpreter to access the centers;
- 6% of patients are migrant workers;
- 32% of patients are Latino and 25% are African American;
- 65% of patients have incomes less than 100% of the federal poverty level (FPL), and 2% have incomes between 100-200% of FPL.[309]

C. PUBLIC HEALTH CLINICS

Public health in the U.S. had its early beginnings in the 1700s, when the federal government began providing a system of medical care for injured and sick merchant seamen.[310] As time progressed, the Public Health Service (PHS) expanded its national mission to focus on other objectives, such as stopping the spread of communicable diseases, improving sanitation, addressing industrial health concerns, and improving the treatment of mental health and substance abuse illnesses.[311] The PHS includes the Centers for Disease Control and Prevention (CDC) and the National Health Service Corps.

The PHS provides grants to states to develop health services, train public health workers, and research health issues. State and county governments operate these initiatives on a local level. Public health programs focus on addressing STIs (gonorrhea and syphilis), infectious diseases, and other health concerns such as nutrition, chronic disease, and occupational and environmental health.[312]

Local health department clinics are another resource for reproductive and health screening care for low-income populations. Women obtaining reproductive health care in public family planning clinics routinely receive basic preventive gynecological services (e.g., pelvic examinations, Pap tests for cancer screenings, STI testing, prenatal and postnatal care, as well as primary health care).[313]

D. SEXUALITY EDUCATION

School-based sex education programs that include medically accurate and comprehensive reproductive health information are another important resource for young people. Other sources of reproductive health information, particularly for youth who may not be enrolled in school or whose needs are not being adequately met in schools, can be found in community based health programs.[314] Community based health programs can be successful in reducing unintended pregnancy, HIV/AIDS, STIs, and unprotected sex; as well as increasing the use of contraceptives, delaying sexual activities, and meeting other health indicators.

E. CHILDREN'S HEALTH INSURANCE PROGRAM

In 1997, the State Children's Health Insurance Program was created to provide affordable health care coverage for low-income children whose family income is above Medicaid eligibility levels but who do not have employer-sponsored health insurance.[315] The program was reauthorized in February 2009 through the Children's Health Insurance Program Reauthorization Act (CHIPRA), and is now called the Children's Health Insurance Program (CHIP). States have the option to participate in CHIP, and all do. CHIP covers children up to age 18, or if still in school, up to age 19. States also have the option of extending CHIP coverage to pregnant women who do not otherwise qualify for Medicaid.

Like Medicaid, CHIP is a federal-state funded partnership. Unlike Medicaid, CHIP is not an entitlement program. Rather, CHIP is funded as a block grant and its funding is determined by Congress, not by how many people are eligible to participate. This means that participating states may have more eligible people than it can cover, whereas states must cover all people eligible for Medicaid.

States can use CHIP funds to expand Medicaid, create separate CHIP programs, or a combination of both. Those that expand Medicaid keep the Medicaid benefit package, including family planning services. However, in separate CHIPs, family planning and prenatal care are not mandatory services and states can choose whether or not to cover such services.

States receive an enhanced federal match under CHIP that is higher than what they receive for their state Medicaid program. Covered services vary from state to state, but CHIP can be another valuable resource for adolescents and young women seeking access to reproductive health care if those services may be included in a state's CHIP program.

States may provide presumptive eligibility to pregnant women who appear to be eligible for CHIP while they await a final determination. States offering prenatal services under CHIP may also cover postpartum services through the end of the month in which the 60-day post partum period ends. Additionally, as in Medicaid, CHIPs cannot impose cost sharing for pregnancy-related services or waiting periods.

F. ABORTION FUNDS

ADVOCACY TIP:
To locate an Abortion Fund, go to: www.nnaf.org/help.html or call (617) 524-6040. To support reproductive justice by joining or starting a Fund or working to eliminate the Hyde Amendment, go to: www.nnaf.org/getinvolved.html.

Abortion funds assist low-income women in securing their right to abortion. Without Medicaid funding or personal funds to cover their abortions, low-income women have resorted to desperate means to raise money for abortions, including borrowing funds or going without paying for food, utilities, or other necessities. Delays caused by the need to raise money to pay for an abortion result in later term abortion at greater costs and health risks, or no abortion at all. Some women who had neither Medicaid coverage for an abortion nor the funds to obtain one, have died because of complications from illegal abortions.[316]

To assist low-income women in exercising their right to abortion services, a group of 24 activist organizations joined together in 1993 to establish the National Network of Abortion Funds (NNAF).[317] NNAF provides community based funding for women who would otherwise not be able to afford access to safe and legal abortions. Currently, NNAF has a network of over 100 community and volunteer organizations in 40 states that assist women in securing access to abortion services.[318] Most of these abortion funds provide direct funding for abortion services, financial assistance for transportation, lodging and meals, pregnancy tests, contraception, and emergency contraception. Some funds provide funding exclusively for child care, meals, transportation, and lodging.[319] Other funds work with legal advocates to assist women in prison. Some provide support and referrals for survivors of rape and those who have been battered.[320] Most women access abortion fund services by telephone (77%), while others contact the funds by word-of-mouth, e-mail, or an in-person interview.

Funds raise over two million dollars per year in direct grant funding to assist more than 20,000 women per year obtain abortions who would otherwise be unable to do so. About 25% of the funds provide loan assistance, but they do not anticipate re-payment because most of the women assisted have incomes below the federal poverty level.[321]

G. MATERNAL AND CHILD HEALTH BLOCK GRANTS

The HHS Health Resources and Services Administration administers a range of programs that focus on the health needs of pregnant women, infants, mothers, children, children with special needs, and families.[322] The largest of these programs is the Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act), which has operated as a federal and state partnership since 1935.[323]

Title V reflects the federal government's support of state initiatives to offer additional health and related services for mothers and children. Title V supported programs have provided prenatal health services to more than 2 million women and primary and preventive health services to more than 17 million children (including nearly 1 million children with special health needs).[324] Among Title V

responsibilities are the MCH Services Block Grant and the federal discretionary grant programs (described below). These programs also inform the states about preventive health services and new developments in the care of mothers and children and promote coordination of services offered under Titles V and XIX (Medicaid), particularly EPSDT.[325]

The MCH Services Block Grant requires that states use the funds to provide greater access to quality maternal and child health services for mothers and children with low-incomes or with limited availability of health services.[326] Typically, low-income mothers and children are those whose family incomes are below 100% FPL, but states determine eligibility for services that they provide under the grant.[327]

The overall objectives of the MCH Services Block Grant are to reduce infant mortality and improve the health of all mothers and children by providing access to comprehensive prenatal and postnatal care. The MCH grants seek to increase the number of children getting health assessments and follow-up diagnostic treatment, offer immunizations and other preventive care services, and provide access to rehabilitative services for children.[328]

The MCH Services Block Grant provides block grants to states to assist them in coordinating health programs, developing systems, and providing a range of direct services.[329] There are several requirements for states to receive and retain a MCH Services Block Grant. For example, states must conduct an assessment of the need for preventive and primary care services every five years. States must contribute $3.00 for every $4.00 of federal funding that is awarded under the block grant and cannot use more than 10% of their allocations for administrative costs.[330] In addition, allocated funds are available for a two-year period (e.g., if funding was allocated in FY 2008, starting on October 1, 2008, it is available through September 30, 2010).[331]

The block grant has three major funding categories:

- *MCH Formula Grants* – These grants represent 85% of the funding component of Title V. They are awarded to the states based on the number of children living in poverty relative to the total number of such children nationally.[332]
- *Special Projects of Regional and National Significance* (SPRANS) – This funding provides:
  - research grants to develop knowledge in improving health care delivery to mothers and children;
  - training grants to assist leadership personnel in conducting effective maternal and child health programs and specialized services (e.g., technical assistance, specialized clinical and laboratory services not usually available, as well as guidelines and manuals);
  - grants to provide testing, counseling, referral, and follow-up of individuals and families at risk or experiencing genetic disorders;
  - grants to support local development of regional programs and other resources, and demonstrate a regional approach to addressing hemophilia and other chronic conditions; and
  - other special projects to improve maternal and child health (e.g., innovations in screening for sickle cell and sudden infant death syndrome, perinatal and women's health, oral health, and adolescent health).[333]
- Community Integrated Services Systems (CISS – This category of grants offers funding for maternal and child health home visiting programs; integrated maternal and child health services delivery systems; maternal and child health centers providing pregnancy services; services for infants; maternal and child health projects in rural areas; outpatient and community based services for children with special needs; and projects to increase the participation of obstetricians and pediatricians in Title V and Medicaid programs.[334]

VII. APPENDIX B

ADVOCACY TIP:
Abortion remains a polarizing political issue and a clear understanding of the parameters in which legal services programs can operate in this arena is crucial to promoting and protecting low-income women's reproductive rights. LSC programs requiring assistance in understanding the prohibitions against use of LSC funds for activities related to abortion coverage should contact the Center for Law and Social Policy.

THE ROLE OF LEGAL SERVICES AGENCIES IN PROMOTING AND PROTECTING REPRODUCTIVE HEALTH FOR LOW-INCOME WOMEN

The Legal Services Corporation (LSC) is a non-profit, private corporation that promotes equal access to justice. Established by Congress, the LSC provides grants for legal assistance for low-income Americans. Three out of four legal services programs' clients are women. [335] Clients receive assistance with domestic abuse, housing, employment, access to health care, and medical debt issues, to name a few. Legal services providers are an important resource for low-income women trying to obtain better access to reproductive health services.

Publicly financed programs such as Medicaid help to make reproductive health services available to low-income women. However, accessing such services can be difficult and impeded by various barriers. The LSC identifies "access to necessary health care as a civil legal need of low-income individuals."[336] As such, legal services programs can work to assist uninsured and underinsured clients overcome barriers to access, and ensure that agencies responsible for providing reproductive health care do so. Legal services programs can also ensure that language access and cultural competency is provided in health care settings so that women are not barred from accessing reproductive healthcare because providers are not meeting their basic service requirements.

Legal services programs are subject to specific LSC-imposed operating restrictions, one of which is a prohibition against representing individuals in litigation and other proceedings in which individuals seek to obtain abortions.[337] Additionally, legal services agencies may not use LSC funds or non-LSC funds to provide assistance to clients in litigation or proceedings to compel individuals or institutions to perform abortions over religious or moral objections.[338]

Outside of the two specific restrictions on abortion-related legal assistance, legal service providers can participate in various ways to promote access to reproductive health care services for their clients, including abortions, subject only to the general LSC restrictions that govern all legal services activities. Legal services programs can partner with non-LSC organizations to promote access to abortion, provided they participate in permissible ways and let their non-LSC colleagues perform LSC-prohibited activities. Legal services providers can increase awareness of existing opportunities to obtain abortions, and may counsel or advise clients about their legal rights to use litigation or administrative proceedings to enforce their rights to obtain abortions.[339] In addition, legal service programs can work to change agency policies, and may provide information or testimony to a legislator or legislative or governmental agencies, provided that they are requested to do so from such parties in writing as required for all LSC legislative activities.

Healthy women are crucial to healthy families and healthy communities. Legal services programs can assist low-income women to access the services and information they need to attain good reproductive health and make their own decisions about childbearing. Through outreach and education efforts, legal services programs can work to inform low-income women about the opportunities and programs available to obtain reproductive health care, and where necessary, empower them to challenge barriers to such care.

Activity	Abortion – LSC Funds	Abortion – Non-LSC Funds*	Non-Abortion Reproductive Health Services
Litigation	No	No	Yes
Proceedings	No**	Maybe	Yes
Other activities as permitted by general LSC restrictions	Yes (e.g., information, advice on legal rights)	Yes (e.g., information, advice on legal rights and participate in rulemaking, responding to written requests by legislators)	Yes

*Such as IOLTA, tribal, and public funds that are expended in accordance with the purposes for which they were provided.
** Proceedings are not permitted if they are for the purpose of assisting individuals procure non-therapeutic abortions or to compel individuals or institutions to provide abortions.

Source: Lourdes Rivera, *Helping Low-Income Women Clients Access Reproductive Health Services* (Clearinghouse Review 2003).

ADVOCACY TIP:

The term "proceedings" is not defined in the Legal Services Act or its regulations.[336] Other references to "proceedings" suggest adversarial settings such as fair hearings or other court actions. Beyond litigation and proceedings, this restriction should not limit advocacy, client education, trainings, or other activities that are otherwise allowable for legal services agencies.

VIII. APPENDIX C

Additional Resources

Federal Resources:
Laws & Regs: 42 U.S.C. § 1396 et seq.; 42 C.F.R. § 430 et seq.

Centers for Medicare and Medicaid Services (CMS):
www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927
State Medicaid Manual
Informal handbook that contains rules and interpretations from CMS.

"Dear State Medicaid Director" Letters
www.cms.hhs.gov/SMDL/
Letters, from CMS to state plan directors, that clarify Medicaid policy in response to inquires from regional offices or members of the public.

Find local federally funded community health centers:
findahealthcenter.hrsa.gov
U.S. Department of Health and Human Services, Health Resources and Services Administration

Find local Title X family planning providers:
www.opaclearinghouse.org/db_search.asp
U.S. Department of Health and Human Services, Office of Public Health & Sciences, Office of Population Affairs

State-specific Resources:

State Medicaid laws, regulations

State Medicaid manuals, provider manuals, guidances and bulletins

County Medicaid Eligibility Manual(s)

Contact list of Medicaid Fair Hearing representatives for individual states or counties

NHeLP Resources:

An Advocate's Guide to the Medicaid Program by Jane Perkins and Sarah Somers, June 2003. 4th Edition forthcoming 2010.
www.healthlaw.org

Preparing and Managing a Medicaid Case: An Introductory Guide (July '06, posted Jan. '07)
www.healthlaw.org/link.cfm?8475

NHeLP's Medicaid Manual for New Attorneys (Dec. '06, posted Jan. '07)
www.healthlaw.org/link.cfm?8476

Other Helpful Web Resources:

Advocates for Youth
www.advocatesforyouth.org
Information concerning how to help adolescents make responsible reproductive/sexual health choices.

The Alan Guttmacher Institute
www.guttmacher.org
In-depth research on family planning, abortion funding and Medicaid.

The American Civil Liberties Union - Reproductive Freedom Project
www.aclu.org/reproductive-freedom
Legal experts working to protect reproductive rights through education, advocacy and litigation.

Black Women's Health Imperative
www.blackwomenshealth.org
Advocacy strategies geared to eliminating health disparities impacting Black women.

Center on Budget and Policy Priorities
www.cbpp.org
Policy analyses of health care issues and Medicaid.

The Center for Law and Social Policy
www.clasp.org
Information regarding Legal Services Corporation programs.

Center for Reproductive Rights
http://reproductiverights.org
Policy reports and legal experts on reproductive health and justice.

Families USA
www.familiesusa.org
Information for health care advocates.

Family Planning Councils of America, Inc.
www.fpcai.org
Private non-profit organizations and family planning agencies.

The Henry J. Kaiser Family Foundation
www.kff.org; www.statehealthfacts.org
Reports, statistics, and information about health care, family planning, and Medicaid.

MergerWatch
www.mergerwatch.org
Information about health center mergers between secular and religious entitities and the impact on the provision of family planning services.

NARAL Pro-Choice New York
www.prochoiceny.org
Low-income Access Project - working to ensure access to reproductive health care through public health care systems.

National Asian Pacific American Women's Forum
www.napawf.org
Providing information and advocacy around social justice and human rights issues impacting Asian Pacific Islander women.

National Coalition of LGBT Health
www.lgbthealth.net/stage/
Information regarding improving the health of the lesbian, gay, bisexual, and transgender community.

National Latina Institute for Reproductive Health
www.latinainstitute.org
Information and advocacy around reproductive justice issues impacting Latinas.

National Women's Health Network
www.nwhn.org
Information and analyses of health policies and social justice issues impacting all women.

National Women's Law Center
www.nwlc.org
Legal advocacy group devoted to protecting and promoting the rights of women.

National Network of Abortion Funds
www.nnaf.org
Association of U.S. abortion funds, providing financial and other support to local abortion funds.

Native American Community Board: Native American Women's Health Education Resource Center
www.nativeshop.org/
Advocacy, information, and programs supporting reproductive justice, health, and human rights of indigenous women.

Planned Parenthood Federation of America
www.plannedparenthood.org
Provides reproductive health care nationwide, as well as leading pro-choice advocacy.

Raising Women's Voices for the Health Care We Need
www.raisingwomensvoices.net/
Advocacy and information to ensure that health reform supports comprehensive reproductive and overall health needs of all women.

SisterSong – Women of Color Reproductive Justice Collective
www.sistersong.net
Advocacy information on reproductive justice issues impacting women of color.

IX. APPENDIX D

CMS REGIONAL OFFICES

REGION 1 – Boston
Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island and Vermont
JFK Federal Building, Suite 2325
Boston, MA 02203-0003
E-mail: robosora@cms.hhs.gov

REGION 2 – New York
New Jersey, New York, Puerto Rico and Virgin Islands
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063
E-mail: robosora@cms.hhs.gov

REGION 3 – Philadelphia
Delaware, District of Columbia, Maryland, Pennsylvania,
Virginia and West Virginia
Suite 216, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106
E-mail: rophiora@cms.hhs.gov

REGION 4 – Atlanta
Georgia, Kentucky, Mississippi, North Carolina, South Carolina
and Tennessee
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909
E-mail: roatlora@cms.hhs.gov

REGION 5 – Chicago
Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin
233 North Michigan Avenue, Suite 600
Chicago, ILL 60601
E-mail: roseaora@cms.hhs.gov

REGION 6 – Dallas
Arkansas, Louisiana, New Mexico, Oklahoma and Texas
1301 Young Street, Suite 714
Dallas, TX 75202
E-mail: roatlora@cms.hhs.gov

REGION 7 – Kansas City
Iowa, Kansas, Missouri and Nebraska
601 East 12th Street, Suite 235
Kansas City, MO 64106
E-mail: roreaora@cms.hhs.gov

REGION 8 - Denver
Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming
1600 Broadway, Suite 700
Denver, CO 80202-4367
E-mail: roreaora@cms.hhs.gov

REGION 9 – San Francisco
Arizona, California, Hawaii, Nevada and the Pacific Territories
90 7th Street, Suite 5-300
San Francisco, CA 94103-6706
E-mail: rosfoora@cms.hhs.gov

REGION 10 – Seattle
Alaska, Idaho, Oregon and Washington
2201 6th Avenue, Suite 801
Seattle, WA 98121
E-mail: roseaora@cms.hhs.gov

X. ENDNOTES

1 Wendy Chavkin & Sara Rosenbaum, *Women's Health and Health Care Reform: The Key Role of Comprehensive Reproductive Health Care* (Columbia University Mailman School of Public Health 2008), available at www.mailmanschool.org/facultypubs/womenshealthcarereform.pdf.

2 *See* U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, Office of the Actuary, *2008 Actuarial Report on the Financial Outlook for Medicaid*, October 2008, available at www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf.

3 The Henry J. Kaiser Family Foundation, *Medicaid's Role for Women: An Update on Women's Health Policy* (2007), available at www.kff.org/womenshealth/upload/7213_03.pdf.

4 *See* Title XIX of the Social Security Act, codified at 42 U.S.C. § 1936 et.seq.

5 *See* The Kaiser Commission on Medicaid and the Uninsured, Medicaid: A Primer (The Henry J. Kaiser Family Foundation 2009), available at www.kff.org/Medicaid/upload/7334-03.pdf.

6 The Medicaid Act is Title XIX of the Social Security Act, and is found at 42 U.S.C. §§ 1396 through 1396v.

7 *See* Title IV of the Civil Rights Act of 1964, codified at 42 U.S.C. § 2000d (prohibiting federal fund recipients from discriminating on the basis of race, color, or national origin); Title II of the Americans with Disabilities Act of 1990, codified at 42 U.S.C. § 12132 (prohibiting public agencies from discriminating against individuals with disabilities); Rehabilitation Act of 1973, codified at 29 U.S.C. § 794 (prohibiting federal fund recipients from discriminating against individuals with disabilities).

8 42 U.S.C. § 1396a(a)(5) (2006).

9 National Health Policy Forum, The Basics: FMAP: The Federal Share of Medicaid Costs (Jan. 15, 2009), available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=research%2Fabout+medicaid%2Fbasics+fmap.pdf.

10 42 U.S.C. § 1396a(a)(27) (2006).

11 42 C.F.R. § 447.15 (2008).

12 *See* Statehealthfacts.org, Medicaid Managed Care Enrollees as a Percentage of State Medicaid Enrollees as of June, 30, 2007 (Henry J. Kaiser Family Foundation 2007), www.statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4# (last visited Aug. 31, 2009).

13 For easy-to-read, basic explanations of managed care and quality of care under managed care *See* the NHeLP fact sheets on Getting the Best Out of Managed Care, www.healthlaw.org/library/folder.71017 (last visited Aug. 31, 2009).

14 42 C.F.R. § 438.206(b)(2) (2008).

15 42 U.S.C. § 1396a(a)(23)(B) (2006); 42 C.F.R. § 431.51(a)(3) (2008); CMS, *State Medicaid Manual* §§ 2088.5, 2112 (2005). Some states have funded family planning services through special demonstration projects, referred to as Section 1115 Family Planning Waivers, and women who participate in Medicaid through Section 1115 family planning demonstration projects that restrict beneficiaries to MCO network providers may not be able to obtain family planning services out-of-network, *see* Guttmacher Institute, *Medicaid's Role in Family Planning* (The Henry J. Kaiser Family Foundation 2007), www.kff.org/womenshealth/upload/7064_03.pdf. *See* page 39 for a discussion of Medicaid's Freedom of Choice in family planning.

16 42 U.S.C. § 1396u-2(b)(6)(C) (2006).

17 42 U.S.C. § 1396u-2(b)(2)(A)(i) (2006); 42 C.F.R. § 438.114(c) (2006).

18 42 U.S.C. § 1396u-2(b)(2)(C) (2006); 42 C.F.R. § 438.114(a) (2008).

19 42 C.F.R. § 438.10(f)(6)(viii) (2008).

20 *See* Patricia Miller & Celina Chelala, Catholics for a Free Choice: Catholic HMOs and Reproductive Health Care, www.catholicsforchoice.org/topics/healthcare/documents/2000catholichmos.pdf.

21 42 C.F.R. § 438.10(f)(6)(vii) (2008).

22 As this Guide was going to print, and as part of the health reform effort, Congress was debating significant changes to Medicaid's eligibility requirements. Eligibility provisions under consideration may significantly change the eligibility requirement s set forth in this section. Check www.healthlaw.org for on-going analysis and updates on the impact of health reform legislation on Medicaid.

23 42 U.S.C. §§ 1396a(10)(A)(i), (ii) (2006).

24 *See* Social Security Act, § 1931, 42 U.S.C. § 1396u-1 (2006).

25 42 U.S.C. § 1396a(a)(10)(A)(ii)(xvii) (2006).

26 Id. § 1396a(a)(10)(C)(ii)(II) (2006); 42 C.F.R. §§ 435.301(b)(1)((ii), 436.301(b)(i)(ii) (2008).

27 *See* The Henry J. Kaiser Family Foundation, *Medicaid's Role for Women: An Update on Women's Health Policy* (2007), available at www.kff.org/womenshealth/upload/7213_03.pdf.

28 42 U.S.C. § 1396a(a)(10)(A)(i)(IV), (VI), (I)(1)(A)-(C), (2)(A)(ii)(II) (2006). *See also* CMS, *State Medicaid Manual* §§ 3300, 3311-3311.5, 3312 (2005).

29 Id. §1396a(a)(10)(A)(ii)(IX) (2006).

30 Id. §1396a(a)(10)(G)(V) (2006).
31 CMS, *State Medicaid Manual* §3311.1(B) (2005).
32 42 U.S.C. § 1396a(e)(5) (2006).
33 42 U.S.C. § 1396a(e)(6) (2006).
34 42 C.F.R. § 435.916 (2008).
35 42 U.S.C. § 1396a(a)(17)(B) (2006).
36 Note that in some states registered domestic partners are legally responsible for one another. Federal Medicaid law does not recognize these relationships for income counting purposes, nor does federal law currently recognize state sanctioned marriages between people of the same gender. Therefore, these legal areas are in flux, and states may handle these situations differently.
37 42 C.F.R. § 436.602(a)(3) (2008).
38 42 U.S.C. § 1396a(a)(17)(B) (2006).
39 42 C.F.R. § 436.608 (2008).
40 42 U.S.C. § 1396a(a)(17)(B) (2006); 42 C.F.R. § 435.845 (2008) (medically needy).
41 CMS, *State Medicaid Manual* § 3230.2 (2005).
42 Id. § 3230.1.
43 Id. § 3230.2(A).
44 *See* 42 U.S.C. §§ 1320b-7(d), 1396a(b)(3) (2006). The citizenship or immigrant status of non-applicant parents or other members of the household are not relevant to a child's eligibility, and states may not require parents to disclose this information.
45 *See* 42 C.F.R. §§ 435.406(a)(1)(i)-(ii), 407(i)(5) (2008). *See also* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6036 (Feb. 8, 2006), *codified at* 42 U.S.C. §§ 1396b(i)(22), 1396b(x) (2009).
46 *See* 8 U.S.C. §§ 1101(a)(22) and 1408, the two remaining outlying possessions of the U.S. are American Samoa and Swain's Island. All citizens are nationals but not all nationals are citizens.
47 *See* 42 C.F.R. § 435.406(v) (2008).
48 Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 211(a), 123 Stat. 8, 49 (amending 42 U.S.C. §1396a(ee)).
49 *See* 42 C.F.R. § 435.407 (2008).
50 *See* id. §§ 435.407(i)(3), 435.904 (2008).
51 *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 211(a)(1)(A)(ii), 123 Stat. 8, 51 (amending 42 U.S.C. §1396(x)(4) (requiring states to give an otherwise eligible person Medicaid while attempting to document citizenship, for at least the same reasonable opportunity period as is offered to qualified immigrants under 42 U.S.C. § 1303b-7(d)(4)). The section applies retroactively as if included in the Deficit Reduction Act of 2005, enacted February 2006.
52 *See* National Health Law Program, *The Children's Health Insurance Program Reauthorization Act*, 234 Hdaksg Acunbasd 9 (Fall 2008/Winter 2009) (available from NHeLP's Los Angeles office).
53 *See* 8 U.S.C. § 1612b(1) (2006). *See also* 8 U.S.C. § 1611 (2006); CMS, *State Medicaid Manual* §§ 3211.3, 3211.6 (2005).
54 *See* National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs – Table 10: State Funded Medical Assistance Programs (2002), available at www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07_2009-03.pdf. For additional information *See* Claudia Schlosberg, Immigrant Access to Health Benefits: A Resource Manual (The Access Project 2002), available at www.accessproject.org/downloads/Immigrant_Access.pdf.
55 *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 214, 123 Stat. 8, 56 (amending 42 U.S.C. § 1396(v)(4)(A)).
56 Id. CHIPRA authorized coverage for pregnant women must include prenatal, delivery and 60 days post-partum care. *See* CHIPRA § 214 (amending 42 U.S.C. §1396(v)(4)(A)(i) and (ii) for a definition of 'pregnant woman' as someone who is pregnant or is within 60 day post-partum period for purposes of the amendment to the Medicaid Act).
57 8 U.S.C. § 1641(b)(1)- (c) (2006).
58 *See* National Health Law Program, *An Advocate's Guide to the Medicaid Program* (2001), for a more detailed discussion about qualified immigrant categories (available from NHeLP's Los Angeles office).
59 *See* 8 U.S.C. § 1641(c) (2006). The visa petition can be filed by a U.S. Citizen or LPR spouse or parent, or the person can self-petition under the Violence Against Women Act (VAWA).
60 PRUCOL is not an immigration category but a category for government benefits and describes persons who are in the U.S. with the knowledge of the Department of Homeland Security (DHS) and DHS is not taking steps to deport the person.
61 42 U.S.C. § 1320b-7 (2006); CMS, *State Medicaid Manual* § 3212 (2005).

62 42 U.S.C. § 1320b-7(d)(2)-(d)(4) (2006).
63 Id. § 1320b-7(d)(4).
64 Immigration Reform and Control Act of 1986, Pub. L. No. 99-603, §121(c)(1), 100 Stat 3359.
65 42 U.S.C. § 1396b(v) (2006).
66 Id. § 1396b-5(3)(A)-(C) (2006) (requiring each Medicare-participating hospital with an emergency room to conduct a medical examination for any patient who comes to the emergency room to determine if an emergency medical condition exists, to provide stabilizing treatment, and to transfer or discharge the patient only if stabilized). *See also Id.* § 1395dd (2006).
67 *See Lewis v. Thompson*, 323 F.3d 567, 580 (2d. Cir. 2001) (found that Medicaid coverage of emergency medical conditions is narrow and does not include conventional prenatal care).
68 *See* Jane Perkins, *Medicaid Coverage of Emergency Medical Conditions: An Update* (National Health Law Program 2007), www.healthlaw.org/library/item.147923-Medicaid_Coverage_of_Emergency_Medical_Conditions_An_Update_June_07 (last visited Aug. 31, 2009).
69 U.S. General Accounting Office, Pub. No. GAO-04-472, *Undocumented Aliens: Questions Persist About Their Impact on Hospitals' Uncompensated Care Costs* 13, 31-32 (2004), *available at* www.gao.gov/new.items/d04472.pdf.
70 Cal. Code of Regs. Tit. 22, § 50740 (2009).
71 *See* 42 C.F.R. §435.908 (2009).
72 *See* 42 U.S.C. § 1396a(a)(53) (2009); 42 C.F.R. § 431.635 (2008).
73 *See* 42 C.F.R. § 431.635 (2008).
74 *See* 42 U.S.C. § 1396a(a)(8) (2006) (providing that all individuals wishing to apply for medical assistance have the opportunity to apply).
75 *See* Id. 1396a(a)(55) (2009); 42 C.F.R. 435.904 (2008).
76 42 C.F.R. § 435.907(c) (2008).
77 Id. § 435.909(b) .
78 *See* 42 U.S.C. § 1320b-7 (2007); 42 C.F.R. § 435.910 (2007).
79 *See* 42 C.F.R. § 435.404 (2007).
80 42 U.S.C. § 1396a(a)(8) (2008).
81 *See* 42 C.F.R. § 435.911 (2007).
82 *See* 42 U.S.C. § 1396a(a)(48) (2008).
83 Id. §§ 435.930(b), 435.916(c) (2009).
84 Id. § 435.916 (2009).
85 *See, e.g., Crippen v. Kheder*, 741 F.2d 102 (6th Cir. 1984); *Stetson v. Blum,* 476 F. Supp. 1331 (S.D.N.Y. 1979), *aff'd,* 628 F.2d 1345 (2d Cir. 1980).
86 42 U.S.C. § 1396a(a)(47) (2008).
87 *See id.* § 1396r-1(a) (2006).
88 *See* Statehealthfacts.org, *50 States Comparison: Has Presumptive Eligibility for Pregnant Women 2009* (Henry J. Kaiser Family Foundation 2009), www.statehealthfacts.org/profileind.jsp?rgn=1&ind=225&cat=4 (last visited Aug. 31, 2009).
89 *See* CMS, *Breast and Cervical Cancer Prevention and Treatment Activity Map* (2005), availavke at www.cms.hhs.gov/MedicaidSpecialCovCond/Downloads/BREASTandCERVICALCANCERPREVENTIONandTREATMENTACTIVITYMAP.pdf.
90 *See* Statehealthfacts.org, *50 States Comparison: Has Presumptive Eligibility for Medicaid and SCHIP 2009* (Henry J. Kaiser Family Foundation 2009), www.statehealthfacts.org:/comparetable.jsp?typ=5&ind=229&cat=4&sub=59&sortc=1&o=a (last visited Aug. 31, 2009).
91 42 U.S.C. § 1396a(a)(34) (2006); 42 C.F.R. § 435.914 (2008).
92 *See* CMS, *State Medicaid Manual* § 2910 (2005) (date of signing outstation application is date of application for retroactive coverage); 42 U.S.C § 1396a(a)34 (2008).
93 42 U.S.C. § 1396a(a)(3) (2006); 42 C.F.R. §§ 431.200 - .246 (2008).
94 S*ee Goldberg v. Kelly*, 397 U.S. 254 (1970).
95 42 C.F.R. § 431.221(d) (2008).
96 *See* The Henry J. Kaiser Family Foundation, *Women's Health Insurance Coverage: An Update on Women's Health Policy* (2008), available at www.kff.org/womenshealth/upload/6000_07.pdf.
97 *See* National Health Law Program, *An Advocate's Guide to the Medicaid Program* (2001), for additional information about the Medicaid program and Medicaid covered services, including citations to the Act and the Code of Federal Regulations (available from NHeLP's Los Angeles office).
98 *See* 42 U.S.C. § 1396a(a)(17) (2006); S. REP. NO. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986 ("Congress intended medical judgments to play a primary role in determining medical necessity ... The Committee's bill provides that the physician is to be the key figure in determining utilization of health services – and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay.").
99 42 U.S.C. § 1396d(r) (2006); 42 C.F.R. § 440.230(d) (2008).
100 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a) (2006); 42 C.F.R. §§ 440.210 (2008).
101 42 U.S.C. § 1396a(a)(10)(C)(iii), (a)(10)(G)(V) (2006); 42 C.F.R. § 440.210(a)(2) (2008); CMS, State Medicaid Manual §§ 3311-3311.3, 4421 (2005).

102 42 U.S.C. § 1396d(a)(xiii)(4)(C) (2006); 42 C.F.R. § 441.20 (2008). *See* also CMS, State Medicaid Manual § 4270 (2005); National Health Law Program, Medicaid Coverage of Reproductive Health Services (1999), www.healthlaw.org/library/attachment.119606?print (last visited Aug. 31, 2009).
103 42 U.S.C. § 1396d(a)(17) (2006); 42 C.F.R. § 440.165 (2008).
104 42 U.S.C. §§ 1396d(a)(xiii)(6)-(27) (2006); 42 C.F.R. § 440.225 (2008).
105 42 U.S.C. §§ 1396a(a)(10)(C)(ii)(II) and 1396a(a)(10)(C)(iii)(II) (2006); 42 C.F.R. § 440.220(a)(1) (2008). If a woman applies for and receives medically needy Medicaid during her pregnancy, the state must also cover her for pregnancy-related care during the 60 day postpartum period. 42 C.F.R. § 440.220(a)(5) (2008).
106 42 U.S.C. § 1396a(a)(10)(C)(iii)(I), (D) (2006); 42 C.F.R. § 440.220(a)(2)-(3) (2008).
107 42 U.S.C. § 1396a(a)(10)(C)(iv) (2006); 42 C.F.R. § 440.220(a)(4) (2008).
108 Courts have recognized that the "basic objective" of the Medicaid program is to provide individuals with medically necessary care and, moreover, that the "touchstone" for evaluating whether a state plan is reasonable is whether medically necessary procedures are covered. *See Hern v. Beye*, 57 F.3d 906, 910-911 (10th Cir. 1995).
109 42 U.S.C. § 1396a(a)(17) (2008).
110 42 C.F.R. § 440.230(c) (2008).
111 *See* Sarah Somers & Jane Perkins, *Medicaid's Amount, Duration and Scope Requirement: Challenging Cuts in Service for Adults*, *available at* www.nls.org/conf2006/medicaid's amount.pdf.
112 *See* 42 U.S.C. § 1396a(a)(30) (2006); 42 C.F.R. §§ 440.230(d), 456.1 *et seq*. (2008).
113 Prior authorization may not be applied to emergency services or to EPSDT screenings. *See Id.* § 1396u-2(b)(2)(A)(i) (2006); 42 C.F.R. § 441.59(a) (2008).
114 Guttmacher Institute, *In Brief: Facts on American Teens' Sexual and Reproductive Health* (2006), available at www.guttmacher.org/pubs/fb_ATSRH.pdf.
115 *See* Hariette B. Fox, Stephanie J. Limb & Margaret A. McManus, *Preliminary Thoughts on Restructuring Medicaid to Promote Adolescent Health* (Incenter Strategies – The National Alliance to Advance Adolescent Health 2007), available at www.incenterstrategies.org/jan07/issuebrief1.pdf.
116 *See id.*
117 *See id.* (citing Brooks-Gunn J., Duncan GJ. The Effects of Poverty*, Children in Poverty,* 1997; 7:55-71.
118 *See* 42 U.S.C. §§ 1396a(a)(10)(A), (43), 1396d(a)(4)(b), (r) (2006).
119 For an in-depth discussion of EPSDT *See* Jane Perkins, *Medicaid Early and Periodic Screening, Diagnosis and Treatment Fact Sheet* (National Health Law Program 2008), www.healthlaw.org/library/attachment.142328 (last visited Aug. 31, 2009) and Jane Perkins & Sarah Somers, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnosis and Treatment for Poor Children and Youth* (National Health Law Program 2003)(available from NHeLP's Los Angeles office). *See* also, e.g., CMS, State Medicaid Manual part 5 (2005).
120 *See* Jane Perkins, *Medicaid Early and Periodic Screening, Diagnosis and Treatment Fact Sheet* (National Health Law Program 2008), www.healthlaw.org/library/attachment.142328 (last visited Aug. 31, 2009) and Jane Perkins & Sarah Somers, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnosis and Treatment for Poor Children and Youth* (National Health Law Program 2003), for an in-depth discussion of EPSDT.
121 42 U.S.C. § 1396d(r)(5) (2006).
122 42 U.S.C. § 1396a(a)(43) (2006); 42 C.F.R. §§ 441.56, 441.62 (2008); CMS, *State Medicaid Manual* part 5 (2005).
123 *See* 42 C.F.R. § 441.61 (2008).
124 *See* National Health Law Program, Medicaid Coverage of Reproductive Health Services (Feb. 2008), available at www.healthlaw.org/library/attachment.119606?print (last visited Aug. 31, 2009).
125 Guttmacher Institute, *Contraceptive Needs and Services, 2006*, available at www.guttmacher.org/pubs/win/allstates2006.pdf..
126 Id.
127 Id.
128 *See* Guttmacher Institute, *Medicaid's Role in Family Planning* (The Henry J. Kaiser Family Foundation 2007), www.kff.org/womenshealth/upload/7064_03.pdf (last visited Aug. 31, 2009).
129 *See* 42 U.S.C. § 1396(d)(a)(4)(C). (2006). *See also* Jane Perkins, *Q&A on Medicaid Coverage of Reproductive Health Services* (National Health Law Program 2008), www.healthlaw.org/library/item.184599.
130 42 U.S.C. §§ 1396o(a),(b) and (c) (2006) (regarding prescription drugs). *See also* Letter from Dennis G. Smith, Director, Center for Medicaid & State Operations, Department of Health & Human Services, Centers for Medicare & Medicaid Services, to State Medicaid Director (June 16, 2006), *available at* www.cms.hhs.gov/smdl/downloads/SMD061606.pdf (last visited Aug. 31, 2009).
131 42 U.S.C. § 1396b(a)(5).
132 *See* 42 CFR § 433.10(c)(1) (2008).
133 *See* id.§ 433.15(b)(2) (2008); CMS, *State Medicaid Manual* §11110 (2005).
134 *See* Section III.B. for definitions of who is "categorically needy" and "medically needy".
135 At least one court has prohibited a state from conditioning family planning services on parental consent. *See T.H. v. Jones*, 425 F. Supp. 873 (D. Utah 1975), *aff'd*, 425 U.S. 986 (1976) (finding violation of Supremacy Clause and Fourteenth Amendment).

136 *See* CMS, *State Medicaid Manual* § 4270.B (2005).
137 *See* 42 U.S.C. § 1315(a) (2006).
138 42 U.S.C. § 1396n(b) (2008).
139 Id. § 1396a(a)(23) (2009).
140 42 U.S.C. § 1396u-2(b)(6)(C) (2006).
141 *See* Rachel Benson Gold & Cory L. Richards, *Medicaid Support for Family Planning in the Managed Care Era,* The Alan Guttmacher Inst. (2001), www.guttmacher.org/pubs/medicaid.pdf (last visited Aug. 31, 2009).
142 *See* CMS, *State Medicaid Manual* § 4270.B (2005).
143 Health Care Financing Administration, Pub. No. 45-4, *State Medicaid Manual* § 4270 (Transmittal No. 36, Sept. 1988). *See also* 42 C.F.R. § 420.230 (2008).
144 *See* CMS, *State Medicaid Manual* § 4270.B.2. (2005).
145 *See* id. § 4270.B.1.
146 42 C.F.R. § 441.20 (2008).
147 42 U.S.C. §1396r-8(d)(2)(B) (2009).
148 Such services may be considered medically necessary procedures and covered at states' regular FMAP percentage, not the enhanced 90% FMAP for family planning services.
149 *See* Usha Ranji, Alexandra M. Stewart, et al., State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings, (The Kaiser Family Foundation and The George Washington University Medical Center, November 2009), available at www.kff.org/womenshealth/upload/8015.pdf.
150 *See* id.
151 National Health Law Program, *Over the Counter or Out of Reach?: A Report on Evolving State Medicaid Policies for Covering Emergency Contraception* (2007), www.healthlaw.org/library/item.149429 (last visited Aug. 31, 2009). *See also* Princeton University Office of Population Research & Association of Reproductive Health Professionals, The Emergency Contraceptive Website, http://ec.princeton.edu/questions/dose.html (last visited Aug. 31, 2009).
152 *See* Ingrid Dries-Daffner et al., *Access to Plan B Emergency Contraception in an OTC Environment*, 11 J. NURSING L. 93, (2007), *available at* www.pharmacyaccess.org/pdfs/DriesDaffner_PlanBOTC.pdf ("...Plan B cannot terminate an existing pregnancy [a fertilized egg already attached to the uterine wall], distinguishing Plan B from abortifacient RU-486.").
153 Tummino v. Torti, 603 F. Supp. 2d 519, 549-50 (E.D.N.Y. 2009).
154 Brian Kalish, *FDA Approves Generic Version of Plan B®*, Wall St. J., June 29, 2009, http://online.wsj.com/article/SB10001424052970203937504574248384059754024.html (last visited Aug. 31, 2009).
155 National Health Law Program, *Over the Counter or Out of Reach?: A Report on Evolving State Medicaid Policies for Covering Emergency Contraception* (2007), www.healthlaw.org/library/item.149429.
156 Pharmacy Access Partnership, *What Consumers Need to Know About Obtaining Plan B Over-the-Counter in Pharmacies* (Aug. 2009), *available at* www.pharmacyaccess.org/pdfs/ConsumerFAQsOTC.pdf.
157 *See* Ingrid Dries-Daffner et al., *Access to Plan B Emergency Contraception in an OTC Environment*, 11 JOURNAL OF NURSING LAW 93 (2007), *available at* www.pharmacyaccess.org/pdfs/DriesDaffner_PlanBOTC.pdf (last visited Aug. 31, 2009).
158 42 C.F.R. § 441.251 (2008).
159 42 U.S.C. § 1396d(a)(xiii)(4) (2006); 42 C.F.R. §§ 441.20, 441.250 *et seq.* (2008) (explaining limitations on and pre-conditions to federal funding for sterilizations).
160 42 C.F.R. §§ 441.250.259 (2008).
161 Id. §§ 441.20, 441.250 et seq. (2008) (explaining limitations on, and pre-conditions to, federal funding for sterilizations).
162 42 C.F.R. § 441.257(b)(1)-(3) (2008).
163 Information from NHeLP's 50-state survey of Medicaid coverage of family planning services and supplies. Publication forthcoming.
164 *See* Renee Schwalberg et al., *Medicaid Coverage of Family Planning Services: Results of a National Survey* (The Henry J. Kaiser Family Foundation 2001), www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13737 (last visited Aug. 31, 2009).
165 *See* CMS, *State Medicaid Manual* § 4270.B.2 (2005).
166 42 C.F.R. § 441.255(a)(1)-(2) (2008).
167 *See* CMS, *State Medicaid Manual* § 4435 (2005).
168 42 U.S.C. § 1396u-2(b)(3)(B) (Supp. 2002). *See also* 42 C.F.R. § 438.102(a)(2) (2008).
169 Potential enrollees can also request detailed information about what services are covered under a particular managed care plan in order to ensure that the family planning services they want are going to be covered, *see* 42 C.F.R. § 438.10(e) (2008).
170 42 C.F.R. § 438.52(b)(2)(ii)(C) (2008).
171 Id. § 438.10(e)(2)(ii)(E).

172 For example, Fidelis Care in New York is a Medicaid MCO that refuses to provide family planning services or to offer referrals so that women can otherwise access services they need and to which they are entitled under Medicaid. Fidelis will only hand members a fact sheet prepared by the State Department of Health. Fideliscare, Family Planning Services, www.fideliscare.org/providers.aspx?view=art&cid=17&aid=481&parent=481 (last visited Aug. 31, 2009). The Fidelis Care member FAQs lists covered services and specific questions about coverage of dental, orthodontia, mental health, adult vaccinations, and substance abuse but does not mention the reproductive health exclusions. Fidelis Care, *Frequently Asked Questions*, www.fideliscare.org/faqs.aspx (last visited Aug. 31, 2009).

173 42 C.F.R. § 438.102(b)(2) (2008).

174 *See* 42 U.S.C. § 1315(a) (2003).

175 *See id.* Note that certain provisions cannot be waived, in particular deeming rules for pregnant women and initiating eligibility determinations at "out stationed" locations frequented by pregnant women, children and youth. *See Id.* § 1396a(l) (2008).

176 *See* Guttmacher Institute, *Medicaid's Role in Family Planning* (The Henry J. Kaiser Family Foundation 2007), www.kff.org/womenshealth/upload/7064_03.pdf.

177 *See* Statehealthfacts.org, *States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid, as of July 1, 2009* (Henry J. Kaiser Family Foundation 2009), www.statehealthfacts.org/comparetable.jsp?cat=10&ind=456&typ=5&gsa=1 (last visited Aug. 31, 2009).

178 *See id.*

179 *See* Guttmacher Institute, *Medicaid's Role in Family Planning* (The Henry J. Kaiser Family Foundation 2007), www.kff.org/womenshealth/upload/7064_03.pdf (last visited Aug. 31, 2009).

180 *See* Statehealthfacts.org, *States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid, as of July 1, 2009* (Henry J. Kaiser Family Foundation 2009), www.statehealthfacts.org/comparetable.jsp?cat=10&ind=456&typ=5&gsa=1 (last visited Aug. 31, 2009).

181 *See* Guttmacher Institute, *Medicaid's Role in Family Planning* (The Henry J. Kaiser Family Foundation 2007), available at www.kff.org/womenshealth/upload/7064_03.pdf.

182 *See id.* (citing Centers for Medicare and Medicaid Services, *Special Terms and Conditions: Project Number 11-W-00142/0, Oregon Family Planning Expansion Project 4* (2007)).

183 *See* Renee Schwalberg et al., *Medicaid Coverage of Family Planning Services: Results of a National Survey,* 37-38 (The Henry J. Kaiser Family Foundation 2001), www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13737 (last visited Aug. 31, 2009).

184 CMS, *State Medicaid Manual* §4421.B.1. (1994).

185 CMS, *State Medicaid Manual* §4421.A.3. (1994).

186 *See* Renee Schwalberg et al., *Medicaid Coverage of Perinatal Services: Results of a National Survey* (The Henry J. Kaiser Family Foundation 2001), www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13738 (last visited Aug. 31, 2009).

187 *See* section VI. for a discussion on Medicaid's prescription drug coverage. States may impose cost sharing on non-preferred prescription drugs to encourage the use of the least (or less) costly effective prescription within a class of drugs: preferred drugs. 42 U.S.C. §§ 1396o(a)- (c) (2006). *See* also Letter from Dennis G. Smith, Director, Center for Medicaid & State Operations, Department of Health & Human Services, Centers for Medicare & Medicaid Services, to State Medicaid Director (June 16, 2006), *available at* www.cms.hhs.gov/smdl/downloads/SMD061606.pdf.

188 42 U.S.C. § 1396o(c) (2006); CMS, *State Medicaid Manual* § 3571.5 (1990) (stating that premiums may be waived in hardship cases).

189 *Id.* § 4421.B.

190 *Id.*

191 In response to reports that women were being required to pay for their epidurals out-of-pocket prior to delivery, Center for Medicaid and State Operations Director Sally K. Richardson directed States to ensure that "where epidurals are a covered benefit under a State's Medicaid program, and the service is determined to be medically necessary, a pregnant Medicaid beneficiary is entitled to receive the service ... [u]nder federal Medicaid law, deductions, cost sharing or similar charges are not permitted for Medicaid services furnished to pregnant women." Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Inappropriate Cash Payments for Medicaid-Covered Services* (1999), *available at* www.cms.hhs.gov/smdl/downloads/SMD012799.pdf.

192 As of 2001, 34 States and D.C. covered birth centers and home births. *See* Renee Schwalberg et al., *Medicaid Coverage of Perinatal Services: Results of a National Survey* (The Henry J. Kaiser Family Foundation 2001), www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13738 (last visited Aug. 31, 2009); Susan Jenkins, *Expanding Reproductive Choice: Ensuring a Range of Birthing Options for Women* (Center for American Progress 2006), www.americanprogress.org/issues/2006/10/hyde_column4.html (last visited Aug. 31, 2009).

193 CMS, *State Medicaid Manual* § 4421.B.4. (2005).

194 42 C.F.R. § 440.210(a)(2)(ii) (2008).

195 *See* Section III.B.1.a.

196 42 C.F.R. § 440.210(a)(2) (2008); CMS, *State Medicaid Manual* § 4421 (2005).

197 *See* Section III.B.1.a.

198 42 C.F.R. § 440.210(a)(2) (2008).

199 *See* Section III.B.1.b.
200 42 C.F.R. § 440.210(a)(2) (2008).
201 *Id.* § 440.220(a)(1), (5) (2005).
202 *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 214, 123 Stat. 8, 56-57 (amending 42 U.S.C. § 1396b(v)(4)(A)(i)-(ii) defining "pregnant woman" as someone who is pregnant or is within the 60 day post-partum period).
203 Cal. Code Regs. tit. 22, § 50740 (2009).
204 Stanley K. Henshaw & Kathryn Kost, *Trends in the Characteristics of Women Obtaining Abortions, 1974 to 2004* (Guttmacher Institute 2008), available at www.guttmacher.org/pubs/2008/09/18/Report_Trends_Women_Obtaining_Abortions.pdf.
205 *See id.*
206 The Henry J. Kaiser Family Foundation, *Abortion in the U.S.: Utilization, Financing, and Access: Women's Health Policy Facts* (2008), www.kff.org/womenshealth/upload/3269-02.pdf (last visited Aug. 31, 2009).
207 The U.S. Supreme Court has upheld the authority of Congress to restrict Medicaid abortion funding. *See Harris v. McRae*, 448 U.S. 297 (1980).
208 Based on these restrictions, 32 States. fund abortions through Medicaid only in the cases of rape, incest, or life endangerment. South Dakota covers abortions only in the cases of life endangerment, which does not comply with federal requirements under the Hyde Amendment. Indiana, Utah, and Wisconsin have expanded coverage to women whose physical health is jeopardized. *See* Guttmacher Institute, State Policies in Brief: An Overview of Abortion Laws (2009), available at www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.
209 The Hyde Amendment is usually included in the Labor-HHS Appropriations Bill or any continuing resolution or omnibus bill that includes funding for the Departments of Labor and Health and Human Services. *See* Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, §§ 507-508, 121 Stat. 1844, 2208-2209 (2007).
210 Abortion is not a family planning service under the Medicaid Act because abortions neither "prevent[s] nor delay[s] pregnancy." *See* CMS, *State Medicaid Manual* § 4270.B. (2005). Prior to the Hyde Amendment, abortions were evaluated in the same manner as other health services.
211 *See* Director, Center for Medicaid and State Operations, Health Care Financing Administration, to State Medicaid Directors (Feb. 12, 1998) (available from NHeLP's Los Angeles office); ; CMS, State Medicaid Manual §§ 4431-32. (2005). Certification must contain the name and address of the patient, 42 C.F.R. § 441.203 (2008).
212 *See* Stephanie Poggi, *Abortion Funding for Poor Women: The Myth of the Rape Exception* (Center for American Progress 2005), www.hyde-30years.nnaf.org/resources/poggi_rape_exception.pdf.
213 *See* Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, to State Medicaid Directors (Feb. 2, 1998) (available from NHeLP's Los Angeles office).
214 *See id.*
215 Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia use their own funds to cover all or most "medically necessary" abortions sought by low-income women under Medicaid. These states cover non-federally funded abortions as a result of a state statute or litigation under the state constitution. In December 2009, the President signed an omnibus appropriations bill that included a provision in lifting the ban on Washington D.C.'s use of local dollars to fund abortions beyond the Hyde limitations.
216 CMS, *State Medicaid Manual* §§ 441.208, 4432.B.2. (2005).
217 42 C.F.R. § 440.230(c) (2008).
218 CMS, *State Medicaid Manual* § 4432.B.2. (2005).
219 *See* Susan Berke Fogel & Tracy A. Weitz, *Health Care Refusals: Undermining Quality Care for Women,* (February 2010).
220 *Roe v. Wade*, 410 U.S. 113 (1973).
221 42 U.S.C. § 300a-7 (2006). The Church Amendment also prohibits institutions from discriminating against providers who do perform abortions and sterilizations.
222 *Id.* § 300a-7(d).
223 Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2004); Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, 2006, Pub. L. No. 109-149, 119 Stat. 2833, 2851; Consolidated Appropriations Act, 2008, H.R. 2764, 110th Cong. § 508(d)(1) (2007).
224 73 Fed. Reg. 78096 (Dec. 19, 2008) (codified at 45 C.F.R. pt. 88).
225 74 Fed. Reg. 10207 (Mar. 10, 2009) (codified at 45 C.F.R. pt. 88, as amended).
226 Family Planning Advocates of New York State Education Fund, *Mainstreaming Access to Emergency Contraception for Rape Victims: State-by-State Analysis of EC in ER Legislation* (2003), available at www.edfundfpa.org/ec/documents/EC_State_by_State.pdf.
227 Mississippi Health Care Rights of Conscience Act codified at 41 Miss. Code Ann. § 107-3 (2004).
228 Guttmacher Institute, *State Policies in Brief: Refusing to Provide Health Services* (2009), available at www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf
229 There are many non-profit religiously-controlled hospitals and health systems that do not impose any religious restrictions on patients or providers. *See generally* Religious Coalition for Reproductive Choice, *Perspectives: A Matter of Faith and Conscience* (2008), www.rcrc.org/perspectives/index.cfm (last visited Aug. 31, 2009).

230 *See* Catholic Health Association of the United States, *Catholic Health Care in the United States: About Catholic Health Care*, www.catholichealthcare.us/about (last visited Aug. 31, 2009).
231 *See id.*
232 United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition*, www.usccb.org/bishops/directives.shtml (last visited Aug. 31, 2009).
233 Centers. for Disease Control & Prevention, Breast Cancer Statistics, www.cdc.gov/cancer/breast/statistics/ (last visited Aug. 31, 2009).
234 *See* Susan G. Komen for the Cure, Understanding Breast Cancer, www.komen.org/breastcancer/whodoesitaffect.html (last visited Aug. 31, 2009).
235 American Cancer Society, What Are the Key Statistics About Cervical Cancer?, www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_cervical_cancer_8.asp?sitearea= (last visited Aug. 31, 2009).
236 *See* Centers for Disease Control & Prevention, Breast Cancer Statistics, www.cdc.gov/cancer/breast/statistics/ (last visited Aug. 31, 2009).
237 *See* American Cancer Society, Cancer Disparities: Key Statistics, www.cancer.org/docroot/SPC/content/SPC_1_Minority_Cancer_Unequal_Burden_Sidebar1.asp (last visited Aug. 31, 2009).
238 Press Release, American Cancer Society, Racial Differences in Severity of Breast Cancer Presentation Confirmed (July 9, 2007).
239 U.S. Department of Health & Human Services, The National Women's Health Information Center, Cervical Cancer (Mar. 2008), www.womenshealth.gov/minority/hispanicamerican/cc.cfm (last visited Aug. 31, 2009).
240 States must agree that if a charge is imposed for the provision of screening services, it will be adjusted to reflect the income of the woman and will not be imposed if a woman's income is less than 100% of the federal poverty level. *See* 42 U.S.C. § 300n (2009).
241 Centers. for Disease Control & Prevention, National Breast and Cervical Cancer Early Detection Program: About the Program (2009), www.cdc.gov/cancer/NBCCEDP/about.htm (last visited Aug. 31, 2009); Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Medicaid Cost Sharing* (2006), *available at* www.cms.hhs.gov/smdl/downloads/SMD061606.pdf.
242 *See* Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381 (2000).
243 *See id.*
244 *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).
245 For a more detailed description of the different CDC-related screens that states can choose to accept in determining eligibility, *See* Letter from Timothy M. Westmoreland, Director of Health Care Financing Administration, to State Health Officials, Breast and Cervical Cancer Prevention and Treatment Act (Jan. 4, 2001), available at www.cms.hhs.gov/MedicaidEligibility/downloads/breastandcervical3.pdf.
246 A diagnosis of a pre-cancerous condition qualifies, and "in need of treatment" is determined by the individual who conducts the screen or any other health professional with whom the individual consults and may include the additional diagnostic treatment. *See Id.*
247 As defined in the Health Insurance Portability and Accountability Act, creditable coverage includes any of the following: a group health plan, such as one obtained through an employer or a spouse s employer; health insurance coverage, including individual coverage; Medicare and Medicaid; CHAMPUS/TriCare; a medical program of the Indian Health Service Act or of a tribal organization; a state health benefits high risk pool; the Federal Employees Health Benefits Program; a public health plan; and a health benefit plan under section 5(e) of the Public Health Service Act. Health Insurance Portability and Accountability Act, 42 U.S.C. § 300gg(c) (2006).
248 *See* Letter from Timothy M. Westmoreland, Director of Health Care Financing Administration, to State Health Officials, Breast and Cervical Cancer Prevention and Treatment Act (Jan. 4, 2001), *available at* www.cms.hhs.gov/MedicaidEligibility/downloads/breastandcervical3.pdf.
249 *See id.*
250 *See* Letter from Dennis G. Smith, Director of Center for Medicare and Medicaid Services, to State Health Officials, Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001, *available at* www.cms.hhs.gov/MedicaidSpecialCovCond/Downloads/CMSLettertoStateHealthOfficials.pdf.
251 *See* Letter from Timothy M. Westmoreland, Director, HCFA, to State Health Officials, Breast and Cervical Cancer Prevention and Treatment Act (Jan. 4, 2001), *available at* www.cms.hhs.gov/MedicaidEligibility/downloads/breastandcervical3.pdf (last visited Aug. 31, 2009).
252 *See* Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381 (2000).
253 Health Resources and Services Administration, *Women's Health USA 2008: Mental Health Care Utilization* (U.S. Department of Health and Human Services 2008), http://mchb.hrsa.gov/whusa08/hsu/pages/309mhcu.html (last visited Aug. 31, 2009).
254 The Commonwealth Fund, *State Medicaid Policy for Reimbursement of Maternal Depression Screening* (2005), www.commonwealthfund.org/Content/Innovations/Tools/2005/Mar/State-Medicaid-Policy-for-Reimbursement-of-Maternal-Depression-Screening.aspx (last visited Aug. 31, 2009).
255 *See* Carey Goldberg, *Mental Illness and Poverty: Does One Cause the Other?,* Bnrsnm Gknad, Mar. 8, 2005, www.boston.com/news/globe/health_science/articles/2005/03/08/mental_illness_and_poverty_does_one_cause_the_other/ (last visited Sept. 24, 2009).
256 The Commonwealth Fund, *State Medicaid Policy for Reimbursement of Maternal Depression Screening* (2005), www.commonwealthfund.org/Content/Innovations/Tools/2005/Mar/State-Medicaid-Policy-for-Reimbursement-of-Maternal-Depression-Screening.aspx (last visited Aug. 31, 2009).
257 *See* www.healthlaw.org for extensive research, resources, and additional information on this topic.
258 Sara Sills, *Protecting Reproductive Health Care for Low-Income Women* (Institute for Reproductive Health Access 2002), www.healthlaw.org/library/item.69396 (last visited Aug. 31, 2009).

259 42 U.S.C. § 2000d (2006). *See also* 45 C.F.R. part 80, app. A (2008) (listing examples of federal financial assistance, including Medicare, Medicaid, and Maternal and Child Health grants).

260 *See* Jane Perkins & Jamie Brooks, *Summary of State Law Requirements Addressing Language Needs in Women's Health* (National Health Law Program 2006), *www.healthlaw.org/library/attachment.81543 (last visited Aug. 31, 2009).*

261 *See* Jane Perkins, Mara Youdelman & Doreena Wong, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (2d ed., National Health Law Program 2003).

262 *See* CMS, *State Medicaid Manual*, § 2900.4 (2005). Pursuant to CMS, *State Medicaid Manual* § 2902, States must provide interpreters at Medicaid hearings.

263 *See* Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311, 47,319 (Aug. 8, 2003), for information regarding when translations are required for smaller LEP groups.

264 *See* Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Policy Guidance on the Title VI Prohibition Against National Origin Discrimination (2000), available at* www.cms.hhs.gov/smdl/downloads/smd083100.pdf. The Children's Health *Insurance Program Reauthorization Act of 2009* authorizes enhanced federal administrative matching payments for the provision of language access services in CHIP and Medicaid programs. State CHIP programs may now receive enhanced federal matching for translation or interpretation services "in connection with the enrollment of, retention of, and use of services under this title by individuals for whom English is not their primary language." The enhanced rate will be the higher of 75 percent or the sum of the state's current federal CHIP administrative matching rate plus five percentage points. *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 201(b), 123 Stat. 8, 39 (amending 42 U.S.C. § 1397ee). Contributing states are: Hawaii, Idaho, Indiana, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Virginia, Vermont, Washington and Wyoming.

265 *See Rosemarie O. Berman, Perceived Learning Needs of Minority Expectant Women and Barriers to Prenatal Education, 15.2 J. Pdqmvasak Ectb. 36 (2006).*

266 Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35.1 Pdqro. Om Sdwtak &Rdoqnc. Hdaksg 16 (2001).

267 *See* 42 C.F.R. § 441.62 (2008).

268 *See* 42 C.F.R. § 441.62 (2008).

269 *Id.* § 431.53 (2008). For additional information on Medicaid coverage of transportation services, *See* Manjusha Kulkarni, Fact Sheet: Medicaid Transportation Services (National Health Law Program 2000), www.healthlaw.org/library/attachment.60642 (last visited Aug. 31, 2009); Leslie Arnold & Jane Perkins, Q&A: Non-Emergency Medical Transportation for Pregnant Women (National Health Law Program 2008), www.healthlaw.org/library/attachment.141115 (last visited Aug. 31, 2009).

270 42 C.F.R. § 440(a) (2008).

271 Courts have come to different conclusions about the standards for the transportation benefit. For example, in *Daniels v. Tennessee Department of Health and Environment*, 1985 U.S. Dist. LEXIS 12145 (M.D. Tenn. Feb. 20, 1985), the Court allowed Tennessee to satisfy the transportation requirement through paid volunteers, while in *Fant v. Stumbo*, 552 F. Supp. 617 (W.D. Ky. 1982), the Court invalidated Kentucky's limit on four visits per month.

272 42 C.F.R. § 440.170 (2008).

273 *See* 42 U.S.C. § 1396(a)(70) added by the Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6083, 120 Stat. 4, 120-121 (2006); Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Section 6083 of the Deficit Reduction Act of 2005* (2006), *available at* www.cms.hhs.gov/smdl/downloads/SMD06009.pdf (last visited Aug. 31, 2009).

274 *See* Sara Sills & Sue Frietsche, *Removing Barriers to Medicaid-Funded Abortion: What Advocates Can Learn from the Pennsylvania Experience* (Robert Jaffe ed., Institute for Reproductive Health Access 2004), *available at* www.womenslawproject.org/brochures/RemovingBarriers.pdf.

275 Leslie Arnold & Jane Perkins, Q&A: Non-Emergency Medical Transportation for Pregnant Women (National Health Law Program 2008), available at www.healthlaw.org/library/attachment.141115.

276 42 C.F.R. §§ 431.53, 440.170 (2008).

277 *See* 42 U.S.C. §§ 1396a(a)(54) (outpatient drugs), 1396d(a)(xiii)(12) (prescription drugs), 1396r-8 (outpatient drugs) (2006); *see also* 42 C.F.R. § 440.120(a) (2008) (defining prescribed drugs).

278 42 U.S.C. § 1396r-8(d)(2) (2006).

279 *Id.* § 1396r-8(a).

280 *Id.* § 1396r-8(k)(6). *See also Edmonds v. Levine*, 417 F. Supp. 2d 1323 (S.D. Fla. 2006).

281 *See* National Conference of State Legislatures, *Recent Medicaid Prescription Drug Laws and Strategies, 2001-2009* (2008), www.ncsl.org/IssuesResearch/Health/RecentMedicaidPharmaceuticalLawsandPolicies/tabid/14456/Default.aspx (last visited Aug. 31, 2009).

282 *See* Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Medicaid Cost Sharing* (2006), *available at* www.cms.hhs.gov/smdl/downloads/SMD061606.pdf. States may impose cost sharing on non-preferred prescription drugs to encourage the use of the least (or less) costly effective prescription within a class of drugs. Women whose choice of contraception is a brand-name method, or beneficiaries using a brand-name drug to treat STIs may be adversely affected if preferred versions do not exist.

283 42 U.S.C. § 1396r-8(d)(1)(A), (5) (2006); Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Hyde Amendment* (1998), *available at* www.cms.hhs.gov/smdl/downloads/SMD061606.pdf.

284 For example, California covers only six two-pill prescriptions for Plan B® (emergency contraception) per year; Maryland allows one prescription every 90 days, s*ee* National Institute for Reproductive Health, *Expanding Medicaid Coverage for EC on the State Level* (2007), www.healthlaw.org/library/item.159837-Expanding_Medicaid_Coverage_for_EC_on_the_State_Level_National_Institute_fo (last visited Aug. 31, 2009).

285 *See* CMS, State Plan Under Title XIX of the Social Security Act, *available at* www.cms.hhs.gov/smdl/downloads/6042Preprint.pdf.

286 42 U.S.C. § 1396r-8(j)(1) (2006); 42 C.F.R. § 456.703(c)(2) (2008). *But see* Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Issues Related to Mental Health Services* (1999) (stating that federal statutory requirements about new medications, including prior authorization requirements, apply to services states carry out via contract), *available at* www.cms.hhs.gov/smdl/downloads/SMD060799b.pdf.

287 *See generally* Claudia Schlosberg & Sareena Jerath, *Fact Sheet: Prescription Drug Coverage Under Medicaid* (National Health Law Program 1999), available at www.healthlaw.org.

288 42 U.S.C. § 1396r-8(k)(4) (2006).

289 For example, the Federal Drug Administration approved a new female condom which will sell between $2.80 and $4.00 a piece, an out-of-pocket cost that may be prohibitive for Medicaid beneficiaries without a prescription.

290 *See* Pharmacy Access Partnership, *Birth Control Within Reach: A National Survey on Women's Attitudes and Interest in Pharmacy Access to Hormonal Contraception* (2005), *available at* www.pharmacyaccess.org/pdfs/ExecutiveSummary.pdf.

291 For example, the Federal Drug Administration approved a new female condom which will sell between $2.80 and $4.00 a piece, an out-of-pocket cost that may be prohibitive for Medicaid beneficiaries without a prescription.

292 42 U.S.C. § 1396(i) (2006).

293 *See* Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter: Tamper-Resistant Prescription Pads* (1999), *available at* www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf.

294 *See generally* National Women's Law Center, *The Pharmacy Refusal Project* (2009), http://nwlc.org/details.cfm?id=2185&section=health (last visited Aug. 31, 2009).

295 *See generally* American Civil Liberties Union, *Religious Refusals and Reproductive Rights: Accessing Birth Control at the Pharmacy* (2007), www.aclu.org/images/asset_upload_file119_29548.pdf.

296 Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504 (1970) (codified as amended at 42 U.S.C. §§ 300 *et seq.*).

297 U.S. Department of Health & Human Services, Office of Public Health and Science, Office of Population Affairs, *Office of Family Planning*, www.hhs.gov/opa/familyplanning/index.html (last visited Aug. 31, 2009); *Silent Victories: The History and Practice of Public Health in Twentieth Century America* 263-264 (John Ward & Christian Warren eds., Oxford University 2007).

298 *Silent Victories: The History and Practice of Public Health in Twentieth Century America* 263-264 (John Ward & Christian Warren eds., Oxford University 2007).

299 42 U.S.C. § 300a-4(c) (2009); OPA Clearinghouse, *About the OPA Clearinghouse*, www.opaclearinghouse.org/about_opac.html (last visited Aug. 31, 2009).

300 U.S. Department of Health & Human Services, Office of Public Health and Science, Office of Population Affairs, *Office of Family Planning*, www.hhs.gov/opa/familyplanning/index.html (last visited Aug. 31, 2009).

301 OPA Clearinghouse, *About the OPA Clearinghouse*, www.opaclearinghouse.org/about_opac.html (last visited Aug. 31, 2009); Region 8 Family Planning Training Center, *Facts About Title X – The National Family Planning Program*, www.region8familyplanning.org/titleXFamilyPlanning.htm (last visited Aug. 31, 2009).

302 OPA Clearinghouse, *About the OPA Clearinghouse*, www.opaclearinghouse.org/about_opac.html (last visited Aug. 31, 2009).

303 Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504 (1970) (codified as amended at 42 U.S.C. §§ 300 *et seq.*). *See also* U.S. Department of Health & Human Services, Office of Public Health and Science, Office of Population Affairs, *Family Planning*, www.hhs.gov/opa/familyplanning/index.html (last visited Aug. 31, 2009); Rachel Benson Gold, *Title X: Three Decades of Accomplishment*, 4.1 Gtssl æbgdq Rdo. Om Pta. Pnk'x 5 (2001), *available at* www.guttmacher.org/pubs/tgr/04/1/gr040105.pdf.

304 Economic Opportunity Act Amendments of 1966, Pub. L. No. 89-794, § 211, 80 Stat. 1451, 1463 (1966). *See also* National Association of Community Health Centers, *About NACHC*, www.nachc.com/about-nachc.cfm (last visited Aug. 31, 2009).

305 National Association of Community Health Centers, *About NACHC*, www.nachc.com/about-nachc.cfm (last visited Aug. 31, 2009); U.S. General Accounting Office, Pub. No. GAO/HES-00-39, *Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success* (2000), *available at* www.gao.gov/new.items/he00039.pdf.

306 U.S. Department of Health and Human Services, Health Resources and Services Administration, *The Health Center Program: What is a Health Center?*, http://bphc.hrsa.gov/about/ (last visited Aug. 31, 2009).

307 U.S. Department of Health and Human Services, Health Resources and Services Administration, *Find Shortage Areas: MUA/P by State and County*, http://muafind.hrsa.gov/ (last visited Aug. 31, 2009).

308 U.S. General Accounting Office, Pub. No. GAO/HES-00-39, *Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success* (2000), *available at* www.gao.gov/new.items/he00039.pdf.
309 *Id.*
310 John L. Parascandola, *Public Health Service*, in *A Historical Guide to the U.S. Government* 487-493 (George Thomas Kurian ed., Oxford University Press 1998), http://lhncbc.nlm.nih.gov/apdb/phsHistory/resources/phs_hist/pub_phs01.html (last visited Aug. 31, 2009).
311 *Id.*
312 *Id.*
313 Jennifer J. Frost, *Public or Private Providers? U.S. Women's Use of Reproductive Health Services*, 33.1 Fam. Plan. Perspect. 4 (2001), *available at* www.guttmacher.org/pubs/journals/3300401.pdf (last visited Aug. 31, 2009).
314 Advocates for Youth, *Science and Success, Second Edition: Sex Education and Other Programs That Work to Prevent Teen Pregnancy, HIV and Sexually Transmitted Infections* (2008), *available at* www.advocatesforyouth.org/storage/advfy/documents/sciencesuccess.pdf.
315 Eligibility levels may be higher than 200%.
316 *See e.g.,* Shawn Towey, Stephanie Poggi & Rachel Roth, *Abortion Funding: A Matter of Justice* 8 (National Network of Abortion Funds 2005), *available at* www.nnaf.org/pdf/NNAF%20Policy%20Report.pdf.
317 National Network of Abortion Funds, *About Us*, http://nnaf.org/aboutus.html (last visited Aug. 31, 2009).
318 Shawn Towey, Stephanie Poggi & Rachel Roth, *Abortion Funding: A Matter of Justice* 8 (National Network of Abortion Funds 2005), *available at* www.nnaf.org/pdf/NNAF%20Policy%20Report.pdf. NNAF fund members are independent organizations that are affiliated with independent or feminist women's clinics, Planned Parenthood clinics, reproductive rights organizations, or sponsored by progressive churches.
319 *Id.*
320 *Id.*
321 National Network of Abortion Funds, *About Abortion Funds*, www.nnaf.org/aboutfunds.html (last visited July 15, 2009).
322 Health Resources and Services Administration, *Fact Sheet: Maternal and Child Health* (U.S. Department of Health and Human Services 2008), *available at* ftp://ftp.hrsa.gov/factsheets/mchb.pdf.
323 Health Resources and Services Administration, *Understanding Title V of the Social Security Act* (U.S. Department of Health and Human Services 2002), *available at* ftp://ftp.hrsa.gov/mchb/titlevtoday/UnderstandingTitleV.pdf.
324 *Id.*
325 *Id.* Congress added an Abstinence Education program to Title V, under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Funding for abstinence education was supplied in 2000.
326 Sharon Kearney Coleman, *CRS Report for Congress: Maternal and Child Health Block Grant* (Congressional Research Service 2004), *available at* www.epi.umn.edu/mch/events/SummerInstitute/2004/jones_blockgrant.pdf.
327 *Id.*
328 Health Resources and Services Administration, *Fact Sheet: Maternal and Child Health* (U.S. Department of Health and Human Services 2008), *available at* ftp://ftp.hrsa.gov/factsheets/mchb.pdf.
329 Sharon Kearney Coleman, *CRS Report for Congress: Maternal and Child Health Block Grant* (Congressional Research Service 2004), *available at* www.epi.umn.edu/mch/events/SummerInstitute/2004/jones_blockgrant.pdf.
330 *Id.*
331 Health Resources and Services Administration, *Understanding Title V of the Social Security Act* (U.S. Department of Health and Human Services 2002), *available at* ftp://ftp.hrsa.gov/mchb/titlevtoday/UnderstandingTitleV.pdf.
332 *Id.*
333 *Id.*
334 *Id.*
335 Legal Services Corporation, *About LSC: What is LSC?*, www.lsc.gov/about/lsc.php (last visited Aug. 31, 2009).
336 *See Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans, a Report of the Legal Services Corporation* (June 2007), *available at* www.lsc.gov/justicegap.pdf.
337 *See* LSC Fact Sheet: *Statutory Restrictions on LSC-Funded Programs* (Apr. 2008), *available at* www.lsc.gov/pdfs/Restrictions.pdf.
338 *See* 42 U.S.C. § 2996f(b)(8)(2009); 45 CFR 1610.2(a)(7), (b)(8)(2009).
339 According to Testimony before the Subcommittee on Commercial & Administrative Law of the House Judiciary Committee, March 31, 2004, "50% of LSC clients are served through advice and counsel efforts", thus illustrating that advice and counsel are primary functions of legal services programs. *Legal Services Corporation before the Subcommittee on Commercial & Administrative Law of the House Committee on the Judiciary*, 108th Cong. 5 (2004), *available at* www.Judiciary.House.gov/Legacy/Barnett033104.pdf.
340 *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i), (10)(A)(ii), (10)(C).
341 *See id.*

NATIONAL HEALTH LAW PROGRAM

Los Angeles Office (Main Office)
2639 South La Cienega Blvd
Los Angeles, CA 90034-2675
ph: (310) 204-6010
fx: (310) 204-0891
nhelp@healthlaw.org

Washington, DC Office
1444 I Street NW, Suite 1105
Washington, DC 20005
ph: (202) 289-7661
fx: (202) 289-7724
nhelpdc@healthlaw.org

North Carolina Office
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
ph: (919) 968-6308
fx: (919) 968-8855
nhelp@healthlaw.org