



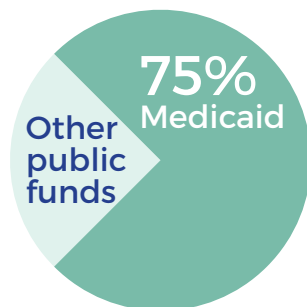
An **Advocate's Guide** to Reproductive and Sexual Health in the Medicaid Program



Chapter IV: Reproductive and Sexual Health Services

Reproductive and sexual health is intricately linked to a person’s overall health and well-being, which makes coverage of reproductive and sexual health services in Medicaid vital. Medicaid covers a wide range of health services which, taken together, are intended to provide a comprehensive package of health care services from infancy to end of life. This chapter describes the many services Medicaid covers that are essential to a person’s reproductive and sexual health including family planning services and supplies, abortion in very limited circumstances, prenatal care, and other services.

Medicaid is a critical source of coverage for a range of reproductive and sexual health services.



Medicaid is the largest financier of publicly funded family planning services, accounting for 75 percent of all public expenditures for family planning. (KFF)

6.2 million women received contraceptive services from 10,700 publicly funded clinics in the U.S. in 2015 (Guttmacher)

An additional **2.4 million** women received Medicaid-funded contraceptive services from private doctors (Guttmacher)

**OVER
57,000**

The number of women in 2013 who were enrolled in Medicaid through the Breast and Cervical Cancer Program. (KFF)



Medicaid is the largest single payer of pregnancy-related services, financing 43 percent of all U.S. births in 2016. (KFF)

Sources: Kaiser Fam. Found., Medicaid’s Role for Women (Mar. 28, 2019), <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>. Guttmacher Inst., Publicly Funded Contraceptive Services at U.S. Clinics, 2015 (April 2017), <https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015>.

A. General Service Categories

In general, the Medicaid Act requires states to provide coverage for broad categories of services, but does not explicitly define the minimum level of each service to be provided. For example, prenatal care and family planning services and supplies are mandatory services, however states have some leeway to determine the extent to which a particular service is covered.¹ Instead, the Medicaid Act requires states to establish reasonable standards, comparable for all eligibility groups, for determining the extent of medical assistance. These standards must be consistent with the objectives of the Medicaid Act.

1. Requirements for Services

To comply with the Medicaid Act, covered services must be available to enrollees consistent with the objectives of the Medicaid Act. The Medicaid Act requires states to establish reasonable standards for determining the services available.² Federal regulations require that each service be “sufficient in amount, duration, and scope to reasonably achieve its purpose.”³ There is no concrete rule as to what constitutes a sufficient service. The requirement is generally understood to mean that all medically necessary treatment within a covered service area must be covered, and that the service must be covered in an amount sufficient to achieve its intended purpose (i.e. meets most people’s need for that service). In addition, states may not arbitrarily deny or reduce the amount, duration, or scope of a mandatory service to an otherwise eligible individual solely based on diagnosis, type of illness, or condition.⁴ Further, the enrollee must have access to medical assistance within a reasonable amount of time.⁵ The ACA also clarified that “medical assistance” furnished through Medicaid requires not just payment for services but also coverage of these services.⁶ Finally, states may place appropriate limits on a service based on such criteria as “medical necessity” or on utilization review criteria.

a. Medical Necessity

States may place appropriate limits on services based on whether the service is a “medical necessity.”⁷ Although the Medicaid Act does not define the term medical necessity, the criteria for meeting this requirement has been largely shaped by case law.⁸ As a result, there is variation in covered services across the states.

The medical necessity standard is more clear within the context of children’s and adolescent’s services. The Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit—the Medicaid benefit for individuals under age 21—defines “medical necessity” as a service that must be provided for a child when “necessary to correct or ameliorate defects and physical and mental illnesses and conditions.” Thus, state Medicaid programs must cover all medically necessary services for children and young adults that could be available under Medicaid, even if it is not a covered service for Medicaid-eligible adults.⁹

b. Utilization Controls, Prior Authorization, Limits to Services

The Medicaid Act allows states to impose utilization controls on the delivery of services.¹⁰ Utilization controls are management techniques designed to steer Medicaid enrollees toward or away from certain drugs or medical procedures. The stated aims are to ensure that enrollees receive the most cost-effective, medically necessary services and to avoid unnecessary program costs. The federal statute does not define “utilization controls,” however there are limits.¹¹ Permissible utilization controls include: (i) medical necessity requirements, (ii) prior authorization—a requirement that the provider receive approval from the plan—for prescription drugs, devices or health services, (iii) second surgical opinions, (iv) lock-in programs requiring an enrollee to receive services from particular providers, and (v) for adults, limits on the number or frequency of services. Prior authorization is not a permissible utilization control for emergency services and EPSDT screens.¹² Medicaid managed care plans may adopt their own utilization controls, subject to certain limitations.¹³ States and Medicaid managed care plans are not permitted to impose utilization controls that interfere with enrollees’ freedom to choose the method of family planning to be used.¹⁴ The Guide provides more information about the use of utilization controls in the family planning context in Section B5 of this Chapter.

2. Mandatory Services for Categorically Needy Enrollees¹⁵

The Medicaid Act requires states to cover a broad array of services for all categorically needy enrollees, including, but not limited to:

- Inpatient hospital services (other than services in an institution for people with mental health diagnoses);
- 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 people with mental health diagnoses) for individuals 21 or older;
- EPSDT services for recipients under age 21;
- Pregnancy-related services and services for conditions that might complicate pregnancy;¹⁶
- Family planning services and supplies;¹⁷
- Physician services;
- Services furnished by a nurse-midwife who is legally authorized under state law to render the care;¹⁸
- Services furnished by a pediatric nurse practitioner or certified family nurse practitioner authorized to render care;¹⁹ and
- Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.²⁰

3. Optional Services for Categorically Needy Enrollees

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

- Clinic services furnished by or under the direction of a physician, including such services furnished by clinic personnel outside the clinic to enrollees 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; and
- Intermediate care facility services for the developmentally disabled (other than institutions for people with mental health diagnoses).²¹

4. Services for Medically Needy Enrollees (Optional Coverage Groups)

States with medically needy Medicaid programs can offer this 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.²² If a pregnant person applies for and receives medically needy Medicaid during their pregnancy, the state must continue to cover pregnancy-related care services through the end of the month in which the 60-day postpartum period falls.²³ The state must also cover ambulatory services for children under age 18 and for individuals entitled to institutional services.²⁴ Individuals entitled to nursing facility services must have access to home health services.²⁵

B. Family Planning Services and Supplies

In 1972, Congress amended the Medicaid Act to require states participating in the Medicaid program to cover family planning services and supplies for all “categorically needy” Medicaid enrollees of child-bearing age who desire such services and supplies.²⁶ States are not required to cover family planning services and supplies for “medically needy” enrollees but may choose to do so.²⁷ States also have the option to extend coverage of family planning and family planning-related services to individuals who do not otherwise qualify for Medicaid through family planning expansion programs. The eligibility criteria for these family planning expansion programs vary and are explained in more detail in Chapter III, Section B5.

While the Medicaid Act does not specifically define what family planning services and supplies are covered, the federal government provides an enhanced 90 percent federal medical assistance percentage (FMAP) for costs associated with providing family planning services to encourage robust

coverage in state programs.²⁸ The state only pays the remaining 10 percent.²⁹ States also receive an enhanced FMAP of 90 percent for administrative costs related to offering, arranging, and furnishing family planning services and supplies.³⁰

1. Scope of Covered Family Planning Services and Supplies

“Family planning services and supplies” is a federally required Medicaid benefit. As with most other categories of Medicaid services, states have some discretion to determine which specific family planning services and supplies to cover as long as the services are sufficient in amount, duration, and scope to reasonably achieve their purpose.³¹ States are also required to ensure that Medicaid enrollees are “free from coercion or mental pressure and free to choose the method of family planning to be used.”³² Thus, the scope of coverage must be sufficient to give enrollees access to their preferred contraceptive method.³³ To accomplish this, CMS issued guidance recommending that states cover all FDA-identified contraceptive methods for beneficiaries, including both prescription and non-prescription methods.³⁴ Moreover, states must cover services necessary to stop or change methods, including the removal of long acting reversible contraceptives (LARCs).³⁵

CMS provided guidance on the types of family planning services that are eligible for an enhanced 90 percent FMAP rate.³⁶ These include:

- 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; and
- Limited infertility services, including sterilization reversals.

Induced abortions and hysterectomies performed solely for family planning purposes are specifically excluded from coverage as a family planning service.³⁷

In states with expanded Medicaid, women who receive Medicaid coverage as a result of the ACA’s expansion (i.e. are newly eligible) must be provided with coverage of all FDA-approved methods of contraception. These methods include oral contraceptives, intrauterine devices, and sterilization methods as required by the ACA. Please refer to Chapter V, Section 2 for more detail about the ACA’s contraceptive coverage requirement for states covering newly eligible enrollees.

States and Medicaid managed care plans are not permitted to impose utilization controls that interfere with an enrollee’s freedom to choose the preferred method of family planning to be used.³⁸ In particular, states and

Medicaid managed care plans may not dictate the use of a particular method first (known as step therapy), impose a prior authorization requirement, or adopt policies that restrict a change in method that would deprive the enrollee of the choice of other appropriate treatments.³⁹

Most Medicaid programs emphasize pregnancy prevention. In fact, the Medicaid Act explicitly allows states to exclude fertility drugs from plan coverage.⁴⁰ Accordingly, conception and fertility services intended to promote childbearing are not included as family planning services in the majority of states. A 2016 survey of state plans found that only nine of the 41 responding states covered fertility testing in their Medicaid program and only one state—Nebraska—covered fertility drugs, but only if infertility is a symptom of a separate medical issue.⁴¹

2. Sterilization

Medicaid coverage of sterilizations vary by state. States that have not expanded Medicaid have discretion to include sterilization for men and women as a family planning service. States that have expanded Medicaid are required to cover sterilization methods for women only, although most states also cover sterilization procedures for men enrolled in their full-scope program. A recent Kaiser Family Foundation survey of 41 states found that all covered vasectomies in their traditional Medicaid programs, while only 23 reported that they covered vasectomies in the Medicaid Expansion.⁴² Seventeen states reported that they cover vasectomies in their family planning expansions.⁴³

Federal Medicaid funds may be used to pay for sterilizations only when the following conditions have been met and upon completion of an informed consent form:

- 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 the date of informed consent and the date of sterilization. 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 expected delivery date.⁴⁴

From the 1920s – 1970s, people with low incomes, women of color and indigenous women, people with disabilities, and immigrants were systematically subjected to government-sponsored eugenic programs of sterilization without their knowledge or consent.⁴⁵ As a result, women of color organizations, low-income health advocates, and their supporters advocated for a consent process for sterilizations.

In 1979, CMS regulations established practices to require an individual's written informed consent prior to sterilization.⁴⁶ This regulation is still in effect today. For the purposes of the consent requirement, sterilization is defined as any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing.⁴⁷ Medicaid-covered methods of sterilization include tubal ligation and vasectomy.⁴⁸

Informed consent for tubal ligation may not be obtained when a pregnant person is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that may affect her state of awareness.⁴⁹ Moreover, a number of conditions must be satisfied before informed consent occurs, including:

- The person who obtains consent for the sterilization procedure must offer to answer any questions the individual to be sterilized may have concerning the procedure;
- The person seeking sterilization must be advised that they are free to withhold or withdraw consent to the procedure at any time before the sterilization procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which they might be otherwise entitled;
- The person seeking sterilization must be provided a description of available alternative methods of contraception and be informed that the sterilization procedure is considered irreversible; and
- An interpreter must be provided if the individual to be sterilized did not understand written consent form or the language used by the person obtaining consent.⁵⁰

Hysterectomy is not considered a family planning service.⁵¹ If a hysterectomy is performed for the sole purpose of rendering a woman permanently incapable of reproducing, it will not be covered by federal funds.⁵² However, if a hysterectomy is medically necessary (or medically indicated), for example, to remove a cancerous uterus, or due to an emergency condition, then it will be covered at the state's regular FMAP rate.⁵³

ADVOCACY TIP: **Informed Consent**

Prior to the procedure, advocates should ensure that the person seeking sterilization has been properly informed of all available contraceptive methods, as well as whether informed consent has been satisfactorily completed. In addition, advocates should be aware of the expedited consent requirements for sterilization that exist for emergencies and medically necessary conditions.

3. Family Planning-Related Services

Family planning-related services are medical, diagnosis, and treatment services provided “pursuant to” a family planning visit.⁵⁴ These services may include cervical and breast cancer screenings, interpersonal violence screenings, and sexual health counseling services that are provided during the course of a family planning visit.⁵⁵ Family planning-related services are matched by CMS at the state’s regular FMAP, while family planning services and supplies are matched at the enhanced 90 percent FMAP.⁵⁶

4. Managed Care

Family planning services and supplies must be covered regardless of whether an enrollee accesses Medicaid benefits through fee-for-service or managed care. Due to the sensitive nature of reproductive and sexual health services and the prolonged period of time that individuals require them, it is important that each enrollee have ready access to a family planning provider with whom they are comfortable and who is familiar with their health history. To help ensure timely access to family planning providers, the federal Medicaid Act provides individuals enrolled in Medicaid managed care plans with the right to receive family planning services from the qualified provider of their choice, as long as the provider participates in the Medicaid program.⁵⁷ Referred to as “freedom of choice,” this protection allows individuals who receive services through a managed care entity to see an out-of-network provider for family planning services.⁵⁸ The cost of obtaining the family planning services received out-of-network cannot cost more to the enrollee than if they had obtained the services in-network (i.e. enrollees may not be charged a co-pay or other cost-sharing).⁵⁹ To help ensure that enrollees are aware of their freedom of choice right, the managed care regulations require plans to inform enrollees of “the extent to which, and how, they may obtain . . . family planning services and supplies” out-of-network and explain that enrollees do not need a referral before seeing a family planning provider.⁶⁰

Federal law also contains other important protections for individuals enrolled in Medicaid managed care plans who are seeking reproductive and sexual health services. Under

ADVOCACY TIP:

Codifying Freedom of Choice into state law

In 2017, advocates in California successfully worked with state legislators to codify Medicaid’s freedom of choice in family planning protection into state law.⁶¹ California’s “Protection of Choice for Family Planning Act” (SB 743) was signed into law by Governor Jerry Brown and went into effect on January 1, 2018. California also has a similar state requirement allowing individuals enrolled in a state Medicaid managed care plan to seek most abortion care services from any qualified Medicaid provider without prior authorization or referral.⁶²

federal regulations, plans must allow female enrollees to directly access in-network women’s health specialists for “routine and preventive” services.⁶³ This means that plans may not require female enrollees who do not have a women’s health specialist as their primary care provider to receive a referral before seeing a women’s health specialist for covered “routine and preventive” services.⁶⁴ CMS has clarified that these services include “initial and follow-up visits for services unique to women such as prenatal care, mammograms, pap smears, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases.”⁶⁵ CMS has also clarified that this requirement extends to female enrollees of all ages, including minors.⁶⁶

Medicaid managed care entities are permitted to refuse to provide coverage or reimbursement for a counseling or referral service if they object to such service on moral or religious grounds.⁶⁷ They may not prevent providers from discussing all relevant treatment options with their patients.⁶⁸ Federal law contains several protections for enrollees in states that contract with plans that refuse to provide or reimburse for family planning services covered under the state plan. First, potential enrollees and enrollees must be informed about covered services that a plan does not provide and how and where to obtain these services.⁶⁹ Second, individuals have the right to disenroll from a managed care plan, a Primary Care Case Manager (PCCM), or a PCCM entity “for cause” at any time.⁷⁰ Enrollees have cause to disenroll if the managed care entity does not, due to moral or religious objections, offer the services the enrollee seeks.⁷¹ Third, enrollees in rural areas can seek services out of network without penalty if the in-network providers do not offer the covered services the enrollee needs due to moral or religious refusals.⁷²

5. Coverage for Outpatient Drugs and Devices

Outpatient prescription drugs are an optional service and governed by a separate Medicaid provision, 42 U.S.C. § 1396r-8.⁷³ All 50 states and the District of Columbia cover prescription drugs. Once a state agrees to cover outpatient prescription drugs, they must comply with federal Medicaid requirements, including amount, duration and scope; comparability; and freedom of choice. The ACA added requirements for managed care plans operating in Medicaid expansion states to offer “benchmark benefits” that include prescription drug coverage.⁷⁴

a. Outpatient Drugs in the Medicaid Program

For specific drugs to be included in the state’s Medicaid program, drug manufacturers must enter into a drug rebate agreement—known as the 340B Drug Pricing Program—for their products.⁷⁵ This means drug manufacturers must give a discount to the state Medicaid program in accordance with a federally mandated formula. Many family planning and safety net providers that participate in Medicaid rely on Medicaid

program discounts as well as the 340B Drug Pricing Program to get the best pricing for contraceptive supplies.

States must cover all FDA-approved prescription drugs of the manufacturers who have entered into 340B programs if the drug is prescribed for a medically accepted indication.⁷⁶ The FDA has identified 20 different contraceptive methods, and the ACA's contraceptive coverage rule specifies that plans must cover all methods, as prescribed.⁷⁷ State Medicaid programs may exclude coverage of prescription drugs to treat certain conditions such as infertility, as well as nonprescription (over the counter) drugs, and prescription vitamins and minerals, except prenatal vitamins.⁷⁸

Although federal rules establish broad coverage for outpatient prescription drugs, states may use prior authorizations to limit or otherwise restrict prescription drug coverage for a covered outpatient drug if the state agency 1) provides a response within 24 hours of the prior authorization request; and 2) provides a 72-hour supply in emergency situations.⁷⁹

i. Drug Formularies

Typically, a prescription drug formulary is a list of outpatient prescription drugs that a health plan agrees to cover. Formularies are one of the most common medical management tools used to reduce healthcare costs by limiting or otherwise restricting access to certain outpatient prescription drugs. The term “formulary” in Medicaid is defined by statute, and differs from “formularies” used by other kinds of health plans.

Medicaid formularies generally consider only the safety and effectiveness of drugs, not their cost.⁸⁰ If a state decides to exclude an outpatient prescription drug from its formulary, it may only do so after finding that the drug does not have a significant, clinical therapeutic advantage over other drugs, and the state must explain the basis for the exclusion in writing.⁸¹ Contraceptive drugs and supplies in Medicaid (and in most health plans) are treated as a prescription drug benefit and are subject to the same formulary restrictions as other drugs.

The Medicaid formulary must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor or the state's drug use review board.⁸² The formulary must include the covered outpatient drugs of any manufacturer which has entered into and complies with a Medicaid rebate agreement (subject to certain exceptions explained below).⁸³ Even if a state excludes an outpatient prescription drug from its formulary, the state must permit coverage of excluded drugs pursuant to a prior authorization program and on a case-by-case basis.⁸⁴

ii. Preferred Drug Lists

Subject to limitations, federal law allows states to designate Medicaid covered prescription drugs as “preferred” and “non-preferred.”⁸⁵ States are also permitted to impose cost sharing (co-payments) on Medicaid enrollees similar to a formulary tiering structure.⁸⁶ Unlike Medicaid formularies, PDLs can consider cost when determining if a prescription drug is a preferred drug.⁸⁷

The allowable level of cost sharing is determined by an enrollee’s income, and some populations and services are exempt.⁸⁸ Most states impose cost-sharing for prescription drugs.⁸⁹ States may set cost-sharing amounts up to \$4.00 per prescription for preferred drugs for individuals under 100 percent FPL, and set a maximum of up to 20 percent of the agency cost of the drug for non-preferred drugs for people above 150 percent FPL.⁹⁰ As a result, there is wide variation in cost sharing amounts for drugs among the states. For example, a Medicaid enrollee seeking a prescription drug on the preferred drug list (PDL) in Arkansas will have to pay \$4, while the co-pay for a non-preferred drug would cost \$8.⁹¹ In Louisiana, co-pays range from \$0.50 - \$3.00 for preferred and non-preferred drugs.⁹² These variations can be a significant financial barrier to accessing necessary services for lower-income Medicaid enrollees.

States 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 (BCCPT) program.⁹³

iii. Other utilization controls

States may impose other utilization controls, such as limits on quantities and refills.⁹⁴ These limits are often imposed on contraceptives. Most states allow only 30-day supplies of oral contraceptive pills.⁹⁵

iv. Managed Care Drug Coverage

Federal regulations require managed care plans, Pre-paid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) to meet the statutory standards for covered outpatient prescription

ADVOCACY TIP:

Eleven states provide Medicaid coverage for a 12-month supply of oral contraceptives, although most limit the ability to dispense a 12-month supply to clinics and medical providers.⁹⁶ A recent California law (SB 999) allows pharmacies to dispense a 12-month supply for enrollees covered through a Medi-Cal managed care plan. Work with your state Medicaid agency and policymakers to extend the supply of contraceptives.

drugs in Medicaid fee-for-service.⁹⁷ States may allow managed care plans to use their own formularies. If a drug is not covered under the managed care plan's formulary, however, the plan must ensure coverage of the off-formulary drug consistent with the prior authorization requirements described above, or the state may elect to provide the drug.⁹⁸ Thus, Medicaid enrollees have access to prescription drugs not covered under a managed care plan's formulary, subject to prior authorization.

Accordingly, Medicaid managed care plans have some flexibility in their formularies to determine which contraceptive other family planning-related products they will cover and to impose some utilization controls. However, it is important to know that Medicaid managed care plans are not permitted to impose utilization controls that interfere with an enrollee's freedom to choose the preferred method of family planning to be used.⁹⁹ In particular, states and plans may not dictate the use of a particular method first (known as step therapy), impose a prior authorization requirement, or adopt policies that restrict a change in method that would deprive the enrollee of the choice of other appropriate treatments.¹⁰⁰ The 2016 Medicaid managed care regulations specified that "[s]tates and managed care plans should avoid practices that delay the provision of a preferred method or that impose medically inappropriate quantity limits, such as allowing only LARC insertion every five years, even when an earlier LARC was expelled or removed."¹⁰¹ However, CMS guidance allows states and plans to require prior authorization to determine that a particular family planning method is "medically necessary and appropriate for the individual."¹⁰² Medicaid's free choice of provider protection for family planning services also allows managed care enrollees to receive covered family planning services (including drugs) from any "qualified provider," even if that provider does not contract with their plan.¹⁰³

v. Off-label uses

States must cover FDA-approved out-patient prescription drugs for medically accepted indications.¹⁰⁴ States also must cover off-label uses when the off-label use is supported by citation or approved to be included in at least one of three compendia:

- (1) American Hospital Formulary Service (AHFS) Drug Information;
- (2) United States Pharmacopeia-Drug Information (or its successor publications); or
- (3) the DRUGDEX Information System.¹⁰⁵

The compendia are available on a subscription basis, so clients and advocates may have difficulty accessing them to determine whether an off-label use is supported or approved to be included, and thus must be covered by the state Medicaid program.¹⁰⁶

b. Over-the-Counter Family Planning

The prescription requirement can be a barrier to accessing family planning supplies for women enrolled in Medicaid. A nationally representative, online survey of adult women and teens found that 39 percent of adults and 29 percent of teens reported likely use of over-the-counter (OTC) progestin-only pills, with an increased likelihood of use if covered by their insurance.¹⁰⁷ While increasing the OTC availability of family planning methods improves access, not all people—including many Medicaid enrollees—will be able to benefit from these changes.

States have the option of refusing to cover OTC drugs and devices in their Medicaid programs. In general, federal Medicaid law permits states to cover OTC drugs and devices under the prescription drug benefit category, but only if the produce was prescribed by a physician or other person authorized to prescribe under state law.¹⁰⁸ When these methods are categorized as a family planning service or supply, they are eligible for the enhanced family planning FMAP rate of 90 percent.

Several state Medicaid programs already cover OTC family planning products such as condoms without a prescription. A few states also cover emergency contraception (EC) as an OTC contraceptive without a prescription.¹⁰⁹ EC is most effective if taken within 72 hours after unprotected sexual intercourse or contraceptive failure, but can be used up to 120 hours after intercourse.¹¹⁰ Yet most state Medicaid programs still require a prescription for OTC EC to be covered. One state—Mississippi—does not cover the drug at all, and some states limit the number of EC prescriptions the state will cover over a specific period of time.¹¹¹ Thus, the prescription-only requirement can prevent a woman from accessing the drug when it is most effective.

c. Pharmacy Refusals

People at all income levels experience situations in which 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 person who cannot find or travel to another pharmacy. Several states permit individual pharmacists or entire institutions to refuse providing contraception.¹¹³ Specifically, pharmacists have been

INNOVATIVE APPROACH:

Some states authorize specially trained pharmacists to prescribe or dispense birth control pills directly from the pharmacy, eliminating a trip to a clinic or other provider. This is referred to as “pharmacy access” and in some states requires pharmacists to also enter into a collaborative agreement with a physician or advanced practice clinician.¹¹²

documented refusing to fill prescriptions for birth control pills, EC, and drugs to help complete a miscarriage.¹¹⁴ 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.¹¹⁵

C. Pregnancy Services¹¹⁶

Medicaid coverage is critical for pregnant people, covering an estimated 43 percent of births in the United States in 2017.¹¹⁷ Federal Medicaid laws are designed to accommodate the heightened need for timely services during pregnancy, and to encourage states to be generous in their coverage for pregnancy care.

Pregnant people with low-incomes who qualify for full-scope Medicaid are immediately eligible to receive comprehensive care, including prenatal care, labor and delivery, postpartum care, and coverage for many other health issues that arise during the pregnancy.¹¹⁸ As explained in Chapter II on eligibility, states must provide full Medicaid coverage to qualified pregnant women. States are also required to provide at least pregnancy-related coverage to a pregnant person who has a household income that exceeds the income limits for full-scope Medicaid coverage, but is at or below the state's income cutoff for pregnancy-related Medicaid. Pregnancy-related Medicaid covers services that are “necessary for the health of a pregnant woman and fetus, or have become necessary as a result of the woman having been pregnant.”¹¹⁹

ADVOCACY TIP:

If a pharmacy refuses to fill a prescription, do the following:

- Write down the name of the pharmacy and the pharmacist.
- 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 enrollee 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.
- File a complaint with the state Medicaid Program.

We use the more gender inclusive term “pregnant people” or “pregnant individuals” as much as possible throughout the Guide. We use the term “pregnant women” or “pregnant woman” when explaining the Medicaid requirements for pregnancy services to conform with the language used in statutes and regulations

1. Prenatal Care

All Medicaid coverage for pregnancy includes prenatal care. These are services provided during pregnancy that are directed at ensuring the health of the pregnant person and their fetus.¹²⁰ The scope of prenatal services is not defined by statute or regulation, therefore states have discretion to determine what types of services are covered. Services often include lab testing, ultrasounds, as well as a regular schedule of prenatal checkups where a health care provider can educate the pregnant enrollee about their pregnancy, monitor any medical conditions, and refer them to any necessary services such as WIC (The Special Supplemental Nutrition Program for Women, Infants, and Children).¹²¹

The ACA included a new requirement mandating Medicaid coverage for services provided at freestanding birth centers, including prenatal services.¹²² These centers are health facilities, separate from a hospital, which are licensed by the state to provide prenatal services, labor and delivery, postpartum care, and/or other ambulatory services.¹²³ Nurse midwives, birth attendants, and any other health professionals working within their scope of practice under state law, can provide these services, and in doing so are not required to be supervised by or associated with a physician or other health care provider.¹²⁴

All Medicaid coverage for pregnant people includes related services for other conditions or complications that exist or are exacerbated due to the pregnancy.¹²⁵ These are any additional services necessary to treat non-pregnancy conditions that might cause pregnancy complications, including “those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus.”¹²⁶ CMS has acknowledged, “because it is difficult to identify what is ‘pregnancy-related’ and because the health of a pregnant woman is intertwined with the health of her expected child, the scope of such [pregnancy-related services] is necessarily comprehensive.”¹²⁷

Additionally, the ACA mandated Medicaid coverage for smoking cessation services and drugs for pregnant individuals, including diagnostic services, therapy, counseling, and over-the-counter and prescription drugs and devices.¹²⁸

2. Labor and Delivery Services

All Medicaid coverage for pregnant people includes labor and delivery services, including vaginal births, cesarean births, anesthesia, and other services necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery.¹²⁹

The ACA added a requirement for states to receive Medicaid reimbursement for labor and delivery services provided at freestanding birth centers.¹³⁰

Freestanding birth centers are typically staffed by midwives and birth attendants in non-hospital birth settings and are a covered benefit in 34 states.¹³¹ However, access remains a challenge for many enrollees. Medicaid reimbursement rates do not adequately cover the costs of providing prenatal, labor, and delivery care, therefore some birth centers limit the number of Medicaid enrollees they will accept or place limits on their services.¹³² Other types of alternative, non-hospital birthing settings and supports vary widely from state to state. As of April 2017, only 21 states provide Medicaid coverage of home births.¹³³ A mere two—Oregon and Minnesota—cover doula services. Doulas provide significant prenatal, childbirth, and postpartum care, and doula services been proven to improve maternal and infant health.¹³⁴ More states should be encouraged to provide coverage for doula services.

ADVOCACY TIP:

Work with your state partners and policymakers to pass legislation specifically authorizing Medicaid coverage of doula services. Check out NHeLP's issue brief, "[Routes to Success for Medicaid Coverage of Doula Care](#)," to gain insights into some of the lessons learned based on the experience of two states, Minnesota and Oregon, that recently added doula coverage in their Medicaid programs.

3. Postpartum Services

All Medicaid coverage for pregnant women includes postpartum services, which are services provided to a woman following a pregnancy for any health condition or complication that is pregnancy-related.¹³⁵ The range of services vary by state to state, and can include breastfeeding support, services for substance use disorders, postpartum contraception, and postpartum depression screenings.¹³⁶ These services are available through the end of the month in the end of the month in which the 60-day postpartum period falls.¹³⁷

4. Pregnancy-related Services

Pregnant people with full-scope Medicaid coverage receive the same Medicaid benefits covered under the state plan for all other categorically needy enrollees, including pregnancy services.¹³⁸ On the other hand, pregnant individuals with restricted scope pregnancy-related Medicaid coverage do not receive the same scope of Medicaid benefits covered under the state plan for other categorically needy enrollees.¹³⁹

Instead, pregnancy-related Medicaid covers services that are "necessary for the health of a pregnant woman and fetus, or have become necessary as a result of the woman having been pregnant."¹⁴⁰ Such services include, but are not limited to, prenatal care, labor and delivery, family planning, as well as "services for other conditions that might complicate the pregnancy" including "those for diagnoses, illnesses, or medical conditions which might threaten the carrying of

the fetus to full term or the safe delivery of the fetus.”¹⁴¹ The actual range of Medicaid services available to pregnant people varies from state to state, and in some instances may be broader than the services provided under the state’s Medicaid program to non-pregnant enrollees.¹⁴² For example, several states provide pregnant Medicaid enrollees with dental services that are not provided to non-pregnant adult Medicaid enrollees.¹⁴³

Enrollees who are covered for pregnancy-related services receive postpartum services through the end of the month in which the 60-day postpartum period falls.¹⁴⁴

States cannot impose deductibles, co-payments, or similar charges for most pregnancy-related services such as routine prenatal care, labor and delivery, and post-partum care.¹⁴⁵ 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.¹⁴⁶ States can, however, impose nominal cost sharing on certain prescription drugs if the drug is not listed on the state’s “preferred” drug listing.¹⁴⁷ Additionally, states are permitted to charge monthly premiums for pregnant people with incomes above 150 percent of the federal poverty level.¹⁴⁸

D. Abortion¹⁴⁹

Approximately half of U.S. pregnancies are unintended, and in 2011, 40 percent of unintended pregnancies in the U.S. ended in abortion.¹⁵⁰ Abortion is a common medical procedure; an estimated one in five women will have an abortion by age 30, and one in four by age 45.¹⁵¹ Despite the need, federal restrictions such as the Hyde Amendment leave abortion care out of reach for many of the 13.5 million women of reproductive age (15 to 49 years old) enrolled in Medicaid.¹⁵²

Federal Medicaid coverage for abortions can be extremely difficult even for enrollees who meet the narrow circumstances where abortions are covered.¹⁵³ When a pregnant person is denied Medicaid coverage for an abortion, they are often forced to delay or forgo abortion care.¹⁵⁴ Forcing a person to carry an unwanted pregnancy to term negatively impacts their health and well-being.¹⁵⁵ Women denied an abortion are three times more likely to be in poverty two years later.¹⁵⁶ Abortion access is also a critical service for cisgender lesbian and bisexual women; one study found a significantly higher incidence of sexual violence reported among lesbian and bisexual women seeking abortions compared to heterosexual women.¹⁵⁷ Transgender men, nonbinary, and gender conforming people assigned female at birth also need abortion services.¹⁵⁸

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

After the Supreme Court’s 1973 *Roe v. Wade* decision upholding the constitutional right to an abortion, abortions were treated as a basic health

service like other Medicaid-covered physician and hospital service.¹⁵⁹ Unfortunately, in 1976, Representative Henry J. Hyde introduced an amendment—known as a “rider”—to the annual Departments of Labor and Health, Education, and Welfare (now HHS) appropriations bill restricting the use of federal funds for abortions.¹⁶⁰ The “Hyde Amendment” prohibited the use of funds appropriated for the Medicaid program to pay for abortions unless the life of the woman would be endangered by carrying the pregnancy to term.

Since its first introduction, Congress has passed a version of the Hyde Amendment every year with some changes to the exceptions to funding restrictions. The current version of the Hyde Amendment allows the use of federal funds to cover abortions in the Medicaid program only when necessary to save the life of the pregnant person, and in cases of pregnancies resulting from rape or incest.¹⁶¹ In *Harris v. McRae*, the U.S. Supreme Court held that the Hyde Amendment’s restrictions on federal funding of abortion do not violate the U.S. constitution, and that the Medicaid statute does not require states to pay for medically necessary abortions for which federal funding is unavailable under the Hyde Amendment.¹⁶²

States must cover abortions for which federal funding is available.¹⁶³ CMS guidance makes clear that abortions falling within the Hyde exceptions are “within the scope of services that are medically necessary” and that participating states are required to cover such abortions in their Medicaid programs.¹⁶⁴ In addition, states can use their own funds to cover all abortions, regardless of whether federal funding is available. See Subsection 4, for a list of states that provide state funding for abortions.

The Hyde Amendment harms pregnant people with low-incomes and women of color the most. An individual seeking an abortion at 10 weeks of pregnancy with an income at the Medicaid eligibility ceiling would need to pay nearly one-third of her family’s monthly income for her abortion.¹⁶⁵ Moreover, 7.5 million women of reproductive age receive Medicaid coverage in states that do not cover abortion.¹⁶⁶ Over half (51 percent) are women of color.¹⁶⁷

2. Hyde Exceptions

Under the current version of the Hyde Amendment, federal funds appropriated to HHS are available for abortions in the Medicaid program “where a woman suffers 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, as certified by a physician, place the woman in danger of death unless an abortion is performed.”¹⁶⁸ Medicaid must cover an abortion under this exception when a physician has determined and certified in writing to the Medicaid agency that the life of the mother would be endangered if the fetus were carried to term.¹⁶⁹ Unfortunately, the definition of life endangerment does not take into account any potentially life-threatening psychological or

emotional harm that may result when a person is forced to continue a pregnancy they do not want.

State Medicaid programs must also cover abortions where the pregnancy resulted from rape or incest.¹⁷⁰ State laws define rape and incest, and may impose reporting or documentation requirements on Medicaid enrollees or Medicaid providers, so long as those requirements are reasonable.¹⁷¹ Each state accordingly decides whether, when, and to whom reporting must occur.¹⁷² However, the reporting requirement “may not serve to deny or impede coverage for abortions.”¹⁷³ States must also waive any reporting or documentation requirements and consider the procedure 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 requirements.”¹⁷⁴

Incidences of rape are underreported so it is difficult to determine the number of abortions that follow from pregnancies due to rape. A 1996 study from the American Journal of Obstetrics and Gynecology estimates that more than 32,000 women experience a rape-related pregnancy each year and that the national rape-related pregnancy rate is five percent per rape among victims of reproductive age (aged twelve to forty-five).¹⁷⁵ In a 2004 survey of 1,209 abortion patients and in-depth interviews of thirty-eight women, one percent of respondents seeking an abortion said that they became pregnant as a result of rape.¹⁷⁶ Medical providers, however, too often are unable to obtain Medicaid reimbursement for abortions provided in cases of pregnancies due to rape or incest.¹⁷⁷

The requirements for Medicaid coverage of abortion vary from state to state. To learn more about the Hyde Amendment, its exceptions, and a state-by-state chart of abortion coverage requirements, see NHeLP’s Q&A entitled, “[Abortion Coverage Under Medicaid.](#)”

3. Coverage for Abortion-Related Services

Medicaid covers prenatal care prior to an abortion, treatment for complications resulting from a medically unsupervised abortion if someone other than a licensed medical provider performed the abortion, and treatment of ectopic pregnancies.¹⁷⁸ Medicaid also covers post-abortion contraception.¹⁷⁹ States may use federal matching funds for services commonly provided to pregnant individuals in the usual course of care under Medicaid, regardless of whether the person is seeking an abortion for which federal-funding is available.¹⁸⁰ For example, if the abortion itself does not meet federal requirements but the post-abortion sterilization does, then the state may claim federal matching funds for the costs of the procedure that are normally associated with performing a sterilization procedure.¹⁸¹

A pregnant, Medicaid-eligible person who thinks or knows they want an abortion 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.¹⁸²

4. State Funding of Abortion

Nine states cover non-federally funded abortions by court order, while six states do so voluntarily.¹⁸³ Some courts have found that the Hyde Amendment's funding restriction violates state constitutions. Successful lawsuits in these states—Alaska, California, Connecticut, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, and Vermont—restored Medicaid coverage of abortions.¹⁸⁴ Hawaii, Illinois, Maryland, New York, Oregon, Vermont, and Washington voluntarily use their own funds to cover abortions beyond rape, incest, and life endangerment in their low-income health programs.¹⁸⁵

5. Abortion Funds

Abortion funds are private, non-profit organizations or informal collectives that assist people with unwanted pregnancies secure an abortion. Without Medicaid funding or personal funds to cover their abortions, pregnant individuals, particularly those with low incomes, 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 a later term abortion procedure at greater cost and health risk, or no abortion at all. Deaths and complications from illegal abortions are still a perilous reality for some.¹⁸⁶

ADVOCACY TIP:

Presumptive eligibility for abortion

Presumptive eligibility (PE) is a process that allows qualified entities to quickly and temporarily enroll people who appear to meet the eligibility criteria for Medicaid coverage to receive immediate, same-day services. States have the option of implementing presumptive eligibility to provide these services to certain categories of Medicaid enrollees, including people who are pregnant. PE for pregnant women covers the cost of an abortion, and has been shown to help reduce barriers to access in states that have implemented the program. Work with your state Medicaid agency to implement presumptive eligibility for pregnant people.

NNAF

To assist low-income people with unwanted pregnancies obtain abortion services, a group of 22 organizations joined together in 1993 to establish the National Network of Abortion Funds (NNAF).¹⁸⁷ NNAF provides community-based funding for those individuals who would otherwise not be able to afford access to safe and legal abortions. NNAF has a nation-wide network with hundreds of community organizations, individual members, and volunteers that assist people seeking abortions.¹⁸⁸

E. Adolescent Health

Nearly 41 percent of high school students in the U.S. have had sex at least once, yet many do not know how to access or do not feel comfortable seeking confidential reproductive or sexual health services.¹⁸⁹ This contributes to higher STI infection rates among youth and young people. Individuals aged 15 to 24 years old account for nearly half of new STI infections each year despite comprising only one-quarter of the sexually active population in the United States.¹⁹⁰

1. Early and Periodic Screening, Diagnostic, and Treatment Services

Medicaid is designed to be an excellent source of health coverage for low-income children and adolescents. In 2016, Medicaid covered 29.8 million children ages 0-18 years old—the equivalent of over one in three children in the U.S.¹⁹¹ Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) is a comprehensive health care benefit for children and youth under 21 years old who are enrolled in Medicaid or enrolled in CHIP when a state operates its program as an extension of Medicaid.¹⁹² EPSDT entitles those eligible to receive medical, vision, hearing, and dental screening at pre-set periodic intervals and when needed to determine whether a health issue or condition exists.¹⁹³

The periodic medical screen is required to include five components: a comprehensive health and developmental history, a comprehensive unclothed physical examination, appropriate immunizations, laboratory tests, and health education and “anticipatory guidance” (counseling on what to expect in a child’s development).¹⁹⁴ Further, the child or adolescent must have access to care and services that are necessary to “correct or ameliorate” an identified health condition if Medicaid can provide the service, even if it does not provide the service for adults under its State Plan.¹⁹⁵

The EPSDT medical screening is especially important for young people. CMS currently lists the American Academy of Pediatrics “Bright Futures” curriculum as an example of a recognized and accepted clinical practice guideline for EPSDT screening. Bright Futures calls for providers to deliver reproductive and sexual health services including: STI screening, HPV vaccines, pregnancy testing,

HIV testing, family planning, and sexuality education and counseling.¹⁹⁶ Bright Futures also recommends that physicians provide “confidential, culturally sensitive and nonjudgmental” sexuality education and counseling to children, adolescents, and their caretakers, and that the entire clinical environment create an atmosphere where the discussion of sexual health is comfortable, regardless of social status, gender, disability, religious beliefs, sexual orientation, ethnic background, or country of origin.¹⁹⁷

The comprehensive health and developmental history assessment should also include a discussion of sexual health.¹⁹⁸ Nevertheless, providers often fail to offer the sexuality education component. An observational study of youth aged 12 to 17 years old found that nearly one-third of physicians did not discuss sexual health with their patients, and when they did, the average discussion lasted 36 seconds.¹⁹⁹ This study also noted that providers did not engage in sexual health discussions unless the patient first raised the topic.

States must meet additional requirements to ensure children and adolescents are informed of the EPSDT benefit. Federal law requires states to use a combination of written and oral communication methods to inform all Medicaid-eligible families with children and adolescents about the benefits of preventive care, EPSDT, and the availability of transportation and appointment scheduling assistance.²⁰⁰ If the child or adolescent, or their family has trouble understanding the written or oral communication about EPSDT, the information must be provided in a manner that the enrollee can understand. This could include using an interpreter, meeting with bilingual providers, or translating written information. Finally, EPSDT should be coordinated with other programs, such as WIC and Head Start, and outreach needs to include information about these programs.²⁰¹

2. Confidentiality and Minor Consent

Youth aged 15-17 are more likely to attend health care visits when they are able to have a private visit with a provider and are assured that their discussions with the provider will remain confidential.²⁰² This is particularly true when a teen or young person is seeking reproductive or sexual health services and discussing their sexual health and history.²⁰³ In a national survey of adolescents between the ages of 12 to 17, the most commonly cited barrier to STI testing was concern that their parents will find out they are having sex.²⁰⁴

Minors, like other Medicaid enrollees, are entitled to receive confidential family planning services covered under the program (and Title X).²⁰⁵ Fortunately, courts have struck down state laws that required parental disclosure for minors who receive family planning services through Title X or Medicaid.²⁰⁶ However, minors and young people who are enrolled in Medicaid coverage through a parent or guardian may still find their confidentiality compromised due to billing and

claims practices, particularly if their coverage is through a Medicaid managed care plan. Plans may submit an explanation of benefits form, denial of claims notice, or other type of communication that inadvertently discloses information about the medical visit and requested sexual health service to the parent or guardian who is the primary policy holder.

States have increasingly recognized the importance of allowing minors (usually aged 12 years and older) to consent to a range of sensitive health care services such as reproductive and sexual health care, mental health services, and substance use treatment. These “minor consent” laws recognize that, while parental involvement is encouraged, many teens and young people will not utilize these sensitive health care services if they are forced to involve their parents or guardians. Twenty-one states and District of Columbia explicitly permit all minors to independently consent to contraceptive services, while several others allow minors to obtain contraceptive services, prenatal, abortion, and STI services without parental involvement under certain circumstances.²⁰⁷

Even with minor consent laws, confidentiality can be a concern because the federal protections that govern confidentiality are not absolute. The Health Insurance Portability and Accountability Act (HIPAA) privacy rule prohibits parents or guardians from accessing minor’s health records when a minor can solely consent to care for a particular service.²⁰⁸ Yet HIPAA also generally allows a parent or guardian who is legally considered to have authority to act on behalf of a minor to access the minor dependent’s medical records, unless an additional or stricter state law prohibits this access or the health care is provided at the direction of the court.²⁰⁹

F. LGBTQ and Gender Affirming Care

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) identified individuals, non-binary, and gender-nonconforming (GNC) people seek many of the same reproductive and sexual health services as their heterosexual and cisgender counterparts. Many LGBTQ and GNC individuals also have unique health care concerns and needs. Yet discrimination, stigma, and other challenges can make it more difficult for them to access appropriate, needed, and affirming care. As a result, many LGBTQ and GNC people experience worse health outcomes or forgo care altogether.

The term “**cisgender**” refers to an individual whose gender identity corresponds with their assigned sex at birth. The term “**transgender**” refers to people whose gender identity and/or gender expression differs from their assigned sex at birth. **Gender non-conforming** refers to people whose gender expression is (1) neither masculine nor feminine or (2) different from traditional or stereotypic expectations of how a man or woman should appear or behave. **Gender non-binary** refers to people whose gender identity is not exclusively male or female. To learn more, please review the resources available on the National Center for Transgender Equality website at <https://transequality.org/about-transgender>.

The enactment of the ACA and other recent legal and policy changes have made improvements to coverage and access to care for LGBTQ and GNC individuals. LGBTQ individuals gained health insurance coverage at a similar rate to heterosexual individuals after the passage of the ACA, and the *Obergefell* ruling required state Medicaid agencies to recognize same-sex marriages for eligibility purposes.²¹⁰ “Newly eligible” enrollees—individuals who gained coverage in states with expanded Medicaid programs—are covered for ten statutory categories of benefits known as the “Essential Health Benefits” with no cost-sharing.²¹¹ These benefits include screenings for HIV, STIs, depression, and other preexisting conditions that LGBTQ and GNC individuals were previously denied from coverage. Further, in an FAQ issued by the Departments of Labor, Health and Human Services, and Treasury in 2015, the Departments clarified that plans subject to the women’s preventive service requirement of § 2713 cannot limit sex-specific preventive care based on an individual’s assigned at birth sex, gender identity, or recorded gender (i.e. the gender listed on a government-issued identification form).²¹² This means that a transgender man with residual breast tissue or an intact cervix who is covered through an Alternative Benefit Plan as part of the newly eligible Medicaid expansion population may receive preventive screenings like mammograms and pap smears/test with no cost-sharing.

Transgender and GNC people diagnosed with gender dysphoria may also seek treatment. The standards of care for treating gender dysphoria involve a range of options depending on the needs and desires of the person seeking treatment. Together, these interventions are known as gender-affirming care.²¹³ Gender-affirming health care interventions may include hormone therapy, surgical interventions, speech and language interventions, and behavioral health services. Not all transgender or non-binary people seek all health care interventions, and some may seek none. These interventions to treat gender dysphoria are considered medically necessary when treatment is consistent with the standard of care.

Gender dysphoria is the clinically significant distress caused by a conflict between a person's assigned gender and the person's gender identity.²¹⁴

Under federal law, state Medicaid programs must cover a broad range of gender-affirming services when they are medically necessary. However, not all states are following the law.²¹⁵ As of April 2019, 19 states and the District of Columbia have laws or policies explicitly requiring Medicaid coverage of transition-related care, and two other states (Iowa and Wisconsin) were recently ordered by a court to cover medically necessary gender-affirming care.²¹⁶ California was the first to do so by court order in cases seeking individual relief in the 1970s. Then, in 2001, a California judge struck down the state's policy of categorically denying Medicaid coverage for gender-affirming surgical treatments.²¹⁷ The state's Medicaid agency then issued guidance in 2013 (and again in 2016) to providers and managed care plans clarifying the scope of coverage for gender dysphoria treatments.²¹⁸ In the last decade, several other states have added Medicaid coverage of gender-affirming care.²¹⁹

Nine states explicitly exclude coverage of certain gender affirming services.²²⁰ Despite current widespread medical consensus supporting transition-related services as medically necessary, many of these exclusions date back to the early 1980s when transition-related care was considered a "cosmetic" or "experimental" service. Since the early 2000s, these discriminatory policies in Medicaid and in private insurance have started to erode.

The remaining states have no explicit Medicaid policy related to gender-affirming care and therefore may not provide coverage at all, may not cover the full range of medically necessary gender-affirming services, or may not cover services consistently.

Even with Medicaid coverage, transgender and GNC people on Medicaid who are diagnosed with gender dysphoria may also struggle to secure needed care. Relatively few providers specialize in gender-affirming care, particularly in more rural areas, and particularly where people seek more specialized procedures, such as bottom surgeries. In addition, health care providers and the facilities they practice in may not use inclusive language in their verbal and/or written communications, which can create negative experiences and deter transgender and GNC individuals from seeking care. In fact, some providers and health care institutions openly discriminate against transgender and GNC people by refusing to provide gender-affirming services. These refusals can be traumatic for individuals and may ultimately prevent them from receiving appropriate treatment. Transgender and bisexual individuals also fare worse when it comes to having a regular provider and more often go without medical care due to cost.²²¹ These disparities are often compounded for transgender people of color, who are

more likely to live in poverty, be unemployed, and experience mistreatment from a health provider than white transgender individuals.²²²

The ACA prohibits health programs and activities receiving federal financial assistance (such as Medicaid agencies) from discrimination on the basis of race, ethnicity, national origin, age, disability, and sex. That section of the ACA, § 1557, is the first-ever federal statute to ban sex discrimination in health care, which has been interpreted to include discrimination on the basis of gender identity and sex stereotypes.²²³ However, as part of an ongoing lawsuit, a federal court has issued an injunction halting enforcement of this provision's protections around gender identity. HHS' Office for Civil Rights also proposed changes to the existing implementing regulations for § 1557 in a June 14, 2019 rulemaking that eliminates gender identity as part of the definition of sex discrimination. It also removes sections of the existing regulations that prohibit health plans from excluding gender-affirming care.²²⁴ For more information about the nondiscrimination provisions of § 1557, please see Chapter VI, Section B.

Despite new protections and increased access, many LGBTQ and GNC people continue to experience discrimination and harassment in health care settings. States and providers are encouraged to find ways to ensure services are delivered in the most inclusive way.

G. Breast and Cervical Cancer Services

Breast cancer is the most common form of cancer among women in the U.S. It is the most common cause of death among Latinx women and the second most common cause of death from a cancer after lung cancer among White, Black, Asian American, Native Hawaiian, Pacific Islander, and Native American/Alaska Native Women.²²⁷ Among Black women, breast cancer incidence rates vary by states—in seven states, the rates are higher among Black women compared to White women.²²⁸ Transgender men and transgender women who use hormone treatments also have an increased risk of breast

ADVOCACY TIP:

Creating LGBTQ Welcoming Health Care Environments

Work with your state Medicaid Department to develop resources and trainings to promote more LGBTQ inclusive health care practices. The New York State Department of Health hosts a webpage with a list of resources to help providers provide LGBTQ appropriate care.²²⁵ The resources include suggestions and recommendations for staff sensitivity trainings, creating a welcoming environment, addressing confidentiality concerns, guidelines for creating inclusive intake forms, and suggestions for discussing safe sex practices in a non-judgmental way with bisexual men and women.²²⁶ When institutions recognize and implement these aspects of LGBTQ care, individuals can feel safer and increase their utilization of reproductive and sexual health care.

cancer compared to cisgender men.²²⁹

Women of color are also disproportionately more likely to die from cervical cancer compared to their percentage of the population.²³⁰ Latinas have the highest rates of new cases of cervical cancer and the second highest death rate from cervical cancer after African-American women.²³¹ 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. Transgender men are also at risk for cervical cancer.²³²

Breast and cervical cancer screenings and treatments are covered Medicaid services. However, in states that have not expanded Medicaid, many low-income people are not eligible for those services. States have two options to provide coverage for breast and cervical cancer screenings and treatments as described below.

1. National Breast and Cervical Cancer Early Detection Program

Individuals who are not enrolled in Medicaid 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).²³³ To be eligible for NBCCEDP screening, the individual's income may not exceed 250 percent FPL, and they must be between the ages of 21 and 64 to be screened for cervical cancer, or between the ages of 40 and 64 for a breast cancer screening.²³⁴ There is no eligibility requirement related to gender. Cisgender women, cisgender men, transgender men, and transgender women who have taken or are taking hormones and meet all other program eligibility requirements may receive services.²³⁵ Covered services can include pelvic exams, Pap tests, HPV tests, clinical breast exams, mammograms, and diagnostic services such as an ultrasound, colposcopy, or biopsy.

There are NBCCEDP grantees in all fifty states.²³⁶ Grantees agree to give priority to people with low incomes to receive preventive screenings, as well as referrals for medical treatment to ensure the appropriate follow-up and support services.

2. Breast and Cervical Cancer Prevention and Treatment Program

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gives states the option of extending Medicaid coverage to women diagnosed with breast and/or cervical cancer through NBCCEDP screening programs.²³⁷ All 50 states and the District of Columbia offer coverage under a Breast and Cervical Cancer Prevention and Treatment (BCCPT) program.²³⁸ States receive an enhanced FMAP from the federal government, equal to its Children's Health Insurance Program match, which funds 65 percent - 83 percent of the total program cost.²³⁹ Other than "nominal" charges for non-preferred prescription

drugs, states cannot impose cost sharing or premiums on women covered under a BCCPT program.²⁴⁰

a. Eligibility

Medicaid coverage for breast and/or cervical cancer treatment is available to women who meet all of the following criteria²⁴¹:

- 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,²⁴²
- Have been found to have breast and/or cervical cancer and are in need of treatment,²⁴³
- Age 65 or younger,
- Do not have any other creditable health insurance,²⁴⁴ and
- Are citizens or qualified immigrants of the U.S., or have satisfactory immigration status.²⁴⁵

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, as well as whether to offer presumptive eligibility to women who have been determined eligible by a qualified entity.²⁴⁶

While there is no income eligibility for the treatment program, there is an income eligibility requirement for the screening program, which is capped at 250 percent FPL subject to state law. 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.²⁴⁷

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.

b. Breast and Cervical Cancer Treatment Services

Women enrolled in Medicaid through a BCCPT program are entitled to full scope Medicaid, and are not limited to services related to cancer treatment. At states' option, available services may include experimental treatments.²⁴⁸

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.²⁴⁹

H. Mental Health

In 2016, an estimated 44.7 million U.S. adults, nearly one in five, had a mental health condition.²⁵⁰ Mental health conditions include depression, anxiety disorders, and serious psychological distress. Some of these conditions are more common among women and even more prevalent among for women of color, queer and transgender women, and women with low incomes. For example, depression is more common among Latina women than white women, and suicide rates among American Indian/Alaska Native women ages 15-44 years of age and Asian American women between the ages of 65 – 84 years old are the highest among their peers.^{251, 252} Black women are also more likely to experience postpartum depression.²⁵³ Many of these women experienced trauma, racism, discrimination, and poverty-related stress. Mental health is also an issue of great concern among many LGBTQ people.²⁵⁴

Women represented two-thirds of users of mental health services, which is consistent with the higher prevalence of certain mental health conditions in women versus men.²⁵⁵ Yet there continues to be an unmet need for mental health treatment and counseling for women. Black and Latina women are less likely to receive treatment for depression than white women, and American Indian or Alaska Native women are the most likely to report an unmet need for mental health treatment.²⁵⁶

As the largest payer for mental health services in the U.S., Medicaid is vitally important to women and people seeking mental health care. 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.²⁵⁷

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.²⁵⁸

The ACA further improved access to mental health and substance use disorder (SUD) services for Medicaid enrollees in at least three critical ways. First, expanding Medicaid coverage to millions of uninsured individuals dramatically expanded access to these services. Second, the minimum benefit requirements for both Medicaid and Marketplace insurance plans include parity for mental health and SUD services. Lastly, the ACA extended the parity requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) to additional insurance products.

MHPAEA builds on existing mental health parity requirements that were put in place in 1996 when Congress passed the Mental Health Parity Act (MHPA), which prohibited group health plans from imposing annual and lifetime dollar caps on mental health benefits that were more restrictive than those on medical and surgical benefits. These requirements also applied to Medicaid managed care plans in states where Medicaid mental health benefits were covered under contract with managed care organizations.²⁵⁹ In 2008, Congress passed MHPAEA, which maintained MHPA's annual and lifetime dollar cap restrictions on mental health benefits and expanded those protections to include SUD services. MHPAEA also extended parity requirements to ensure financial requirements and treatment limitations would not be more restrictive than those for medical and surgical benefits.²⁶⁰ Mental health and SUD services are a required benefit under the ten essential health benefits for state that elect to provide Alternative Benefit Plans (ABPs) coverage for their Medicaid expansion population. By extending the MHPAEA's requirements to ABPs, these mental health and SUD benefits must be offered in parity with other services.

Endnotes

- 1 See generally Nat'l Health Law Program, *An Advocate's Guide to the Medicaid Program* (2013), <https://healthlaw.org/resource/advocates-guide-to-the-medicaid-program-agmp/> (giving additional information about mandatory and optional Medicaid covered services, including citations to the Act and the Code of Federal Regulations).
- 2 42 U.S.C. § 1396a(a)(17).
- 3 42 C.F.R. § 440.230(b).
- 4 42 C.F.R. § 440.230(c).
- 5 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930.
- 6 42 U.S.C. § 1396d(a).
- 7 42 C.F.R. § 440.230(d).
- 8 See Jane Perkins & Mara Youdelman, Nat'l Health Law Prog., *Q & A: Defining Medical Necessity* (2013), <https://healthlaw.org/resource/q-a-defining-medical-necessity/>.
- 9 42 U.S.C. § 1396(a)(43)(C); 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 441.50-62.
- 10 42 U.S.C. § 1396a(a)(30); 42 C.F.R. § 440.230(d); 42 C.F.R. §§ 456.1-725.
- 11 Courts have placed limits on the extent to which a state Medicaid agency can impose utilization controls to restrict the use of medically necessary services. See *Bontrager v. Indiana Fam. & Soc. Servs. Admin.*, 697 F.3d 604 (2012) (holding that Indiana violated the Medicaid Act when it denied medically necessary dental work because the enrollee had exceeded the annual cap on dental services).
- 12 See 42 U.S.C. § 1396u-2(b)(2)(A)(i); 42 C.F.R. § 441.59(a).
- 13 42 C.F.R. § 438.210(a)(4).
- 14 42 C.F.R. 438.210(a)(4)(ii); see also Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27634 (May 6, 2016) [hereinafter Managed Care Rule] (noting that states and managed care plans may not use utilization controls that "effectively deprive" enrollees of "free choice of equally appropriate [family planning] treatments"). See also 2016 Dear State Health Official letter, *infra* note 33.
- 15 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a); 42 C.F.R. § 440.210.
- 16 42 U.S.C. § 1396a(a)(10)(C)(iii)(II); 42 U.S.C. § 1396a(a)(10)(G)(V); 42 C.F.R. § 440.210(a)(2); CMS, STATE MEDICAID MANUAL §§ 3311-3311.3, 4421.

- 17 42 U.S.C. § 1396d(a)(xiii)(4)(C); 42 C.F.R. § 441.20; see also CMS, STATE MEDICAID MANUAL § 4270.
- 18 42 U.S.C. § 1396d(a)(17); 42 C.F.R. § 440.165; 42 C.F.R. § 441.21.
- 19 42 U.S.C. § 1396d(a)(21); 42 C.F.R. § 440.166.
- 20 42 U.S.C. § 1396d(bb).
- 21 42 U.S.C. §§ 1396d(a)(1)-(29); 42 C.F.R. § 440.225.
- 22 42 U.S.C. §§ 1396a(a)(10)(C)(ii)-(iii); 42 C.F.R. § 440.220(a)(1).
- 23 42 C.F.R. § 440.220(a)(5).
- 24 42 U.S.C. § 1396a(a)(10)(C)(iii); 42 C.F.R. § 440.220(a)(2)(i) (designating ambulatory services as a required service).
- 25 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.220(a)(3)(designating home health services as a required service).
- 26 42 U.S.C. § 1396d(a)(4)(C).
- 27 42 U.S.C. § 1396a(a)(10)(G).
- 28 42 U.S.C. § 1396b(a)(5).
- 29 42 C.F.R. § 433.10(c)(1).
- 30 42 C.F.R. § 433.15(b)(2).
- 31 42 C.F.R. § 440.230(b).
- 32 42 C.F.R. § 441.20.
- 33 See CMS, Dear State Health Official (June 14, 2016) (#16-008) at 3 [hereinafter 2016 SHO letter], <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.
- 34 *Id.*
- 35 *Id.*
- 36 See CMS, STATE MEDICAID MANUAL § 4270.B.1. Notably, most Medicaid programs emphasize pregnancy prevention. In fact, the Medicaid Act explicitly allows states to exclude fertility drugs from coverage. 42 U.S.C. §1396r-8(d)(2)(B). Accordingly, conception and infertility services intended to promote childbearing are not included as family planning services in the majority of states. A 2015 survey of 41 states' traditional Medicaid, ACA expansion and Family Planning Waiver plans found that only 9 of the 41 responding states cover fertility testing for both women and men in traditional Medicaid; 6 of the 25 responding ACA expansion states cover fertility testing and only 5 states provide coverage for both genders through all three eligibility pathways. See Walls, et al., Kaiser Family Found. *Medicaid Coverage of Family Planning Benefits: Results from a State Survey* (Sept. 15, 2016), <https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/> [hereinafter referred to as Kaiser Family Planning Survey];

- 37 See CMS, STATE MEDICAID MANUAL § 4270.B.
- 38 42 C.F.R. 438.210(a)(4)(ii); 2016 SHO Letter, *supra* note 33. See also Managed Care Rule, *supra* note 14, at 27634 (noting that states and managed care plans may not use utilization controls that “effectively deprive” enrollees of “free choice of equally appropriate [family planning] treatments”).
- 39 Managed Care Rule, *supra* note 14, at 27,634; see 2016 SHO Letter, *supra* note 33.
- 40 42 U.S.C. §1396r-8(d)(2)(B).
- 41 See Kaiser Family Planning Survey, *supra* note 36.
- 42 *Id.* at 17.
- 43 *Id.*
- 44 42 C.F.R. § 441.253.
- 45 See Alexandra Minna Stern, *Sterilized in the Name of Public Health: Race, Immigration, and Reproductive Control in Modern California*, 95 AM. J. PUB. HEALTH 1128, 1129-34 (2005), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449330/pdf/0951128.pdf>; see also Corey Johnson, *Females Inmates Sterilized in California Prisons Without Approval*, CTR. FOR INVESTIGATIVE REPORTING (July 7, 2013), <https://www.revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/>. More recent reports allege that prison officials and providers authorized sterilizations of incarcerated women in California without their prior knowledge and consent from 2006 – 2010.
- 46 42 C.F.R. § 441.257.
- 47 42 C.F.R. § 441.251.
- 48 See Kaiser Family Planning Survey, *supra* note 36.
- 49 42 C.F.R. § 441.257(b)(1)-(3).
- 50 42 C.F.R. § 441.257(a)(1)-(6).
- 51 42 C.F.R. § 50.207(a); see CMS, STATE MEDICAID MANUAL § 4270.B.2.
- 52 42 C.F.R. § 441.255(a)(1).
- 53 See CMS, STATE MEDICAID MANUAL § 4435. The woman and her representative, if any, must be informed orally and in writing that the hysterectomy will render her incapable of reproducing before surgery. The woman must acknowledge this information in writing, but the written acknowledgement can be accomplished either before or after the procedure.
- 54 See CMS, Dear State Medicaid Director Letter (April 16, 2014) (SMDL #14-003), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf> (clarifying the scope of family planning and family planning related services).

- 55 *Id.*
- 56 *Id.*
- 57 42 U.S.C. § 1396a(a)(23)(B); 42 U.S.C. § 1396n(b); 42 C.F.R. § 431.51(a)(3).
- 58 42 C.F.R. § 431.51(b)(2).
- 59 42 U.S.C. § 1396u-2(b)(6)(C).
- 60 42 C.F.R. § 438.10(g)(2)(vii).
- 61 Ana B. Ibarra, *California Bill Would Protect Patients' Access To Their Chosen Family Planning Providers*, CALIFORNIA HEALTHLINE (May 16, 2017), <https://californiahealthline.org/news/california-considers-shoring-up-protections-for-planned-parenthood-other-clinics>.
- 62 Cal. Dep't of Health Care Servs., *Letter to all Medi-Cal Managed Care Health Plans, All Plan Letter No. 15-020: Abortion Services* (Sept. 30, 2015), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-020.pdf>
- 63 42 C.F.R. § 438.206(b)(2).
- 64 *Id.*
- 65 Managed Care Rule, *supra* note 14, at 27667. For a review of the 2016 Medicaid Managed Care final rule and its application to reproductive and sexual health care, see Catherine McKee, Nat'l Health Law Prog., *Medicaid Managed Care Final Regulations and Reproductive Care* (Jun. 2016), <https://healthlaw.org/resource/issue-brief-5-medicare-managed-care-final-regulations-and-reproductive-health/>.
- 66 *Id.*
- 67 42 U.S.C. § 1396u-2(b)(3)(B)(i); 42 C.F.R. § 438.102(a)(2). See Chapter VI, Section A for more information about religious and moral refusals.
- 68 42 U.S.C. § 1396u-2(b)(3)(A).
- 69 42 C.F.R. § 438.10(e)(2)(v); 42 C.F.R. § 438.10(g)(2)(ii). Note that on Nov. 8, 2018, CMS issued a Notice of Proposed Rulemaking that proposed to limit use of taglines to written materials that “are critical to obtaining services.” While the rule has not been finalized, it is unclear whether information “critical to obtaining services” would include services that a plan does not provide.
- 70 42 C.F.R. § 438.56(c)(1).
- 71 42 C.F.R. § 438.56(d)(2)(ii).
- 72 42 C.F.R. § 438.52(b)(2)(ii)(C).
- 73 See 42 U.S.C. § 1396a(a)(54) (outpatient drugs), 42 C.F.R. § 1396d(a)(xiii)(12) (prescription drugs), 42 C.F.R. § 1396r-8 (payment for covered outpatient drugs) (2006); see also 42 C.F.R. § 440.120(a) (defining prescribed drugs).
- 74 42 U.S.C. § 1396u-7(b)(2)(A)(iv) (added by ACA § 2001(c) (listing prescription drugs as a required “basic service” for benchmark-equivalent plans).

- 75 42 U.S.C. § 1396r-8(a). The “340B Program” established by Congress in 1992 to address concerns that drug manufacturers were attempting to raise best prices by reducing discounts to safety net providers. See H.R. Rep. No. 384, 102s Cong., 2d Sess..Pt. 2 at 10-12 (1992).
- 76 42 U.S.C. § 1396r-8(k)(6); *see also* *Edmonds v. Levine*, 417 F. Supp. 2d 1323 (S.D. Fla. 2006).
- 77 U.S. Food and Drug Administration, Birth Control Guide (2011), <https://www.fda.gov/media/99605/download>.
- 78 42 U.S.C. § 1396r-8(d)(2).
- 79 42 U.S.C. § 1396r-8(d)(5). Note the 72-hour emergency supply does not apply to drugs listed in 42 U.S.C. § 1396r-8(d)(2).
- 80 42 U.S.C. § 1396r-8(d)(4)(C).
- 81 42 U.S.C. § 1396r-8(d)(4)(C).
- 82 42 U.S.C. § 1396r-8(d)(4)(A). These are often called Pharmacy and Therapeutics (P&T) committees.
- 83 42 U.S.C. § 1396r-8(d)(4)(B).
- 84 42 U.S.C. § 1396r-8(d)(4)(C); *see also* *Pharma. Research and Mfrs. of Am. v. Meadows*, 304 F.3d 1197, 1207.1208 (11th Cir. 2006).
- 85 42 U.S.C. §1396o-1(c)(1); *see also* David Machledt & Jane Perkins, Nat’l Health Law Prog., *Medicaid Premiums and Cost Sharing* (March 26, 2014), <https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/>.
- 86 42 U.S.C. § 1396o(a)(3).
- 87 *See Meadows*, 304 F.3d at 1203 (Florida’s PDL was not a formulary under 42 U.S.C. 1396r-8(d)(4) and instead a prior authorization program under (d)(5), because state could consider economic factors); *see also* *U.S. ex rel. King v. Solvay S.A.*, No. 06-2662, 2015 WL 338032 (S.D. Tex. 2015).
- 88 *See* 42 U.S.C. § 1396o; *see* 42 U.S.C. § 1396o-1; 42 C.F.R. § 447.53; *see also* 2016 SHO Letter, *supra* note 33. 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 who utilize a brand-name (non-generic) contraceptive method, or enrollees using a brand-name drug to treat STIs may be adversely affected if preferred versions do not exist.
- 89 Machledt & Perkins, *supra* note 84, at 5.
- 90 42 C.F.R. § 447.52(b). Beginning in Oct. 2015, states were permitted to increase these limits with each fiscal year.
- 91 Kaiser Family Found., *Premium and Cost Sharing Requirements for Selected Services for Medicaid Adults in January 2018: Findings From a 50-State Survey* Table 20 (Jan. 2018), <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2018-Table-20.pdf>.

- 92 *Id.*
- 93 See CMS, Dear State Medicaid Director Letter 2-3 (June 16, 2006) (SMDL # 06-015), available at www.cms.hhs.gov/smdl/downloads/SMD061606.pdf.
- 94 42 U.S.C. § 1396r-8(d)(6). See also Nat'l Conf. of State Legislatures *Recent Medicaid Prescription Drug Laws and Strategies* (June 1, 2016), <http://www.ncsl.org/research/health/medicaid-pharmaceutical-laws-and-policies.aspx>.
- 95 See Kaiser Family Planning Survey, *supra* note 36 (noting that supply limits are the most common restriction for oral contraceptives reported by state Medicaid programs).
- 96 Kaiser Family Planning Survey, *supra* note 36.
- 97 42 C.F.R. § 438.3(s).
- 98 *Id.*
- 99 42 C.F.R. 438.210(a)(4)(ii); 2016 SHO Letter, *supra* note 33. See also Managed Care Rule, *supra* note 14, at 27634 (noting that states and managed care plans may not use utilization controls that “effectively deprive” enrollees of “free choice of equally appropriate [family planning] treatments”).
- 100 Managed Care Rule, *supra* note 14, at 27,634; see 2016 SHO Letter, *supra* note 33.
- 101 See 2016 SHO Letter, *supra* note 33, at 2.
- 102 *Id.* The guidance lists examples of criteria that may be considered such “severity of side effects, clinical effectiveness, difference in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service.”
- 103 42 C.F.R. § 431.51(b)(2).
- 104 See 42 U.S.C. § 1396r-8(d)(1)(B)(i).
- 105 42 U.S.C. § 1396r-8(k)(6); 42 U.S.C. § 1396r-8(k)(g)(1)(B)(i).
- 106 See *Edmonds*, 417 F.Supp.2d 1323.
- 107 Kate Grindlay and Daniel Grossman, Women’s Health Issues (Mar-Apr 2019), Vol. 28, Issue 2, pp 144-151, *Interest in Over-the-Counter Access to a Progestin-Only Pill among Women in the United States*, [https://www.whijournal.com/article/S1049-3867\(17\)30292-X/pdf](https://www.whijournal.com/article/S1049-3867(17)30292-X/pdf).
- 108 42 U.S.C. § 1396r-8(k)(4).
- 109 Currently, eight states offer EC without a prescription: Hawaii, Illinois, Maryland, New Jersey, New York, Oklahoma, Oregon, and Washington. See Office of Population Res. at Princeton Univ., *The Emergency Contraception Website: State Medicaid Coverage of Non-prescription Contraception*, <http://ec.princeton.edu/info/Medicaid.html>.

- 110 Am. Coll. of Obstetrician and Gynecologists, *Access to Emergency Contraception, Committee Opinion Number 542* (2012), available at <https://www.ncbi.nlm.nih.gov/pubmed/23090563>.
- 111 See Office of Population Res. at Princeton Univ., *The Emergency Contraception Website: State Medicaid Coverage of Non-prescription Contraception*, <http://ec.princeton.edu/info/Medicaid.html>.
- 112 Free the Pill, *What is the law in your state?* (Jan. 24, 2019), <http://freethepill.org/wp-content/uploads/2019/01/FTP-state-tracking-1.24.19.pdf>.
- 113 Guttmacher Inst., *Refusing to Provide Health Services* (Dec. 1, 2017), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.
- 114 See generally Nat'l Women's Law Ctr., *Pharmacy Refusals 101* (2015), http://nwlc.org/wp-content/uploads/2015/08/pharmacy_refusals_101.pdf.
- 115 *Id.* See generally ACLU, *Religious Refusals and Reproductive Rights: Accessing Birth Control at the Pharmacy* (2007), <https://www.aclu.org/sites/default/files/pdfs/reproductiverights/finalreport.pdf>.
- 116 We use the more gender inclusive term “pregnant people” or “pregnant individuals” as much as possible throughout the Guide. We use the term “pregnant women” or “pregnant woman” when explaining the Medicaid requirements for pregnancy services to conform with the language used in statutes and regulations.
- 117 National Ctr. for Health Statistics, *Births in the United States, 2017* (2018), <https://www.cdc.gov/nchs/products/databriefs/db318.htm>.
- 118 CMS, STATE MEDICAID MANUAL § 4421.B.
- 119 42 C.F.R. § 440.210(a)(2)(i); 42 U.S.C. §§ 1396o(a)(2)(B) (prohibiting deductions, cost-sharing, or similar charges for pregnancy-related services for pregnant women); 42 C.F.R. §§ 447.53(d), 447.56(a)(vii) (permitting cost-sharing for non-preferred but not for preferred prescription drugs for pregnant women in Medicaid); Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost-sharing; Exchanges; Eligibility and Enrollment; 78 Fed. Reg. 42160, 42,281 (July 15, 2013) (clarifying family planning supplies and services, including contraceptives, are exempt from cost-sharing). See Chapter IV, Section C *infra* for more information about the scope of pregnancy-related services that must be provided.
- 120 CMS, STATE MEDICAID MANUAL § 4421.B.2.
- 121 Kaiser Family Found., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey* (Apr. 2017) [hereinafter Kaiser Pregnancy Services Survey], <https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-and-perinatal-benefits-survey-results/>.
- 122 42 U.S.C. § 1396d(l)(3)(C).
- 123 42 U.S.C. § 1396d(l)(3)(B).

- 124 42 U.S.C. § 1396d(l)(3)(C).
- 125 CMS, STATE MEDICAID MANUAL § 4421.B.3.
- 126 42 C.F.R. § 4410.20(a)(2)(ii).
- 127 Medicaid Program, Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144, 17,149 (Mar. 23, 2012).
- 128 42 U.S.C. §§ 1396d(a)(4)(A), (b); see also Kaiser Family Found., *Medicaid Benefits: Tobacco Cessation Services for Pregnant Women* (2012), <https://www.kff.org/other/state-indicator/tobacco-cessation-products-other-than-as-required-for-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- 129 CMS, STATE MEDICAID MANUAL § 4421.B.3.
- 130 42 U.S.C. § 1396d(a)(28)
- 131 Kaiser Family Found., *Medicaid Benefits: Freestanding Birth Center Services* (2018), <http://kff.org/other/state-indicator/medicaid-benefits-freestanding-birth-center-services>.
- 132 Brigitte Courtot, et al, *Panel Paper: Midwifery and Birth Center Care Under State Medicaid Programs* (Nov. 2018), <https://appam.confex.com/appam/2018/webprogram/Paper27539.html>. See also Kaiser Fam. Found., *Medicaid Benefits: Freestanding Birth Center Services* (2018), <http://kff.org/other/state-indicator/medicaid-benefits-freestanding-birth-center-services>.
- 133 Kaiser Pregnancy Services Survey, *supra* note 121, at 3-4.
- 134 Choices in Childbirth & Nat'l P'ship for Women & Fams., *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health* (2016), <http://transform.childbirthconnection.org/reports/doula/>.
- 135 CMS, STATE MEDICAID MANUAL § 4421.B.4.
- 136 See Kaiser Pregnancy Services Survey, *supra* note 121
- 137 42 U.S.C. § 1396a(e)(5-6); 42 C.F.R. § 435.170; 42 C.F.R. § 440.210(a)(3).
- 138 42 C.F.R. § 440.210(a).
- 139 Most states with pregnancy-related coverage provide the equivalent of full-scope Medicaid and have been recognized as meeting the minimum essential coverage (MEC) requirement. Pursuant to a CMS review, three states—Arkansas, Idaho and South Dakota—were not approved as MEC because they did not provide equivalent services. See Amy Chen, Nat'l Health Law Prog., *Pregnancy-Related Medicaid and Minimum Essential Coverage* (2017), available at <https://healthlaw.org/resource/issue-brief-pregnancy-related-medicaid-and-minimum-essential-coverage/> and CMS, *Medicaid Secretary-Approved Minimum Essential Coverage* (2016), <https://www.medicaid.gov/medicaid/benefits/downloads/state-mec-designations.pdf>.

- 140 42 C.F.R. § 4410.210(a)(2)(i); see also CMS, STATE MEDICAID MANUAL § 4421.B.1 (defining pregnancy-related services as “services necessary to treat conditions or complications that exist or are exacerbated because of the pregnancy”).
- 141 42 C.F.R. § 4410.210(a)(2)(ii).
- 142 CMS, STATE MEDICAID MANUAL § 4421.A.3.
- 143 For example, Idaho provides pregnant women and adults with disabilities, with limited oral health benefits beyond merely the emergency treatment available for other adults. See Ctr. for Health Care Strategies, *Medicaid Adult Benefits: An Overview* (2017), https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_051617.pdf. In Virginia, the state expanded comprehensive dental benefits to pregnant women in its Medicaid program, while still limiting non-pregnant adults to medically necessary oral surgical procedures. See Kaiser Fam. Found., *Medicaid Reforms Medicaid to Expand Coverage, Control Costs, and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016*, Table 20, (2015), <http://files.kff.org/attachment/report-medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016>; see also Medicaid and CHIP Payment and Access Comm’n (MACPC), *Report to Congress: Coverage of Medicaid Dental Benefits for Adults* app. 2A (2015), <https://www.macpac.gov/publication/coverage-of-medicaid-dental-benefits-for-adults-3/>.
- 144 42 C.F.R. § 440.220(a)(5).
- 145 42 U.S.C. §§ 1396o(a)(2)(B), (prohibiting deductions, cost-sharing, or similar charges for pregnancy-related services for pregnant women); 42 C.F.R. §§ 447.53(d), 447.56(a)(vii) (permitting cost-sharing for non-preferred but not for preferred prescription drugs for pregnant women in Medicaid); Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost-sharing; Exchanges; Eligibility and Enrollment; 78 Fed. Reg. 42160, 42,281 (July 15, 2013) (clarifying family planning supplies and services, including contraceptives, are exempt from cost-sharing).
- 146 42 U.S.C. §§ 1396o(a)(2)(B), (b)(2)(B).
- 147 42 U.S.C. §§ 1396o(a)(3), (b)(3).
- 148 42 U.S.C. § 1396o(c)(1). However, note that § 1396o(c)(3) provides that states can waive the premium payment requirement where the state has determined the requirement would create an undue hardship. States also cannot terminate a person’s Medicaid eligibility based on failure to pay premiums unless the nonpayment has continued for 60 or more days. 42 U.S.C. § 1396o(c)(3).

- 148 We use the more gender inclusive term “pregnant people” or “pregnant individuals” as much as possible throughout the Guide. We use the term “pregnant women” or “pregnant woman” when explaining the Medicaid requirements for pregnancy services to conform with the language used in statutes and regulations.
- 150 Guttmacher Inst., Fact Sheet: *Unintended Pregnancy in the United States* (Jan. 2019), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- 151 Guttmacher Inst., Fact Sheet: *Induced Abortion in the United States* (Jan. 2018), <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>.
- 152 See Usha Ranji et al., Kaiser Family Found., *Medicaid and Family Planning: Background and Implications of the ACA* (Feb. 2016), <https://www.kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/>.
- 153 See U.S. Gov’t Accountability Office (GAO), *Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements* (Jan. 2019), <https://www.gao.gov/products/GAO-19-159>.
- 154 Stanley Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature Review* 28 (2009), <https://www.guttmacher.org/pubs/MedicaidLitReview.pdf> (reviewing thirty-eight studies on impact of Medicaid restrictions on abortion and finding that approximately twenty-five percent of women were forced to carry pregnancies to term and many other women delayed abortion care by days or weeks while trying to acquire money).
- 155 See The Nat’l Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* (2018), <https://doi.org/10.17226/24950>.
- 156 Reprod. Health Tech. Project, *Two Sides of the Same Coin: Integrating Economic & Reproductive Justice* 2, 14 (2015), <http://rhttp.org/wp-content/uploads/2016/08/Two-Sides-of-the-Same-Coin-Integrating-Economic-and-Reproductive-Justice.pdf>. Women who carry unwanted pregnancies to term are also more likely to stay in contact with an abusive partner, and the existing children of women denied an abortion scored lower on child development than the children of mothers who received an abortion. See Jane Mauldon et al., *Effect of Abortion vs. Carrying to Term on a Woman’s Relationship with the Man Involved in the Pregnancy*, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH (Sept. 8, 2014), <http://onlinelibrary.wiley.com/doi/10.1363/47e2315/pdf>; and Diana Green Foster & M. Antonia Biggs, *Advancing New Standards in Reproductive Health, Effect of an unwanted pregnancy carried to term on existing children’s health, development and care*, <https://doi.org/10.1016/j.jpeds.2018.09.026>.

157 Rachel Jones et al., *Sexual Orientation and Exposure to Violence Among U.S. Patients Undergoing Abortions*, 132 OBSTETRICS & GYNECOLOGY 605-611 (Sep. 2018), doi:10.1097/AOG.0000000000002732.

158 In a study of almost 200 transgender men, 17 percent became pregnant and roughly 12 percent of those who became pregnant had an abortion. Alexis Light et al., *Family planning and contraceptive use in transgender men*, CONTRACEPTION JOURNAL, Vol. 9 (4) (2018), <https://doi.org/10.1016/j.contraception.2018.06.006>.

159 Jon O. Shimabukuro, Cong. Research Serv., RL33467, *Abortion: Judicial History and Legislative Response* 12 (2017), <https://fas.org/sgp/crs/misc/RL33467.pdf>.

160 *Id.*

161 The current version of the Hyde Amendment states:

(a) None of the funds appropriated in [the Consolidated Appropriations Act], and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

...

The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers 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, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113 §§ 506-507, 129 Stat. 2242, 2649.

- 162 448 U.S. 297, 326-27 (1980). (dissenting, Justice Brennan wrote that “the Hyde Amendment is nothing less than an attempt by Congress to circumvent the dictates of the Constitution and achieve indirectly what *Roe v. Wade* said it could not do directly.”). *Id.* at 331. See also Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 WM. & MARY J. WOMEN & L. 5 (2014) (discussing history of abortion funding and arguing that the Court wrongly decided *McRae*).
- 163 Health Care Financing Admin. (HCFA), Dear State Medicaid Director Letter (Feb. 12, 1998) [hereinafter HCFA Letter] (citing Oct. 1, 1993 letter affirming federal funding for Hyde abortions). See also *Planned Parenthood Affiliates of Mich. v. Engler*, 73 F.3d 634, 638 (6th Cir. 1996) (“All circuits to address the interplay between the 1994 Hyde Amendment and state laws restricting abortion funding have held that a state participating in Medicaid must fund abortions of pregnancies resulting from rape or incest, as well as abortions necessary to save the life of the mother.”) (internal citations omitted).
- 164 HCFA Letter, *supra* note 163, at 1.
- 165 Megan K. Donovan, *In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact*, 20 GUTTMACHER POL’Y REV. 1, 2 (2017), <https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact>.
- 166 *Id.*
- 167 *Id.*
- 168 Consolidated Appropriations Act, Pub. L. No. 114-113, § 507, 129 Stat. at 2649; 42 C.F.R. § 441.203; see also HCFA Letter, *supra* note 163; CMS, STATE MEDICAID MANUAL § 4431. Certification must contain the name and address of the patient. 42 C.F.R. § 441.203.
- 169 42 C.F.R. §§ 441.203; 441.206 (providing that federal reimbursement is not available if “the Medicaid agency has paid without first having received the certifications and documentation specified in [42 C.F.R. § 441.203]”); CMS, STATE MEDICAID MANUAL § 4431; see also *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 184-85 (3d Cir. 1995) (invalidating Pennsylvania’s second physician certification requirement in cases of life endangerment).
- 170 Consolidated Appropriations Act, Pub. L. No. 114-113 § 507, 129 Stat. at 2649; HCFA Letter, *supra* note 163; CMS, STATE MEDICAID MANUAL § 4431. Despite these clear federal mandates, however, South Dakota refuses to cover abortions in cases of rape and incest in violation of federal Medicaid law. See S.D. Codified Laws § 28-6-4.5. See also GAO report, *supra* note 154, at 15.
- 171 See HCFA Letter, *supra* note 163 a (“The definition of rape and incest should be determined in accordance with each State’s own law.”).

- 172 *Id.*
- 173 *Id.*
- 174 *Id.*; see also *Knoll*, 61 F.3d at 185 (invalidating Pennsylvania’s reporting requirement for women seeking Medicaid covered abortions in cases of rape and incest because it lacked a waiver as required by HCFA). Notwithstanding these clear federal directives, some states impose reporting requirements without a waiver. See, e.g., Az. Health Care Cost Containment System, Medical Policy Manual § 410-16, Ex. 410-4; see also IA. ADMIN. CODE r. 441.78.1(17)(d); see also MD. CODE OF REGS. § 10.09.02.04(G) (2); see also WY. STAT. ANN. § 35-6-117; see, e.g. Md. Med. Assistance Program, Certification for Abortion (DHMH 521); see also Iowa Dep’t of Health & Human Servs., Certification Regarding Abortion (July 2011) <http://dhs.iowa.gov/sites/default/files/470-0836.pdf>.
- 175 Melisa M. Holmes et al., *Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 AM. J. OBSTETRICS & GYNECOLOGY 320 (1996).
- 176 Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110,113 (2005).
- 177 Amanda Dennis & Kelly Blanchard, *Abortion Providers’ Experiences with Medicaid Abortion Coverage Policies: A Qualitative Multistate Study*, 48 HEALTH SERVS. RES. 236, 241 (2012) (finding that abortion providers in thirteen of fifteen states studied reported reimbursement for only thirty-six percent of abortion cases for which they should have received federal funding).
- 178 CMS, STATE MEDICAID MANUAL § 4432.B.2.
- 179 Megan Donovan, Guttmacher Inst., *Postabortion Contraception: Emerging Opportunities and Barriers*, (Oct. 2, 2017), <https://www.guttmacher.org/gpr/2017/10/postabortion-contraception-emerging-opportunities-and-barriers>.
- 180 *Id.*
- 181 *Id.*
- 182 *Id.*
- 183 Guttmacher Inst., *State Funding of Abortion Under Medicaid* (Jan. 1, 2019) <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>.
- 184 *Id.*
- 185 *Id.*
- 186 See Laura Basset, *The Return of the Back-Alley Abortion*, HUFFINGTON POST (May 15, 2014), http://www.huffingtonpost.com/2014/04/03/back-alley-abortions_n_5065301.html.

- 187 Nat'l Network of Abortion Funds, *Fall 2018 Newsletter*, <https://abortionfunds.org/fall-newsletter-2018/>.
- 188 See Nat'l Network of Abortion Funds website, abortionfunds.org (last visited Jun. 22, 2019).
- 189 CDC, *Youth Risk Behavior Surveillance-United States, 2015*, 65 MORBIDITY AND MORTALITY WEEKLY REP. 1, 1 (2016), available at https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf.
- 190 See Guttmacher Inst., *American Teens' Sexual and Reproductive Health 3* (2017), <https://www.guttmacher.org/fact-sheet/american-teens-sexual-and-reproductive-health>.
- 191 Kaiser Family Found., *Health Insurance Coverage of Children 0-18* (2016), <https://www.kff.org/other/state-indicator/children>.
- 192 42 C.F.R. § 457.70(a). States can establish their version of CHIP as a separate program, as an expansion of Medicaid, or as a combination of those two options. See Chapter VII, Section B *infra* for a fuller review of the CHIP program.
- 193 42 U.S.C. § 1396d(r). For a comprehensive overview of EPSDT, see CMS, *EPSDT—A Guide for States: Coverage in the Medical Benefit for Children and Adolescents* (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
- 194 42 U.S.C. § 1396d(r)(1)(B); see also CMS, STATE MEDICAID MANUAL § 5122(A).
- 195 42 U.S.C. § 1396d(r)(5).
- 196 CMS, STATE MEDICAID MANUAL § 5123.2.
- 197 Am. Acad. of Pediatrics, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* 174 (Joseph F. Hagan, Jr. et al. eds., 2017). A free pocket guide version of the Bright Futures guidelines is available online: https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_POCKETGUIDE.pdf.
- 198 *Id.*
- 199 See Steven Alexander et al., *Sexuality Talk During Adolescent Health Maintenance Visits* 168 JAMA PEDIATRICS 163 (2014).
- 200 42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.56(1).
- 201 42 C.F.R. § 441.61.
- 202 Eighteen percent of all adolescents aged 15-17 reported that they would not seek sexual and reproductive health services because of confidentiality concerns. Liza Fuentes et al., *Adolescents and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. OF ADOLESCENT HEALTH 36 (2017), [http://www.jahonline.org/article/S1054-139X\(17\)30508-6/fulltext](http://www.jahonline.org/article/S1054-139X(17)30508-6/fulltext).

- 203 Abigail English et. al., Guttmacher Inst., *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies* 3 (2012), <https://www.guttmacher.org/pubs/confidentiality-review.pdf>.
- 204 Liza Fuentes et al., *Adolescents and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. OF ADOLESCENT HEALTH 36 (2017), [http://www.jahonline.org/article/S1054-139X\(17\)30508-6/fulltext](http://www.jahonline.org/article/S1054-139X(17)30508-6/fulltext).
- 205 42 U.S.C. §§ 1396a(a)(7), 1396d(a)(4)(C); and 42 CFR § 441.20.
- 206 *Planned Parenthood Federation of New York v. Heckler*, 712 F. 2d 650 (DC Cir. 1983); *National Family Planning and Reproductive Health Association v. Department of Health and Human Services*, F. 2d 650 (DC Cir. 1983); and *T.H. v. Jones*, 425 F. Supp. 873 (D. Utah), 425 U.S. 986 (1976), *aff'd in part*.
- 207 Guttmacher Inst., *An Overview of Minor's Consent Law* (Feb. 1, 2018), <https://www.guttmacher.org/print/state-policy/explore/overview-minors-consent-law>.
- 208 45 C.F.R. § 164.502; See also Nat'l Institute for Health Care Management, *Protecting Confidential Health Services for Adolescents & Young Adults: Strategies & Considerations for Health Plans* (2011), <http://www.nihcm.org/images/stories/NIHCM-Confidentiality-Final.pdf>.
- 209 45 C.F.R. § 161.502.
- 210 *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015). See also Kaiser Family Found., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S* (May 2018) [hereinafter, Kaiser LGBT Health Coverage], <https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/>.
- 211 See Chapter V, Section B *infra* for an overview of the Essential Health Benefits.
- 212 U.S. Dep't of Labor, HHS, & Treasury, *FAQs About Affordable Care Act Implementation (Part XXVI)* at 6 (May 11, 2015), https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf.
- 213 See World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, Vol. 7, <https://www.wpath.org/publications/soc>.
- 214 Am. Psychiatric Ass'n, *What Is Gender Dysphoria?* (Feb. 2016), <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> (last visited June 23, 2019).
- 215 For a list of Medicaid coverage policies for transition-related care by state, see Movement Advancement Project, *Healthcare Laws and Policies: Medicaid Coverage for Transition-Related Care* (Jan. 2019), <https://www.lgbtmap.org/img/maps/citations-medicaid.pdf>.

- 216 These states are California, Colorado, Connecticut, District of Columbia, Hawaii, Iowa, Illinois, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington. Movement Advancement Project, *supra* note 217.
- 217 *Doe v. Bonta*, Sacramento Superior Court of the State of California (case no. 00CS00954, January 29, 2001).
- 218 See Abigail Coursolle, Nat'l Health Law Prog., *California Pride: Medi-Cal Coverage of Gender-Affirming Care Has Come a Long Way* (June 2018), <https://healthlaw.org/california-pride-medi-cal-coverage-of-gender-affirming-care-has-come-a-long-way/>.
- 219 See *Cruz v. Zucker*, 218 F.Supp.3d 246 (S.D. New York Jul. 29, 2016), *Good v. Iowa*, 924 N.W.2d 853 (Ia. S. Ct. 2019).
- 220 States that explicitly exclude coverage are Alaska, Georgia, Maine, Missouri, Nebraska, Ohio, Tennessee, Wisconsin, and Wyoming. Movement Advancement Project, *supra* note 217. However, on April 23, 2019, a District Court in Wisconsin issued a preliminary injunction invalidating the state's categorical exclusion of coverage for medically necessary gender-affirming care and treatments for transgender Medicaid beneficiaries. *Flack v. Wis. Dep't Health Servs*, No. 3:18-cv-00309 (W.D. Wis. Apr. 23, 2019).
- 221 See Kaiser LGBT Health Coverage, *supra* note 210.
- 222 Nat'l Center for Transgender Equality, *2015 U.S. Transgender Survey*, <http://www.ustranssurvey.org/reports>.
- 223 See Jennifer Lav, Nat'l Health Law Prog., *Q&A on Section 1557 of the Affordable Care Act: Protections for Transgender Individuals*, <https://healthlaw.org/resource/q-a-section-1557-of-the-affordable-care-act-protections-for-transgender-individuals/>.
- 224 See Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 115 (Jun. 14, 2019).
- 225 New York State Dep't of Health, Lesbian, Gay, Bisexual and Transgender Health webpage, <https://www.health.ny.gov/diseases/aids/consumers/lgbt/> (last visited Jun. 23, 2019).
- 226 For example, bisexual men and women often face the stigma that they are “promiscuous, high-risk, dangerous” because they may have sex with people of different genders but that providers should still make sure that they have the knowledge to make safe sexual decisions.

- 227 CDC, *Cancer Among Women Breast Cancer Statistics*, <https://www.cdc.gov/cancer/breast/statistics/index.htm> (last updated June 7, 2017). See also American Cancer Society, *Facts & Figures Report: Cancer Rates Vary Widely Among Asian Americans, Native Hawaiians, and Pacific Islanders*, <https://www.cancer.org/latest-news/facts-figures-report-cancer-rates-vary-widely-among-asian-americans-native-hawaiians-and-pacific-islanders.html>.
- 228 The states are Alabama, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, and Tennessee.
- 229 Christel J M deBlok et al, *Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands* *BMJ* 365 (May 14, 2019), doi: <https://doi.org/10.1136/bmj.l1652>.
- 230 See CDC, *HPV-Associated Cancers Rates by Race and Ethnicity* (Aug. 2, 2019), <https://www.cdc.gov/cancer/hpv/statistics/race.htm> (last visited Aug. 30, 2019).
- 231 See CDC, *Cancer Rates by Race and Ethnicity*, <https://www.cdc.gov/cancer/cervical/statistics/race.htm> (last updated June 19, 2017).
- 232 Katherine T. Hsiao, UCSF Center of Excellence for Transgender Health, *Screening for cervical cancer in transgender men*, <http://transhealth.ucsf.edu/trans?page=guidelines-cervical-cancer> (last visited June 20, 2019).
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- 234 CDC, *National Breast and Cervical Cancer Early Detection Program (NBCCEDP): About the Program*, <https://www.cdc.gov/cancer/nbccedp/index.htm> (last updated Nov. 13, 2017); CMS, *Dear State Medicaid Director Letter at 2 (SMDL # 06-015)* (June 16, 2006), www.cms.hhs.gov/smdl/downloads/SMD061606.pdf.
- 235 CDC, *Updated NBCCEDP Guidelines* (Dec. 2013), <https://assets2.hrc.org/files/assets/resources/AskDrMiller122013.pdf?ga=2.74519634.1971214535.1561098765-201037313.1561098765>.
- 236 See CDC, *NBCCEDP: About the Program*, *supra* note 234.
- 237 See *Breast and Cervical Cancer Prevention and Treatment Act of 2000*, Pub. L. No. 106-354, 114 Stat. 1381 (2000) (codified at 42 U.S.C. § 1396a(10)(A)(ii) (XVIII)).
- 238 See CDC, *NBCCEDP: About the Program*, *supra* note 234.
- 239 42 U.S.C. § 1396d(b).
- 240 See *Deficit Reduction Act of 2005*, Pub. L. No. 109-171, 120 Stat. 4 (2006).
- 241 BCCPT restricts eligibility to women.

- 242 For a more detailed description of the different CDC-related screens that states can choose to accept in determining eligibility, see HHS, Dear State Health Official Letter (Jan. 4, 2001), <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho010401.pdf>.
- 243 See *id.* 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.
- 244 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-3(c).
- 245 See HHS Letter, *supra* note 242.
- 246 *Id.*
- 247 Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001, 115 Stat. 2384 (2002).
- 248 *Id.*
- 249 42 U.S.C. § 1396a(a)(10)(G)(XIV).
- 250 Substance Abuse and Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (2017), <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#summary>.
- 251 Nat’l Alliance on Mental Illness, *Press Release: Women & Depression. 1 in 8; Twice The Rate of Men* (Apr. 28, 2008), <https://www.nami.org/Press-Media/Press-Releases/2008/Women-Depression-1-in-8;-twice-the-rate-of-men>.
- 252 National Institutes of Health (NIH), Office of Research on Women’s Health, *Women of Color Health Data Book 74*, <https://orwh.od.nih.gov/sites/orwh/files/docs/WoC-Databook-FINAL.pdf>.
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- 254 Nat’l Alliance on Mental Illness, LGBTQ, <https://www.nami.org/Find-Support/LGBTQ> (last visited Jun. 23, 2019).
- 255 HRSA, *Mental Health Care Utilization* (2013), <https://mchb.hrsa.gov/whusa13/health-services-utilization/p/mental-health-care-utilization.html>.
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- 258 See EPSDT—A Guide for States: Coverage in the Medical Benefit for Children and Adolescents, *supra* note 193, at 10-12.
- 259 42 U.S.C. § 1396b(m)(1)(A). The Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 498 & 558, added sections 1932(b)(8) and 2103(f)(2) to apply pieces of the MHPA to MCOs as defined in 42 U.S.C. § 1908(m)(1)(A).
- 260 42 U.S.C. § 1396u-7(b)(6).