



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

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## Chapter VII. Other Reproductive and Sexual Health Programs

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Not all people with low incomes are eligible for full-scope Medicaid coverage. Those who are not eligible, such as certain immigrants or adolescents, may be able to receive reproductive and sexual health care through a safety net provider or a publicly funded family planning program. These safety net programs provide critical services to communities of color, youth and young people, and other marginalized communities who are not eligible for or able to access Medicaid-funded services. Yet some of these programs have been eliminated or dramatically reshaped under the Trump administration. Check [healthlaw.org](http://healthlaw.org) for timely updates and analyses on the latest changes.

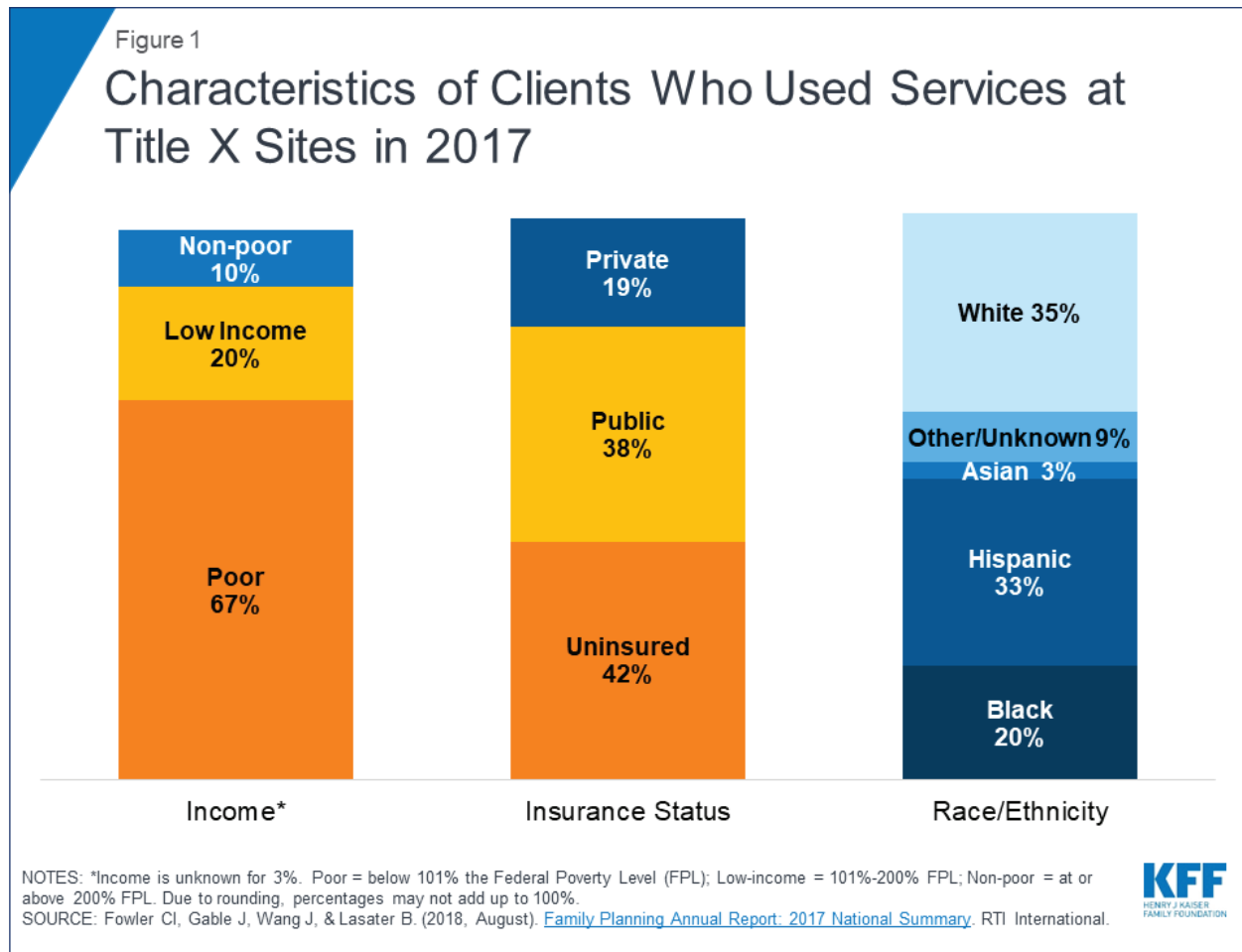
### A. Title X

This section is current as of August 28, 2019. In March, HHS finalized a rule that makes significant and harmful changes to how the Title X program is administered, who it serves, and what services are available. The rule is being challenged in the courts, however most sections of the final rule have gone into effect. NHeLP is closely monitoring the legal challenges and any subsequent program changes, and will update this section accordingly.

On March 4, 2019, the administration finalized a rule that imposes a number of harmful restrictions and requirements on family planning providers who receive Title X funds.<sup>1</sup> The rule was scheduled to go into effect on May 3, 2019, however several legal challenges delayed its implementation until July 15, 2019. The physical separation requirements of the final rule will not go into effect until March 4, 2020.<sup>2</sup>

The Title X Family Planning Program was created in 1970 to provide a range of reproductive health options, promote positive birth outcomes, and improve the health of low-income individuals and their families.<sup>3</sup> HHS administers Title X through the Office of Population Affairs (OPA) and provides federal grants to support the delivery of family planning clinical services, training for family planning clinic personnel, data collection and family planning research, and community-based outreach and education.

In 2017, Title X funded a network of nearly 4,000 clinics nationwide that collectively served over 4 million people per year.<sup>4</sup> The program is designed to prioritize funding for projects that provided free or low-cost services to people with low incomes. Title X providers are prohibited from imposing fees or cost-sharing on individuals with a family income at or below 100 percent the Federal Poverty Level (FPL).<sup>5</sup> Adolescents seeking Title X services are assessed on the basis of their own income, rather than their family income.<sup>6</sup> Individuals with incomes between 101 – 250 percent FPL are charged on a sliding scale based upon their ability to pay.<sup>7</sup> Ninety percent of the individuals served through Title X funded programs in 2017 had incomes at or below 250 percent of the federal poverty level and received subsidized or no-cost services.<sup>8</sup>



## 1. Program requirements under the old rule

Under the previous rule, Title X-funded clinics and projects were required to provide a range of “medically approved” services including a broad range of FDA-approved contraceptive methods on a voluntary and confidential basis.<sup>9</sup> The rule required providers to offer nondirective pregnancy options counseling to people who are pregnant. This type of counseling describes the practice of providing neutral, factual information and counseling about the full range of pregnancy options including prenatal care and delivery; infant care, foster care, adoption; and abortion.<sup>10</sup> Providers could provide referrals for each options upon request.

Recipients of Title X funding must also follow the CDC and OPA recommendations for providing Quality Family Planning services, which include pap tests and breast cancer screenings.<sup>11</sup>

By law, Title X providers are prohibited from using Title X funds for to cover abortions, and abortion providers had to segregate Title X funds from other sources of funding.<sup>12</sup> The program also has long-standing requirements for voluntary participation; individuals cannot be coerced to accept services or use or not use any particular method of family planning.<sup>13</sup> Additionally, every Title X grantee clinic or project must have safeguards in place to ensure client confidentiality.<sup>14</sup>

Although family planning services are publicly funded through other federal programs (primarily Medicaid), Title X remains the only federal program dedicated to providing individuals with family planning and other related preventive health services. Since its inception, Title X has proven to be a critical, cost-effective source of high quality reproductive and sexual health care for millions of individuals.<sup>15</sup> Even after the passage of the Affordable Care Act, Title X continued to serve as a necessary safety-net for those remaining uninsured or seeking confidential services.<sup>16</sup>

## 2. Changes to Title X under the final rule

The final rule went into effect after the U.S. Court of Appeals for the Ninth Circuit granted a request from the Department of Health and Human Services (HHS) to lift preliminary injunctions issued by lower courts in California, Oregon, and Washington.<sup>17</sup> Several lawsuits are still making their way through the courts, however Title X grantees were required to submit a compliance plan to HHS by August 19, 2019 stating their “good faith” intent to comply with the new rule.<sup>18</sup> This prompted some providers, including Planned Parenthood and other grantees, and several state departments of health to reject Title X funding.<sup>19</sup>

While it’s too early to assess the actual impact of the new rule, it will almost certainly cause harm to the reproductive and sexual health and well-being of individuals with low-incomes and people of color. The new rule introduces a

definition of family planning to include abstinence and “natural family planning methods or other fertility-based methods,” and eliminates the current requirement that recipients of Title X funds provide a broad range of “medically approved” contraceptive methods.<sup>20</sup> Removing this requirement opened the door to Title X-funded recipients that refuse to offer a broad range of FDA-approved contraceptive methods. In fact, a faith-based clinic operating as “Obria Group” was awarded a \$1.7 million award from OFP when the new rule was announced even though the organization does not provide hormonal contraception based on religious objections.<sup>21</sup> When the courts temporarily stayed the rule—requiring Title X grant awardees to adopt the existing program requirements described above, Obria Group filed a lawsuit against HHS claiming that complying with the Title X rules violates their free speech and religious freedom rights. Obria subsequently dropped the lawsuit when HHS assured providers with religious objections they would not have to comply with the rule’s current requirement to provide abortion referrals or offer hormonal contraceptives.<sup>22</sup>

The final rule also eliminates the long-standing requirement for providers to offer nondirective pregnancy options counseling that includes abortion. Instead, it limits who can provide options counseling to doctors and advanced practice providers, but not other trained clinic staff. It also prohibits a project from referring patients to an abortion provider even if the patient requests one.<sup>23</sup> The final rule goes further to require providers to refer all pregnant people to prenatal care, regardless of whether the individual chooses this option.<sup>24</sup> Additionally, the rule threatens patient confidentiality for minors by requiring Title X providers to encourage “family participation” to compel adolescent patients to share information about their sexual history with their parents and include their parents in their family planning care.<sup>25</sup>

The final rule imposes onerous physical separation and enhanced financial separation requirements that will go into effect on March 4, 2020. This aspect of the rule requires Title X grantees to have “objective integrity and independence” from prohibited activities including (but not limited to): separate examination, consultation, treatment, and waiting rooms; separate phone numbers, email addresses, and websites; separate staff; separate workstations; separate electronic or paper-based health care; and even separate office entrances and exits.<sup>26</sup>

Finally, Title X-funded entities must document all implementation efforts in detail and must agree to substantial HHS oversight.<sup>27</sup>

## B. Children’s Health Insurance Program

In 1997, Congress created the Children’s Health Insurance Program (CHIP) to provide affordable health care coverage for low-income children whose family income is above Medicaid eligibility levels. Since then, Congress has reauthorized the program through various bills including the Children’s Health

Insurance Program Reauthorization Act (CHIPRA) and the ACA.<sup>28</sup> In early 2018, Congress passed a six-year extension of CHIP funding through FY 2023, and two weeks later passed a continuing resolution that included an additional four years of CHIP funding.<sup>29</sup>

Like Medicaid, CHIP is a federal-state funded partnership. Unlike Medicaid, however, CHIP is not an entitlement program. Rather, CHIP is funded as a block grant and Congress determines the funding amount. This means that participating states may have more people who are eligible for CHIP than it can cover and funding can run out, whereas states are required to cover all people eligible for Medicaid. In addition, depending on the design of the CHIP program, some states impose a waiting period on potential CHIP enrollees to guard against “crowd out”—the substitution of private health insurance by public health coverage.<sup>30</sup> During the waiting period, a child seeking to enroll in CHIP must be without health insurance for a period of time before they are eligible to enroll.<sup>31</sup> HHS issued ACA implementing regulations that helped reduce some of the CHIP coverage barriers caused by waiting periods by limiting the time period to no more than 90 days and requiring states to adopt certain good cause exemptions.<sup>32</sup> As of November 2016, only fifteen states have a waiting period.<sup>33</sup>

The ACA also created a Maintenance of Effort (MOE) requirement for state enrollment of children in CHIP and Medicaid programs that was set to expire on September 30, 2019. MOE refers to the requirement on states to maintain certain coverage levels for children enrolled in Medicaid and CHIP. States that are unable to cover all eligible children under CHIP (for example, if they run out of federal funding) can enroll children in comparable Marketplace insurance.<sup>34</sup> The 2018 continuing resolution extended the MOE requirement through September 30, 2027, however the requirement will be limited to children in families with incomes at or below 300 percent FPL after October 1, 2019.<sup>35</sup>

## 1. Program design

States have the option to participate in CHIP, and currently all do.<sup>36</sup> States have flexibility to design their CHIP program in one of three ways:

1. Expanding their state Medicaid program;
2. Creating a separate CHIP program; or
3. Creating a combination model that has both a separate CHIP program and Medicaid expansion.

As of January 2017, eight states, the District of Columbia, and five territories operated CHIP as a Medicaid expansion; two states operated separate CHIP programs; and 40 states operated a combination program.<sup>37</sup> States that use a Medicaid-expansion CHIP program must generally follow federal Medicaid rules. Separate CHIP programs generally operate under a separate set of federal rules that allow states to design benefit packages that look more like commercial

insurance than Medicaid. States may also use separate CHIP programs in order to charge premiums, to create waiting periods, and to brand and market their CHIP programs separate from Medicaid. Some states that use a combination model use a Medicaid-expansion CHIP program to cover younger or lower-income children and a separate CHIP program for others.

In general, states must use CHIP funds to provide coverage to uninsured, low-income children who do not qualify for Medicaid. States have flexibility in determining the income eligibility limits. Most states cover children up to or above 200 percent of FPL, and some states use federal CHIP funds to expand coverage above 300 percent FPL.<sup>38</sup>

States receive an enhanced federal match for CHIP enrollees that is higher than what they receive for their state Medicaid program. Covered services vary from state to state. For example, states that adopted the ACA option to expand Medicaid must offer the same Medicaid benefit package for CHIP enrollees. These include family planning services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that includes health education related to sexual health. States with a separate CHIP program are not required to cover family planning services, prenatal care, and other benefits, and can choose whether or not to cover such services.

## 2. Coverage Options

CHIP covers children up to age 18, or if still in school, up to age 19.<sup>39</sup> States also have the option of extending CHIP coverage to pregnant women who do not otherwise qualify for Medicaid.<sup>40</sup> Five states use CHIP funds to cover pregnant people with family incomes ranging from 200-300 percent FPL.<sup>41</sup> In addition, states offering prenatal services under CHIP may cover postpartum services through the end of the month in which the 60-day postpartum period falls.<sup>42</sup> As in Medicaid, CHIP programs cannot impose cost sharing or waiting periods for pregnancy-related services.<sup>43</sup>

States have several other CHIP coverage options, particularly for people who are pregnant. States may choose to provide presumptive eligibility for CHIP coverage to children and/or pregnant women.<sup>44</sup> Presumptive eligibility allows states to authorize qualified entities to provide immediate, same-day services to an individual who appears to meet the eligibility criteria for coverage while they wait for a final determination.

States also have an option to provide coverage in CHIP and Medicaid to “lawfully residing” immigrant women and children subject to the “five year bar” (i.e. immigrants who are of a qualified status but have to wait five years before they may obtain coverage).<sup>45</sup> Also known as the “ICHIA option” (named after the Legal Immigrant Children’s Health Improvement Act, which was later incorporated in CHIPRA), 33 states and the District of Columbia currently provide coverage for

children, and 24 states and District of Columbia provide coverage for pregnant women.<sup>46</sup>

In addition to ICHIA, states have the option to provide coverage to the fetus of pregnant person, regardless of immigration status. The “unborn child” rule offers states a way to provide prenatal care and promote healthy pregnancies, regardless of the pregnant person’s immigration status.<sup>47</sup> This includes providing care to immigrants during the five year bar, undocumented immigrants, (i.e. immigrants who are of a qualified status but are subject to a five-year waiting period before they may obtain coverage), undocumented immigrants, and other immigrants who do not meet the definition of “qualified” as required for CHIP eligibility. Sixteen states have implemented this option.<sup>48</sup>

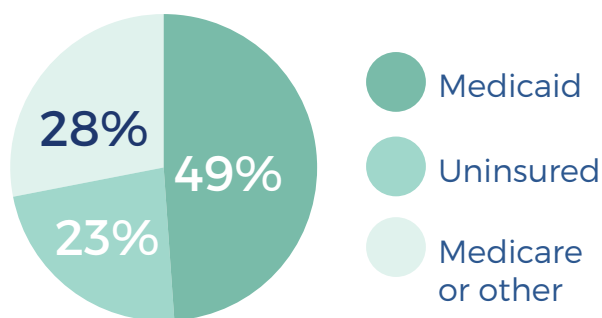
### C. Community Health Centers

The Economic Opportunity Amendments Act of 1966 authorized the Neighborhood Health Center Program, which created 50 community health centers (CHCs) to address the critical health needs of homeless individuals, communities of color, low-income populations, people with chronic conditions, and the uninsured.<sup>49</sup> The ACA expanded this safety network and created the Community Health Center Fund to provide \$11 billion over five years to establish new CHCs and maintain existing ones.<sup>50</sup> As of August 2018, nearly 1,400 health centers operate over 12,000 health delivery sites which provide health care to over 27 million individuals annually at sliding scale or no-cost.<sup>51</sup>

Community Health Centers—which include federally qualified health centers and health center program look-alikes—are required to be located in a medically underserved area (MUA), or to serve a medically underserved population (MUP). MUAs and MUPs are designated by the Health Resources and Services Administration (HRSA) as areas that have a shortage of primary care providers, significant rates of infant mortality and poverty, and/or a large number of elderly persons.<sup>52</sup> Centers are staffed with clinical professionals including physicians, nurses, dentists, and mental health and substance use disorder counselors. They also provide ancillary services (such as radiology and laboratory testing) as well as services that assist patients with getting access to health care (e.g., language interpretation and transportation).<sup>53</sup>



## Demographic Profile of CHC Patients



**49 percent of patients are Medicaid or CHIP enrollees**



**69 percent** of patients have incomes less than 100 percent of the federal poverty level (FPL), and **91 percent** have incomes under 200 percent of FPL.

**36%**  
of health center patients  
are Latinx

**22%**  
are African-American

**5%**  
are Asian/Native  
Hawaiian/Pacific Islander

**1.5%**  
are American Indian/  
tribal/indigenous

Source: Nat'l Ass'n of Cmty. Health Ctrs., *Community Health Center Chart Book*, Fig. 1.5, 1.8, 1.9 (Jan. 2019), <http://www.nachc.org/wp-content/uploads/2019/01/Community-Health-Center-Chartbook-FINAL-1.28.19.pdf>.

Women at CHCs are more likely to receive preventive services such as pap smears and mammograms compared to other primary care providers.<sup>54</sup> CHCs also serve a disproportionately higher number of people of color. As a result, CHCs have helped reduce disparities in access to critical preventive services among women of color. For example, African-American and Latinx women at CHCs are more likely to receive mammograms than their national counterparts.<sup>55</sup> Pregnant CHC patients also have lower rates of low birth weight babies compared to the U.S. population across all racial groups, particularly among African-American, American Indian/Alaska Native, Latinx and Asian women who on average have higher rates of low-birth weight babies compared to their white counterparts.<sup>56</sup>

### D. Public Health Clinics

The Public Health Service (PHS) began in the 1700s, when the federal government began providing a system of medical care for injured and sick merchant seamen. As time progressed, PHS expanded its national mission to focus on other objectives, such as stopping the spread of communicable diseases, improving sanitation, addressing industrial health concerns, and improving the treatment of mental health and substance use disorders.<sup>57</sup> The PHS includes all agencies within HHS, including the CDC and the Commissioned Corps of the U.S. Public Health Service.<sup>58</sup>

The PHS provides grants to states to develop health services, train public health workers, and research health issues. State and county governments operate these initiatives on a local level. Congress included the Prevention and Public Health Fund in the ACA to increase the capacity of public health programs and invest in the fight against health disparities, improve behavioral health access, prevent HIV/AIDS transmission, and more. The ACA authorized \$18.75 billion for the fund between FY 2010 and FY 2022 and \$2 billion per year after that, however Congress has passed multiple bills that amend the ACA to cut and redirect money from the fund to pay for non-public health proposals.<sup>59</sup>

Local health department clinics are another resource for reproductive and health screening care for low-income populations. Women obtaining reproductive health care in public family planning clinics routinely receive basic preventive gynecological services (e.g., pelvic examinations, Pap tests for cancer screenings, STI testing, prenatal and postnatal care), as well as primary health care.<sup>60</sup>

## E. School-Based Health Centers

There are nearly 2,000 school-based health centers (SBHCs) operating in the United States. Community Health Centers, hospitals, and local health departments, in conjunction with schools, often operate school-based health centers. These centers usually provide a full range of health services, including primary medical care, mental and behavioral health, dental care, and substance use disorder counseling.<sup>61</sup> Most school-based health centers also provide confidential, age-appropriate reproductive and sexual health services and counseling such as pregnancy testing, gynecological exams, and STI prevention.<sup>62</sup> Yet, only half of SBHCs are permitted to prescribe or provide oral contraceptives including emergency contraception.<sup>63</sup> Schools with SBHC that do prescribe and dispense contraceptives onsite have seen an increased use in contraceptives among sexually active students.<sup>64</sup>

Funding for SBHCs varies from school to school. Most SBHCs bill Medicaid and other insurers for services or impose patient fees, although such billing practices may trigger confidentiality concerns (see Section xx on Minor Consent and Confidentiality). The ACA had appropriated an additional \$200 million through 2013 to increase the capacity of SBHCs.<sup>65</sup> In December 2014, CMS abandoned previous guidance and clarified that Medicaid funding can be used to pay for covered services provided in school-based health centers to Medicaid-eligible enrollees.<sup>66</sup>

## F. Sexual Health Education in Schools

School-based sexual health and sexuality education programs play a critical role in providing medically accurate, developmentally appropriate, and comprehensive reproductive and sexual health information for young people to make healthy decisions about their sexual health and sexuality. Programs—and the types of funds supporting them—vary from school to school. The CDC's

Division of Adolescent and School Health and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention fund state and local agencies to enhance their capacity to implement school-based health promotion and disease prevention approaches, including through sexual health education.

HHS' Office of Adolescent Health administers the Teen Pregnancy Prevention (TPP) Program, which was created in 2010 as a national, evidence-based initiative to implement and evaluate innovative approaches to adolescent (aged 10-19) sexual health and sexuality education and to reduce pregnancies among adolescents. The Trump administration, however, shifted the program from one grounded in evidence to one emphasizing abstinence-only when it comes to the sexual and reproductive health and rights of young people. Grantees were informed that funding would unexpectedly terminate two years ahead of schedule at the end of June 2018.<sup>67</sup> To date, the program has remained unfunded.

The Administration on Children, Youth, and Families Family and Youth Services Bureau within HHS also funds states, U.S. territories, and tribes or tribal organizations to provide evidence-based sexuality education through the Personal Responsibility Education Program (PREP).<sup>68</sup> PREP programs educate adolescents on both abstinence and contraception, and targets 10-19 year olds who are homeless, in foster care, live in rural areas or geographic areas with high teen birth rates, teens of color, and pregnant and parenting youth.<sup>69</sup> Congress recently extended funding for PREP at \$75 million per year through FY 2019 in the Bipartisan Budget Act of 2018.<sup>70</sup> However, Congress has also spent over \$2 billion since 1981 to fund Title V abstinence-only education program despite decades of evidence showing such programs are ineffective and fail to address the needs of young people who are already sexually active.<sup>71</sup>

## G. Maternal and Child Health Block Grants

HRSA administers a range of programs that focus on the health needs of individuals and families who are geographically isolated, and/or economically or medically vulnerable. The oldest of these programs is the Maternal and Child Health (MCH) Services Block Grant. The MCH Services Block Grant was authorized under Title V of the Social Security Act, and operates as a federal and state partnership.<sup>72</sup> It is also one of the largest federal block grant programs, funding 59 states and jurisdictions to provide health care and public health services for an estimated 56 million people in FY 2017, including nearly 86 percent of all pregnant people and 99 percent of all infants.<sup>73</sup>

The overall objectives of the MCH Services Block Grant are to reduce infant mortality and improve the health of the low-income maternal and child health population.<sup>74</sup> States determine eligibility for the services they provide under the grant, but typically serve low-income pregnant people, mothers, children, children with special needs and their families.<sup>75</sup> There are several requirements for states to receive and retain a MCH Services Block Grant. States must conduct

an assessment of the need for preventive and primary care services every five years. States must contribute \$3.00 for every \$4.00 of federal funding that is awarded under the block grant and cannot use more than 10 percent of their allocations for administrative costs.<sup>76</sup>

The block grant has three major funding categories:

1. MCH Formula Grants – These grants represent 85 percent of the funding component of Title V. They are awarded to the states based on the number of children living in poverty relative to the total number of such children nationally.<sup>77</sup>
2. Special Projects of Regional and National Significance (SPRANS) – This funding provides grants for research, training and other special projects to improve maternal and child health (e.g., innovations in screening for sickle cell and sudden infant death syndrome, perinatal and women’s health, oral health, and adolescent health).<sup>78</sup>
3. Community Integrated Services Systems (CISS) – This category of grants offers funding for maternal and child health home visiting programs; integrated maternal and child health services delivery systems; maternal and child health centers providing pregnancy services; services for infants; maternal and child health projects in rural areas; outpatient and community based services for children with special needs; and projects to increase the participation of obstetricians and pediatricians in Title V and Medicaid programs.<sup>79</sup>

The ACA also authorized HHS to issue grants for new prenatal, early childhood, and childhood home visitation programs.<sup>80</sup> The Maternal, Infant, and Early Childhood Home Visiting Program was established in 2010, creating the first nationwide home visiting program.<sup>81</sup> To receive funding, states were required to conduct a needs assessment to identify important problem trends (such as low birth weights, infant mortality, and domestic violence) in at-risk communities.<sup>82</sup> The program targets parents and caregivers of children from infancy until 5 years old, and allows families to elect to receive home visits through a local organization, which provides assistance and resources aimed to increase access to healthcare, childcare services, and prenatal and post-natal care.<sup>83</sup>

## H. Ryan White HIV/AIDS Program

The annual number of new HIV diagnoses in the U.S. has remained stable in recent years, yet diagnoses have increased among some populations. Gay and bisexual men are most affected by HIV, with the highest rates of new diagnoses among Black and Latinx gay and bisexual men.<sup>84</sup> HIV diagnoses among women have declined in recent years, however many women—an estimated one in nine women—are unaware they have HIV.<sup>85</sup> Overall HIV diagnoses rates among women

have decreased 21 percent between 2010-2016 except for white women 55 years and older.<sup>86</sup> Among those individuals diagnosed with HIV in 2016, 76 percent were linked to HIV medical care within 1 month. Yet disparities in access to care also persist. One survey of adults diagnosed with HIV in 11 states and the District of Columbia found only 38 percent of African Americans living with HIV received consistent care (compared to 49 percent of Whites and 50 percent of Latinos).<sup>87</sup>

To address some of the gaps in HIV/AIDS treatment and support services, Congress enacted the Ryan White CARE (Comprehensive AIDS Resource Emergency) Act in 1990 to address the quality and availability of care for individuals and families most affected by HIV – low-income populations, uninsured or underinsured people, and communities of color.<sup>88</sup> The Act was amended and reauthorized four times – in 1996, 2000, 2006, and 2009—and is now known as the Ryan White HIV/AIDS Program (RWHAP).

RWHAP is the largest federal program to serve people with HIV in the U.S. reaching over half of those diagnosed with HIV.<sup>89</sup> By statute, RWHAP is a “payer-of-last-resort,” which means the program is designed to fill in the gaps for those who have no other source of coverage or face coverage limits.<sup>90</sup> Nearly two-thirds of those who received a RWHAP-funded service had incomes at or below the federal poverty level, and an additional 28 percent had incomes between 101-250 percent of the FPL. Federal funding for the RWHAP must be appropriated by Congress every year and, in some states, is coupled with requirements for state funding or matching. RWHAP is administered by HHS and HRSA’s HIV/AIDS Bureau (HAB).<sup>91</sup>

RWHAP is comprised of five “parts” to address the diverse needs of people living with HIV and give grantees discretion to design more flexible programs.

**Part A:** funds medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are counties/cities that are the most severely affected by the HIV/AIDS epidemic.<sup>92</sup> Grantees must spend at least 75 percent of Part A grant funds on core medical services which are limited to the following: outpatient and ambulatory medical care, AIDS Drug Assistance Program (ADAP), AIDS pharmaceutical assistance, oral health care, early intervention services, assistance with health insurance premiums and cost-sharing for low-income people, medical nutrition therapy, hospice care, home and community-based health services, care for mental health and substance use disorders, and medical management.<sup>93</sup> Grantees can spend no more than 25 percent on support services, which must be linked to medical outcomes, and include medical transportation, language access services, respite care for caregivers, case management, and substance use residential services.<sup>94</sup>

Part A grants also include Minority AIDS Initiative funds that are intended to support services targeting racial and ethnic communities of color. EMAs must also establish Planning Councils, local bodies tasked with assessing needs,

developing HIV care delivery plans, and setting priorities for funding. Most TGAs are not required to have Planning Councils.

**Part B:** provides funds to all 50 States, the District of Columbia, U.S. territories, and U.S.- Associated Jurisdictions to improve the quality and accessibility of HIV/AIDS support services and care. Part B also includes grants to ADAP, a critical program that helps people with HIV purchase medications and cover the cost of their health insurance premiums, co-pays, coinsurance, and deductibles. Further, ADAP acts as a safety net to fill in coverage gaps and ensure continuity of care.<sup>95</sup>

In 2016, over 230,000 people enrolled in Part B received ADAP-funded services.<sup>96</sup> Since 2010, ACA implementation and Medicaid expansion has allowed states to redirect previous expenditures associated with ADAP towards Medicaid or marketplace coverage. Yet approximately half of ADAP enrollees reside in a state that has not expanded their Medicaid program.<sup>97</sup> More than half of ADAP enrollees are people of color and approximately one in four are female.<sup>98</sup>

**Part C:** funds local community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people living with HIV through Early Intervention Services program grants. Part C also funds Capacity Development grants, which help organizations more effectively deliver HIV care and services.

**Part D:** funds local, community-based organizations to provide outpatient, ambulatory, family-centered primary and specialty medical care for women, infants, children and youth living with HIV. Part D funding may also be used to provide support services to people living with HIV and their affected family members.

**Part F:** provides funding for a variety of programs that support clinician training, technical assistance, and the development of innovative models of care to improve health outcomes and reduce HIV transmission. These include:

- the Special Projects of National Significance Program, which funds innovative models of care and also supports the development of effective HIV care delivery systems,
- the AIDS Education and Training Centers Program, which supports a network of regional and national centers that conduct targeted education and training programs for health care providers who treat people living with HIV/AIDS/,
- Dental Programs that provide funding for oral health care for people living with HIV, and
- the Minority AIDS Initiative, which is a component that runs throughout each section of RWHAP and specifically focuses on addressing the disproportionate impact of HIV/AIDS on communities of color.

# Endnotes

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- 1 42 C.F.R. § 59, 84 Fed. Reg. 7741-7791.
- 2 HHS, Office of Population Affairs, Title X Final Rule Compliance and Enforcement, *Myth vs. Fact*, <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/statutes-and-regulations/compliance-with-statutory-program-integrity-requirements/myth-vs-fact/index.html> (last visited August 30, 2019).
- 3 Title X of the Public Health Service Act (codified at 42 U.S.C. §§300 to 300a-8).
- 4 U.S. Dep't of Health & Human Servs., Office of Population Affairs, Title X Family Planning Annual Report 2017 Summary [hereinafter Title X 2017 Report], <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html> (last visited on June 18, 2019).
- 5 42 C.F.R. § 59.5(a)(6)-(7); 42 C.F.R. §59.2.
- 6 42 C.F.R. § 59.2.
- 7 42 C.F.R. § 59.5(a)(8).
- 8 Title X 2017 Report, *supra* note 4.
- 9 HHS, Office of Population Affairs, *Program Requirements for Title X Funded Family Planning Projects v. 1* (Apr. 2014) at 16, <https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf>.
- 10 *Id.*
- 11 CDC, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* (Apr. 25, 2014), <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>.
- 12 42 U.S.C. § 300a-6.
- 13 42 U.S.C. § 300a-5; 42 C.F.R. § 59.5 (a)(2).
- 14 42 C.F.R. § 59.11.

- 15 See Kinsey Hasstedt, Guttmacher Inst., *Title X: An Essential Investment, Now More than Ever* (2013), <https://www.guttmacher.org/gpr/2013/09/title-x-essential-investment-now-more-ever>. See also Kinsey Hasstedt, Guttmacher Inst., *Title X: The Lynchpin of Publicly Funded Family Planning in the United States* (Aug. 10, 2015), <https://www.guttmacher.org/article/2015/08/title-x-lynchpin-publicly-funded-family-planning-united-states>.
- 16 See Adam Sonfield et al., Guttmacher Inst., *Moving Forward: Family Planning in the Era of Health Reform* (2014), <https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform>.
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- 24 42 C.F.R. § 59.14(b).
- 25 42 C.F.R. § 59.2.
- 26 42 C.F.R. § 59.15. Because the separation requirements apply to the Title X project, they apply to all entities funded by the project: grantees, subrecipients, and service sites.
- 27 42 C.F.R. § 59.17.



- 28 The program was reauthorized in February 2009 through the Children’s Health Insurance Program Reauthorization Act, Pub. L. No. 111-148, 123 Stat. 8 (codified at 42 U.S.C. § 1397aa). The ACA reauthorized CHIP through 2019 but only funded it through 2015; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2713(a)(4), 124 Stat. 119, 131 (codified at 42 U.S.C. § 300gg-13(a)(4)). In 2015, Congress continued CHIP funding for an additional two years as part of the Medicare Access and CHIP Reauthorization Act of 2015; Medicare Access and CHIP Reauthorization Act, Pub. L. No. 114-10, 129 Stat. 87.
- 29 The HEALTHY KIDS Act, Pub. L. 115-120, and Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Pub. L. No. 115-123.
- 30 Social Security Act § 2102(b)(3)(C) (codified at 42 U.S.C. 1397bb)(requiring states to include in their state plan a description of how the state ensures that CHIP coverage does not substitute for coverage under group health plans).
- 31 See Tricia Brooks, Georgetown Univ. Health Pol’y Inst., Center for Children and Families, *Making Kids Wait for Coverage Makes No Sense in a Reformed Health System* (Feb. 2015), <http://ccf.georgetown.edu/wp-content/uploads/2015/03/Making-Kids-Wait-for-Coverage-Makes-No-Sense-in-a-Reformed-Health-System-2015.pdf>.
- 32 42 C.F.R. § 457.805.
- 33 CMS, Waiting Periods in CHIP, <https://www.medicaid.gov/chip/eligibility-standards/waiting-periods/index.html> (last visited June 19, 2019). Prior to January 1, 2014, 36 states instituted waiting periods ranging from one month to 12 months to address the requirement to avoid crowd out.
- 34 42 U.S.C. § 1397ee(d)(3)(C) (requiring the Secretary to review the benefits and cost-sharing in qualified health plans and certify those plans that are at least comparable to CHIP). HHS’ 2015 report found no QHPs were comparable and thus did not certify any plans. See Dep’t of Health and Hum. Servs., *Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans* (Nov. 25, 2015), <https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf>.
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- 36 Arizona froze its CHIP program from 2014-2016, and then re-opened it. See Tricia Brooks et al., Georgetown Univ. Health Pol’y Inst., Ctr. for Child. & Families, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child’s Health Care Costs* (2014), <https://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf>.

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- 38 For a breakdown of CHIP and Medicaid children's income eligibility level by state, see Georgetown Univ. Health Pol'y Inst., Ctr. for Child. & Families & Kaiser Fam. Found., Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey Table 1 (Mar. 2019), <https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey-introduction/>.
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- 44 42 U.S.C. 1396r-1a (presumptive eligibility for children) and 42 U.S.C. § 1397ll(c) (presumptive eligibility for pregnant women).
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