



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



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Forward

Founded in 1969, the National Health Law Program (NHeLP) protects and advances the health rights of low-income and marginalized people to access high quality health care, particularly in publicly funded health programs. We work to mainstream sexual and reproductive health in a seamless system of quality affordable care, and apply a reproductive justice framework to our advocacy and analysis. As such, our vision for that system includes the full range of reproductive and sexual health services, including abortion, family planning, and pregnancy care delivered with dignity in a culturally and linguistically responsive environment, free from judgment and coercion, and where cost is never a barrier.

An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program ("Guide") will familiarize readers with the basics of the Medicaid program and highlight features that support reproductive and sexual health. Since the *Guide* was first published in February 2010, the United States Congress passed and President Obama enacted the Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA). The ACA

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

—World Health Organization:
United Nations 1995 Fourth World Conference on Women, Beijing.

brought substantial changes to the Medicaid program and the entire health care system, including the modes of access to health coverage and the benefits that must be covered.

The *Guide* provides a brief overview of the Medicaid program, and explains the complex eligibility categories and requirements for the program with a focus on those categories that affect people seeking reproductive and sexual health care. The *Guide* also details the various reproductive and sexual health services available to Medicaid enrollees. The *Guide* also describes barriers and protections to accessing reproductive and sexual health services in Medicaid and other publicly funded reproductive and sexual health programs. Lastly, the *Guide* provides a brief overview of the administrative structure of and application process for the Medicaid program.¹ Wherever possible, we also highlight best practices, policy recommendations, advocacy tips, and legal strategies to strengthen existing programs and address reproductive and sexual health disparities.

Reproductive Justice and the *Guide*

In 1994, a group of black women created the term “reproductive justice” and helped catalyze an advocacy and organizing movement that elevates and centers the leadership of women of color and LGBTQ people.² Reproductive justice exposes the systems of oppression that deny people their reproductive and sexual autonomy, and considers the various linked social and economic conditions that can affect a person’s ability to make health decisions about their body, sexuality, and reproductive future. For NHeLP, reproductive justice requires that all individuals—including people with low incomes, people without health insurance, and people enrolled in

A Note on Gender

At the outset, we note that the *Guide* frequently uses the words “woman” or “women.” This is not intended to be exclusionary, and NHeLP recognizes that cisgender and transgender women, and gender non-conforming and non-binary individuals need access to the reproductive and sexual health services discussed in the *Guide*.³ Accordingly, the *Guide* uses the pronouns “they” and “theirs” as much as possible in recognition of the variations in gender identity and expression in all communities. We’ve tried to limit the use of “woman” or “women” when necessary to explain the Medicaid requirements for reproductive and sexual health services in conformity with the language used in the statute and regulations, and in conformity with cited research or data. NHeLP’s goal is that the *Guide* serves as a valuable resource for anyone who needs access to the coverage and care discussed throughout this publication.

Medicaid—have the means and ability to direct their own reproductive and sexual health decisions, including the right to have a child, not to have a child, and to parent the children they already have.⁴ This framework must be integrated into Medicaid policies to ensure people enrolled in the program can determine the type and scope of reproductive and sexual health services that are appropriate for them. As such, NHeLP incorporates a reproductive justice framework throughout the *Guide* and urges advocates to actively engage with reproductive justice organizations and leaders in policy discussions and campaigns.

A. Acknowledgements

An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program is the product of a collaborative process among NHeLP's Los Angeles CA, Chapel Hill NC, and Washington D.C., offices. We greatly appreciate the work of Priscilla Huang, Julia Quinn, and Jamille Fields who spearheaded the overall work of the updated *Guide*. We also wish to thank all the NHeLP attorneys who worked on the *Guide*: Amy Chen, Abigail Coursolle, Leonardo Cuello, Elizabeth Edwards, Michelle Lilienfeld, Catherine McKee, Sarah Somers, Wayne Turner, and Mara Youdelman, as well as former NHeLP attorneys Erin Armstrong, Amber Hartgens, Agata Pelka, Deborah Reid, Dipti Singh, and Marisa Spalding. Special acknowledgement and thanks are extended to NHeLP's Director of Reproductive Health, Susan Berke Fogel, and NHeLP's Legal Director, Jane Perkins for their editorial contributions, exhaustive reviews, invaluable insights, and untiring support and encouragement. We also appreciate the contributions of MaryKathryn Hurd, Ryan Marcus, Kate McDonald and their team at McDermott, Will & Emery for their pro bono assistance with the citations, and to Amanda Puglisi from Studio A Design for her elegant graphic design.

An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program would not have been possible without the generous support of the Brush Foundation, Ford Foundation, General Service Foundation, The Educational Foundation of America, The Moriah Fund, and The William and Flora Hewlett Foundation. The opinions expressed in this *Guide* are those of NHeLP and do not necessarily reflect the views of NHeLP's donors.

B. Acronym List

ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act
ADAP	HIV/AIDS Drug Assistance Program
AFDC	Aid to Families with Dependent Children
BCCPT	Breast and Cervical Cancer Prevention and Treatment
CDC	Centers for Disease Control
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicaid and Medicare Services
DHS	Department of Homeland Security
DRA	Deficit Reduction Act
EC	Emergency Contraception
EHB	Essential Health Benefit
EPSDT	Early Periodic Screening, Diagnostic, and Treatment
FDA	Federal Drug Administration
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
GNC	Gender Nonconforming
HCBS	Home and Community-Based Services
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
ICHIA	Legal Immigrant Children's Health Insurance Act
IOM	Institute of Medicine
LARC	Long-acting Reversible Contraceptive
LEP	Limited English Proficient
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LPR	Legal Permanent Resident
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization

MHPA	Mental Health Parity Act
MHPAEA	Mental Health Parity and Addiction Equity Act
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NBBCCEDP	National Breast and Cervical Cancer Early Detection Program
NEMT	Non-Emergency Medical Transportation
OCR	Office of Civil Rights
OPA	Office of Population Affairs
PCCM	Primary Care Case Manager
PDLs	Preferred Drug Lists
RWHAP	Ryan White HIV/AIDS Program
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
USPSTF	United States Preventive Services Task Force

Endnotes

- 1 The information in this *Guide* is up to date as of June 2019.
- 2 See SisterSong website, <http://sistersong.net/reproductive-justice> (explaining the history of reproductive justice); see also Asian Communities for Reproductive Justice, *A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice* (2005), <http://forwardtogether.org/assets/docs/ACRJ-A-New-Vision.pdf>.
- 3 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 people whose gender identity is not exclusively male or female. To learn more about non-binary, gender non-conforming, and transgender people, please review the resources available on the National Center for Transgender Equality website at <https://transequality.org/about-transgender>.
- 4 See *id.*, [SisterSong website](#).

Chapter I.

Overview of the Medicaid Program

An individual's reproductive and sexual health is a fundamental component of their overall health and well-being. It is also inextricably linked to the health and economic welfare of their family and community. A growing body of epigenetic research has shown that a person's health outcomes are influenced by the social conditions and experiences of their biological mother.¹ Further, a person's ability to attain and maintain a healthy and productive life includes the ability to determine their own reproductive and sexual future. The average American woman spends approximately 30 years of her life avoiding pregnancy, regardless of whether she chooses to have a child or not.²

Access to quality, comprehensive health care is a requirement for anyone to be equal, participating, and productive members of society. Medicaid in particular has long been and continues to be one of the most important sources of reproductive and sexual health care for people with low incomes, and is the single largest source of public funding for family planning services and supplies.³ In 2014, there were 67.5 million U.S. women of reproductive age (13-44). Over half (38.3 million) were in need of contraceptive services and supplies.⁴ More than half (20.2 million) of reproductive-age women who utilized Medicaid and other public-funded contraceptive services were either under 20 years old or had an income below 250 percent of the federal poverty level.⁵

The passage and enactment of the Affordable Care Act (ACA) included an expansion of Medicaid coverage and new private insurance options, resulting in dramatic decreases in the number of uninsured. The proportion of reproductive-aged women without health insurance fell from 20 percent in 2013 to 12 percent in 2017.⁶ During the same time period, there was a 22 percent increase in the number of reproductive-aged women covered by Medicaid.⁷ Additionally, the ACA made significant improvements to the health care landscape, creating new options for states to administer their Medicaid program such as expanding coverage to single adults and a State Plan Amendment option to cover family planning services and supplies. The ACA also created a wide array of consumer protections including explicit anti-discrimination language based on race, color, national origin, sex, age, and disability. Despite the improvements and coverage gains, Medicaid and the ACA are under threat. As of this writing, efforts to undermine or repeal the ACA

and to fundamentally restructure and loosen consumer protections in Medicaid are underway. Fortunately, there is strong public support for Medicaid as more people recognize its role as an essential program for individuals with low incomes and their families.

A. The Medicaid Program

The Medicaid program was established in 1965 as part of President Lyndon Johnson's War on Poverty.⁸ It is the primary health care safety net for low-income individuals in the U.S., however, Medicaid does not cover all low-income individuals. To be eligible, a person must meet very specific financial and other criteria. Traditionally, Medicaid covered certain low-income parents (including pregnant women), children, seniors, and individuals with disabilities. Under the ACA, some state Medicaid programs now also cover low-income individuals who do not fall into one of these traditional Medicaid categories, such as childless adults.

Medicaid is the nation's largest public health insurance program covering nearly 73 million Americans as of November 2018, many of whom live below, at, or just above the federal poverty level (FPL).⁹ The 2019 FPL for a family of three living in the 48 contiguous states and the District of Columbia is \$21,330; the FPL for a family of four is \$25,750.¹⁰ Hawaii and Alaska have higher poverty guidelines.¹¹

Medicaid operates as a state-federal partnership with the federal government paying a percentage of the costs known as the Federal Medical Assistance Percentage (FMAP). In exchange, states must comply with minimum requirements set forth in the federal Medicaid rules. All 50 states, the District of Columbia, and five U.S. territories operate Medicaid programs.¹²

B. The Affordable Care Act and Medicaid Expansion

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA), into law.¹³ The ACA required states to expand Medicaid coverage to non-pregnant, non-disabled childless adults under age 65 with incomes below roughly 138 percent of the FPL.¹⁴ In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court effectively made the Medicaid adult expansion optional to the states.¹⁵

At this writing, 36 states and the District of Columbia have adopted the Medicaid expansion.¹⁶ In the 14 states that have not expanded Medicaid, more than two million people fall within the "coverage gap"—adults who have incomes above the eligibility limit for their state Medicaid program, but below the income limit to qualify for tax subsidies used to purchase insurance on the health insurance Marketplaces.¹⁷ For example, Texas—the state with the largest

share of adults in the coverage gap—limits Medicaid eligibility for adult parents and caretakers at 15 percent FPL. This means an adult parent caring for a child in Texas can qualify for Medicaid only if they have a monthly income of \$104 or less.¹⁸ Failing to expand Medicaid disproportionately affects those living in Southern states and communities of color. Advocates in those states continue to encourage their state legislatures and governors to expand Medicaid.¹⁹

As additional states expand their Medicaid programs and millions of additional low-income people become eligible for Medicaid, it is important to note that many newly covered individuals will transition between the health care marketplaces and Medicaid as their income and circumstances fluctuate. While Medicaid is the focus of this *Guide*, advocates should also have some understanding of coverage within the health insurance marketplaces.

C. Program Structure and Administration

Medicaid is a cooperative federal and state program.²⁰ While state participation is voluntary, currently all 50 states, the District of Columbia, and five U.S. territories participate. The federal government reimburses participating states for a specified percentage of program expenditures, and in return, states agree to comply with federal Medicaid rules, applicable regulations, and minimum standards of coverage.²¹ States must cover certain categories of individuals and provide certain benefits, and all state Medicaid programs must comply with federal anti-discrimination laws, including Title VI of the Civil Rights Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act.²²

States have flexibility to cover additional groups of individuals and additional services. As a result, Medicaid programs vary from state to state.

1. Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the agency within the U.S. Department of Health and Human Services (HHS) responsible for administering the Medicaid program. CMS promulgates regulations that implement the Medicaid statute and govern the administration of the program, and issues guidelines that interpret the statute and regulations.²³ These guidelines are found in the State Medicaid Manual, as well as “Dear State Medicaid Director” and “Dear State Health Official” letters.²⁴ Each CMS regional office maintains regular contact with the state Medicaid agencies in its region.

2. Single State Agency

In each state, a single state agency is responsible for the administration and effective operation of the Medicaid program.²⁵ In many states, county offices also play a role in administering Medicaid. Some of those counties contribute to

the cost of providing Medicaid coverage. The single state agency may also contract with private entities and other state agencies, such as the mental health department, to assist with operating Medicaid.²⁶ The state agency must stay informed of its agents' and contractors' activities and ensure they comply with federal and state law and the state Medicaid plan (discussed below).

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

3. State Medicaid Plan

To receive federal funding, each state must have in effect a comprehensive, written state plan that has been approved by the HHS Secretary.²⁷ The state Medicaid plan describes the nature and scope of the state's Medicaid program and includes assurances that the program will operate in conformity with the federal statute, regulations, and other requirements.²⁸ Whenever necessary, a state must submit a state plan amendment to the HHS Secretary for approval to reflect changes in federal statute, regulation, or court decisions, as well as material changes in state law, policy, organization, or operation of the program.²⁹ After reasonable notice and opportunity for a hearing, HHS may delay or withhold federal Medicaid reimbursements if the state plan no longer complies with federal requirements or if the state administers its approved state plan in a way that fails to comply with federal provisions.³⁰

4. Federal Financial Participation

The federal government shares the cost of each state's Medicaid program by reimbursing a substantial portion

ADVOCACY TIP: Using Medicaid Guidance

When advocating on behalf of a client with a state Medicaid agency, first look to agency guidance such as the manual for Medicaid eligibility workers and the Medicaid Provider Manual that explains which services are covered. These documents are often available online. Medicaid agency workers are often very familiar with agency policies, so if they are able help your client, rely on them. If these resources do not resolve your client's issue, next look to the state regulation. If that is not helpful, check the state statute. If the state regulation affords no relief, move on to the federal regulation and then, if necessary, to the federal Medicaid Act itself.

of both Medicaid services and administrative costs. The federal payment is called the “federal financial participation.”³¹ The reimbursement rate each state receives is called the “federal medical assistance percentage” (FMAP) and varies between 50 and 77 percent.³² The FMAP is based on two factors—the per capita income of the state and the actual amount of qualified Medicaid spending.³³ As a result, states with a low per capita income such as Alabama have a higher FMAP (71.97 percent in FY2020) compared with states with a higher per capita income such as Connecticut (50 percent). By law, the FMAP cannot be lower than 50 percent.

States receive an enhanced FMAP for certain expenditures, such as family planning services and supplies, which are reimbursed at a 90 percent FMAP.³⁴ The ACA also provides the option for states to obtain an additional one per cent FMAP by covering without cost-sharing all preventive services graded A or B by the United States Preventive Services Task Force and all approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices.³⁵

States receive an enhanced FMAP for individuals “newly eligible” under the Medicaid expansion. For these individuals, the matching rate was 100 percent during the calendar years 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.³⁶ States that covered some newly eligible individuals before the enactment of the ACA did not receive the full FMAP for these individuals between 2014 and 2019, but had their current matching rate adjusted upwards over time to correspond to the 90 percent FMAP in year 2019.³⁷

In addition, states receive federal payments for the administrative cost of operating their Medicaid programs. The administrative matching rate is usually 50 percent, although some administrative activities receive a higher FMAP.³⁸

5. Service Delivery

Medicaid is a vendor payment program, meaning health care providers provide Medicaid services directly to enrollees and are paid through the state Medicaid program. Medicaid providers are not employees of the Medicaid program, nor do Medicaid agencies directly provide services.³⁹ Medicaid was established as a vendor payment program to avoid a two-track system of health care, thereby enabling Medicaid patients to see private health care providers who also serve privately insured patients.

Note on terminology:

This *Guide* uses the term “enrollee” to describe individuals with Medicaid coverage, regardless of whether the individual receives services through a fee-for-service model, managed care plan, or a limited scope Medicaid program.

Although all Medicaid enrollees see private health care providers who have chosen to participate in the Medicaid program, some receive services through a traditional fee-for-service model, while others are enrolled in Medicaid managed care. Enrollment in managed care can affect enrollees' access to health services, as discussed below.

a. Fee-for-Service

Like other insurance models, Medicaid had traditionally operated using “fee-for-service” payments. Each provider contracts individually with the state to furnish services to Medicaid enrollees. After the provider furnishes the covered service to the patient, they submit a claim to the state, and the state then pays the provider a fee for that particular claim. Health care providers who participate in Medicaid must accept Medicaid payment as payment in full; they may not collect additional payment from Medicaid patients, with the exception of cost sharing authorized under federal law and the state plan.⁴⁰ In fee-for-service Medicaid, an enrollee may obtain services from any health care provider who participates in the Medicaid program.⁴¹

b. Medicaid Managed Care

State Medicaid programs make extensive use of managed care programs.⁴² States must ensure that managed care enrollees have access to all services covered under the state Medicaid plan. As of 2017, over 80 percent of all Medicaid enrollees receive some or all of their services through a managed care arrangement.⁴³ Under these arrangements, states contract with various kinds of managed care entities, including managed care organizations (MCOs), prepaid health plans (PHPs), primary care case managers (PCCMs), and primary care case management entities (PCCM entities) to provide services to enrollees.⁴⁴

MCOs cover comprehensive services, whereas PHPs provide a more limited range of services.⁴⁵ MCOs and PHPs operate on a “capitated” basis. This means that the state pays the plan a set amount of money per member, per month, regardless of how much or how little care the enrollee receives.⁴⁶ This *Guide* refers to MCOs and PHPs collectively as “plans.” PCCMs are primary care providers or group practices that receive a per-member-per-month payment in return for locating, coordinating, and monitoring health care services. PCCM entities provide some additional services to enrollees.⁴⁷

Generally, Medicaid managed care plans contract with a network of health providers to render services to enrollees. With some exceptions, enrollees must obtain the services through a provider in the network, or

the plan will not cover them. Plans must have a network of appropriate providers to ensure that enrollees have adequate access to covered services, and must show that the network has a sufficient number, mix, and geographic distribution of providers to meet the needs of the Medicaid population. This concept is known as “network adequacy.”⁴⁸ If a particular covered service is not available in-network, the plan must cover the service out-of-network.⁴⁹ Individuals enrolled in a managed care plan typically must choose a primary care provider (PCP); if they do not, they will be assigned one. For most non-emergency services, the enrollee must first go to the PCP, who will refer the enrollee to a specialist if necessary. In addition, federal regulations require plans to ensure that women have direct access to a women’s health specialist within the network.⁵⁰

Medicaid managed care plans are also required to have family planning providers in their networks.⁵¹ In addition, the federal Medicaid Act provides individuals enrolled in Medicaid managed care plans with the right to receive family planning services from a qualified provider of their choice, in- or out-of-network, as long as the provider participates in the Medicaid program.⁵² This protection is known as “free choice of family planning provider” or “freedom of choice.”⁵³ 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 copay or other cost-sharing).⁵⁴

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.⁵⁵ Enrollees living in rural areas may also access an out-of-network provider if they cannot obtain a service due to a provider’s moral or religious objections.⁵⁶ See Section B4 in Chapter IV for more information about federal protections for people enrolled in Medicaid managed care plans who are seeking reproductive and sexual health services.

i. Emergency Care

In a medical emergency, managed care enrollees are not limited to in-network emergency rooms, and enrollees may, and should, go to the nearest emergency room.⁵⁷ The managed care plan must pay for the emergency care if a “prudent lay-person” would have thought she was having a medical emergency, even if the medical condition later turns out not to have required emergency treatment.⁵⁸ Plans must inform Medicaid managed care enrollees of the extent to which, and how, emergency coverage is provided.⁵⁹

ii. Medicaid Services Not Included in Managed Care (“Carve outs”)

In some states, managed care plans provide most of the day-to-day health care for their enrollees but do not contract to pay for complex, specialty, or unusually expensive care such as dental or behavioral health services. These services are said to be “carved out” of the plan’s contract. A few states have entered into Medicaid managed care contracts with plans that refuse to cover certain reproductive and sexual health services due to religious objections.⁶⁰ In such cases, enrollees must obtain these services through fee-for-service Medicaid. Enrollees must be informed of the services that the managed care plan does not cover and how and where to obtain them.⁶¹ Because enrollees must take extra steps to access carved out services, they may experience barriers to obtaining care.

c. Premium Assistance

Premium assistance is an alternative delivery model in which state Medicaid programs pay the necessary private insurance premiums to enroll Medicaid-eligible individuals into a private insurance plan. Premium assistance can be conducted through a state plan amendment or a Section 1115 demonstration waiver. Historically, CMS limited the use of premium assistance to purchase group or employer-sponsored health plans for Medicaid enrollees.⁶² After the ACA, CMS issued guidance allowing limited use of premium assistance to purchase individual marketplace coverage for primarily low-income adults who do not otherwise qualify for Medicaid.⁶³

6. Medicaid Demonstration Projects (Waivers)

The HHS Secretary may waive a limited number of federal statutory and regulatory requirements to allow states to conduct demonstration or pilot programs, known generally as “waiver programs.” There are three primary types of federal Medicaid waivers: experimental demonstration project waivers (known as section 1115 demonstration waivers), managed care waivers, and home and community-based services waivers (known as HCBS waivers). Approvals typically state that Medicaid Act provisions not specifically waived continue in full force and effect.

ADVOCACY TIP: Closely Aligned Benefits

The individual market premium assistance model can only be used for individuals entitled to benefit packages that are “closely aligned” with Marketplace benefits. Therefore, “medically frail” individuals that are entitled to more generous benefits packages, such as people with disabilities, children with special health needs, and older adults with chronic health conditions, should not be placed into such premium assistance models.

Section 1115 demonstration waivers allow the Secretary of HHS to grant states waivers of certain, otherwise mandatory Medicaid requirements in order to test experimental projects that promote the objectives of the Medicaid program.⁶⁴ Medicaid's objectives are to help states furnish medical assistance, rehabilitation, and other services to individuals with incomes and resources that are insufficient to meet the costs of needed medical care. Historically, the Secretary and states have used these waivers to create state-specific policy approaches to meet the health care needs of people with low incomes. However, the Trump administration is trying to use Section 1115 waivers to implement policy changes that put access to family planning and other Medicaid services at risk. See Chapter III for a fuller explanation about the role of demonstration waivers in Medicaid family planning, and visit NHeLP's webpage on waivers for more information and updates.

Managed care waivers, authorized through Section 1915(b) of the Social Security Act, allow the HHS Secretary to waive provisions of the Medicaid Act to promote cost-effectiveness and efficiency.⁶⁵ Over the years, states have typically received permission to waive requirements for statewideness, comparability of services among groups of beneficiaries, and free choice of provider.⁶⁶ The typical 1915(b) waiver uses prepaid, risk-based managed care programs and/or primary care case management systems, which pay participating providers a monthly case management fee per enrollee.

HCBS waivers are authorized through Section 1915(c) of the Social Security Act. These waivers allow states to provide home- and community-based services to certain groups of individuals who would be eligible for Medicaid if living in an institution and, but for the services provided through a waiver, would require the level of care provided in a hospital, nursing facility, or intermediate care facility.⁶⁷ The HHS Secretary is authorized to grant waivers of the comparability, statewideness, and financial eligibility requirements.⁶⁸

D. Due Process

Medicaid provides important due process rights, many of which are enforceable through legal action. One of the most important protections of the Medicaid Program are the rights of applicants and enrollees to receive a notice and obtain a hearing when benefits are denied, terminated or reduced.⁶⁹ It has long been recognized that Medicaid enrollees have a property interest in Medicaid benefits.⁷⁰ Because they have a property interest, Medicaid applicants and beneficiaries right to benefits are protected by the Due Process Clause of the U.S. Constitution.⁷¹ These rights were articulated by the U.S. Supreme Court in its landmark decision of *Goldberg v. Kelly*.⁷²

1. Notice and Hearing

Medicaid applicants and enrollees have the right to notice and the opportunity for an administrative hearing when their claims for assistance are denied or not acted on within a reasonable time.⁷³ These rights are triggered when the Medicaid agency takes adverse action against an applicant or enrollee, including denying, modifying, or terminating eligibility or services.⁷⁴

Notices must be in writing and contain a statement of the action the state is planning to take; reasons for the action; citation to the law supporting or requiring the action; explanation of the right to a hearing; explanation of the right to continued benefits pending a hearing decision; and a statement that the individual has the right to be represented by a personal representative or attorney (at their own expense).⁷⁵ When the intended action involves termination of eligibility or suspension, termination, or reduction of services, the notice generally must be sent at least ten days before the date of the action.⁷⁶

States must give applicants and enrollees a reasonable time, not to exceed 90 days from the day the notice is mailed, to request a hearing.⁷⁷ If an enrollee requests a hearing prior to the effective date of the adverse action, the recipient has a right to receive continued benefits pending the result of the hearing.⁷⁸

An impartial hearing officer who was not directly involved in the original decision must conduct the administrative hearing at a reasonable time, date, and place.⁷⁹ Before the hearing, the applicant or enrollee must be allowed to review their file and all documents that the agency will use at the hearing.⁸⁰ At the hearing, the applicant or enrollee must be allowed to present witnesses, present arguments without interference from the other side, and cross-examine witnesses.⁸¹

Hearing decisions must be in writing and based exclusively on the evidence submitted at the hearing.⁸² Generally, a decision must be issued within 90 days of the request for a hearing.⁸³ If the hearing decision is favorable to the applicant or enrollee, the state must make corrective payments retroactive to the date that the incorrect action was taken.⁸⁴ If the adverse action is upheld, the state may recover from the enrollee the costs of any continued benefits.⁸⁵ In all states, individuals may appeal a final agency decision to state court.

2. Due Process Protections in Medicaid Managed Care

Enrollees who receive services through a managed care plan are entitled to similar due process protections at the plan-level.⁸⁶ Managed care plans must have a grievance and appeal system in place for enrollees.⁸⁷ Enrollees have the right to notice and a plan-level appeal when their plan makes an “adverse benefit determination.”⁸⁸ An adverse benefit determination includes, among other things: the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for

medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the delay of a service; and a dispute involving cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.⁸⁹

Generally, enrollees must exhaust the plan-level appeal before requesting an administrative hearing.⁹⁰ However, if the plan fails to resolve the appeal within the time frame specified in the regulations, the enrollee is deemed to have exhausted the in-plan appeal process and may immediately request a state fair hearing.⁹¹

Enrollees may file a grievance with the state or with their plan at any time about matters that are not adverse benefit determinations, such as the quality of care or services received or rude treatment.⁹² Enrollees do not have a right to appeal the resolution of a grievance.

3. Discrimination Claims

All state Medicaid programs must comply with federal anti-discrimination laws, including Title VI of the Civil Rights Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act.⁹³

In general, individuals who experience discrimination may file an administrative complaint with HHS' Office for Civil Rights (OCR), or may seek enforcement in federal court. A complaint must be filed within 180 days of the discrimination occurring, however OCR can extend the filing period if the complainant can show good cause.⁹⁴ OCR will review the complaint, investigate if it believes it has merit, determine whether any violation has occurred, and if so, take action to remedy it.

Individuals who experience discriminatory action from a Medicaid managed care plan may be able to file a complaint with the state's Medicaid agency. Many states also have their own civil rights laws and civil rights office that can investigate and prosecute discrimination claims based on state violations.

Endnotes

- 1 See Shannon Sullivan, *Inheriting Racist Disparities in Health: Epigenetics and the Transgenerational Effect of White Racism*, 1 CRITICAL PHILOSOPHY OF RACE 190-218 (2013), muse.jhu.edu/article/520501.

- 2 Guttmacher Inst., *Unintended Pregnancy in the U.S.* (2016), <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.pdf>.
- 3 See Adam Sonfield, Guttmacher Inst., *The Central Role of Medicaid in the Nation's Family Planning Effort* at 7, 10 (2012), <http://www.guttmacher.org/pubs/gpr/15/2/gpr150207.pdf> (stating that Medicaid provides 75% of public funding for family planning services and supplies).
- 4 Jennifer J. Frost, Lori Frohwirth & Mia R. Zolna, Guttmacher Inst., *Contraceptive Needs and Services 2014 Update*, GUTTMACHER INST. (2016) <https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update>.
- 5 *Id.*
- 6 Guttmacher Inst., *Gains in Insurance Coverage for Reproductive-Age Women at a Crossroads* (Dec. 2018), <https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads>.
- 7 *Id.*
- 8 The Medicaid Act is Title XIX of the Social Security Act, codified at 42 U.S.C. §§ 1396 through 1396w-5.
- 9 U.S. Dep't of Health & Human Servs., *November 2018 Medicaid & CHIP Enrollment Data Highlights*, <https://data.medicaid.gov/Enrollment/2018-11-Updated-applications-eligibility-da/3h6z-kzwb/data>.
- 10 The federal government revises the FPL each year, and it increases with each additional family member. U.S. Dep't of Health & Human Servs., *Poverty Guidelines for 2019*, <https://aspe.hhs.gov/poverty-guidelines>.
- 11 *Id.*
- 12 Medicaid operates in five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.
- 13 The Patient Protection and Affordable Care Act Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), amended by the Health Care and Education Reconciliation Act (Pub. L. No 111-152, 124 Stat. 1029 (March 30, 2010) (collectively known as the "Affordable Care Act").
- 14 42 U.S.C. § 1396a.
- 15 *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).
- 16 Idaho, Nebraska, and Utah have adopted the Medicaid expansion, but had not implemented it as of January 2019. Kaiser Family Found., *Status of State Medicaid Expansion Decisions* (Jan. 4, 2019), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.
- 17 Kaiser Family Found., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

- 18 Texas Health and Human Services, Medicaid for Adults, <https://hhs.texas.gov/services/health/medicaid-chip/programs/medicaid-adults> (last visited, Jun. 16, 2019).
- 19 Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision* (Nov. 8, 2017), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
- 20 See *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986) (“The Federal Government shares the costs of Medicaid with states that elect to participate in the program.”).
- 21 *Id.* at 157.
- 22 See 42 U.S.C. § 1396a(a)(10)(A) (describing the “categorically needy,” to whom the state must extend Medicaid benefits); see Title VI of the Civil Rights Act of 1964, codified at 42 U.S.C. § 2000d et seq. (prohibiting federal fund recipients from discriminating on the basis of race, color, or national origin); Title II of the Americans with Disabilities Act of 1990, codified at 42 U.S.C. § 12131 et seq. (prohibiting public agencies from discriminating against individuals with disabilities); Rehabilitation Act of 1973, codified at 29 U.S.C. § 794 (prohibiting federal fund recipients from discriminating against individuals with disabilities); see also 42 U.S.C. § 18116 (prohibiting health programs and activities that receive federal financial assistance from discriminating against individuals on the basis of grounds prohibited in Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973).
- 23 See 42 U.S.C. § 1302(a). In addition, the Secretary of the Treasury and the Secretary of Labor are also charged with promulgating regulations as necessary.
- 24 CMS, FEDERAL POLICY GUIDANCE, available at <https://www.medicaid.gov/federal-policy-Guidance/index.html>.
- 25 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.
- 26 See 42 C.F.R. § 431.10(c)(3) (stating that a state agency must specify whether or not it contracts for eligibility services).
- 27 42 C.F.R. § 430.10; see generally 42 U.S.C. § 1396a.
- 28 42 U.S.C. § 1396a(a) (listing required contents of the state plan).
- 29 42 C.F.R. § 430.12(c).
- 30 See 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.15, 430.35.
- 31 See 42 U.S.C. § 1396b(a); 42 U.S.C. § 1396d(b).

- 32 For FY 2020 FMAP figures, see Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2019 Through September 30, 2020, 83 Fed. Reg. 61157 (Nov. 28, 2018).
- 33 See 42 U.S.C. § 1396d(b) (describing FMAP calculation).
- 34 42 U.S.C. § 1396b(a)(5).
- 35 ACA § 4106 (codified at 42 U.S.C. 1396d(b); CMS, Dear State Medicaid Director 1-2 (SMD # 13-002) (Feb. 1, 2013), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-002.pdf>
- 36 42 U.S.C. § 1396d(y)(1).
- 37 42 U.S.C. § 1396d(z).
- 38 42 U.S.C. § 1396b(a)(7)(covering at 50 percent amounts expended for “proper and efficient administration of the State plan”).
- 39 See 42 U.S.C. § 1396a(a)(27).
- 40 42 U.S.C. § 1396a(a)(25)(C); 42 C.F.R. §§ 447.15, 447.20.
- 41 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51.
- 42 See generally 42 U.S.C. §§ 1396b(m), 1396d(t), 1396u-2; 42 C.F.R. §§ 438.1 – 438.812.
- 43 CMS, 2017 Share of Medicaid Enrollees in Managed Care, <https://data.medicaid.gov/Enrollment/2017-Share-of-Medicaid-Enrollees-in-Managed-Care/ikdz-jh6q> (last visited June 20, 2019).
- 44 See 42 U.S.C. §§ 1396u-2(a)(1)(B); 42 U.S.C. § 1396b(m)(1)(A); 42 U.S.C. § 1396d(t); 42 C.F.R. § 438.2.
- 45 42 C.F.R. § 438.2.
- 46 See 42 C.F.R. § 438.2; CMS, STATE MEDICAID MANUAL § 2089.
- 47 42 C.F.R. § 438.2. For more information on how these managed care arrangements work, see Nat’l Health Law Prog., *The Advocate’s Guide to the Medicaid Program* 2.12 (Oct. 31, 2012).
- 48 On November 14, 2018, CMS proposed revisions to the Medicaid managed care regulations that included removing the requirement that states use time and distance standards to ensure provider network adequacy. See 83 Fed. Reg. 57264-57299 (Nov. 14, 2018).
- 49 42 C.F.R. § 438.206(b)(4).
- 50 42 C.F.R. §§ 438.206(b)(2).
- 51 42 C.F.R. §§ 438.206(b)(7).
- 52 42 U.S.C. § 1396a(a)(23)(B); 42 U.S.C. § 1396n(b); 42 C.F.R. § 431.51(a)(3).
- 53 42 C.F.R. § 431.51(b)(2).

- 54 42 U.S.C. § 1396u-2(b)(6)(C).
- 55 42 C.F.R. § 438.10(g)(2)(vii).
- 56 42 C.F.R. § 438.52(b)(2)(ii)(C).
- 57 42 U.S.C. § 1396u-2(b)(2)(A)(i); 42 C.F.R. § 438.114(c).
- 58 42 U.S.C. § 1396u-2(b)(2)(C); 42 C.F.R. § 438.114(a)-(c).
- 59 42 C.F.R. § 438.10(g)(2)(v).
- 60 Kaiser Family Found., *Medicaid Coverage of Family Planning Benefits: Results from a State Survey* (Sept. 15, 2016), <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey-managed-care-and-family-planning-services/> (reporting four out of 31 states that responded to the survey had contracts with managed care organizations with religious exemptions).
- 61 42 C.F.R. § 438.10(g)(2)(i)-(ii).
- 62 42 C.F.R. §§ 1396e-1(a)-(b)(permitting states to assist with premium payments for group and employer-sponsored insurance coverage for Medicaid-eligible adults and Medicaid-eligible youth under age 19).
- 63 CMS, *Frequently Asked Questions-Medicaid and the Affordable Care Act: Premium Assistance* (Mar. 2013), <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>. For an analysis of the FAQ, see Leonardo Cuello & Jane Perkins, Nat'l Health Law Prog., *Premium Assistance FAQ Summary* (2013), <https://healthlaw.org/resource/frequently-asked-questions-regarding-premium-assistance-under-the-affordable-care-act/>; see also Leonardo Cuello, Nat'l Health Law Prog., *Health Advocate: Medicaid Expansion and Premium Assistance* (2014), <https://healthlaw.org/resource/health-advocate-medicaid-expansion-and-premium-assistance/>.
- 64 42 U.S.C. § 1315(a).
- 65 42 U.S.C. § 1396n(b).
- 66 42 U.S.C. § 1396n(a) provides that a state will not be deemed out of compliance with statewideness (§ 1396a(a)(1)), comparability (§ 1396a(a)(10)), or freedom of choice (§ 1396a(a)(23)) requirements solely because it contracts with an organization that has agreed to provide care and services in addition to those offered under the state plan, arranges through a competitive bidding or other process for laboratory services, or (after notice and opportunity for a hearing) locks over-utilizing individuals into a specified provider for a reasonable time. See *Knapp v. Armstrong*, 2012 WL 640890 (D. Idaho Feb. 26, 2012) (finding Freedom of Choice requirement waived even though approval did not specifically reference § 1396n(b)(4)).
- 67 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e).
- 68 42 U.S.C. §§ 1396n(c)(3), (d)(3), (e)(3); 42 C.F.R. § 435.217.

- 69 For a fuller description of Medicaid due process protections, see Kim Lewis & Wayne Turner, Nat'l Health Law Prog., *What Makes Medicaid, Medicaid? – Consumer Protections and Due Process* 6-9 (2017), <https://healthlaw.org/resource/what-makes-medicaid-medicaid-consumer-protections-and-due-process/>.
- 70 See generally *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972).
- 71 See U.S. Const., amend. XIV, § 1.
- 72 *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) (holding welfare recipients have due process rights to effective notices and pre-termination, impartial hearings before benefits may be terminated); see also 42 C.F.R. § 431.205(d).
- 73 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200–246.
- 74 42 C.F.R. § 431.220(a). Enrollees have a right to notice, but not to a hearing, when a federal or state law implements an automatic change that affects some or all recipients. 42 C.F.R. § 431.220(b).
- 75 42 C.F.R. § 431.210; see also *Goldberg v. Kelly*, 397 U.S. 254 (1970).
- 76 42 C.F.R. § 431.211; see also 42 C.F.R. §§ 431.213, 431.214 for circumstances in which advance notice is not required or situations in which the agency may shorten the period of advance notice to five days. See also CMS, STATE MEDICAID MANUAL § 2901.1.
- 77 42 C.F.R. § 431.221(d).
- 78 42 C.F.R. § 431.210(e), 42 C.F.R. § 431.230(a). In addition, states have the option to reinstate services to an enrollee who requests a hearing no more than 10 days after the adverse action has taken place. 42 C.F.R. § 431.231.
- 79 42 C.F.R. § 431.240(a). States may choose to have the state Medicaid agency or a local agency conduct hearings. If a state elects to have a local agency conduct hearings, applicants and enrollees have a right to appeal to the Medicaid agency. In addition, states have the option to allow the exchange or another entity to conduct hearings for applicants subject to MAGI rules and denied eligibility. However, even if a state elects this option, these applicants must be given a choice to have their hearing before the state Medicaid agency. 42 C.F.R. § 431.205(b).
- 80 42 C.F.R. § 431.242(a).
- 81 42 C.F.R. § 431.242(b)-(e).
- 82 42 C.F.R. § 431.244.
- 83 42 C.F.R. § 431.244(f).
- 84 42 C.F.R. § 431.246(a); CMS, STATE MEDICAID MANUAL § 6320.
- 85 42 C.F.R. § 431.230(b); CMS, STATE MEDICAID MANUAL § 2904.2.
- 86 See 42 U.S.C. § 1396u-2(a)(1)(A)(i)-(b)(4); 42 C.F.R. §§ 438.400–424.

- 87 42 C.F.R. § 438.402. For a detailed description of Medicaid managed care grievance and appeal requirements, see Jane Perkins, Medicaid Managed Care Final Regulations Grievance & Appeals Systems, NAT'L HEALTH LAW PROGRAM (May 12, 2016), <https://healthlaw.org/resource/issue-brief-2-medicaid-managed-care-final-regulations-grievance-appeals-systems/>.
- 88 42 C.F.R. §§ 438.402, 404.
- 89 42 C.F.R. § 438.400.
- 90 42 C.F.R. § 438.402(c).
- 91 *Id.*
- 92 42 C.F.R. §§ 438.400, 400.402(c)(2).
- 93 See 42 U.S.C. § 1396a(a)(10)(A) (describing the “categorically needy,” to whom the state must extend Medicaid benefits); see Title VI of the Civil Rights Act of 1964, codified at 42 U.S.C. § 2000d *et seq.* (prohibiting federal fund recipients from discriminating on the basis of race, color, or national origin); Title II of the Americans with Disabilities Act of 1990, codified at 42 U.S.C. § 12131 *et seq.* (prohibiting public agencies from discriminating against individuals with disabilities); Rehabilitation Act of 1973, codified at 29 U.S.C. § 794 (prohibiting federal fund recipients from discriminating against individuals with disabilities); see *also* 42 U.S.C. § 18116 (prohibiting health programs and activities that receive federal financial assistance from discriminating against individuals on the basis of grounds prohibited in Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973).
- 94 See HHS Office of Civil Rights, How to File a Civil Rights Complaint webpage, <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html> (last visited June 20, 2019).

Chapter II.

Medicaid Eligibility

The Medicaid program is the largest public health insurance program for people with low incomes in the U.S., and plays a particularly important role for low-income women. Women are more likely to be employed in low-wage or part-time jobs that do not offer employer insurance.

Medicaid is also an important source of care for women of color. Thirty-one percent of Black women of reproductive age, 27 percent of Hispanic/Latina women, and 19 percent of Asian American women are covered by Medicaid, compared to 15 percent of white women of the same age. Health disparities in the U.S. impact people at all income levels, but low-income women and women of color carry a disproportionate burden of illness. Approximately 63 percent of women enrolled in Medicaid had incomes below 200 FPL in 2017.¹

To be eligible for Medicaid, individuals must fit into a coverage category, meet certain income and citizenship or immigration requirements, and be a resident of the state in which they are applying. States must cover certain population groups and have the option to cover others.²

A. Coverage Categories

Medicaid eligibility can be divided into three groups: (a) the mandatory categorically needy; (b) the optional categorically needy; and (c) the medically needy. These eligibility categories determine the set of benefits an individual receives. Federal law requires states to provide Medicaid coverage to those individuals who fall in the mandatory categorically needy. States have the option to cover the optional categorically needy and the medically needy. The ACA also made significant changes to the Medicaid eligibility framework while preserving long-standing Medicaid categories.

1. Mandatory Categorically Needy

All states that participate in Medicaid must include certain groups within their programs.³ There are a number of mandatory population groups, and the rules for deciding whether an individual falls within a covered group can be complicated.¹⁴

States must cover certain groups of families and children. Historically, individuals who qualified for cash assistance through Aid to Families with Dependent Children (AFDC) automatically qualified for Medicaid.⁵ In 1996, Congress “de-linked” Medicaid from welfare programs and, for some groups, tied eligibility to poverty-level status. For example, under federal law, pregnant women and low-income children under 19 years old qualify for Medicaid if their household incomes are below 133 percent FPL.⁶ States also must provide Medicaid coverage to certain individuals who were formerly enrolled in foster care until they reach 26 years old, regardless of their income.⁷ Notably, when Congress repealed AFDC in 1996, it extended mandatory Medicaid to individuals and families who would have qualified for AFDC based on the rules that were in effect in the state in 1996.⁸ States also must provide Medicaid to certain “aged, blind, and disabled” individuals. For example, most states must cover individuals receiving Supplemental Security Income (SSI) benefits.⁹ Other mandatory eligibility groups include individuals who lost SSI benefits and certain working individuals with disabilities.¹⁰

The ACA created a new mandatory category expanding Medicaid to non-pregnant adults under age 65 with incomes up to 138 percent FPL who do not fall into one of the other Medicaid eligibility groups.¹¹ This category is referred to as the Medicaid expansion population or “newly eligible.” As enacted, the ACA required all states participating in Medicaid to cover this group by January 1, 2014. However, under the U.S. Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*, HHS cannot penalize states that do not cover newly eligible individuals, rendering the expansion optional to the states.¹² As a result, 36 states and the District of Columbia have expanded their Medicaid programs to include this newly eligible category.¹³ These states received an increased federal matching rate to cover newly eligible individuals as follows: 100 percent in 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.¹⁴

2. Optional Categorically Needy

States have the option to cover a number of other eligibility groups.¹⁵ In general, individuals within these groups have limited incomes and cannot afford to pay for a health care crisis. As with the mandatory covered populations, states’ coverage options reflect an attempt to offer a safety net to vulnerable populations, such as children, pregnant women, and people with disabilities and/or medical conditions. For example, states have the option to cover children and pregnant people whose household incomes are below a certain percentage of the FPL (e.g., 185 percent FPL).¹⁶ Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, states may provide full-scope Medicaid benefits to uninsured individuals under age 65 who have been diagnosed with breast or cervical cancer.¹⁷ States also have the option to cover a number of “aged, blind, and disabled” populations.¹⁸ In addition, the ACA allows

states to provide family planning services and supplies to individuals who do not otherwise qualify for Medicaid, are not pregnant, and have incomes up to the eligibility level established for pregnant people in the state.¹⁹

3. Medically Needy

The medically needy category is an additional optional coverage group consisting of individuals who fall within a federal eligibility category, such as the aged, blind or disabled, but whose income or resources are too high to meet the categorically needy eligibility criteria.²⁰ These individuals qualify for Medicaid by “spending down” their excess income on health care to the point where they meet the income eligibility level. States have considerable flexibility to decide which population groups to cover; however, states choosing the medically needy option must at least include children under age 18 and pregnant people who, but for income and resources, would be covered as categorically needy.²¹ The medically needy option is important because it often provides coverage to people who have significant health care needs and have accumulated large medical bills.

4. Eligibility for Pregnancy Services²²

The federal Medicaid statute and regulations establish both mandatory and optional categories of state coverage for pregnant people. Across all categories of Medicaid coverage, family size includes the pregnant person plus the number of children they expect to deliver.²³ For example, a pregnant person with a singleton pregnancy is considered a household of two, while a person with a twin pregnancy is considered a household of three.

Once a pregnant person’s eligibility for Medicaid is established, they remain eligible for Medicaid through the end of the month in which the 60-day postpartum period falls, regardless of any change in family income during that period.²⁴ In addition, a child born to a person with Medicaid coverage including emergency Medicaid for labor and delivery on the date of delivery is automatically eligible for Medicaid until their first birthday, regardless of the immigration status of the parent or changes in family income.²⁵ The eligibility category for these children is called “deemed newborns.”

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 the statute and regulations.

a. Mandatory Pregnancy Coverage Categories

As noted, states must provide full Medicaid coverage to certain populations known as the mandatory categorically needy. This population includes “qualified pregnant women,” defined as a woman whose pregnancy has been medically verified, and who would have been eligible for AFDC based on the income requirements that were in place on July 16, 1996, if their child had been born and was living with her in the month(s) such aid would be paid.²⁶ In setting this income limit, with respect to full scope Medicaid coverage for qualified pregnant women, a state is not permitted to go below the AFDC income limits that were in effect in that state on May 1, 1988.²⁷

Where a pregnant person does not meet the income limits for full Medicaid coverage as a “qualified pregnant woman,” a state is still required to provide at least *pregnancy-related coverage* if their household income is:

- 1) At or below 133 percent of the federal poverty level; or
- 2) At or below the Medicaid income limit the state had set for pregnancy-related coverage as of December 19, 1989, if such limit was higher than 133 percent of the federal poverty level.²⁸

While income limits for pregnancy-related Medicaid vary, this requirement means states cannot drop eligibility below a range of 133-185 percent of FPL, depending on the state.²⁹ States have the option to provide Medicaid coverage to pregnant people with family incomes even higher than the 133-185 percent FPL floor.³⁰ As of January 2018, twenty-seven states and the District of Columbia have Medicaid income eligibility limits at or above 200 percent of the federal poverty level.³¹

STATE	MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL)	MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/'89 (Percent of the FPL)
Alabama	146%	100%
Alaska	205%	100%
Arizona	161%	100%
Arkansas	214%	100%
California	213%	185%
Colorado	200%	75%
Connecticut	263%	185%
Delaware	217%	100%

STATE	MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL)	MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/'89 (Percent of the FPL)
D.C.	211%	100%
Florida	196%	150%
Georgia	225%	100%
Hawaii	196%	185%
Idaho	138%	75%
Illinois	213%	100%
Indiana	218%	100%
Iowa	380%	185%
Kansas	171%	150%
Kentucky	200%	125%
Louisiana	138%	100%
Maine	214%	185%
Maryland	264%	185%
Massachusetts	205%	185%
Michigan	200%	185%
Minnesota	283%	185%
Mississippi	199%	185%
Missouri	201%	100%
Montana	162%	100%
Nebraska	199%	100%
Nevada	165%	75%
New Hampshire	201%	75%
New Jersey	199%	100%
New Mexico	255%	100%
New York	223%	185%
North Carolina	201%	150%
North Dakota	152%	75%
Ohio	205%	100%
Oklahoma	138%	100%
Oregon	190%	85%

STATE	MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL)	MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/'89 (Percent of the FPL)
Pennsylvania	220%	100%
Rhode Island	195%	185%
South Carolina	199%	185%
South Dakota	138%	100%
Tennessee	200%	100%
Texas	203%	130%
Utah	144%	100%
Vermont	213%	185%
Virginia	148%	100%
Washington	198%	185%
West Virginia	163%	150%
Wisconsin	306%	82%
Wyoming	159%	100%

Source: Kaiser Fam. Foundation, Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level (Jan. 2019), <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level>.

Because a pregnant person may be eligible for more than one coverage category, their coverage options can vary in states that have expanded Medicaid. An individual who is pregnant at the time of application is not eligible for coverage under the Medicaid expansion category.³² However, an individual who is already enrolled in the Medicaid expansion category at the time they become pregnant can remain covered until the time of their redetermination.³³ In addition, the state must inform them of other potential coverage categories, and give the enrollee the option to switch categories if they are eligible.³⁴

ADVOCACY TIP:

An individual who is enrolled in a qualified health plan (QHP) offered through the Marketplace and then becomes pregnant may also become eligible for pregnancy-related Medicaid. In some cases, Medicaid may be a more favorable coverage option for such people, as Medicaid has no cost sharing for pregnancy-related services. However, to preserve continuity of care, women should be able to choose whether to remain on their QHP, or to move to pregnancy related Medicaid.³⁵ Individuals cannot be enrolled in both Medicaid and Marketplace coverage simultaneously.

b. Optional Pregnancy Coverage Categories

States that choose to provide optional Medicaid coverage for the medically needy must also include pregnant women.³⁶ At a minimum, this coverage must include prenatal care, labor and delivery, and postpartum care through the end of the month in which the 60-day postpartum period falls.³⁷

States also have the option to cover pregnant immigrants who have been lawfully residing in the United States for less than five years through a State Plan Amendment approved by the Centers for Medicare and Medicaid Services (CMS).³⁸ This is known as the ICHIA (Legal Immigrant Children's Health Improvement Act) option.³⁹

Federal regulations also allow states to provide prenatal care through the Children's Health Insurance Program (CHIP). Five states use CHIP funds to cover pregnant people with family incomes ranging from 200-300 percent FPL who cannot otherwise obtain affordable coverage.⁴⁰ Pregnant immigrants who are undocumented may also qualify for CHIP coverage of prenatal care through the "unborn child" option if they live in one of the 16 states that have implemented the option.⁴¹ This option allows states to provide CHIP coverage for a fetus, and, by extension, coverage for prenatal care, labor, delivery, and postpartum care to the pregnant person regardless of immigration status.⁴² In states that do not offer this coverage, undocumented pregnant immigrants only qualify for emergency Medicaid, which is limited to labor and delivery services.⁴³

c. Presumptive eligibility for Pregnant Women⁴⁴

Presumptive eligibility allows states to authorize qualified entities to provide an individual who, based on preliminary information, appears to meet the eligibility criteria for Medicaid coverage to receive immediate, same-day Medicaid services prior to an eligibility determination. States have the option of implementing presumptive eligibility to provide these services to certain categories of Medicaid enrollees, including pregnant women.⁴⁵ Presumptive eligibility for pregnancy only covers ambulatory prenatal care.⁴⁶ Some states that have elected to provide presumptive eligibility coverage for pregnant people also include abortion services.

To enroll, a pregnant person must complete an application with a qualified entity authorized by the state, such as hospitals, community health centers, and schools. The qualified entity must notify the state Medicaid agency of a presumptive eligibility determination within five days and inform the individual to file a full application for coverage before the end of the presumptive eligibility period.⁴⁷ Documentation for eligibility factors such as citizenship is not required for a presumptive

eligibility determination but will be required when the full application is filed.⁴⁸ A state may use a simplified version of the full Medicaid application as its presumptive eligibility form to streamline the process.⁴⁹ These added flexibility allows providers to receive reimbursement (and states to receive federal matching funds) for the services provided to the individual, even if the individual is later found not to be eligible.

ADVOCACY TIP:

State advocates should encourage their state to implement presumptive eligibility for their family planning expansion programs. The traditional application for Medicaid can be a lengthy process as applicants must compile various pieces of documentation. Presumptive eligibility can help reduce barriers to timely care.

The presumptive eligibility period ends with and includes the day on which a formal eligibility determination is made, or the last day of the month after the month during which the individual was determined presumptively eligible, whichever is earlier.⁵⁰ Presumptive eligibility for pregnant women is authorized once per pregnancy.⁵¹

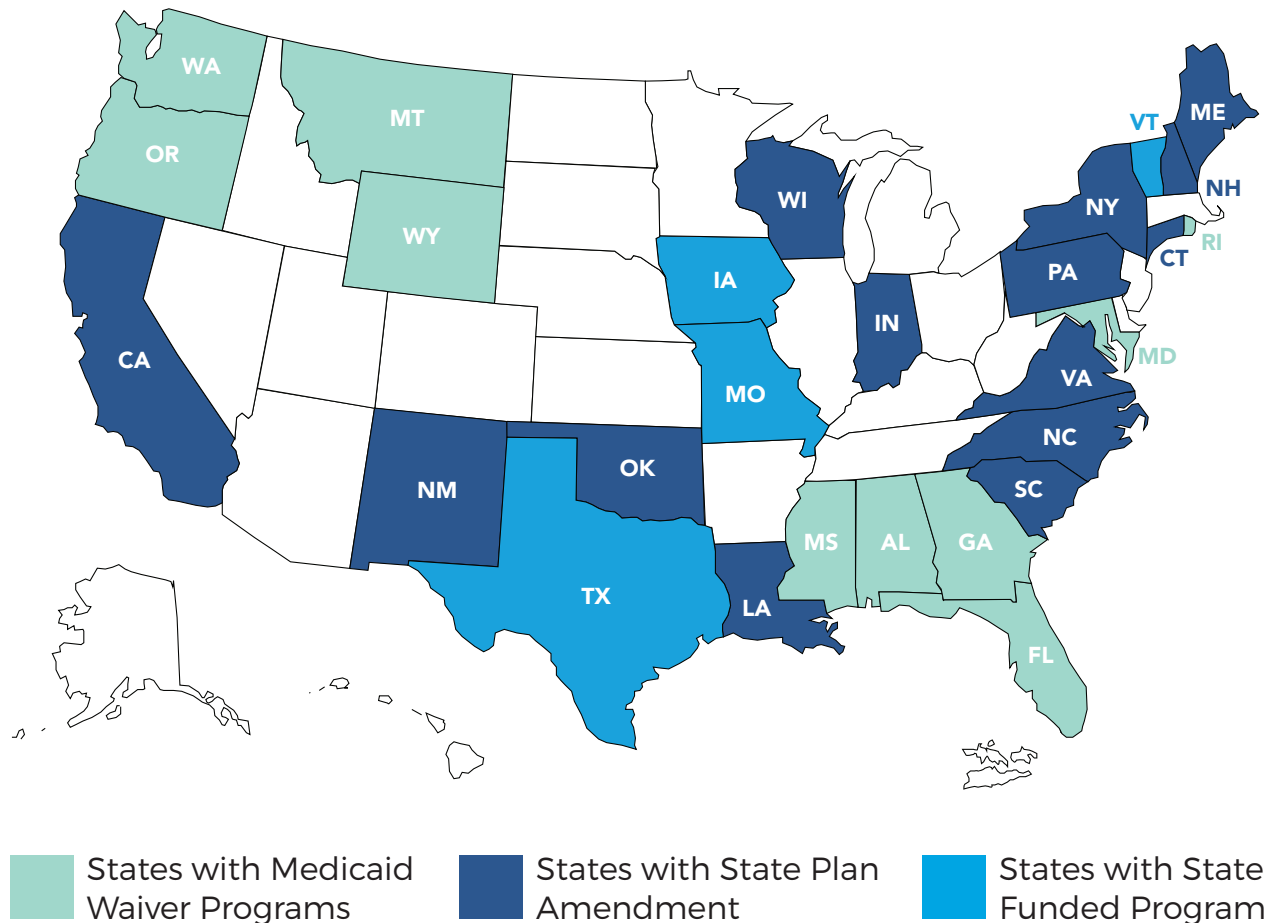
d. Retroactive eligibility

States must pay for medical services included under the state Medicaid plan (such as pregnancy services) that were provided to an individual during the three month period prior to the month of application for Medicaid if the applicant would have been eligible had he applied for coverage at that time.⁵² The three-month retroactive coverage period runs from the date of application, not the date of the eligibility determination.

5. Eligibility for Family Planning Expansion Programs

Family planning services and supplies is a mandatory Medicaid service. States have the option to extend coverage of family planning and family planning-related services to individuals not otherwise eligible for Medicaid. Historically, states implemented this optional coverage by requesting CMS approval of time-limited pilot or demonstration projects commonly known as “demonstration waivers” granted under Section 1115 of the Social Security Act. However, the ACA created a new option for states to permanently incorporate this coverage into their Medicaid programs through a process called a State Plan Amendment (SPA). At the time of this publication, a total of 25 states have family planning expansion programs in place—10 of them operate their programs through a demonstration waiver, and 15 have implemented the family planning SPA option.⁵³ While these programs are not an adequate substitute for comprehensive Medicaid coverage, they remain an important source of limited coverage for many low-income individuals, particularly in states that have yet to expand their Medicaid programs under the Affordable Care Act.

Medicaid Family Planning Eligibility Expansions



Source: Guttmacher Inst., Medicaid Family Planning Eligibility Expansions (as of July 1, 2019), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>.

a. Family Planning State Plan Amendment (SPA)

Recognizing the benefits and successes of family planning expansions, the ACA created a family planning SPA option. States may implement this new optional eligibility category by amending its state Medicaid plan. To date, 15 states have implemented this option to provide coverage for family planning services, supplies, and related services to individuals (men and women) who:

- are not pregnant;
- do not exceed the income eligibility level established by the state, which may not exceed the highest income level for pregnant women under the state's Medicaid or CHIP state plan; and
- are of child-bearing age.

States cannot limit eligibility based on gender or age beyond the general requirement that individuals must be of child-bearing age.⁵⁴ Individuals

who apply for full-scope Medicaid but only qualify for the state's SPA must be offered enrollment in the family planning SPA. Similarly, individuals who apply for the SPA but qualify for full-scope Medicaid must be enrolled in full Medicaid.

CMS provided guidance to states seeking to apply for a family planning SPA.⁵⁵ States that currently operate a family planning program through a demonstration waiver can convert the existing waiver to a SPA. These states may continue to use the eligibility standards and procedures that were in place under the state's waiver on or before January 1, 2007.⁵⁶

Individuals enrolled in a family planning SPA must receive coverage for the same package of family planning services and supplies that other categorically needy enrollees in the state receive under full scope Medicaid.⁵⁷ These services and supplies are reimbursable at the 90 percent FMAP rate.⁵⁸ Additionally, states must cover family planning-related services, which are reimbursed at the state's regular FMAP for Medicaid services. Chapter IV, Section B provides an overview of the family planning services and supplies and family planning-related services covered through the SPA. States can also offer presumptive eligibility for family planning expansion programs.⁵⁹

b. Family Planning Section 1115 Demonstrations

Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive certain provisions of the Medicaid Act at the request of a state to implement time-limited "experimental, pilot, or demonstration project[s] likely to promote the objectives of the Medicaid statute."⁶⁰ Some states have used this authority to expand their family planning programs.

The eligibility criteria for family planning waivers vary by state. Most base eligibility on income, while others extend coverage to individuals who are losing Medicaid coverage under a different eligibility category, such as pregnancy-related Medicaid.⁶¹ Most family planning waivers cover individuals at any point in their reproductive lives, however some states require an enrollee to be at least 19 years old.⁶² Some cover both men and women, while others exclude men from eligibility. Some states also delineate the upper age of "child-bearing age," which can result in some older but still fertile women denied services.

States have applied for §1115 waivers to implement a broad range of policies and programs beyond family planning. Some of these demonstration programs have been used to provide women and other medically underserved individuals with more coverage options and/or services, while others have been used to illegally restrict access to coverage and care.⁶³

B. Financial Eligibility

Generally, to qualify for Medicaid, individuals must fall into an eligibility category and meet specific financial eligibility criteria. States evaluate financial eligibility for each applicant at the time of application, when the recipient reports income changes, and at each periodic redetermination. Traditionally, states considered available pre-tax income and resources, subject to certain disregards and deductions.

ADVOCACY TIP: Family Planning Expansion Options

Advocates in states with family planning expansion programs should educate stakeholders about the continued role that family planning expansions play. Advocates in states with family planning waivers should assess opportunities to encourage the state to transition to a more permanent family planning SPA.

The ACA brought significant changes to the methodology that states use to determine financial eligibility in many Medicaid categories, CHIP, and other public programs (as well as for premium tax credits and cost sharing reductions for coverage purchased through the health insurance Marketplaces).⁶⁴ As of January 1, 2014, states must use Modified Adjusted Gross Income (MAGI), a simplified methodology based on federal income tax rules in applicable categories.⁶⁵ MAGI aims to introduce nationwide uniformity across states and across programs; it is also used to evaluate eligibility for CHIP and for premium tax credits and cost-sharing subsidies available through the Marketplace. For some Medicaid enrollees, states continue to use the old Medicaid income counting methodology.⁶⁶

1. Modified Adjusted Gross Income (MAGI)

MAGI has two principal components: income counting and household composition. First, MAGI counts total household income according to federal tax law. Second, MAGI rules determine household composition and family size. Household income is then compared to the FPL for the particular family size to determine eligibility for Medicaid. States must conduct a separate MAGI determination for each individual seeking Medicaid coverage. The MAGI rules are quite complicated. Although the sections below provide a brief overview, consult NHeLP's [Advocate's Guide to MAGI](#) for more comprehensive and detailed information.⁶⁷

a. Populations and eligibility categories subject to MAGI

States must apply MAGI to most Medicaid eligibility categories, including adults newly eligible under the Medicaid expansion, parents and caretaker relatives, those who qualify for Medicaid based on the 1996 AFDC eligibility rules, pregnant women in all eligibility groups, and most children.⁶⁸

In addition, states that provide family planning services and supplies to individuals through a §1115 demonstration project or a state plan amendment must use MAGI rules to determine financial eligibility. In fact, the ACA requires states to apply MAGI in all §1115 demonstration projects for populations and eligibility groups subject to MAGI and prohibits HHS from waiving MAGI rules, except in very limited circumstances.⁶⁹

However, MAGI does not apply to all populations and eligibility groups. For example, “aged, blind, and disabled” eligibility groups and SSI recipients are exempt from MAGI.⁷⁰ Other eligibility groups, including women who qualify for Medicaid due to a breast or cervical cancer diagnosis, are not subject to MAGI rules because federal law does not require them to meet particular financial eligibility criteria.⁷¹

b. Calculating income

Subject to a few exceptions, determining income is based on calculating one’s Adjusted Gross Income (AGI) as reported for federal income tax purposes.⁷² Common forms of countable income include: wages, salaries, and tips (earned income), self-employment profits or losses, Social Security benefits, unemployment benefits, alimony received, state income tax refunds, and interest and dividends (unearned income).⁷³ AGI is then “modified” by adding in certain foreign income, interest income, and non-taxable Social Security benefits adjusted gross income to transform it into MAGI.⁷⁴

Significantly, none of the previous Medicaid income deductions and disregards apply under MAGI.⁷⁵ The ACA introduced a standard income disregard of 5 percent FPL when overall eligibility is at stake.⁷⁶ This means that states apply the income disregard when individuals would not otherwise qualify for Medicaid or CHIP without the disregard.⁷⁷ As a result, the actual eligibility standard for newly eligible individuals is 138 percent FPL (133 percent plus the 5 percent disregard). MAGI determination does not include consideration of available assets.⁷⁸

c. Determining Household Composition and Income

States determine eligibility for all Medicaid applicants based on their current monthly household income and family size.⁷⁹ The rules defining household composition and income are quite complex. Tax relationships, living arrangements, legal status, and other factors determine an applicant’s household.⁸⁰ In addition, household composition (e.g. who is in the household) is not necessarily the same as household size. In addition to household size, states may choose whose income to count. Using MAGI-based methodology, states have the flexibility to consider either the income of only the applicant, or the income of the applicant and all legally responsible household members.⁸¹

To maximize Medicaid eligibility states may (1) include every potential member in the household to determine household size; (2) increase that household size by one; or (3) count the income of only the applicant. Under these options, the states can consider which one will yield the lowest possible income as a percentage of the federal poverty line. Household income and family size together are then compared to the financial eligibility criteria (expressed in terms of percent of the FPL) to determine eligibility for Medicaid.⁸²

When conducting eligibility redeterminations, states can opt to use either the current monthly household income and size, or a projected annual household income and size for the remaining months of the calendar year.⁸³ For both applicants and enrollees, states can opt to use a “reasonable method” to include a prorated portion of predictable future income and/or to account for a predictable increase or decrease in future income, such as from seasonal work.⁸⁴

d. MAGI Rules for Family Planning Expansion Programs

States that provide family planning services and supplies to individuals through a §1115 demonstration project or a state plan amendment must use MAGI rules to determine financial eligibility. The ACA gives states some flexibility when determining the income and family size of the individual applying for such limited-scope coverage.⁸⁵ States with family planning programs offered under a state plan amendment have the option to consider only the income of the individual applying for family planning benefits instead of that of the entire household. In addition, a state can apply the same eligibility rules it uses for pregnancy-related services when determining eligibility for limited scope family planning services, including counting a pregnant applicant as a household of two.⁸⁶

This flexibility allows state Medicaid agencies to enroll individuals into their family planning expansion programs who, based on the income of the applicant’s parent, spouse, or other household member, might not otherwise qualify. This is especially important for ensuring that individuals are able to access family planning services and supplies confidentially without household members’ involvement. States must indicate on their family planning SPA application which income calculation will be used.

e. MAGI Rules for Pregnancy

A pregnant person applying for Medicaid, must be counted as one, plus the number of children they expect to have, when determining household size. However, when determining eligibility for other individuals who have a pregnant person in their household, states have flexibility. The state can elect to count the pregnant person as one person,

two people, or one person plus the number of children they expect to deliver.⁸⁷ Thus, for the purposes of the pregnant person's own eligibility, a pregnant person expecting twins would be counted as three people. If other individuals in the household apply for coverage, the pregnant person would, at state option, be counted as one, two, or three people.

Once an individual's household composition is established, the next step is to determine whether to include the income of each individual household member in the calculation of total household income. Generally, for purposes of Medicaid and CHIP, the total household income is the sum of the MAGI income for each member of the household who is required to file a federal income tax return.⁸⁸ For example, if a parent claims a child as a dependent, the child's income is not included in the parent's total household income unless the income is high enough to require that the child file a tax return.⁸⁹

2. Traditional Methodology for Determining Eligibility

States continue to use the traditional methodology to determine financial eligibility for some populations and eligibility groups. Under the traditional methodology, states consider available income and assets, subject to certain disregards and deductions. The traditional rules on counting income and determining household size and income differ significantly from the MAGI rules. For more information about the traditional methodology, see NHeLP's *The Advocate's Guide to the Medicaid Program*.⁹² Note, however, the rules vary significantly from state to state. For state-specific information, see your state Medicaid eligibility manual.

ADVOCACY TIP: Pregnancy Coverage for Individuals Under 21

Under the traditional income eligibility rules, states could disregard parental income when considering the household income of a pregnant minor. Under MAGI rules, this kind of selective disregard is no longer available. However, CMS guidance outlined a process for states to preserve this coverage by disregarding all income for pregnant individuals under age 21 (or under 18, 19, or 20) if the state acted before January 1, 2014.⁹⁰ Check your state plan (or with your Medicaid agency) to see if your state did so.⁹¹

C. Eligibility Based on Citizenship and Immigration Status

A person seeking to enroll in full-scope Medicaid must be a U.S. citizen or have qualified immigration status.⁹³ Certain "qualified" immigrants may receive full Medicaid benefits, while "not qualified" immigrants may receive only emergency Medicaid services, including labor and delivery.⁹⁴

1. Qualified Immigrants

Qualified immigrants include:

- Lawful permanent residents (those with “green cards”);⁹⁵
- Refugees, people granted asylum;⁹⁶
- Cuban and Haitian entrants;⁹⁷
- Certain individuals who are survivors of intimate partner violence or have experienced extreme cruelty, and their children and/or parents (if there is a substantial connection between the battery or cruelty and the need for Medicaid);⁹⁸
- Certain survivors of trafficking;⁹⁹
- Individuals granted conditional entry;¹⁰⁰
- Individuals granted withholding of deportation/removal;¹⁰¹
- Individuals paroled into the U.S. for at least one year;¹⁰² and
- Other limited immigrant categories.¹⁰³

Qualified immigrants are further divided into two groups: those lawfully residing in the U.S. before August 22, 1996 and those arriving in the country after August 22, 1996. Immigrants who were lawfully residing in the U.S. before August 22, 1996, if otherwise eligible, may receive full Medicaid benefits, subject to certain time limits.¹⁰⁴ Most immigrants who arrived after August 22, 1996 are prohibited from receiving Medicaid for a period of five years after entry into the country, with some exceptions.¹⁰⁵ However, six states exclude even qualified immigrant adults who arrived on or after August 22, 1996 from Medicaid regardless of how long they have been in the country.¹⁰⁶ Congress created an option in CHIPRA for states to lift the five-year bar for qualified immigrant children and pregnant people who are lawfully residing in the U.S.¹⁰⁷ Some states also use their own funds to provide health care to immigrants subject to the five year bar.¹⁰⁸

2. “Not qualified” Immigrants

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

- Individuals permanently residing under color of law (PRUCOL);¹⁰⁹
- Non-immigrants, such as students, residents from Compact of Free Association nations, and tourists in the U.S. temporarily; and
- Persons without proper documentation or undocumented immigrants.

3. Emergency Medicaid for Immigrants

Not qualified immigrants, as well as qualified immigrants who are subject to the five-year bar, are eligible for care and services necessary for the treatment of an emergency medical condition provided they meet all other Medicaid eligibility requirements except for immigration status.¹¹⁰

The Medicaid Act defines an emergency medical condition as:

“A medical condition, (including emergency labor and delivery), manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient’s health in serious jeopardy,
- (b) serious impairment to bodily function, and/or
- (c) serious dysfunction of any bodily organ or part.”¹¹¹

Federal law does not clearly define when an emergency condition ends, thus making it difficult to determine how much care a patient is entitled to receive as a result of an emergency condition. According to CMS, “each case needs to be evaluated on its own merits, and the determination of what constitutes an emergency medical service is left to the state Medicaid agency and its medical advisors.”¹¹² States thus have some flexibility in defining what constitutes an emergency. However, CMS has determined that emergency medical care for immigrants does not extend to pregnancy-related services, such as prenatal and post-partum care.¹¹³

D. State Residency

To receive Medicaid coverage in a particular state, a person must be a resident of that state. In general, residency is the state where the individual is living and either intends to reside (with or without a fixed address) or has entered with a job commitment or in search of a job.¹¹⁴ The same rule applies to individuals under 21 years old who are capable of indicating intent and are emancipated or married.¹¹⁵ For most other individuals under 21 years old, residency is the state where the individual resides or the state of residency of the parent or caretaker with whom the individual resides.¹¹⁶ States cannot use evidence of immigration status to determine that an individual is not a state resident.¹¹⁷ Individuals who are in institutions are not considered residents of the state in which they are institutionalized.

INNOVATIVE APPROACH:

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

E. Applying for Medicaid

States must give individuals who want to apply for Medicaid the opportunity to do so without delay. It is important to note that some individuals are automatically entitled to and enrolled in Medicaid due to their enrollment in another benefits program. For example, in most states, individuals who receive SSI benefits are automatically entitled to Medicaid; in these instances, states cannot require such individuals to submit an application for Medicaid benefits.¹¹⁸

Some applicants may be eligible for Medicaid under more than one category. To enable applicants to make an informed decision about which category to select, states must provide information to applicants about the different eligibility options and benefit packages available.¹¹⁹

1. How to apply

States must use a single, streamlined application that serves as an application for Medicaid, CHIP, and financial assistance for purchasing a Qualified Health Plan (QHP) offered through a Marketplace.¹²⁰ The application must be accessible to persons who are limited-English proficient and individuals with disabilities.¹²¹

States must accept an application submitted on behalf of an applicant by an adult in the applicant's household or family or by an applicant's authorized representative. If the applicant is a minor or incapacitated, states must accept an application from a person "acting responsibly for the applicant."¹²² Individuals may submit an application online, by mail, in person, over the phone, or "through other commonly available electronic means."¹²³ In addition, states must ensure certain groups of children and pregnant women can apply in person at "outstation" locations other than the local social services offices.¹²⁴

States must provide assistance to individuals seeking help with the application process and also allow individuals to have a person or persons of their choice assist with the application process or a redetermination of eligibility.¹²⁵ For populations and eligibility groups subject to MAGI, states cannot require an in-person interview as part of the application process.¹²⁶

2. Documentation and Verification of Information

States require individuals applying for Medicaid to provide information sufficient to determine their eligibility for the program, including their social security number (SSN).¹²⁷ States may accept attestation (as opposed to documentation) of most of the information needed to determine eligibility.¹²⁸

Verification procedures vary from state to state.¹²⁹ Generally, states use federal and state databases to electronically verify the information in the application.¹³⁰ Most Medicaid applicants must provide satisfactory documentation of citizenship or immigration status at the time of application.¹³¹ Applicants are

exempt from this requirement if they are:

- Receiving Supplemental Security Income (SSI) benefits (current and former);
- Receiving Social Security Disability Insurance (SSDI) benefits;
- Entitled to or enrolled in any part of Medicare; or
- Children who are in federally funded foster care, or who are receiving federal adoption or foster care assistance.¹³²

If the information the applicant furnishes is “reasonably compatible” with the information the state obtains, the state must make an eligibility determination using that information.¹³³ If an applicant does not present satisfactory documentation of citizenship or immigration status (or if the qualified immigration status of an applicant is not verified), the state must provide the applicant with a “reasonable opportunity” to secure the documentation.¹³⁴ If the applicant is otherwise eligible, the state must provide Medicaid coverage during the reasonable opportunity period.¹³⁵ If the individual fails to provide satisfactory documentation before the end of the reasonable opportunity period, the state will terminate coverage.¹³⁶

States also have the option to adopt an alternate verification process for U.S. citizens and U.S. nationals.¹³⁷ Applicants provide their name, SSN, and date of birth, which the state then sends to the Social Security Administration (SSA). If the SSA responds that the applicant has appropriate citizenship or immigration status, the applicant will have met the documentation requirement. If not, the state must make a “reasonable effort to identify and address” the reason for the inconsistency, and if the state does not resolve the inconsistency, provide the applicant with 90 days to present satisfactory documentation of citizenship or nationality.¹³⁸ States must provide coverage to otherwise eligible individuals pending the completion of the verification process.¹³⁹

3. Time Frame for Determining Eligibility

The Medicaid Act requires states to determine eligibility with “reasonable promptness.”¹⁴⁰ Except in unusual circumstances, applications for Medicaid must be decided within 90 days in cases involving disability determinations and within 45 days in all other cases.¹⁴¹

States must mail a written determination to the applicant or to his or her representative.¹⁴² The state will provide individuals found eligible for Medicaid with a Medicaid card, coupon or other evidence of eligibility. States need to have a method of making Medicaid available to individuals who are homeless or do not have a fixed mailing address.¹⁴³

ADVOCACY TIP: Medicaid Eligibility Time Frame

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

4. Eligibility Redeterminations

Once a person is found eligible, the state agency must continue to provide Medicaid benefits until the person is found ineligible.¹⁴⁴ States must consider all possible bases for eligibility before finding an enrollee ineligible for Medicaid.¹⁴⁵

For enrollees whose eligibility is based on MAGI rules, states must redetermine eligibility “once every 12 months, and no more frequently than once every 12 months.”¹⁴⁶ For other enrollees, states must conduct a redetermination at least once a year.¹⁴⁷ In addition, states must promptly re-determine eligibility for an enrollee if they receive information about a change in circumstances that may affect their eligibility.¹⁴⁸

When possible, states must conduct a redetermination without requesting information from the applicant.¹⁴⁹ If a state does not have access to the information necessary to redetermine eligibility for an enrollee subject to MAGI rules, it must provide the enrollee with a renewal form containing the information available to the state and at least 30 days to respond with the necessary information.¹⁵⁰ The state must then verify information furnished by the applicant using the process described earlier.¹⁵¹ If a state terminates eligibility for failure to respond to the renewal form, the state must reconsider eligibility if the enrollee subsequently submits the renewal form within 90 days (or longer at the option of the state) after the date of termination.¹⁵²

5. Presumptive Eligibility

Presumptive eligibility allows states to authorize qualified entities or qualified providers to provide an individual who, based on preliminary information, appears to meet the eligibility criteria for Medicaid coverage to receive immediate, same-day Medicaid services prior to an eligibility determination. States may elect to provide a presumptive eligibility period to certain categories of Medicaid enrollees, including pregnant women, women with breast or cervical cancer, children, and individuals receiving only family planning services and supplies through a family planning state planning amendment (SPA).¹⁵³

The scope of coverage available under presumptive eligibility varies depending on the eligibility group. For pregnant women, presumptive eligibility covers outpatient ambulatory prenatal care including abortions.¹⁵⁴ For other individuals, presumptive eligibility covers all services to which they will be entitled if ultimately found eligible for coverage.¹⁵⁵

ADVOCACY TIP: **Mail-in Applications**

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

Presumptive eligibility coverage begins on the day a qualified provider or a qualified entity makes the preliminary determination that an adult or child is eligible for coverage and can last for up to 60 days.¹⁵⁶ Pregnant women cannot have more than one period of presumptive eligibility per pregnancy.¹⁵⁷ For children, presumptive eligibility continues until the earlier of: (i) the day on which the Medicaid agency makes an eligibility determination or, (ii) if no regular application is filed, the last day of the month following the month during which the qualified provider or qualified entity made the preliminary eligibility determination.¹⁵⁸ The kind of provider or entity that may determine presumptive eligibility varies depending on the eligibility group.¹⁵⁹ Effective January 2014, the Affordable Care Act allows hospitals to make presumptive eligibility determinations in every state for all individuals eligible for Medicaid on the basis of MAGI.¹⁶⁰

When a provider makes a good faith determination that the patient is eligible for Medicaid, the provider will be reimbursed for services provided during the eligibility period even if the patient is ultimately found not eligible or fails to complete the full Medicaid application.

6. Retroactive Eligibility

The Medicaid Act requires that states must pay for Medicaid-covered services provided during the three-month period prior to the month of application if the applicant would have been eligible for Medicaid had they applied for coverage at the time the services were rendered.¹⁶¹ The three-month retroactive coverage period runs backwards from the month the applicant applied and includes covered services provided in or after the third month before the month of application.¹⁶² As of April 2019, ten states eliminated retroactive eligibility through an 1115 waiver.¹⁶³

Endnotes

- 1 Kaiser Family Found., *Women's Health Insurance Coverage* (Dec. 2018), <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>.
- 2 42 U.S.C. § 1396a(a)(10)(A)(i) – (ii).
- 3 See 42 U.S.C. § 1396a(a)(10)(A)(i); CMS, STATE MEDICAID MANUAL §§ 3300-3493.
- 4 For a comprehensive discussion of the mandatory categorically needy eligibility groups, see Nat'l Health Law Prog., *An Advocate's Guide to the Medicaid Program* § 3.3-3.10 (2011).

- 5 See 42 U.S.C. § 1396u-1.
- 6 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), (VI), (VII); 42 U.S.C. § 1396a(l).
- 7 42 U.S.C. §1396a(a)(10)(A)(i)(IX).
- 8 The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No.104-193, § 114,110 Stat. 2105, 2177 (1996); see 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 U.S.C. § 1396u-1; see *also* CMS, STATE MEDICAID MANUAL § 3301.1. Pursuant to the ACA, states have converted their AFDC 1996 financial eligibility criteria to a MAGI eligibility standard. See Section B *infra* for more information on MAGI.
- 9 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120. However, some states have exercised the “209(b) option” to use more restrictive eligibility rules than the SSI program. See 42 U.S.C. § 1396a(f); see also 42 C.F.R. § 435.121.
- 10 See, e.g., 42 U.S.C. § 1383c (establishing eligibility of certain individuals who have lost SSI benefits); see *also* 42 U.S.C. § 1396a(a)(10)(A)(i)(II) (establishing eligibility of “qualified severely impaired individuals”).
- 11 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
- 12 *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 576 U.S. 519 (2012).
- 13 Nat’l Conf. of State Legislatures, *Affordable Care Act Medicaid Expansion* (2017), <http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx>.
- 14 42 U.S.C. § 1396d(y)(1).
- 15 For a comprehensive list of optional categorically needy groups, see Wayne Turner, Nat’l Health Law Prog., *The Advocate’s Guide to MAGI* (Updated 2018) [hereinafter MAGI Guide], <https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/>.
- 16 42 U.S.C. § 1396a(a)(10)(A)(ii)(IX).
- 17 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); 42 U.S.C. § 1396a(aa).
- 18 42 U.S.C. § 1396a(a)(10)(A)(ii)(IV), (V) (establishing eligibility of certain individuals in institutions).
- 19 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXI); 42 U.S.C. § 1396a(ii). See Section 5 *infra* for a fuller explanation.
- 20 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. §§ 435.300-.350; 42 C.F.R. §§ 435,800-.845; 42 C.F.R. §§ 436.800-.845.
- 21 42 U.S.C. § 1396a(a)(10)(C)(ii)(II); 42 C.F.R. §§ 435.301(b)(1)(i)-(ii).
- 22 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.
- 23 42 C.F.R. § 435.603(b).

- 24 42 U.S.C. § 1396a(e)(5)-(6); 42 C.F.R. § 435.170; 42 C.F.R. § 440.210(a)(3).
- 25 42 C.F.R. § 435.117(b).
- 26 42 U.S.C. § 1396a(a)(10)(A)(i)(III); 42 U.S.C. § 1396d(n)(1)(A); 42 U.S.C. § 1396u-1(b)(1)(A); 42 C.F.R. § 435.116(a)(1).
- 27 42 C.F.R. § 435.110.
- 28 42 U.S.C. § 1396a(a)(10)(A)(i)(IV); 42 U.S.C. § 1396a(l)(1)(A)-(C); 42 U.S.C. § 1396a(l)(2)(B). *See also* Amy Chen, Nat'l Health Law Prog., *Q&A on Pregnant Women's Coverage Under Medicaid and the ACA* (Sept. 2018), <https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/>.
- 29 42 U.S.C. § 1396a(a)(10)(A)(i)(IV); 42 U.S.C. § 1396a(l)(1)(A); 42 U.S.C. § 1396a(l)(2)(A)(i); 42 C.F.R. § 435.116.
- 30 42 C.F.R. § 1396a(a)(10)(A)(ii)(IX).
- 31 Kaiser Fam. Found., *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level as of January 2018*, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level>.
- 32 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
- 33 42 C.F.R. § 435.170.
- 34 *Id.*
- 35 Internal Revenue Serv., *Eligibility for Minimum Essential Coverage Under Pregnancy-Based Medicaid and CHIP Programs Notice 2014-71* (Nov. 7, 2014), <https://www.irs.gov/pub/irs-drop/n-14-71.pdf> (clarifying that a QHP enrollee who becomes eligible for pregnancy Medicaid coverage that is considered MEC, will only be considered eligible for MEC if they actually enroll in that coverage. They can thus choose to retain their QHP subsidies rather than enrolling in the Medicaid coverage).
- 36 42 U.S.C. §§ 1396a(a)(10)(C)(ii)(II).
- 37 42 C.F.R. §§ 440.220(a)(1), (a)(5).
- 38 42 U.S.C. § 1396b(v)(4)(A)(i)-(ii).
- 39 As of January 2019, 24 states and the District of Columbia, cover lawfully residing pregnant immigrants without the five-year wait through this option. Kaiser Fam. Found., *Medicaid/CHIP Coverage of Lawfully Residing Immigrant Children and Pregnant Women* (Jan. 1, 2018), <https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women>. *See* Chapter VII, Section B, for more information about pregnancy coverage under ICHIA.
- 40 42 U.S.C. § 1397II(a).

- 41 Kaiser Fam. Found., *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level as of January 2018*, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level>.
- 42 CMS, Dear State Health Official (May 11, 2009)(SHO # 09-006)(guidance on amending CHIP plan to provide coverage for pregnant women), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO051109.pdf>.
- 43 42 U.S.C. § 1396b(v)(1-3). See Chapter VII, Section B, for more information about pregnancy coverage under CHIP.
- 44 This section provides an overview of presumptive eligibility coverage for pregnant women. See Section E5 *supra* for an explanation of presumptive eligibility coverage in general.
- 45 42 U.S.C. § 1396a(a)(47); 42 U.S.C. § 1396r-1.
- 46 42 U.S.C. § 1396r-1(a).
- 47 42 U.S.C. § 1396r-1(c)(2). See also CMS, *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (Jan 2014) [hereinafter CMS FAQs], <https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Hospital-PE-01-23-14.pdf>.
- 48 CMS FAQs, *supra* note 47.
- 49 42 U.S.C. § 1396r-1c(c)(1); See also CMS FAQs, *supra* note 47.
- 50 42 U.S.C. § 1396r-1c(b)(1).
- 51 42 CFR §435.1103(a).
- 52 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914; CMS, STATE MEDICAID MANUAL §§ 2910.
- 53 Guttmacher Inst., *State Laws and Policies: Medicaid Family Planning Eligibility Expansions* (Jan. 1, 2019), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>.
- 54 42 U.S.C. § 1396a(ii); 42 U.S.C. § (10)(G)(XVI); see also July 2010 CMS Letter, *infra* note 55.
- 55 See CMS, Dear State Health Official (July 2, 2010)(SMDL # 18-005) [hereinafter July 2010 CMS Letter] (guidance on family planning services option).
- 56 42 U.S.C. § 1396a(ii)(2); see also July 2010 CMS Letter, *supra* note 55.
- 57 July 2010 CMS Letter, *supra* note 55.
- 58 *Id.*
- 59 42 U.S.C. § 1396r-1c(a); see also July 2010 CMS Letter, *supra* note 55.

- 60 See 42 U.S.C. § 1315(a).
- 61 Florida is the only state where eligibility is based on women losing Medicaid coverage for any reason. Rhode Island and Wyoming deem eligibility if a person loses Medicaid coverage postpartum. Guttmacher Inst., *State Laws and Policies: Medicaid Expansion Family Planning Eligibility Expansions* (Jan. 1, 2019), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>.
- 62 *Id.*
- 63 See Chapter III for a fuller discussion about §1115 demonstration programs.
- 64 This guide uses the term “Marketplace” herein, but the term is interchangeable with “Exchange.”
- 65 See 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603.
- 66 See 42 U.S.C. § 1396a(e)(14)(D).
- 67 MAGI Guide, *supra*, note 15.
- 68 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603(a).
- 69 42 U.S.C. §§ 1396a(e)(14)(A)-(F).
- 70 42 U.S.C. § 1396a(e)(14)(D).
- 71 42 U.S.C. § 1396a(e)(14)(D); 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), 42 U.S.C. § 1396a(aa).
- 72 42 C.F.R. § 435.603(e).
- 73 26 U.S.C. § 36B(d)(2)(B).
- 74 See 26 U.S.C. § 36B(d)(2)(B); 42 C.F.R. § 435.603(e)(2).
- 75 42 U.S.C. § 1396a(e)(14)(B).
- 76 42 U.S.C. § 1396a(e)(14)(C); 42 U.S.C. § 1396a(e)(1)(1).
- 77 42 C.F.R. §§ 435.603(d)(1), (d)(4).
- 78 42 U.S.C. § 1396a(e)(14)(C); 42 C.F.R. § 435.603(g).
- 79 42 C.F.R. § 435.603(h)(1)
- 80 It is important to note that the household composition rules for Medicaid and CHIP differ from those for premium tax credits and cost-sharing reductions. *Compare* 42 C.F.R. § 435.603(b) with 26 U.S.C. § 36B. See MAGI Guide, *supra* note 15 for a detailed overview.
- 81 42 C.F.R. § 435.603(h)(3).
- 82 26 U.S.C. § 36B(d)(2).
- 83 42 C.F.R. § 435.603(h)(2).
- 84 42 C.F.R. § 435.603(h)(3).
- 85 42 U.S.C. § 1396a(ii)(1)(A); 42 C.F.R. § 435.214(c).
- 86 42 C.F.R. § 435.214(c).

- 87 42 C.F.R. § 435.603(b).
- 88 42 C.F.R. § 435.603(d)(1).
- 89 42 C.F.R. § 435.603(d)(2).
- 90 See 42 C.F.R. §435.222; see also CMS, *Answers to Frequently Asked Questions: Telephonic Applications, Medicaid and CHIP Eligibility Policy and 75/25 Federal Matching Rate* (Aug. 9, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-08-09-2013.pdf>.
- 91 CMS posts SPAs approved after June 1, 2009 on its website. See CMS, *Medicaid State Plan Amendments*, <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html> (last visited June 21, 2019).
- 92 Nat'l Health Law Progr., *The Advocate's Guide to the Medicaid Program* (2013), <https://healthlaw.org/resource/advocates-guide-to-the-medicaid-program-agmp/>
- 93 See 42 U.S.C. § 1320b-7(d); 42 U.S.C. § 1396a(b)(3). The citizenship or immigrant status of non-applicant parents or other members of the household are not relevant to a child's eligibility, and states may not require parents to disclose this information. Nat'l Immigration Law Ctr., *Frequently Asked Questions, The Affordable Care Act & Mixed-Status Families* (Dec. 2014) https://www.nilc.org/issues/health-care/aca_mixedstatusfams/.
- 94 42 U.S.C. § 1396b(v)(3)(A)-(C). Emergency Medicaid covers the treatment of an emergency medical condition, which is defined as “a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part.” *Id.*
- 95 8 U.S.C. § 1641(b)(1).
- 96 8 U.S.C. § 1641(b)(2)-(3).
- 97 8 U.S.C. § 1641(b)(7).
- 98 8 U.S.C. §§ 1641(c)(1)-(3).
- 99 8 U.S.C. § 1641(c)(4).
- 100 8 U.S.C. § 1641(b)(6).
- 101 8 U.S.C. § 1641(b)(5).
- 102 8 U.S.C. § 1641(b)(4).
- 103 8 U.S.C. § 1612.
- 104 42 U.S.C. § 1612(b).
- 105 8 U.S.C. § 1613; see also CMS, STATE MEDICAID MANUAL §§ 3211.3, 3211.6.

- 106 Tanya Broder et al., Nat'l Immigration Law Center, *Overview of Immigrant Eligibility for Federal Programs* (Dec. 2015), <https://www.nilc.org/wp-content/uploads/2015/12/overview-immeligfedprograms-2015-12-09.pdf> ("Wyoming, Alabama, Mississippi, North Dakota, Texas, and Virginia do not provide Medicaid to all qualified immigrants who complete the federal five-year ban. Texas and Virginia, however, provide health coverage to lawfully residing children, regardless of their date of entry into the U.S.").
- 107 42 U.S.C. § 1396b(v)(4)(A); see also CMS, Dear State Medicaid Official (July 10, 2010)(SHO # 10-006), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf>.
- 108 See Nat'l Immigration Law Center., *Medical Assistance Programs for Immigrants in Various States* (2015), <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states-2015-09.pdf>.
- 109 20 C.F.R. § 416.1618. PRUCOL is not an immigration category but a benefit eligibility category that describes persons who are in the U.S. with the knowledge of the Department of Homeland Security but have no plans to remove or deport them. Some states provide health coverage for PRUCOLs, and the term is interpreted differently depending on the state and benefit program.
- 110 42 U.S.C. § 1396b(v).
- 111 42 U.S.C. § 1396b(v)(3)(A)-(C). This is the same definition used in the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires each Medicare-participating hospital with an emergency room to conduct a medical examination for any patient who comes to the emergency room to determine if an emergency medical condition exists, to provide stabilizing treatment, and to transfer or discharge the patient only if stabilized. See 42 U.S.C. § 1395dd.
- 112 U.S. Gen. Acct. Office, Pub. No. GAO-04-472, *Undocumented Aliens: Questions Persist About Their Impact on Hospitals' Uncompensated Care Costs* 13, 31-32 (2004), www.gao.gov/new.items/d04472.pdf.
- 113 See *Lewis v. Thompson*, 252 F.3d 567, 580 (2d. Cir. 2001) (finding that Medicaid coverage of emergency medical conditions is narrow and does not include conventional prenatal care).
- 114 42 C.F.R. § 435.403(i)(1).
- 115 42 C.F.R. § 435.403(h).
- 116 42 C.F.R. § 435.403(h)(3).
- 117 42 C.F.R. § 435.956(c)(2).
- 118 42 C.F.R. § 435.909.
- 119 42 C.F.R. §§ 435.905, 435.404.

- 120 42 U.S.C. § 18083; 42 C.F.R. § 435.907(a). For populations and eligibility groups not subject to MAGI, states also have the option to use a single, streamlined application with necessary supplemental forms or a separate application. See 42 C.F.R. § 435.907(c).
- 121 42 C.F.R. § 435.907(g).
- 122 42 C.F.R. § 435.907(a).
- 123 42 C.F.R. §§ 435.907(a)(1)-(5).
- 124 42 C.F.R. § 435.904. “Outstation” locations include federally qualified health centers and hospitals that serve a large number of low-income and uninsured patients
- 125 42 C.F.R. § 435.908.
- 126 42 C.F.R. § 435.907(d). The same requirement applies in the redetermination context. 42 C.F.R. § 435.916(a)(2)(iv).
- 127 42 C.F.R. § 435.910. In certain circumstances, an applicant need not provide a SSN, and the state will provide them with a Medicaid identification number. 42 C.F.R. § 435.910(h). If an applicant cannot recall or does not have a SSN, the state must assist the individual in completing an application for a SSN. 42 C.F.R. § 435.910(e). The state cannot deny or delay services pending issuance or verification of a SSN. 42 C.F.R. § 435.910(f).
- 128 42 C.F.R. § 435.945(a).
- 129 See 42 C.F.R. § 435.945(j) (requiring states to adopt a verification plan).
- 130 See 42 C.F.R. §§ 435.940-960 (setting forth income and eligibility verification requirements).
- 131 42 U.S.C. § 1396a(a)(46); 42 U.S.C. § 1320b-7(d)(1)(A); 42 U.S.C. § (2)(A)-(B); 42 C.F.R. § 435.406(a). For a list of documents constituting satisfactory evidence of citizenship or nationality, see 42 C.F.R. § 435.407.
- 132 42 U.S.C. § 1396b(x)(2). In addition, individuals seeking emergency Medicaid need not present a SSN or document their immigration status. 42 C.F.R. § 435.406(b).
- 133 42 C.F.R. § 435.952(b).
- 134 42 U.S.C. § 1320b-7(d)(4)(A)-(B); 42 C.F.R. § 435.952(c)(2)(iii).
- 135 See CMS, Dear State Health Official (SHO # 09-016) 2-3 (Dec. 28, 2009), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-28-09-corrected.pdf> (guidance on citizenship documentation requirement).
- 136 42 U.S.C. § 1302b-7(d)(5).
- 137 42 U.S.C. § 1396a(ee). See also Donna Cohen Ross, Ctr. on Budget & Pol’y Priorities, *New Citizenship Documentation Option for Medicaid and CHIP Is Up and Running* (Apr. 20, 2010) at 2, <http://www.cbpp.org/sites/default/files/atoms/files/4-20-10health.pdf>.

- 138 42 U.S.C. § 1396a(ee)(1)(B).
- 139 42 U.S.C. § 1396a(ee)(1)(B); see also 2009 CMS letter *supra* note 135 (“States are expected to move forward with enrolling individuals during this verification period and eligibility may not be delayed, denied, or terminated pending the completion of the data matching process.”).
- 140 42 U.S.C. § 1396a(a)(8).
- 141 42 C.F.R. § 435.912(c)(3).
- 142 42 C.F.R. § 435.913.
- 143 42 U.S.C. § 1396a(a)(48).
- 144 42 C.F.R. § 435.930(b).
- 145 42 C.F.R. § 435.916(f)(1). This automatic review process is sometimes referred to as an ex parte redetermination. See, e.g., *Crippen v. Khader*, 741 F.2d 102, 105 (6th Cir. 1984) (citing *Mass. Ass’n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir. 1983); *Stenson v. Blum*, 476 F. Supp. 1331 (S.D.N.Y. 1979).
- 146 42 C.F.R. § 435.916(a).
- 147 42 C.F.R. § 435.916(b).
- 148 42 C.F.R. § 435.916(d).
- 149 42 C.F.R. §§ 435.916(a)(2)-(b).
- 150 42 C.F.R. § 435.916(a)(3)(i)(B). States have the option to follow this process for enrollees not subject to MAGI rules. 42 C.F.R. § 435.916(b).
- 151 42 C.F.R. § 435.916(a)(3)(ii).
- 152 42 C.F.R. § 435.916(a)(3)(iii).
- 153 42 U.S.C. § 1396a(a)(47); 42 U.S.C. § 1396r-1.
- 154 42 U.S.C. § 1396r-1(a). See Chapter IV, Section C for more information about the scope of services covered for pregnant women.
- 155 42 U.S.C. §§ 1396r-1a(a) (children); 42 U.S.C. § 1396r-1b(a) (breast or cervical cancer patients); 42 U.S.C. § 1396r-1c(a) (family planning).
- 156 See 42 U.S.C. §§ 1396r-1(b)(1) (pregnant women), 1396r-1a(b)(2) (children), 1396r-1b(b)(1) (certain breast or cervical cancer patients), 1396r-1c(b)(1) (family planning services). Generally, the qualified provider or entity makes a preliminary determination that the applicant falls within the eligibility group and meets the financial eligibility requirements.
- 157 42 C.F.R. § 435.1103(a).
- 158 42 C.F.R. § 435.1101.
- 159 See 42 U.S.C. §§ 1396r-1(b)(2) (pregnant women); 42 U.S.C. § 1396r-1a(b)(2)(A) (children); 42 U.S.C. § 1396r-1b(b)(2) (breast or cervical cancer patients); 42 U.S.C. § 1396r-1c(b)(2) (family planning).
- 160 42 U.S.C. § 1396a(a)(47)(B); 42 C.F.R. § 435.1110; see also CMS FAQs *supra* note 47.

- 161 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a).
- 162 See CMS, STATE MEDICAID MANUAL § 2910(date of signing outstation application is date of application for retroactive coverage); 42 U.S.C § 1396a(a)(34).
- 163 These states are AR, AZ, FL, IA, IN, KY, MA, ME, NH, and NM. Some of the waivers were approved as part of a broader package to expand coverage with additional protections to encourage enrollment. Sarah Grusin, Nat'l Health Law Prog., *Sec. 1115 Waiver Tracking Chart* (Apr. 2019), <https://healthlaw.org/resource/sec-1115-waiver-tracking-chart-3-2/>.

Chapter III.

Section 1115 Demonstration Waivers

Section 1115 of the Social Security Act allows states to request waivers of certain, but not all, Medicaid requirements in order to test experimental projects that further the longstanding objectives of the Medicaid program. Those objectives are to enable states 1) to furnish medical assistance, as far as practicable, to individuals who lack the income and resources to meet the costs of necessary medical care, and 2) to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.¹

States have used § 1115 waivers to go outside the boundaries of their state Medicaid plans to implement experimental projects designed to expand Medicaid eligibility and services and to improve access to health care. Waiver requests must be approved by the Centers for Medicare & Medicaid Services (CMS), are to have robust evaluation components, and must be budget neutral. CMS's authority to approve waivers is limited:

1. The waiver must implement an “experimental, pilot, or demonstration” project;
2. The waiver must be limited to Medicaid provisions in 42 U.S.C. §1396a;
3. The experiment must be likely to promote Medicaid’s objectives; and
4. The waiver of Medicaid’s requirements must be limited to the extent and period needed to carry out the experiment.²

A. Waiver Approvals Over Time

Early § 1115 Medicaid waivers focused on experimenting with nominal cost sharing.³ Congress later amended the Medicaid Act to add detailed provisions—outside of § 1396a—establishing states’ options for imposing premiums and cost sharing and stated its belief that this would “give[] the Secretary sufficient flexibility in this regard to make further exercise of the Secretary’s demonstration authority unnecessary.”⁴

During the 1990s, the Clinton administration approved a number of states’ requests to implement § 1115 waivers to expand Medicaid coverage to childless adults while transitioning the service delivery system from fee-for-service provider payments to capitated managed care.⁵ Congress subsequently amended the Medicaid Act to describe, in detail, the states’ options for using managed care for providing medical assistance.⁶

The Obama administration approved waivers for Delivery System Reform Incentive Programs designed to improve health outcomes while controlling costs.⁷ Such reforms included quality and value controls in managed care contracts, implementation of health homes for individuals with chronic conditions, and new delivery and payment models for individuals dually eligible for Medicaid and Medicare.⁸ The administration also used § 1115 waivers as a tool for limited Medicaid expansion after the U.S. Supreme Court decided *National Federation of Independent Business v. Sebelius* in 2012.⁹ For example, Arkansas expanded Medicaid coverage using private insurance exchanges and subsidies. Indiana expanded coverage but added conditions on eligibility, including premium payments.¹⁰

Over the years, § 1115 waivers have also been used during emergencies, such as 9/11 and Hurricane Katrina, to enable affected states to get Medicaid to needy individuals quickly and continuously.¹¹

In the reproductive and sexual health context, some states have used or are using § 1115 demonstration projects to expand family planning coverage to certain groups of individuals who were not otherwise eligible for Medicaid. Ten states currently operate expanded family planning programs through § 1115, which have been a critical source of limited Medicaid coverage for individuals seeking a range of reproductive and sexual health care services.¹² These experiments were so effective that Congress included a provision in the ACA allowing states to permanently add coverage of family planning services as a state plan amendment (SPA). As a result, states have been phasing out their use of § 1115 waiver authority in favor of the SPA option to provide family planning services.¹³

States have also used § 1115 to redesign service delivery systems and/or cover services that were not typically covered under a state's Medicaid plan. For example, several states conducted or are currently conducting demonstration projects to provide earlier access to treatment for people living with HIV.

INNOVATIVE APPROACH:

Six states—Arizona, California, Colorado, Maine, Massachusetts, Oregon, and the District of Columbia—have approved § 1115 waivers to provide care for people living with HIV.¹⁴ Each state has taken a different approach to conducting its demonstration, but all sought to provide earlier access to treatment. Maine assigns each enrollee a nurse coordinator to coordinate the social, pharmacy, and medical needs of people living with HIV. The District of Columbia used Department of Defense drug pricing to provide less costly antiretroviral HIV medication.¹⁵

B. Waivers Used to Limit Eligibility and Enrollment

Recent § 1115 waivers under the Trump administration have looked very different compared to past waivers. Several states have applied for—and CMS has approved—projects that impose unprecedented and harmful restrictions on Medicaid enrollees.

If allowed to stand, these waivers could fundamentally transform the nature of the Medicaid program and exacerbate health inequities. Research has shown that Medicaid coverage enables individuals to obtain care and use preventive services such as cervical cancer screenings and family planning.¹⁶ Waivers that limit coverage put women of color, people with disabilities, LGBTQ people, and other underserved populations who rely on Medicaid as their only source of affordable health care coverage at risk.

1. Work requirements

On January 11, 2018, for the first time in the 50-year history of the Medicaid program, the Trump Administration released a policy encouraging states to apply “work and community engagement” requirements to a segment of the state’s Medicaid population. Those subject to the requirement will be terminated from health care coverage unless they meet a monthly minimum of work or volunteer hours and show proof that they worked, looked for work, volunteered, went to school, or participated in a job-training program.

As of January 2019, CMS has approved seven waiver projects with work requirements—Arkansas, Indiana, Kentucky, New Hampshire, Maine, Michigan, and Wisconsin—although most have not yet gone into effect.¹⁷ In early 2018, sixteen Kentucky Medicaid enrollees challenged Kentucky’s demonstration project, the first one CMS approved under the new policy. On June 29, 2018, the D.C. federal court vacated the approval of Kentucky’s waiver project and remanded the matter to HHS for further review.¹⁸ A group of Medicaid enrollees in Arkansas have also filed a lawsuit challenging their state’s CMS-approved project.¹⁹ Ten states have pending waiver proposals that seek to impose work requirements on Medicaid enrollees.²⁰

Work requirements undermine reproductive health and economic security. They are unnecessary and have been shown to be ineffective in other public benefits programs.²¹ Work requirements also create an unnecessary burden on Medicaid enrollees. While the waivers exclude some populations—such as pregnant people, caretakers of dependents or people with disabilities, and people with disabilities—excluded individuals will still be subject to the waiver’s reporting and documentation requirements. These requirements may be so confusing and complex that some will lose their Medicaid coverage because they are unable to navigate these processes and/or unable to meet the administrative requirements to qualify for exemptions. Work requirements are

also unworkable for many low-income workers. For example, women are concentrated in certain low-wage jobs with inconsistent work hours and/or have jobs in the informal economy that do not provide proof of employment. Work requirements also recycle historical stereotypes that stigmatize poor people, people of color and people with chronic and disabling conditions.²²

2. Lockout periods

As of January 2019, seven states—Arkansas, Indiana, Kentucky, Maine, Michigan, New Mexico, and Wisconsin—include lock out penalties in their § 1115 projects. Another two states have pending applications that include this penalty.²³ Lockouts bar otherwise eligible individuals from receiving Medicaid coverage during the lockout period. The length of the lockout period varies from state-to-state and ranges from three to nine months. Lockout periods can apply to individuals who fail to pay premiums, meet work requirements, complete paperwork or report changes in circumstances. For those locked out as a result of failing to meet work requirements, this complication only increases the barriers to finding a stable job that meets the criteria of the state. For most Medicaid enrollees, being locked out of the program means they have no other viable and affordable health care coverage option. Many individuals rely on Medicaid coverage because they do not have access to marketplace coverage. Thus, the disruption of a lockout period can be all the difference in accessing life-saving care.

3. Enrollment Limits

There currently are no time limits in the Medicaid program. However, two states submitted waivers requesting authority to place limits on how long an individual can be enrolled in Medicaid (known as an “enrollment cap”) or how long an individual can receive Medicaid coverage over the course of their lifetime (known as “lifetime limits”).²⁴

Enrollment caps add an unnecessary restriction on eligible individuals seeking Medicaid coverage. These restrictions impose an arbitrary limit on the number of people who can access coverage that has nothing to do with meeting program requirements. Enrollment caps will have a disproportionate impact on women of color, who are more likely to have low incomes and more likely to be enrolled in Medicaid coverage for longer periods of time.

In May 2018, CMS announced it would not approve state requests to impose lifetime limits on Medicaid coverage.²⁵ If, however, CMS were to reverse its policy, approval of the requests would allow those states to limit enrollees to only 36 to 60 months of Medicaid coverage. This means that a single parent working full time at minimum wage and qualifying for Medicaid might lose access to health care for up to five years, even if their job does not offer coverage.

C. Waivers Used to Exclude Abortion Providers

While states are phasing out their use of § 1115 authority to provide family planning services, ten states currently use this authority to expand coverage for individuals seeking family planning services and supplies who are not otherwise eligible for Medicaid.²⁶ Advocates should be troubled, however, that some states are seeking to use family planning waivers to restrict reproductive and sexual health services under Medicaid.

Texas, the first state to apply for such a waiver, submitted a demonstration project application to waive the “freedom of choice” of family planning provider protection in order to exclude abortion providers.²⁷ As of January 2019, Tennessee has also applied for an exclusion, and South Carolina submitted a similar application to CMS. These waivers are a clear attack on Planned Parenthood and other abortion providers. They ignore the longstanding “freedom of choice” protection that allows Medicaid enrollees to seek family planning services from any Medicaid provider, whether or not the provider is in the enrollee’s managed care network.²⁸ If implemented, the Texas waiver would not cover counseling for or provision of emergency contraception and would not pay for family planning services that include a “diagnosis related to elective termination of pregnancy or emergency contraception.”²⁹

D. Waivers Used to Limit Benefits and Increase Costs

1. Elimination of vital services

Several state waiver applications also include proposals to eliminate coverage of key Medicaid benefits, such as non-emergency medical transportation (NEMT) and Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) services for 19 and 20 year-olds.³⁰ NEMT is an important benefit because it provides a means for Medicaid enrollees—such as people with disabilities and people living in rural communities and other areas with limited public transportation options—to travel to their providers to access care.³¹ 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.³² EPSDT covers medical, vision, hearing, and dental screenings, including age-appropriate health education.³³ The elimination of such benefits undermines the Medicaid program and will exacerbate existing health and health care disparities within waiver states.

For example, in an evaluation of Iowa’s NEMT waiver, implemented in 2014, fourteen percent of new Medicaid enrollees with incomes under the federal poverty level (FPL) reported they could not obtain transportation to or from a health care visit.³⁴ An evaluation of Indiana’s NEMT waiver that went into effect in 2015 found six percent of enrollees without state-provided NEMT cited transportation as a reason for missing an appointment in the six months prior to their participation in the survey.³⁵

2. Premiums and co-pays

Several states are also seeking to impose premiums and heightened co-pays on individuals enrolled in Medicaid.³⁶ Under federal Medicaid law, premiums are generally prohibited for individuals with incomes below 150 percent FPL, and certain groups are exempt. Medicaid includes flexibility for states to use copayments, but they must generally be nominal in amount. These protections are in place because individuals enrolled in the Medicaid program lack the financial resources to pay high fees to access care.

Other states have submitted waiver applications to impose emergency department co-pays and/or missed appointment fees on Medicaid enrollees. Kentucky and Wisconsin have received approval for such changes.

Premiums and co-pays impede an individual's access to health care services and their ability to enroll in health insurance. In one study of the Alabama Children's Health Insurance Program, the increase in premiums reduced the number of Black parents who renewed their child's enrollment by 5.9 percent.³⁷ Co-pays deter individuals from seeking the care they need. Studies demonstrate that even small levels of cost-sharing are associated with reduced use of *necessary* health services by low-income people, including preventive and primary care.

E. Public Participation and Transparency

§ 1115 of the Social Security Act and its implementing regulations include detailed requirements regarding transparency and public participation during the development, approval, and monitoring of a demonstration project.³⁸ These requirements were put in place by the ACA, which also directed HHS to promulgate regulations outlining a public notice and comment period at both the state and federal levels that is "sufficient to ensure a meaningful level of public input."³⁹ HHS regulations clarified that the public notice and comment period must include public hearings and written comments.

ADVOCACY TIP:

States and CMS must follow a particular public comment process when developing, reviewing, and approving a waiver request under § 1115. This process includes a 30-day state public notice and comment period before a state submits an application for an initial demonstration or an application to extend an existing demonstration.⁴⁰ After receiving an application, CMS must also provide a 30-day federal public notice and comment period. Thus, advocates have more than one opportunity to get involved with the design and review of § 1115 waiver requests.⁴¹ Make sure to submit written comments, supported by expert opinions and research to the state Medicaid agency, and resubmit your comments again during the federal process.

F. Reduced Oversight and Monitoring

Section 1115 waiver approvals typically include special terms and conditions that require states to submit periodic monitoring and performance reports to CMS. These reports allow CMS and other public stakeholders to oversee and track the effects of the project throughout the demonstration period.

On November 6, 2017, CMS announced a set of “Section 1115 Demonstration Process Improvements” that included expediting the approval of certain proposals and reducing the number and frequency of monitoring reports.⁴² CMS’s new efforts to reduce the state’s administrative burden and “streamline” monitoring and reporting requirements are concerning. Congress intended for approved 1115 waivers to include “a detailed research methodology and comprehensive evaluation for the demonstration.”⁴³ Implementing regulations establish reporting and monitoring procedures designed to ensure that CMS has adequate information concerning both a state’s compliance with these requirements and the effectiveness of the demonstration. The expedited processes announced by CMS threaten to undermine both Congressional intent and CMS’s duly promulgated regulations.

For detailed information about how states are using § 1115 demonstration projects, see NHeLP’s webpage on Medicaid waivers at <http://www.healthlaw.org>

Endnotes

- 1 42 U.S.C. § 1396-1.
- 2 42 U.S.C. § 1315(a).
- 3 Jane Perkins, Nat’l Health Law Prog., *Fact Sheet: Legal Issues in Section 1115 Medicaid Waivers* (2018), <https://healthlaw.org/resource/fact-sheet-legal-issues-in-section-1115-medicaid-waivers/>.
- 4 *Id.* See also Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367 (enacting § 1396o and amending § 1396a(a)(14) to its current form); H.R. Rep. No. 97-757, pt. 1, at 6, 97th Cong. 2nd Sess. 1982, Report on Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982 (August 17, 1982).

- 5 *Id.*
- 6 Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat 251 (amending 42 U.S.C. §§ 1396n and enacting 1396u-2).
- 7 *Id.*
- 8 Alexandra Gates et al., Kaiser Fam. Found., *An Overview of Delivery System Reform Incentive Payment Waivers* (Sep. 29, 2014), <https://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.
- 9 *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) (finding states could not be denied federal funding if they refused to implement the Affordable Care Act's expansion of Medicaid to adults with incomes below 133% of the federal poverty level).
- 10 Perkins, *supra*, note 3.
- 11 *Id.*
- 12 Alabama, Georgia, Florida, Maryland, Mississippi, Montana, Oregon, Rhode Island, Washington, and Wyoming currently have § 1115 family planning waivers. Utah has submitted a § 1115 application to expand their family planning program.
- 13 For information about eligibility for family planning expansion programs, see Chapter II, Section 5.
- 14 *See* HHS, Health Res. and Serv. Admin., *Impact of Medicaid 1115 Waivers on the Ryan White HIV/AIDS Program: Case studies on Experiences of RWHAP Providers and Clients* (2015), <https://hab.hrsa.gov/sites/default/files/hab/Global/medicaidwaivers.pdf>; Jamille Fields & Deborah Reid, Nat'l Health Law Prog., *Earlier Access to Treatment for Women Living with HIV: The Affordable Care Act's Medicaid Expansion and Section 1115 Demonstration Projects* (2015), <https://healthlaw.org/resource/earlier-access-to-care-for-uninsured-women-living-with-hiv-and-the-aca/>.
- 15 Fields & Reid, *supra* note 14.
- 16 Medicaid and CHIP Payment and Access Commission, *Access in Brief: Use of Cervical, Breast, and Colon Cancer tests*, 3 (2016) <https://www.macpac.gov/publication/access-in-brief-use-of-cervical-breast-and-colon-cancer-tests-among-adult-medicaid-enrollees/>; Guttmacher Inst., *Publicly Funded Family Planning Services in the United States* (Sept. 2016), <https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states>.
- 17 Sarah Grusin, Nat'l Health Law Prog., *Sec. 1115 Waiver Tracking Chart* (Jan. 9, 2019) [hereinafter Waiver Tracker], <https://healthlaw.org/resource/sec-1115-waiver-tracking-chart-3-2/>.

- 18 *Stewart v. Azar*, 2018 WL 3203384 (D.D.C. June 29, 2018) (holding the Secretary of HHS's approval was arbitrary and capricious). Nat'l Health Law Prog., Kentucky Equal Justice Center, the Southern Poverty Law Center, and Jenner & Block LLP are representing the Kentucky plaintiffs.
- 19 Nat'l Health Law Prog., Legal Aid of Arkansas, and Southern Poverty Law Center are representing the Arkansas plaintiffs.
- 20 As of January 2019, Alabama, Arizona, Mississippi, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Utah, and Virginia have pending waiver requests. Waiver Tracker, *supra* note 17.
- 21 MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>.
- 22 Vanita Gupta & Fatima Goss Graves, USA TODAY, *Medicaid Work Requirements Are A Throwback to Rejected Racial Stereotypes* (2018), <https://www.usatoday.com/story/opinion/2018/01/11/medicaid-work-requirements-throwback-rejected-racial-stereotypes-gupta-graves-column/1024134001/>.
- 23 As of January 2019, South Dakota and Utah have submitted 1115 waiver applications that include lockouts. Waiver Tracker, *supra* note 17.
- 24 As of January 2019, AZ and UT have pending applications for a limit on the total number of months an individual can received Medicaid over the course of a lifetime. Utah is also seeking an enrollment cap in their waiver application. Kansas included a lifetime limit in their waiver application, however it was rejected. Waiver Tracker, *supra* note 17.
- 25 Nathaniel Weixel, *Trump administration won't approve lifetime limits on Medicaid*, THE HILL, Mar. 15, 2018, <https://thehill.com/policy/healthcare/medicaid/387760-trump-administration-wont-approve-lifetime-limits-on-medicaid>.
- 26 Guttmacher Inst., *Medicaid Family Planning Eligibility Expansions*, <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions> (Jan. 1, 2019).
- 27 Tex. Health & Human Services Comm'n, *Healthy Texas Women Section 1115 Demonstration Waiver Application*, 3, (2017), <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/healthy-texas-women-1115-waiver> [hereinafter Tex. Healthy Texas Women Waiver]. In 2011, Indiana was the first state to seek CMS approval to exclude Medicaid participation of abortion providers through a state plan amendment. CMS denied the request citing the state's violation of the free choice of family planning provider requirement. See CMS, Letter from Donald Berwick, Administrator, to Patricia Casanova, Director of the Indiana Office of Medicaid Policy and Planning (June 1, 2011). Letter on file at NHeLP.

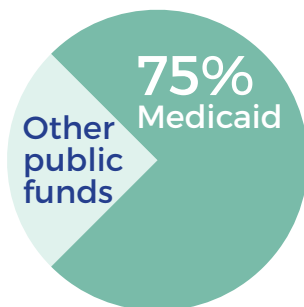
- 28 42 U.S.C. § 1396a(a)(23).
- 29 Tex. Healthy Texas Women Waiver, *supra* note 27, at Attachment B: Benefit Specifications and Provider Qualifications.
- 30 CMS approved waivers of NEMT coverage from Kentucky and Indiana, and is considering waivers from Arizona and Massachusetts. UT has a pending waiver application to eliminate EPSDT requirements for young people under 21 years of age. Waiver Tracker, *supra* note 17.
- 31 42 C.F.R. § 431.53.
- 32 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 42 C.F.R. § 457.70(a). As of the writing of this guide, nine states and the District of Columbia operate CHIP as an expansion of Medicaid, two states operate CHIP as a separate program, and 39 states, as a combination of the two approaches. See Medicaid & CHIP Payment & Access Comm’n, *FactSheet: State Children’s Health Insurance Program (CHIP) 1* (2017), <https://www.macpac.gov/publication/state-childrens-health-insurance-program-chip-fact-sheet/>.
- 33 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(b), 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.
- 34 Suzanne Bentler et al., Univ. of Iowa Public Policy Center, *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan at 23* (March 2016), https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health.
- 35 The Lewin Group, *Indiana 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver*, Prepared for Indiana Family and Social Services Administration, Executive Summary, 4 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-evl-rpt-11022016.pdf>.
- 36 As of January 2019, Kentucky, Indiana, Maine, Michigan, New Mexico, and Wisconsin have received approval to impose premiums on individuals with incomes under 150 percent FPL. North Carolina and Virginia are seeking similar proposals. Waiver Tracker, *supra* note 17.
- 37 Michael A. Morrissey et al., *The Effects of Premium Changes on ALL Kids, Alabama’s CHIP Program*, 2 MEDICARE & MEDICAID RES. REV. E12 (2012), https://www.cms.gov/mmrr/Downloads/MMRR2012_002_03_A01.pdf.
- 38 42 U.S.C. § 1315(a). For more information, see Catherine McKee & Jane Perkins, Nat’l Health Law Prog., *Waiver Requests: Transparency & Opportunity for Public Comment* (2017), <https://healthlaw.org/resource/sec-1115-waiver-requests-transparency-opportunity-for-public-comment/>.

- 39 42 U.S.C. § 1315(d)(2)(A), (C).
- 40 42 C.F.R. § 431.408(a).
- 41 Jane Perkins & Catherine McKee, Nat'l Health Law Prog., *Section 1115 Waiver Requests: Transparency and Opportunity for Public Comment* (Apr. 2017), <https://healthlaw.org/resource/sec-1115-waiver-requests-transparency-opportunity-for-public-comment/>.
- 42 CMS, CMCS Informational Bulletin, Section 1115 Demonstration Process Improvements (Nov. 6, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf>.
- 43 H. R. Rep. No. 3982, pt. 2 at 307-08 (1981).

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 product 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

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.

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

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-medicaid-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%22colId%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-abortion_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/ccioo/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).
- 233 States must agree that if a charge is imposed for screening services, it will be adjusted to reflect the income of the woman and will not be imposed if a woman's income is less than 100 percent of the federal poverty level. 42 U.S.C. § 300n.
- 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>.
- 253 *Id.* at 147.
- 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>.
- 256 NIH Women of Color Health Data Book, at 147.

- 257 For a general overview of Medicaid coverage of behavioral health services, see CMS, Behavioral Health Services, <https://www.medicaid.gov/medicaid/benefits/bhs/index.html> (last visited Jun. 23, 2019). For a description of inpatient psychiatric services for individuals under age 21, see CMS, Inpatient Psychiatric Services for Individuals Under Age 21, <https://www.medicaid.gov/medicaid/ltss/institutional/psych-under-21/index.html> (last visited Jun. 23, 2019).
- 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).

Chapter V: Reproductive and Sexual Health Services for the Medicaid Expansion Population

The Deficit Reduction Act (DRA) of 2005 gave states flexibility to develop alternative Medicaid benefit packages for select groups of Medicaid enrollees that differ from the state's existing plan.¹ These Alternative Benefit Plans (ABPs), formerly known as Medicaid benchmarks, gained new significance under the ACA. Prior to the ACA, only a few states had selected the option to provide Medicaid benchmark benefits to enrollees in their state. With the enactment of the ACA, states that expand their Medicaid program must now offer ABPs to the newly eligible Medicaid population.² Thus, ABPs are important because they are the basis of benefits packages for some existing Medicaid populations at state option (as initially provided under the DRA of 2005) and the newly eligible Medicaid expansion population (as provided under the ACA).³

Most newly eligible Medicaid populations—those residing in states that have expanded their Medicaid program—are enrolled in Medicaid programs that have aligned their benefits.⁴ “Aligned benefits” means the state modeled its ABP package after the state's existing Medicaid state plan benefits rather than after a public employee or commercial market plan. Alignment of benefits can be advantageous for a number of reasons, including ensuring comprehensive services for enrollees, minimizing disruption for individuals moving among different eligibility categories, and reducing the state's administrative burden. However, “alignment” does not mean benefits are identical. It means the ABP includes all of the state plan services, but may include additional services as well.

States that offer “non-aligned” benefits, i.e., they do not model their ABP package after the state's existing Medicaid state plan benefits, must establish a process to identify exempt populations.⁵ For example, pregnant women, individuals who are blind or have a disability, women in the breast or cervical cancer program, and medically needy or spend-down populations are considered “exempt” for ABP purposes.⁶ States cannot require these and other groups of exempt individuals to enroll in the state's approved ABP package, but must create a process to identify and notify these individuals of their benefits options.

A. ABPs and Essential Health Benefits

The ACA also included a requirement that ABPs provide, at a minimum, coverage for a core set of basic services known as Essential Health Benefits (EHBs). This requirement ensures that individuals enrolled through their state's Medicaid expansion program receive coverage for the following ten categories of service the ACA deemed as “essential”:

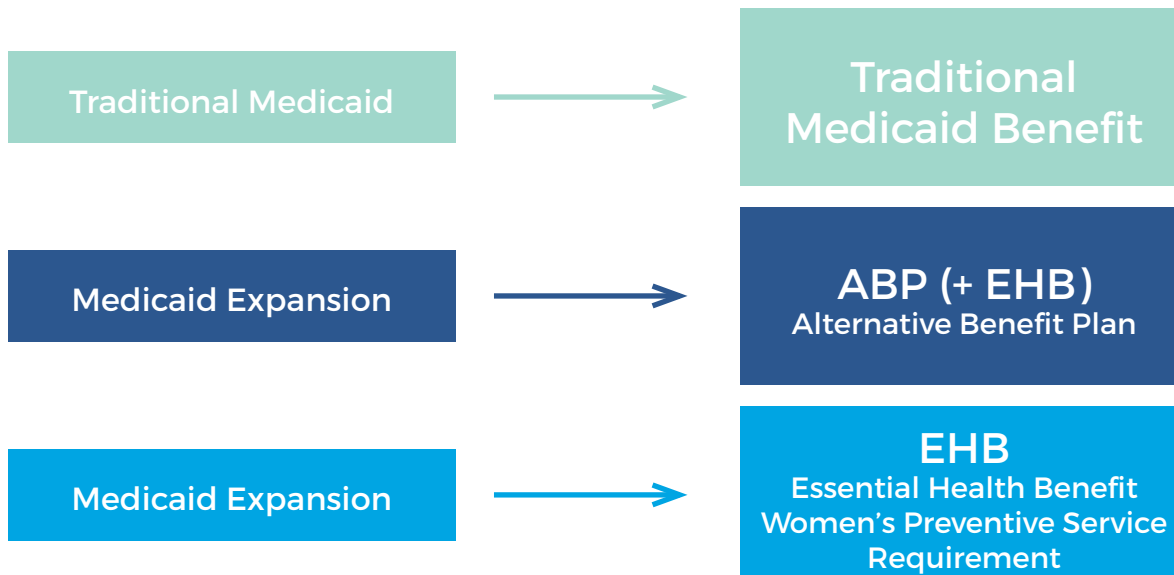
EHB TEN STATUTORY CATEGORIES OF BENEFITS

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services (including chronic disease management); and
10. Pediatric services, including oral and vision care.

In the EHB final rule of 2013, HHS tied the EHB's preventive service requirement to the ACA's preventive services requirement in §2713 of the Public Health Service Act (PHSA).⁷ To comply with §2713 of the PHSA, plans that are subject to the requirement, including ABPs, must cover:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA.

THREE BIG BUCKETS OF BENEFITS



B. ABPs and Preventive Services for Women

Section 2713 requires ABPs to cover a range of preventive services for adults and children.⁸ ABPs may not impose cost sharing on Medicaid enrollees who seek such services. As described, the EHBs also incorporate through regulation the additional ACA requirement that cover women's preventive services.⁹ This requirement ensures a specific set of preventive services for women are also covered without cost-sharing.¹⁰ The required services are based on a set of recommendations from the Health Resources and Services Administration (HRSA).¹¹ These services are listed below:¹²

PREVENTIVE SERVICE	DESCRIPTION
Breast Cancer Screening for Average-Risk Women	Annual or biennial mammography screening for average-risk women ages 40-74 in consultation with health care provider.
Breastfeeding Services and Supplies	Comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period).
Screening for Cervical Cancer	Cervical cancer screening for average-risk women ages 21-65 years.

PREVENTIVE SERVICE	DESCRIPTION
Contraception	Full range of female-controlled FDA-approved contraceptive methods (18 prescribed methods), sterilization procedures, and effective family planning practices for adolescent and adult women. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., management, and evaluation as well as changes to and removal or discontinuation of the contraceptive method).
Screening for Gestational Diabetes Mellitus	Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation. Women with risk factors for gestational diabetes should be screened at the first prenatal visit.
Screening for Human Immunodeficiency Virus	Annual counseling and testing for HIV for all sexually active adolescents and women throughout the lifespan.
Screening for Interpersonal and Domestic Violence	Annual screening and counseling for interpersonal and domestic violence for adolescents and women. ¹³ When needed, provide or make referrals for initial intervention services.
Counseling for Sexually Transmitted Infections (STIs)	Directed behavioral counseling for all sexually active adolescents and adult women at an increased risk for STIs based on sexual history and risk factors.
Well-Woman Preventive Visits	Annual preventive care visit beginning in adolescence and continuing across the lifespan to obtain recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.

Preventive services are an important benefit for all cisgender and transgender women, and women of color in particular. Women of color are more likely to suffer from preventable health conditions and to delay/forgo care due to the cost of care. The median time of survival for black women who are diagnosed with breast cancer is nearly three years shorter than that of white women. Researchers in the *Journal of the American Medical Association* attributed this disparity, in part, to more advanced disease at the time of diagnosis.¹⁴ The ACA's requirements to cover a range of women's preventive services—including mammograms, cancer screenings, and well-woman visits—with no out-of-pocket costs will help more women of color receive an earlier diagnosis and treatment. Further, the overlapping requirement for Medicaid ABPs to comply with both the preventive services requirement and Medicaid's requirement to cover family planning services and supplies helps to ensure that women enrolled in ABPs are guaranteed coverage for a range of preventive services that most commercial insurance plans must also cover under the ACA.¹⁵

Importantly, the women's preventive services requirement to provide contraception with no cost sharing covers the full range of 18 FDA-approved contraceptive methods used by women, including female sterilization and contraceptives that are generally available over-the-counter and prescribed to women.¹⁶ Additionally, HHS has clarified that the ACA contraceptive coverage requirement includes related follow-up and side effect management, and device removal.¹⁷

Yet, the federal requirement also lacks some important coverage groups and services. For example, while the women's preventive service requirement cannot be limited to an individual's sex assigned at birth, gender identity, or recorded gender when medically appropriate, it does not extend to men or include male methods of contraception.¹⁸ Medicaid managed care plans are also permitted to use "reasonable medical management techniques" as a way to limit enrollee's usage of preventive services and control costs.¹⁹ As a result, plans may limit no-cost coverage to only one form of contraception in each of the FDA-approved contraceptive method categories, as long as doing so would be medically appropriate.²⁰ A more detailed review of utilization controls in family planning is provided in Chapter IV, Section B5.

Endnotes

- 1 42 U.S.C. § 1396u-7 (added by Deficit Reduction Act § 6044 and amended by CHIPRA § 611 and ACA §§ 2001, 2303); 42 C.F.R. §§ 440.300-440.390 (eff. July 1, 2010) (added by Benchmark Benefit and Benchmark-Equivalent Coverage, 73 Fed. Reg. 73724 (Dec. 3, 2008), as amended by 74 Fed. Reg. 5809 (Feb. 2, 2009); 74 Fed. Reg. 15221 (Apr. 3, 2009), 74 Fed. Reg. 62501 (Nov. 30, 2009), and 75 Fed. Reg. 23101 (Apr. 30, 2010)).
- 2 See ACA § 2001(a)(2) (adding 42 U.S.C. § 1396a(k)(1)). Individuals who fall within one of the 42 U.S.C. § 1396u-7 excluded groups cannot be required to enroll into benchmark coverage. See 42 U.S.C. § 1396a(k)(1); CMS, Dear State Medicaid Director at 3 (SMDL # 10-005) (Apr. 9, 2010), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smdl10005.pdf>.
- 3 See Michelle Lilienfeld, Nat'l Health Law Prog., *Alternative Benefit Plans for the Medicaid Expansion Population* (2014), <https://healthlaw.org/resource/alternative-benefit-plans-for-the-medicaid-expansion-population/> [hereinafter Lilienfeld, *Alternative Benefit Plans*].
- 4 Lilienfeld, *Alternative Benefit Plans*, *supra* note 3.
- 5 For a list of ABP coverage options for states that opt not to align, see Michelle Lilienfeld, Nat'l Health Law Prog., *Health Advocate: Alternative Benefit Plans*, <https://healthlaw.org/resource/health-advocate-alternative-benefit-plans/>.
- 6 42 U.S.C. § 1396a(k)(1). Enrollees in the new adult expansion group who meet an ABP exemption “must be given the option of an Alternative Benefit Plan that includes all benefits available under the approved State plan” instead of being required to receive the ABP that the state has selected for the expansion group. See 42 C.F.R. § 440.315; see generally Lilienfeld, *Alternative Benefit Plans*, *supra* note 3.
- 7 45 C.F.R. § 156.115(a)(4). Plans required to cover the ten EHB categories must also provide benefits that “include preventive services described in [45 C.F.R. § 147.130].” 45 C.F.R. § 147.130 lists what the services plans need to cover in order to comply with § 2713 of the PHSA.
- 8 ACA § 1001 (adding § 2713 of the Public Health Services Act) (codified at 42 U.S.C. § 300gg-13(a)).

- 9 45 C.F.R. § 156.115(a)(4). For a fuller explanation of this coverage requirement see Nat'l Health Law Prog, *Q and A: Preventive Services for Women Coverage Requirements (Updated)* (July 2013), <https://healthlaw.org/resource/q-a-preventive-services-for-women-coverage-requirements-updated/>. The ACA' coverage for preventive services applies to "women," however joint federal guidance clarified that sex-specific recommended preventive care cannot be based on an individual's assigned at birth sex, gender identity, or government-recorded gender. See U.S. Dep't of Labor, HHS, and Treasury, *FAQs About Affordable Care Act Implementation* (Part XXVI) at 6, (May 11, 2015) [hereinafter Joint FAQs Part XXVI], https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf.
- 10 U.S. Dep't of Labor, HHS, and Treasury, *Frequently Asked Questions about Affordable Care Act Implementation* (Part XII) (Feb. 20, 2013) [hereinafter Joint FAQs Part XII], <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf>.
- 11 HRSA's initial recommendations were adopted in 2011 from an expert committee convened by the Institutes of Medicine (IOM). See IOM, *Clinical Preventive Services for Women: Closing the Gaps* (July 19, 2011), <http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx>. HRSA subsequently updated the guidelines in 2016 based on recommendations from the Women's Preventive Services Initiative, a committee convened by the American College of Obstetricians and Gynecologists. See Women's Preventive Services Initiative, *Recommendations for Preventive Services for Women* (2017), <https://www.womenspreventivehealth.org/final-report/>.
- 12 HRSA, *Women's Preventive Services Guidelines* webpage, <https://www.hrsa.gov/womens-guidelines/index.html> (last visited Jun. 24, 2019).
- 13 Interpersonal violence screenings involve the patient answering a series of questions, either self-administered or in response to provider prompts, to discern signs of abuse. For many women, interpersonal violence and HIV are often a cyclical intersection. Women in violent relationships are four times more likely than women in non-violent relationships to contract STIs, including HIV. Interpersonal violence among women with HIV is more than double the national rate. Thus, the ACA preventive service requirement to cover interpersonal violence screenings can help address the risk for HIV infection. See Lindsey Dawson & Jennifer Kates, Kaiser Family Found., *HIV, Intimate Partner Violence, and Women: New Opportunities under the Affordable Care Act* (Oct. 21, 2014), <http://kff.org/hiv/aids/issue-brief/hiv-intimate-partner-violence-and-women-new-opportunities-under-the-affordable-care-act/>.

- 14 Jeffrey Silber, et al., *Characteristics Associated with Differences in Survival Among Black and White Women with Breast Cancer*, JAMA 310(4), 389-397 (2013); Erin Armstrong, Network for Public Health, *How Affordable Care Act Requirements May Help Address Health Disparities* (Aug. 27, 2013), https://www.networkforphl.org/the_network_blog/2013/08/27/231/how_affordable_care_act_requirements_may_help_address_health_disparities.
- 15 42 C.F.R. § 440.345(b) (requiring that Alternative Benefit Plans cover family planning services and supplies).
- 16 Joint FAQs (XII), *supra* note 10 at 7.
- 17 *Id.* at 8.
- 18 Joint FAQs (Part XXVI), *supra* note 9.
- 19 The extent of permissible medical management techniques is not defined, however federal regulations and guidelines permit plans and issuers to determine the “frequency, method, treatment, or setting” in which the service is delivered. 45 C.F.R. § 147.130(a)(4).
- 20 Joint FAQs (XII), *supra* note 10, at 7.

Chapter VI:

Access to Care

Even with Medicaid coverage, many enrollees face barriers to accessing comprehensive reproductive and sexual health care. An individual may have a provider who refuses to provide a specific family planning service, or they may encounter discrimination because of their gender identity. People with limited English proficiency often encounter challenges communicating with their provider, and many Medicaid enrollees reside in areas with limited public transportation options.

A. Refusal Clauses/Religious Exemptions

Refusal clauses or so-called “conscience clauses” are state and federal statutes or regulations that shield individuals and institutions from liability for failing to provide health services, counseling, and/or referrals that they would otherwise have a duty to provide as medical professionals and that patients would normally expect as part of their care. Refusal clauses permit a provider’s personal or religious belief, or an institution’s ideological or religious fidelity, to trump patient need, evidence, or medical conditions. Refusals often directly contradict medical practice guidelines and standards of care.¹

While people of all socio-economic levels are negatively impacted by refusals, people with low incomes, women of color, and LGBTQ individuals are disproportionately harmed because they may be unable to access alternative sources of care.

1. Federal Refusal Clauses

The first major federal refusal clauses were adopted in 1973 shortly after the landmark Supreme Court decision, *Roe v. Wade*.² A federal law commonly known as the Church Amendment (named after its author, Senator Frank Church) was enacted to prohibit the federal government from conditioning the receipt of certain federal funds to institutions and individuals on the provision of abortion and sterilization services.³ It further prohibits “discrimination” against providers for their refusal or their willingness to participate in abortions and sterilizations. The Church Amendment also allows individuals to refuse to “perform or assist in the performance of a health care service program or research activity to which they have a religious or personal moral objection.”⁴

Congress added another refusal provision, the Weldon Amendment, as an annual rider that was first attached to the 2005 Federal Appropriations Act. It prohibits “discrimination” by any federal agency or state or local government against an entity or individual who refuses to provide, pay for, provide coverage for, or provide referrals for abortion services.⁵

The Office for Civil Rights is designated to receive and investigate complaints of violations of the Church and Weldon Amendments.⁶ There are no laws that protect providers from discrimination for providing abortion or sterilization services. These refusal clauses already allow health professionals, personnel, and institutions to refuse to provide services that they would otherwise be required to provide under law or medical guidelines.

Despite these long-standing protections, the Trump administration has issued new regulations and initiatives that expand the application of religious and moral refusals. In October 2017, HHS released new regulations that allow various non-profit and private entities to opt out of the ACA’s contraceptive coverage requirement. The regulations were a response to two cases brought by religious employers, *Burwell v. Hobby Lobby* and *Zubik v. Burwell*. In *Hobby Lobby*, the U.S. Supreme Court allowed certain employers to deny its employees’ contraceptive coverage based on religious beliefs.⁷ The U.S. Supreme Court in *Zubik v. Burwell* vacated the lower court’s ruling and remanded the six cases that had been consolidated under that title to their respective courts of appeals with the instruction to “arrive at an approach going forward that accommodates petitioners’ religious exercise while at the same time ensuring that women covered by petitioners’ health plans receive full and equal health coverage, including contraceptive coverage.”⁸

Under the new rules, most employers, insurers and universities with “sincerely held religious beliefs” or “moral convictions” may exclude some or all contraceptive methods and services from their health plan if the employer has a moral or religious objection.⁹ HHS also created in January 2018 a new Conscience and Religious Freedom Division (“Division”) within the Office for Civil Rights (OCR) to enforce federal laws “protecting the rights of conscience and religious freedom.”¹⁰ While the HHS rules have been temporarily enjoined and the new Division has not yet taken any enforcement action, these changes will undoubtedly have a detrimental impact on women, LGBTQ and GNC individuals, and other people in need of sexual and reproductive health services, gender-affirming care, end-of-life care. More recently, on June 14, 2019, OCR proposed numerous revisions to the regulations implementing the non-discrimination provision of the ACA (§ 1557). The proposal includes exempting any religiously-affiliated hospital, clinic, or health insurance company from complying with the sex discrimination provisions of § 1557 and allowing covered entities from turning people away because of their gender identity or sexual orientation, or because they had an abortion.¹¹

2. State Refusal Clauses

Most states have enacted refusal clauses that allow health care providers and institutions to refuse to provide abortion services. A smaller number of states allow providers and institutions to refuse to provide contraception or sterilization services. Some states also allow pharmacists to refuse to fill prescriptions for birth control, nurses to refuse to provide information or referrals to patients, and emergency rooms to refuse to provide emergency contraception to victims of sexual assault.¹² A few states have very broad refusal clauses that allow virtually anyone in the health care system to refuse to participate in any service to which they have an objection. In Mississippi, for example, an admitting clerk can refuse to admit a patient into a hospital if the clerk objects to the service the patient is going to receive.¹³

Some refusal clauses also allow providers to opt out of providing counseling, information, and referrals.¹⁴ These refusals shield providers from complying with legal and ethical mandates regarding informed consent and the requirement to inform patients of all reasonable treatment options.

POLICIES ALLOWING PROVIDERS TO REFUSE							
STATE	REFUSAL						
	Abortion		Contraception			Sterilization	
	Individual Provider	Institution	Individual Provider	Pharmacist	Institution	Individual Provider	Institution
Federal Policy	X	X				X	X
Alabama	X	X					
Alaska	X	Private					
Arizona	X [†]	X [‡]	X	X	X		
Arkansas	X	X	X	X	Private	X	X
California	X	Religious					
Colorado			X	*	Private		
Connecticut	X						
Delaware	X	X					
Florida	X	X	X	*			
Georgia	X	X		X		X	X
Hawaii	X	X					
Idaho	X	X	X	X		X	X
Illinois	X	X	X	*	X	X	X
Indiana	X	Private					
Iowa	X	Private					
Kansas	X	X	*†	*†		X	X
Kentucky	X	X				X	
Louisiana	X	X					
Maine	X	X	X	*	Private	X	X
Maryland	X	X				X	X
Massachusetts	X	Private			Private	X	Private
Michigan	X	X					
Minnesota	X	Private					
Mississippi	X	X	X	X	X	X	X
Missouri	X	X					
Montana	X	Private				X	Private
Nebraska	X	X					
Nevada	X	Private					
New Jersey	X	Private				X	Private
New Mexico	X	X					X
New York	X	X					
North Carolina	X	X					
North Dakota	X	X					
Ohio	X	X					
Oklahoma	X	X					
Oregon	X	Private					

POLICIES ALLOWING PROVIDERS TO REFUSE

STATE	REFUSAL						
	Abortion		Contraception			Sterilization	
	Individual Provider	Institution	Individual Provider	Pharmacist	Institution	Individual Provider	Institution
Pennsylvania	X	Private				X	Private
Rhode Island	X					X	
South Carolina	X	Private					
South Dakota	X	X		X			
Tennessee	X	X	X	*	Private		
Texas	X	Private					
Utah	X	X					
Virginia	X	X					
Washington	X	X				X	X
West Virginia						X	X
Wisconsin	X	X				X	X
Wyoming	X	Private					
STATE TOTAL	46	44	9	6	8	17	16

Note: Unless indicated, the right to refuse applies to all institutions-private, religious and public.

* A broadly worded refusal clause may apply. In Illinois a state court held that a regulation requiring pharmacies to provide emergency contraception cannot be enforced against pharmacies that refuse to dispense the medication.

‡ In Arizona private hospitals and health facilities may restrict the information providers give to patients about lawful health care services if the institution's objection to providing the information is based on sincerely held religious or moral beliefs.

† The law permits refusal if the provider "reasonably believes" the drug or device "may result" in an abortion.

Source: Guttmacher Inst., *Refusing to Provide Health Services* (as of July 1, 2019), <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>

3. Institutional Restrictions

The largest group of restrictions, and the ones that have the greatest impact on access to care, are imposed by institutions controlled by some religious entities.¹⁵ These institutions prohibit the delivery of many reproductive and sexual health services on their premises. The impact is that they interfere with the ability of health care providers to deliver care that meets accepted medical practice guidelines. The broadest religiously based health care restrictions are those imposed by Catholic health systems. According to the Catholic Health Association, the Catholic health ministry is "comprised of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states" and is "the largest group of nonprofit health care providers in the nation."¹⁶ One in seven patients in the U.S. is cared for in a Catholic hospital each day.

Catholic health facilities are governed by the Ethical and Religious Directives for Catholic Health Care Services (the Directives). Promulgated by the U.S. Conference of Catholic Bishops, the Directives impose religious doctrine on health care delivery.¹⁷ The Directives specify a range of services that are prohibited, including family planning (even to prevent pregnancy as a result of a rape), sterilization, abortion, assisted reproductive technology, the distribution of condoms even when intended to prevent HIV/AIDS or other sexually transmitted infections, and some end of life decisions. The prohibition on abortion applies to any direct termination of any pregnancy; there are no exceptions for rape, incest, the health or life of the woman, or the condition of the fetus. Under the Directives, treatment options are not subject to patient control or physician recommendation. Physicians must agree to abide by the Directives in order to obtain admitting privileges, and other health care workers are contractually bound by them as a condition of employment.

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

ADVOCACY TIP:

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

B. Non-Discrimination Protections Under ACA § 1557

This section is current as of June 21, 2019. On June 14, 2019, HHS published a proposed rule that would undermine or repeal key provisions of a regulation issued under the ACA's nondiscrimination provision, § 1557.¹⁸ NHeLP is actively working to defend against the proposed rollbacks and will update this section accordingly.

The Affordable Care Act (“ACA”) includes a nondiscrimination provision, § 1557, which prohibits discrimination on the basis of race, color, national origin (including immigration status and English language proficiency), sex, age, and disability.¹⁹ Section 1557 builds on and references four longstanding federal civil rights laws and their implementing regulations: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.²⁰ Section 1557 applies to health care programs and activities receiving federal financial assistance or funding; programs administered by the federal government, including Medicaid and Medicare; and entities created under Title I of the ACA. Covered entities include hospitals, clinics, and health care provider’s offices; and issuers selling health insurance plans within and outside of the ACA Marketplaces.²¹ If an entity is principally engaged in providing or administering health services or health insurance coverage, the current regulations state that all of its activities are covered by § 1557 if any part receives federal financial assistance.²²

Importantly, § 1557 extends prohibitions against sex discrimination in health care and applies those and other nondiscrimination provisions directly to the Marketplaces and health programs that HHS administers. Section 1557 is therefore the first federal civil rights law to prohibit discrimination on the basis of sex in health care.

Section 1557 of the Affordable Care Act is the first federal civil rights law to prohibit sex discrimination in health care.

HHS issued a final rule in May 2016 prohibiting discrimination on the basis of, among other factors, pregnancy, termination of pregnancy, and recovery from pregnancy, childbirth, or related medical conditions.²³ The final 2016 rule also makes clear that § 1557 explicitly prohibits discrimination on the basis of gender identity and sex stereotyping.²⁴ These protections include a prohibition on insurance plan exclusions that categorically exclude transgender individuals from coverage for health care services related to gender transition. The regulation also requires health care providers and insurance carriers to provide medically necessary services regardless of an individual's sex assigned at birth, gender identity, or legal gender marker.²⁵ For example, a transgender man cannot be denied treatment for ovarian cancer. In addition, there is a requirement to treat transgender individuals in accordance with their gender identity in, for example, assigning hospital rooms.

The final rule was less groundbreaking as to whether § 1557's prohibition of sex discrimination encompasses discrimination on the basis of sexual orientation; HHS sought comment in the proposed regulation as to whether it should, and ultimately decided to monitor evolving legal landscape on this issue before ruling definitively. Recent decisions from both the Equal Employment Opportunity Commission and some federal courts, however, indicate that the answer is "yes," sex discrimination includes sexual orientation.²⁶

Section 1557 is an important tool for women, LGBTQ individuals, people of color, people with disabilities, individuals with limited proficiency in English, and other communities to bring claims against discriminatory actions rooted in several categories. Section 1557 provides a private cause of action whereby individuals who experience discrimination can file in federal court.²⁷ The June 14, 2019 proposed rule, eliminates this provision, however multiple courts have found that § 1557 provides a private cause of action.²⁸ The new rule also proposes to limit the remedies available to persons who experience discrimination and seeks to preclude many disparate impact and most intersectional claims.

Despite the proposed changes, § 1557 is still the law. Individuals who experience discrimination may still file an administrative complaint with their state insurance commission, HHS' Office for Civil Rights, or may seek enforcement § 1557 in federal court.

C. Language Access for People with Limited English Proficiency

Language-related barriers may severely limit an individual's opportunity to access health care, assess options, express choices, and ask questions or seek assistance. These barriers also apply in the family planning context.²⁹ Over 25

million people in the U.S. are limited English proficient (LEP), meaning they speak English less than “very well.”³⁰

In the health care context, an individual is limited English proficient if they are unable to speak, read, write English at a level necessary for interactions with health care entities/providers. Language access encompasses the array of services that may be provided to an LEP individual to ensure access. Language access can include oral interpreting, written translations, provision of services directly in a non-English language, and taglines.

Title VI of the Civil Rights Act of 1964 provides that “no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”³¹ Discrimination under Title VI has been interpreted to include preventing meaningful access to federally funded services for “national origin minorities” and those with limited English proficiency.³² Programs that receive federal funding – including Medicaid, CHIP, Marketplaces, and Title X family planning clinics – must take reasonable steps to ensure that people with limited English proficiency have meaningful access to their programs and services. As of 2008, 35 states had enacted one or more laws that address women’s health services for LEP individuals.³³

The nondiscrimination language in § 1557 of the ACA explicitly extends the protections of Title VI to the health insurance Marketplaces, the qualified health plans that participate in them, and federally administered programs.³⁴ Current § 1557 regulations require covered entities to take reasonable steps to provide meaningful access to each LEP individual eligible to be served or likely to be encountered.³⁵ These can include taglines on all significant documents, translation services, and access to qualified interpreters.³⁶ Current regulations also require covered entities to post notices informing patients of the availability of language access services, as well as auxiliary aids and services for people with disabilities.

The June 14, 2019 proposed changes to the § 1557 rule significantly weakens protections for individuals who are LEP. The proposed rulemaking seeks to remove requirements for taglines and posted notices.³⁷ It also eliminates recommendations that covered entities develop language access plans to help them be prepared to meet the needs of individuals with LEP.

Regardless of the potential changes to the § 1557 regulation, Medicaid agencies, health plans, and health care providers are still subject to a number of legal and regulatory requirements to provide meaningful access to LEP individuals.³⁸ Information about the Medicaid program (in particular, long-term care services and childhood preventive care) must be provided in a language that applicants and enrollees can understand, and delivered in a culturally appropriate

manner.³⁹ Federal guidelines require that state Medicaid agencies and contractors such as Medicaid managed care plans provide both oral and written communication to LEP applicants to ensure that those entitled to receive Medicaid are not denied due to language barriers.⁴⁰

To comply with the federal guidelines regarding written materials, state Medicaid programs should, at a minimum, provide written translations of “vital” documents (e.g., applications, intake forms, consent and complaint forms, eligibility and service notices) into the languages spoken by significant LEP populations in the state.⁴¹

ADVOCACY TIP: State Language Access Protections

Every state and the District of Columbia has enacted laws that have recognized the need for linguistically appropriate health care and have adopted measures that require or encourage health and social service providers to overcome language barriers. Check out NHeLP's [updated 50-State Summary](#) of state laws and regulations regarding services to LEP persons in health care settings.

State Medicaid programs must also inform LEP Medicaid enrollees that they are entitled to an interpreter. However, state Medicaid agencies do not have to actually pay for interpreters in Medicaid provider offices (although the state itself must provide language services in its Medicaid offices). Enrollees may designate family or friends to interpret; however, HHS regulations prohibit the use of minors (under age 18) except in emergencies and adults accompanying patients except in emergencies or with patient consent.⁴² Often, these individuals may not understand the role of an interpreter or have sufficient proficiency in both languages, including medical terminology, to provide accurate interpretation.⁴³

States have the option of claiming Medicaid and/or CHIP reimbursement for the cost of interpreting services either as an administrative expense or optional covered service.⁴⁴ States that designate language services as an “administrative service” can be reimbursed 50 percent of their costs from the federal government, while states that claim reimbursement as a covered service can receive a higher match, depending on their state’s FMAP.⁴⁵ Fifteen states and the District of Columbia have currently opted to pay for these services.⁴⁶

If the state does not pay for language services, the financial responsibility falls to providers who must still provide language services to comply with Title VI and ACA § 1557.

D. Public Charge and Immigration-Related Barriers and Fears

This section is current as of August 25, 2019. On August 14, 2019, the Department of Homeland Security published a final rule that changes the definition and standards of public charge inadmissibility. Several lawsuits have been filed to block the rule. If the courts allow the rule to be implemented, it will go into effect on October 15, 2019.

Under the current policy, public charge is used in immigration law to consider whether a person is likely to become “primarily dependent on the government for subsistence” as demonstrated by either the receipt of cash assistance for income maintenance, or institutionalization for long-term care at government expense.⁴⁷ A public charge assessment is made when an individual applies for admission to the U.S. or applies for lawful permanent resident status (also known as a “green card”). Some immigrant categories are exempt from the public charge test or can qualify for a waiver.⁴⁸ In 1999, the Immigration and Naturalization Service (now the Department of Homeland Security, or DHS) issued guidance clarifying that receipt of health care and other noncash benefits would not put immigrant enrollees or their family members at risk of a public charge determination.⁴⁹

The public charge test has long caused confusion among immigrants, including those who are exempt from consideration and their family members. An increasingly hostile climate towards immigrants in recent years have also escalated public charge fears. In October 2018, DHS issued a notice of proposed rulemaking with proposed changes to the current policy on public charge.⁵⁰ After completing its review, DHS published a final rule on August 14, 2019.⁵¹ The final regulation makes significant and harmful changes to public charge including expanding the types of public benefit programs that would be considered in a public benefit determination to include non-emergency Medicaid, SNAP, and a number of federal housing programs– all of which were previously excluded from public charge considerations.⁵² Children and young adults under 21 years old and pregnant women (up to 60 days postpartum) who receive Medicaid benefits are exempt from the public charge final rule.⁵³ Medicaid benefits provided under the Individuals with Disabilities Education Act and school-based Medicaid services are also exempt.⁵⁴

The final rule also redefines public charge as an individual who is “more likely than not to receive one or more public benefits for more than 12 months in the aggregate in any 36-month period.”⁵⁵ DHS also introduces new standards and heavily weighted factors based on age, health, family status, income and resources, education and skills, and the validity of an affidavit of support that will have to be considered in public charge determinations.⁵⁶

While the rule has not yet gone into effect, many immigrants and their family members are fearful about applying for or utilizing Medicaid and other public benefit programs, and have consequently disenrolled from those programs or stopped seeking services.⁵⁷ A nation-wide survey conducted prior to the final rule found one in seven adults in immigrant families reported avoiding public benefit programs due to fears of risking the future green card status of themselves or a family member, and over one in five adults in low-income families reported this fear.⁵⁸

Many immigrants also fear that their personal information will be reported to DHS, which deters them from applying for public programs or seeking publicly funded services despite meeting eligibility requirements. These fears are triggered by questions about immigration status on benefit application forms. In 2000, HHS and the Department of Agriculture issued “Tri-Agency Guidance” to address these concerns.⁵⁹ The Guidance encouraged states to eliminate unnecessary questions related to immigration status and allow family or household members who are seeking to apply on behalf of an immigrant applicant to be designated as non-applicants. Despite these guidance documents, confusion and concerns about public charge, reporting, and other immigration related barriers remain.

E. Access for Women with Disabilities

Approximately 27 million women in the U.S. have a disability.⁶⁰ Women have a higher prevalence of disability and almost all disability types compared to men.⁶¹ Individuals with disabilities are significantly more likely to rely on Medicaid for their health care coverage than individuals without a disability, and one study showed that half of all women with disabilities access health care through Medicaid.⁶²

Yet women with disabilities often encounter barriers that prevent them from accessing reproductive and sexual services, including pregnancy services.⁶³ Many women with disabilities experience stigma, discrimination, and physical and informational barriers to care. A reproductive justice approach to providing sexual and reproductive health services must affirm the autonomy of women with disabilities and help facilitate self-determination and informed decision-making.⁶⁴

Several laws provide the legal foundation for promoting accessibility for people with disabilities. Section 504 of the Rehabilitation Act of 1973 prohibits recipients of federal funds from discriminating on the basis of disability. The Americans with Disabilities Act also prohibits discrimination in public accommodations, including health care providers’ offices and facilities.⁶⁵ Section 1557 of the Affordable Care Act also prohibits discrimination on the basis of disability (and race, color, national origin, sex, or age) in certain health programs and activities. The final 2016 regulations include specific requirements for

websites and physical accessibility as well as the provision of auxiliary aids and services needed to assist with communication.⁶⁶ However, the June 2019 proposed rulemaking eliminates notice requirements that are critical to informing individuals about their rights and the availability of auxiliary aids and services for individuals with disabilities free of charge and in a timely manner, as well as materials in alternate formats.⁶⁷

1. Provider Attitudes and Physical Accessibility

Many providers lack the training and knowledge necessary provide respectful, accessible, and affirming reproductive and sexual health services to people with disabilities.⁶⁸ Providers may hold stereotypes that women with disabilities are not sexually active even though they have the same rate of sexually activity as women without disabilities.⁶⁹ As a result, providers may not initiate discussions about the full range of contraceptive options or fail to screen people with disabilities for STIs.⁷⁰ When a person with a disability does request contraceptive services, providers may recommend a contraceptive method that is not appropriate given their disability or personal preferences.⁷¹ Moreover, providers do not always provide reasonable accommodations, such as providing extended time or sign language interpreters, to ensure that people with disabilities have equal access to services.⁷² Information may not always be provided in accessible formats, preventing women who are blind or with visual impairments from important information about their reproductive, prenatal, or sexual health.

Family planning centers or OB/GYN offices may not have the appropriate equipment or facilities that are accessible to women with certain physical disabilities. For example, standard gynecological exam tables and mammography equipment are not suitable for some women with limited mobility. The ACA tried to alleviate this problem by requiring the Architectural and Transportation Barriers Compliance Board, in consultation with the FDA, to promulgate regulations establishing minimum physical accessibility standards for medical diagnostic equipment in all health care settings.⁷³ Medical diagnostic equipment explicitly includes exam tables and mammography equipment.

Given these barriers to accessing care, many women with disabilities delay or even forgo routine gynecological care. In fact, compared with women who do not have disabilities, women with disabilities are less likely to have routine Pap tests and mammograms.⁷⁴ Medicaid-enrolled women with disabilities are also less likely to receive adequate prenatal care and more likely to deliver a preterm or low birth weight baby.⁷⁵

2. Women Enrolled in Medicare and Medicaid (Dual Eligibility)

Nearly one million women of child-bearing age are enrolled in both Medicaid and Medicare based on disability. Their reproductive and sexual health needs

are often overlooked due to stigma, access barriers, and stereotypes, and they face the added challenge of having to navigating a Medicare program that was designed to serve older adults, not women of child-bearing age. While the Medicaid statute explicitly requires coverage of family planning services, the Medicare statute does not even mention family planning services.⁷⁶ As is the case with federal Medicaid funding, Medicare only covers abortions that fall within the narrow Hyde exceptions.⁷⁷

Women enrolled in both Medicare and Medicaid face unique barriers to obtaining reproductive and sexual health services. First, generally Medicare only covers certain family planning services for non-contraceptive purposes.⁷⁸ Second, when Medicare does not cover a particular service, women often have difficulty accessing Medicaid coverage for that service. Under federal law, Medicaid is generally the payer of last resort. With some exceptions, Medicaid will not pay a provider for a service delivered to an individual who is also enrolled in Medicare unless the provider has first billed Medicare for the service and received a denial.⁷⁹ This process presents a problem for women seeking reproductive or sexual health services given that many abortion and family planning providers do not participate in Medicare, and therefore cannot bill Medicare or get the Medicare denial needed to then bill and receive payment from Medicaid. There is one explicit exception. CMS has made clear that providers need not bill Medicare first for LARCs and related services.⁸⁰

F. Transportation

Transportation access is critical to accessing health care services. People in rural and urban areas with limited public transportation options or where certain providers are scarce may forgo health care services simply because they lack transportation to and from care. Lack of transportation is of particular concern for women seeking reproductive and sexual health services in the many areas where there are limited family planning or abortion providers. Nearly 90 percent of counties in the U.S. do not have an abortion provider and at least 27 cities with a population of 50,000 are “abortion deserts,” meaning cities from which people have to travel more than 100 miles to get abortion care.⁸¹ Medicaid transportation services are an important tool for helping women access medical services, including abortion, pregnancy, and family planning services.

1. Non-Emergency Medical Transportation (NEMT)

States Medicaid plans must specify that the Medicaid agency will ensure necessary transportation for enrollees to and from providers and describe the methods the state will use to ensure transportation.⁸² In addition, adolescents, children, and their families are entitled to assistance with scheduling appointments, information about transportation services, and receiving transportation services as part of the EPSDT benefit.⁸³ Travel assistance includes:

- The cost of transportation by ambulance, taxicab, common carrier, or other appropriate means,

- The costs of meals and lodging to and from medical care—such as prenatal, family planning or abortion services—and while receiving medical care, and
- The expenses of an attendant when a person’s medical condition does not allow them to travel alone, including an attendant’s salary if they are not a relative.⁸⁴

States may cover NEMT as an administrative expense.⁸⁵ In addition, states have the option to cover NEMT services as a medical benefit in their state plans, which includes coverage for transportation and “other travel related expenses” necessary to secure medical examinations and treatment for an enrollee.⁸⁶ States may also cover transportation as both an administrative expense and as a medical benefit.⁸⁷

Whether a state classifies NEMT services as a medical benefit or an administrative expense determines the federal reimbursement rate that the state receives.⁸⁸ States are reimbursed for medical services at a rate based on state per capita income, and the federal match can range from 50 percent to 74 percent.⁸⁹ The federal payment rate for administrative costs is typically 50 percent.⁹⁰ Thus, a state may receive a higher federal payment rate if it categorizes transportation as a medical service. If NEMT is classified as a medical service expense, the state generally must meet federal state plan requirements set forth in 42 U.S.C. § 1396a, such as ensuring comparability, statewideness, and freedom of choice in providers.⁹¹ However, the Deficit Reduction Act of 2005, Pub. L. 109-171 (2006), authorized states to implement brokerage programs to provide NEMT services.⁹² States electing this option do not need to adhere to the Medicaid Act’s statewideness, comparability, or freedom of choice requirements.⁹³ Most states use brokers to manage their NEMT benefit for at least some Medicaid enrollees and/or in certain geographic locations. Transportation services furnished through a broker may include wheelchair vans, taxis, stretch cars, transit passes and tickets, secured transportation and other transportation methods covered under the state plan, including reimbursement for family members or friends who provide transportation in some cases.⁹⁴

Courts have interpreted the NEMT requirement to have two components. First, states must comply with the administrative requirement—i.e., the state plan must

ADVOCACY TIP: Transportation for Pregnant Women

States have some flexibility in determining the modes of non-emergency transportation. When advocating for scope of benefits and coverage for pregnant women, the stage of pregnancy and the condition of the woman should be considered in determining transportation options.

actually contain an adequate description of how the Medicaid program will ensure transportation.⁹⁵ Second, courts have also interpreted the provision to include a substantive component—i.e., the Medicaid program must actually ensure that needed transportation is available to enrollees.⁹⁶ Courts have struck down various restrictions on transportation for Medicaid enrollees as inconsistent with the regulation such as limits on the number of trips per month, only providing transportation by ambulance, and limiting the benefit to non-ambulatory enrollees.⁹⁷

2. Emergency Transportation

The requirement to cover transportation “necessary to ensure examination and treatment” extends to emergency ambulance services to a hospital. In addition to general emergencies, emergent conditions for women include labor, abdominal pain that could indicate ectopic pregnancy, or excessive bleeding post abortion care.⁹⁸

Endnotes

- 1 See Susan Berke Fogel, Nat’l Health Law Prog., *Health Care Refusals: Undermining Quality Care for Women* 14 (July, 2013), <https://healthlaw.org/resource/health-care-refusals-undermining-quality-care-for-women/>.
- 2 *Roe v. Wade*, 410 U.S. 113 (1973).
- 3 42 U.S.C. § 300a-7.
- 4 42 U.S.C. § 300a-7(d).
- 5 Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2004); Depts. of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, 2006, Pub. L. No. 109-149, 119 Stat. 2833, 2851; Consolidated Appropriations Act, 2008, H.R. 2764, 110th Cong. § 508(d)(1) (2007).
- 6 45 C.F.R. § 88.2.
- 7 *Burwell v. Hobby Lobby*, 573 U.S. 682 (2014) (holding that the Religious Freedom Restoration Act applies to regulations that govern the activities of closely held for-profit corporations and permits a closely held for-profit corporation to deny its employees contraceptive coverage to which the employees are otherwise entitled by ACA, based on the religious objections of the corporation’s owners).

- 8 *Zubik v. Burwell*, 136 S.Ct. 1557 (2016) at 4.
- 9 See 82 Fed. Reg. 47,838 (Oct. 13, 2017), <https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf>, and 82 Fed. Reg. 47,792 (Oct. 13, 2017), <https://www.govinfo.gov/content/pkg/FR-2017-10-13/pdf/2017-21851.pdf>.
- 10 U.S. Dept. of Health & Human Servs., *HHS Announces New Conscience and Religious Freedom Division* (Jan. 18, 2018), <https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html>.
- 11 Proposed 45 C.F.R. § 92.6 (b), 2019 Proposed OCR Rule *infra* note 18.
- 12 Guttmacher Inst., *Refusing to Provide Health Services* (Feb.1, 2019), <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>.
- 13 Mississippi Health Care Rights of Conscience Act (codified at 41 Miss. Code Ann. § 107-3).
- 14 See Guttmacher, *Refusing to Provide Health Services*, *supra* note 12.
- 15 There are many non-profit, religiously-controlled hospitals and health systems that do not impose any religious restrictions on patients or providers. See generally Religious Coal. for Reprod. Choice, *Perspectives: A Matter of Faith and Conscience*, <http://rcrc.org/faith-perspectives/>.
- 16 See Catholic Health Ass’n of the U.S., *Catholic Health Care in the United States: About Facts & Statistics*, <http://www.chausa.org/about/about/facts-statistics> (last updated Jan. 2019).
- 17 See U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, (6th ed. 2018), <http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf>
- 18 See Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 115 (Jun. 14, 2019) [hereinafter 2019 Proposed OCR Rule].
- 19 42 U.S.C. § 18116(a).
- 20 See Title IV of the Civil Rights Act of 1964, codified at 42 U.S.C. § 2000d (prohibiting federal fund recipients from discriminating on the basis of race, color, or national origin); Title II of the Americans with Disabilities Act of 1990, codified at 42 U.S.C. § 12132 (prohibiting public agencies from discriminating against individuals with disabilities); Rehabilitation Act of 1973, codified at 29 U.S.C. § 794 (prohibiting federal fund recipients from discriminating against individuals with disabilities); see also 42 U.S.C. § 18116 (prohibiting health programs and activities that receive federal financial assistance from discriminating against individuals on the basis of grounds prohibited in Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973).

- 21 45 C.F.R. § 92.4.
- 22 45 C.F.R. § 92.2(b)(2).
- 23 See 45 C.F.R. § 86.40(b) (prohibiting discrimination on the basis of “pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom”).
- 24 Nondiscrimination in Health and Health Education Programs or Activities, 81 Fed. Reg 31375, 31388 (May 18, 2016) (clarifying “on the basis of sex includes, but is not limited to, discrimination on the basis of...sex stereotyping and gender identity”).
- 25 However, on December 31, 2016, the U.S. District Court for the Northern District of Texas issued a nationwide preliminary injunction prohibiting HHS from enforcing certain provisions of its 1557 implementing regulations that prohibit discrimination on the basis of gender identity or termination of pregnancy. See *Franciscan Alliance v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex. 2016).
- 26 *Baldwin v. Foxx*, EEOC Appeal No. 0120133080, Agency No. 2012-24738-FAA-03, at 5-6 (July 15, 2015) (holding that sexual orientation is inextricably linked to sex, therefore an allegation of discrimination on the basis of sexual orientation is necessarily an allegation of sex discrimination); see also *Deneffe v. SkyWest, Inc.*, 2015 WL 2265373, at *6 (D. Colo. May 11, 2015); see also *Terveer v. Billington*, 34 F. Supp. 3d 100, 116 (D.D.C. 2014); see generally *Boutillier v. Hartford Pub. Schs.*, 2014 WL 4794527 (D. Conn. 2014).
- 27 42 U.S.C. § 18116; 45 C.F.R. § 92.302(d).
- 28 See, e.g., *Audia v. Briar Place, Ltd.*, No. 17 CV 6618, 2018 WL 1920082, at 3 (N.D. Ill. Apr. 24, 2018); *Briscoe v. Health Care Serv. Corp.*, 281 F.Supp.3d 725, 737 (N.D. Ill. 2017); *Esparza v. Univ. Med. Ctr. Mgmt. Corp.*, No. CV 17-4803, 2017 WL 4791185, at *5 (E.D. La. Oct. 24, 2017); *Se. Pennsylvania Transp. Auth. v. Gilead Scis., Inc.*, 102 F.Supp.3d 688, 698 (E.D. Pa. 2015); *Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 848 (D.S.C. 2015); *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *7 n.3 (D. Minn. Mar. 16, 2015).
- 29 See generally Sara Sills et al., Nat’l Health Law Prog. & Inst. For Reproductive Health Access, *Protecting Reproductive Health Care for Low-Income Women* (2013), <https://healthlaw.org/resource/protecting-reproductive-health-care-for-low-income-women/>.
- 30 See U.S. Census Bureau, *Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over: 2009-2013* (Oct. 2015), <https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html>.
- 31 42 U.S.C. § 2000d. See also 45 C.F.R. pt. 80, app. A (listing examples of federal financial assistance, including Medicare, Medicaid, and Maternal and Child Health grants).

- 32 For more information about Title VI and the Affordable Care Act, see Mara Youdelman, Nat'l Health Law Prog., *The ACA and Application of § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges* (2011), <https://healthlaw.org/resource/the-aca-and-application-of-%C2%A7-1557-and-title-vi-of-the-civil-rights-act-of-1964/>.
- 33 See Jane Perkins & Jamie Brooks, Nat'l Health Law Prog., *Summary of State Law Requirements Addressing Language Needs in Women's Health* 5-6 (2006), <https://healthlaw.org/resource/summary-of-state-law-requirements-addressing-language-needs-in-womens-health/>
- 34 42 U.S.C. § 18116; 45 C.F.R. pt. 2.
- 35 45 C.F.R. §§ 92.201-92.204, 45 C.F.R. Appendix B_to_part_92 - Sample Tagline Informing Individuals With Limited English Proficiency of Language Assistance Services; See also, Jane Perkins, et al., Nat'l Health Law Prog., *Highlights of the Section 1557 Final Rule* (May 16, 2016), <https://healthlaw.org/resource/issue-brief-highlights-of-the-section-1557-final-rule/>.
- 36 Taglines are short 1-2 sentence descriptions in a non-English language that inform an individual with LEP how to access language services. After finalizing the current regulations, OCR provided model taglines translated in multiple languages.
- 37 See proposed 45 C.F.R. § 92.102, 2019 Proposed OCR Rule, *supra* note 18.
- 38 See Jane Perkins, Kaiser Fam. Found., *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities* (2003), <https://www.kff.org/medicaid/report/ensuring-linguistic-access-in-health-care-settings-2/>.
- 39 *Id.*
- 40 See CMS, STATE MEDICAID MANUAL § 2900. Furthermore, pursuant to § 2902 of the State Medicaid Manual, states must provide interpreters at Medicaid hearings.
- 41 To learn more about when translations are required for smaller LEP groups, see *id.*
- 42 45 C.F.R. § 92.201(e).
- 43 See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311, 47,319 (Aug. 8, 2003).
- 44 42 U.S.C. § 1397ee(a)(1).

- 45 The Children’s Health Insurance Program Reauthorization Act of 2009 authorized enhanced federal administrative matching payments for the provision of language access services in CHIP and Medicaid programs. State CHIP programs may now receive enhanced federal matching for translation or interpretation services “in connection with the enrollment of, retention of, and use of services under this title by individuals for whom English is not their primary language.” The enhanced rate is also available for language services provided to children enrolled in Medicaid (but not adults). The enhanced rate is the higher of 75 percent or the sum of the state’s current federal matching rate plus five percentage points. See Children’s Health Insurance Program Reauthorization Act (CHIPRA), Pub. L. No. 111-148, § 201(b), 123 Stat. 8, 39 (codified at 42 U.S.C. § 1397ee(a)(1)(D)(iv)).
- 46 As of NHeLP’s last review, the contributing states are Connecticut, Hawaii, Idaho, Iowa, Kansas, Maine, Minnesota, Montana, New Hampshire, New York, Texas (single language interpreters), Utah, Vermont, Washington, Wyoming and the District of Columbia. Hawaii and Virginia stopped reimbursement of language services. For a fuller explanation, see Mara Youdelman, Nat’l Health Law Prog., *Medicaid and CHIP Reimbursement Models for Language Services* (2017), <https://healthlaw.org/resource/medicaid-and-chip-reimbursement-models-for-language-services/>.
- 47 8 U.S.C. § 1182 (a)(4). For more information about public charge, see Mara Youdelman, Nat’l Health Law Prog., *What is a “Public Charge” and Does Receipt of Health Benefits Impact It?* (2017), <https://healthlaw.org/resource/what-is-a-public-charge-and-does-receipt-of-health-benefits-impact-it/>.
- 48 Exempt categories include refugees, asylees, survivors of trafficking, domestic violence, or other serious crimes (T or U visa applicants/holders), VAWA self-petitioners, special immigrant juveniles, certain people paroled into the U.S., and other categories of immigrants.
- 49 Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689 (May 26, 1999). See also U.S. Dep’t of Just., Inadmissibility and Deportability on Public Charge Grounds, 64 FR 28676–88 (May 26, 1999); U.S. Dept. of State, INA 212(A)(4) Public Charge: Policy Guidance, 9 FAM 40.41.
- 50 See Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 196 (October 10, 2018). See also Protecting Immigrant Families campaign website at <https://protectingimmigrantfamilies.org/> for summaries and analyses of the proposed rule.
- 51 Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41292-41508 (Aug. 14, 2019), <https://www.federalregister.gov/documents/2019/08/14/2019-17142/inadmissibility-on-public-charge-grounds> [hereinafter “DHS Final Rule”].
- 52 DHS Final Rule, *supra* note 51 (adding 8 C.F.R. § 212.21(b).)

- 53 DHS Final Rule at 41297 *supra* note 51 (adding 8 C.F.R. § 212.21(b)(5)(iv).
- 54 DHS Final Rule at 41383, *supra* note 51 (adding 8 C.F.R. § 212.21(b)(5)(iii) - (iii).
- 55 DHS Final Rule, *supra* note 51 (adding 8 C.F.R. § 212.21(a).
- 56 DHS Final Rule, *supra* note 51 (adding 8 C.F.R. § 212.22(b).
- 57 Colby Itkowitz, *This White House proposal has legal immigrants forgoing healthcare services out of fear* (Aug. 8, 2018), LA TIMES, <https://www.latimes.com/politics/la-na-pol-health-care-immigration-20180808-story.html>.
- 58 Hamutal Bernstein, et al., Urban Institute, *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018* (May 22, 2019), <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>.
- 59 See HHS and USDA, *Policy Guidance Regarding Inquires into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits* (Sept. 21, 2000), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/tri-agency/index.html>.
- 60 CDC, *Disability and Health Information for Women with Disabilities*, <https://www.cdc.gov/ncbddd/disabilityandhealth/women.html> (last viewed Jun. 26, 2019).
- 61 CDC, *Prevalence of Disabilities and Health Care Access by Disability Status and Type among Adults—United States, 2016* (Aug. 2018), Morbidity and Mortality Weekly Report, <https://www.cdc.gov/mmwr/volumes/67/wr/mm6732a3.htm>.
- 62 Kaiser Family Found., *Half of Women with Disabilities Are Covered by Medicaid* (Mar. 13, 2013), <http://kff.org/womens-health-policy/slide/half-of-women-with-disabilities-are-covered-by-medicaid/>.
- 63 See William Mosher et al., *Disparities in receipt of family planning services by disability status: New estimates from the National Survey of Family Growth*, 10 DISABIL HEALTH J. 394–399 (2017), <https://dx.doi.org/10.1016%2Fj.dhjo.2017.03.014>. See also National Council on Disability, *Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and their Children* (2012), <https://www.ncd.gov/publications/2012/Sep272012>.
- 64 For example, in 2018, a group of human rights advocates drafted a set of affirming principles that integrate disability health/rights/justice values with the reproductive health/rights/justice framework. See Nairobi Principles on Abortion, Prenatal Testing and Disability, <https://nairobiprinciples.creaworld.org/principles/> (last visited Jun. 26, 2019).

- 65 For a detailed analysis of the ADA's legal guarantees of equal access in women's health, see Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 ST. LOUIS UNIV. J. OF HEALTH LAW & POLICY 15 (2008), https://www.slu.edu/law/academics/journals/health-law-policy/pdfs/issues/v2-i1/pendo_article_0.pdf.
- 66 45 C.F.R. § 92.8.
- 67 See proposed 45 C.F.R. § 92.102, 2019 Proposed OCR Rule, *supra* note 18.
- 68 See generally Anita Silvers et al., *Reproductive Rights and Access to Reproductive Services for Women with Disabilities*, 18 AMA J ETHICS 430-427 (Apr 2016), [doi:10.1001/journalofethics.2016](https://doi.org/10.1001/journalofethics.2016). See also Becker et al., *Reproductive Health Care Experiences of Women with Physical Disabilities: A Qualitative Study*, 12 ARCHIVES OF PHYSICAL AND MED. REHABILITATION S26-S30 (1997).
- 69 Renee Monique Haynes, et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-based Data from Seven States*, CONTRACEPTION (Dec. 15, 2017).
- 70 See Anita Silvers, *supra* note 68.
- 71 *Id.* See also JP Wu, et al. *Female Sterilization is more common among women with physical and/or sensory disabilities than women without disabilities in the United States*, 10 DISABILITY AND HEALTH J. 400-405 (2017).
- 72 Pendo, *supra* note 65, at 16-17.
- 73 Section 4203 of the Affordable Care Act amended Title V of the Rehabilitation Act to allow for the establishment of standards for accessible medical diagnostic equipment.
- 74 See LI lezzoni et al., *Trends in mammography over time for women with and without chronic disability*, 24 J. WOMENS HEALTH 593-601 (2015); LI lezzoni et al., *Trends in pap testing over time for women with and without chronic disability*, 50 AM. J. PREV. MED. 210-219 (2016).
- 75 Willi Horner-Johnson et al., *Differences in Prenatal Care by Presence and Type of Maternal Disability*, 56 AM. J. OF PREVENTIVE MEDICINE 376-382 (2019), <https://doi.org/10.1016/j.amepre.2018.10.021>.
- 76 Kaiser Fam. Found., *Private and Public Coverage of Contraceptive Services and Supplies in the United States* (July 10, 2015), <https://www.kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/>.
- 77 CMS, Medicare National Coverage Determinations (NCD) for Abortion §140.1, <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=127&ncdver=2&bc=AAAAGAAAAAAA&>.

- 78 With exceptions for certain listed preventive services, Part A and Part B do not cover items and services that are “not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.” 42 U.S.C. § 1395y(a)(1)(A). Given this restrictive coverage standard, Medicare does not cover sterilization services when performed primarily for contraceptive purposes. See CMS, National Coverage Determination (NCD) for Sterilization § 230.3, <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=13&ncdver=1&bc=AAAAGAAAAAAA&>. However, plans that provide Part D coverage are not required to exclude drugs that do not meet the Part A and Part B coverage standard. 42 U.S.C. § 1395w-102(e)(3)(A). Many Part D plans do appear to cover contraceptive drugs when used for contraceptive purposes or a medically accepted indication.
- 79 42 U.S.C. § 1396a(a)(25); 42 C.F.R. §§ 433.137- 433.140; CMS, STATE MEDICAID MANUAL § 3900.
- 80 CMS, Frequently Asked Questions Medicaid Family Planning Services and Supplies, (Jan. 11, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11117.pdf>.
- 81 See Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability In the United States*, 46 PERSPECTS. ON SEX AND REPROD. HEALTH 17-27 (2017) and Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance from Major U.S. Cities: Systematic Online Search*, 20 J. MED. INTERNET RES 5 (2018), <https://www.jmir.org/2018/5/e186/>.
- 82 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53; see also HEW, MEDICAL ASSISTANCE MANUAL § 6-20-20; *Harris v. James*, 896 F. Supp. 1120, 1133 (M.D. Ala. 1995) rev’d 896 F. Supp. 1120 (M.D. Ala. 1995) (finding 42 C.F.R. § 431.53 to be unenforceable pursuant to § 1983).
- 83 See 42 C.F.R. § 441.62; see CMS, STATE MEDICAID MANUAL § 5150 (transportation and appointment scheduling for individuals receiving EPSDT services).
- 84 42 C.F.R. § 440.170.
- 85 See 42 U.S.C. § 1396b(a)(7); see 42 C.F.R. § 433.15(b)(7).
- 86 See 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 440.170; see Ctrs. For Medicare & Medicaid Servs., STATE MEDICAID MANUAL § 2113; see also HEW, Medical Assistance Manual § 6-20-20.
- 87 42 C.F.R. § 440.170(a)(3); see also CMS, STATE MEDICAID MANUAL § 2113.
- 88 Compare 42 U.S.C. § 1396a(a)(4)(A) and 42 C.F.R. § 431.53 (regarding coverage as administrative expense) with 42 U.S.C. § 1396a(a)(27) and 42 C.F.R. § 440.170 (regarding coverage as a service).

- 89 42 U.S.C. § 1301(a)(8); see *also* Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2015 Through September 30, 2016, 79 Fed. Reg. 71,426, 71,428 (Dec. 2, 2014).
- 90 These matching rates can vary. For example, family planning services and supplies receive a 90 percent federal matching rate. See 42 U.S.C. § 1396d(a)(4)(C) (requiring coverage); see *also* 42 U.S.C. § 1396b(a)(5) (establishing matching rate).
- 91 The Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6083, 120 Stat. 120-21 (adding 42 U.S.C. § 1396a(a)(70)); see *also* CMS, Dear State Medicaid Director Letter (SMDL # 06-010) (March 31, 2006) (discussing options).
- 92 See 42 U.S.C. § 1396a(a)(70). Before this provision was added in 2006, states needed to obtain waivers to establish such brokerages.
- 93 42 C.F.R. § 440.170(a)(4). See Chapter I, Section A for more information about these general service requirements.
- 94 42 U.S.C. § 1396a(a)(70)(A); 42 C.F.R. § 440.170(a)(4). For additional information about NEMT services, see Abbi Coursolle et al., Nat’l Health Law Prog., *Current Issues in NEMT* (Nov. 2016), <https://healthlaw.org/resource/issue-brief-current-issues-in-nemt/>.
- 95 See, e.g., *Smith v. Vowell*, 379 F. Supp. 139, 145 (W.D. Tex. 1974) *aff’d*, 504 F.2d 759 (5th Cir. 1974) (holding that there was a violation where state “fail[ed] properly to formulate and implement a State Medical Assistance plan with regard to transportation”); see also *Bingham v. Obledo*, 147 Cal. App. 3d 401, 404 (Cal. Ct. App. 1983) (finding that the state’s failure to provide for transportation of enrollees without disabilities in plan did not comply with the requirement, regardless of whether state actually provided services to those enrollees).
- 96 See *Smith*, 379 F. Supp. at 153-54 (“Finally, the State of Texas advances the preposterous argument that its only obligation under the regulation is merely a rhetorical one—that it only has to formulate a plan but not really to put it into effect . . . The answer to that argument can be found in simple logic, for if such a program were to prevail, the entire structure of the Federally mandated Social Security program as explicated by law and statute would become nugatory and void . . . The approach here advocated by the defendants would simply make a mockery of the Social Security Act and would lead to administrative chaos.”) (internal citations omitted); *Morgan v. Cohen*, 665 F. Supp. 1164, 1177 (E.D. Pa. 1987) (“[T]ransportation provided must be adequate for each individual’s particular combination of physical limitations, geographic location, and available sources of medical care. . . . Thus, although DPW must publish a plan to assure transportation, the details of each Medicaid recipient’s transportation must be determined on a case-by-case basis.”) (internal citations omitted).

- 97 *Fant v. Stumbo*, 552 F. Supp. 617, 619 (W.D. Ky. 1982) (striking down proposed limitation on transportation to four trips per month, holding that “any regulation which seeks to limit transportation for necessary medical treatment is contrary to the federal statutes and regulations and is thus invalid”); *Smith*, 379 F. Supp.at 155 (providing only emergency transportation did not comply with federal requirements); *Conti v. Ferguson*, 2001 WL 770898, at *6 (R.I. Super. July 5, 2001) (holding that the state may not “limit [] its coverage of necessary non-emergency transportation to non-ambulatory individuals only”).
- 98 42 C.F.R. § 431.53.

Chapter VII. Other Reproductive and Sexual Health Programs

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 for timely updates and analyses on the latest changes.

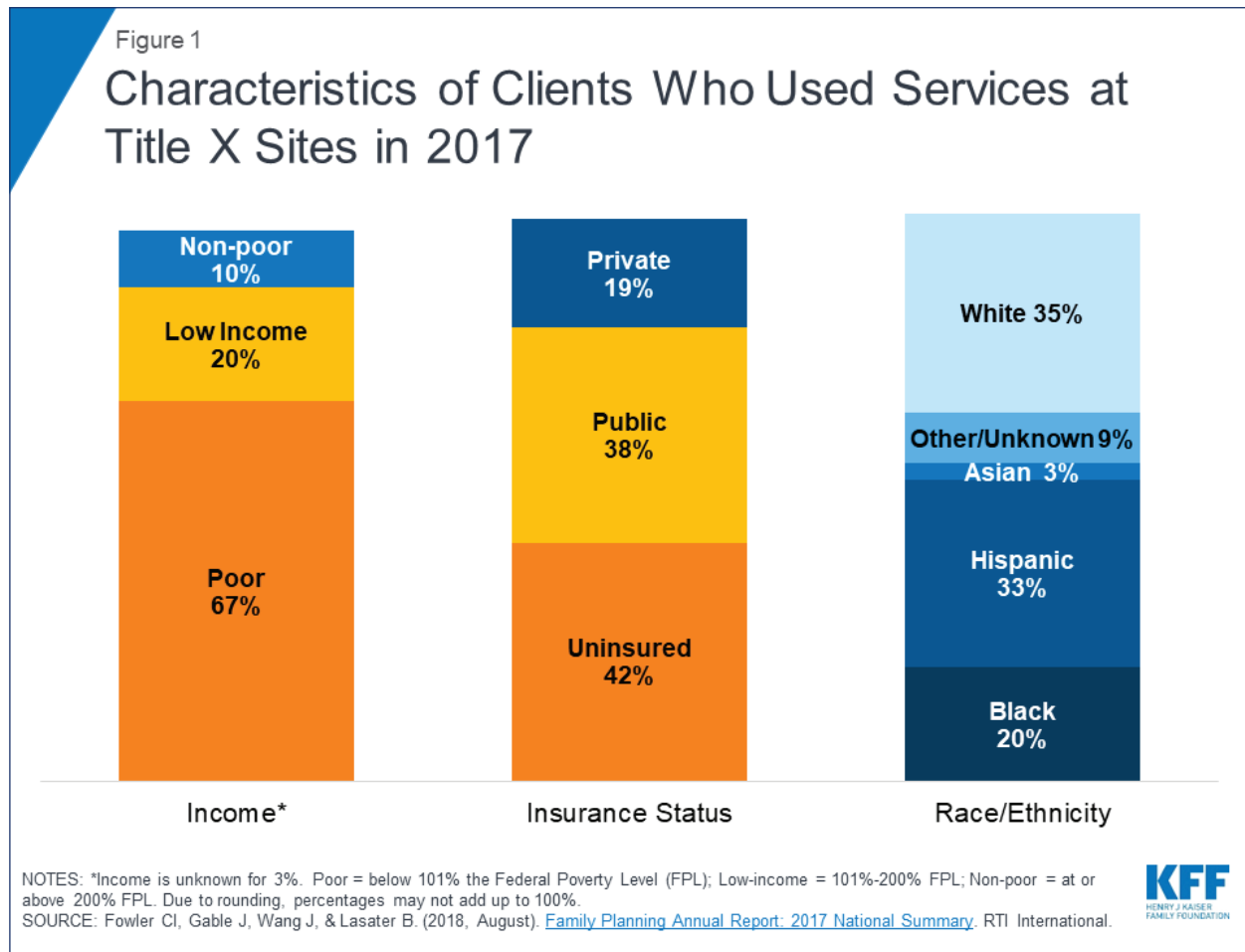
A. Title X

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.¹ 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, 2020.²

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.³ 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.⁴ 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).⁵ Adolescents seeking Title X services are assessed on the basis of their own income, rather than their family income.⁶ Individuals with incomes between 101 – 250 percent FPL are charged on a sliding scale based upon their ability to pay.⁷ 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.⁸



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.⁹ 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.¹⁰ 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.¹¹

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.¹² 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.¹³ Additionally, every Title X grantee clinic or project must have safeguards in place to ensure client confidentiality.¹⁴

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.¹⁵ 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.¹⁶

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.¹⁷ 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.¹⁸ This prompted some providers, including Planned Parenthood and other grantees, and several state departments of health to reject Title X funding.¹⁹

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.²⁰ 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.²¹ 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.²²

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.²³ The final rule goes further to require providers to refer all pregnant people to prenatal care, regardless of whether the individual chooses this option.²⁴ 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.²⁵

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.²⁶

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

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.²⁸ 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.²⁹

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.³⁰ 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.³¹ 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.³² As of November 2016, only fifteen states have a waiting period.³³

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.³⁴ 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, 2019.³⁵

1. Program design

States have the option to participate in CHIP, and currently all do.³⁶ 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.³⁷ 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.³⁸

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 19.³⁹ States also have the option of extending CHIP coverage to pregnant women who do not otherwise qualify for Medicaid.⁴⁰ Five states use CHIP funds to cover pregnant people with family incomes ranging from 200-300 percent FPL.⁴¹ 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.⁴² As in Medicaid, CHIP programs cannot impose cost sharing or waiting periods for pregnancy-related services.⁴³

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.⁴⁴ 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).⁴⁵ 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.⁴⁶

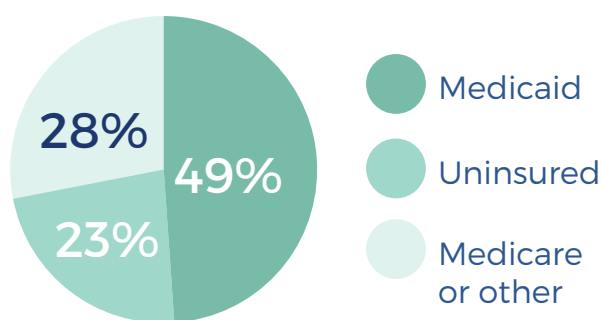
In addition to ICHIA, states have the option to provide coverage to the fetus of pregnant person, regardless of immigration status. The “unborn child” rule offers states a way to provide prenatal care and promote healthy pregnancies, regardless of the pregnant person’s immigration status.⁴⁷ This includes 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.⁴⁸

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.⁴⁹ 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.⁵⁰ 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.⁵¹

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.⁵² 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).⁵³

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.⁵⁴ 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.⁵⁵ 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.⁵⁶

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.⁵⁷ The PHS includes all agencies within HHS, including the CDC and the Commissioned Corps of the U.S. Public Health Service.⁵⁸

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.⁵⁹

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.⁶⁰

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.⁶¹ 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.⁶² Yet, only half of SBHCs are permitted to prescribe or provide oral contraceptives including emergency contraception.⁶³ Schools with SBHC that do prescribe and dispense contraceptives onsite have seen an increased use in contraceptives among sexually active students.⁶⁴

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.⁶⁵ 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.⁶⁶

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 2018.⁶⁷ 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).⁶⁸ 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.⁶⁹ Congress recently extended funding for PREP at \$75 million per year through FY 2019 in the Bipartisan Budget Act of 2018.⁷⁰ 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.⁷¹

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.⁷² 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.⁷³

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.⁷⁴ 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.⁷⁵ 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.⁷⁶

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.⁷⁷
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).⁷⁸
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.⁷⁹

The ACA also authorized HHS to issue grants for new prenatal, early childhood, and childhood home visitation programs.⁸⁰ The Maternal, Infant, and Early Childhood Home Visiting Program was established in 2010, creating the first nationwide home visiting program.⁸¹ 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.⁸² 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.⁸³

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.⁸⁴ HIV diagnoses among women have declined in recent years, however many women—an estimated one in nine women—are unaware they have HIV.⁸⁵ Overall HIV diagnoses rates among women

have decreased 21 percent between 2010-2016 except for white women 55 years and older.⁸⁶ 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).⁸⁷

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.⁸⁸ 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.⁸⁹ 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.⁹⁰ 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).⁹¹

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.⁹² 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.⁹³ 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.⁹⁴

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.⁹⁵

In 2016, over 230,000 people enrolled in Part B received ADAP-funded services.⁹⁶ 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.⁹⁷ More than half of ADAP enrollees are people of color and approximately one in four are female.⁹⁸

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

- 1 42 C.F.R. § 59, 84 Fed. Reg. 7741-7791.
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- 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>.
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- 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>.
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- 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>.
- 17 *State of California v. Alex M. Azar*, Nos. 19-15974, 19-15979; *State of Oregon v. Azar*, No. 19-35386; *State of Washington v. Azar*, No. 19-35394, 927 F.3d 1068 (Ninth Cir. Jun. 20, 2019) (three-judge panel granting HHS' motion to stay district courts' preliminary injunction orders); 927 F.3d 1045 (Ninth Cir. Jul. 11, 2019) (en banc court denying appellees' emergency motions to stay the three-judge panel's order).
- 18 See HHS, Sample Compliance Plan <https://www.hhs.gov/opa/sites/default/files/sample-compliance-plan-part-1.pdf>.
- 19 Rachel Benson Gold & Lauren Cross, Guttmacher Inst., *The Title X Gag Rule is Wreaking Havoc-Just as Trump Intended* (Aug. 2019) <https://www.guttmacher.org/article/2019/08/title-x-gag-rule-wreaking-havoc-just-trump-intended>.
- 20 42 C.F.R. § 59.2.
- 21 Dennis Carter, *An Anti-Choice Group Pledged It Would 'Never' Provide Contraception as It Pursued Title X Funds*, REWIRE NEWS (May 14, 2019), <https://rewirenews.link/2Hj1RNq>.
- 22 HHS, Letter Re: Obria Group, Inc. et al. (collectively, Obria) v. U.S. Department of Health and Human Services (HHS) et al., No. 8:19-cv-905 (C.D. Cal.) (Jun. 13, 2019), <https://s3.amazonaws.com/becketnewsite/Rienzi-Letter-and-Enclosure.pdf>.
- 23 42 C.F.R. § 59.14(a); see also Nat'l Family Planning & Reproductive Health Assoc., *Analysis of 2019 Final Rule on Title X Family Planning Program* (March 4, 2019), <https://www.nationalfamilyplanning.org/file/2019-Title-X-Final-Rule---Detailed-Analysis---3.4.2019-FINAL.pdf?erid=2027774&trid=1259d859-55a2-426a-8d0b-53b2caaac783>.
- 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>.
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- 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.
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- 35 42 U.S.C. § 1397ee(d). The MOE provision was extended through the enactment of the HEALTHY KIDS Act and ACCESS Act in 2019.
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- 37 Medicaid & CHIP Payment & Access Comm’n, Key CHIP Design Features, <https://www.macpac.gov/subtopic/key-design-features/> (last visited Jun. 19, 2019).
- 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/>.
- 39 42 U.S.C. § 1397jj(c)(1).
- 40 42 U.S.C. § 1397II(a). CHIP eligibility for pregnant women must be set at least at 185% FPL or the level it was in 2008, but may be set higher.
- 41 Kaiser Fam. Found., *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults* (Mar. 31, 2019), Table 2, <https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>.
- 42 42 U.S.C. § 1397II(f)(2).
- 43 42 U.S.C. § 1397II(b)(5)-(6).
- 44 42 U.S.C. 1396r-1a (presumptive eligibility for children) and 42 U.S.C. § 1397II(c) (presumptive eligibility for pregnant women).
- 45 42 U.S.C. 1396b(v)(4)(a). See also CMS, Dear State Health Official (July 1, 2010) (SHO # 10-006) (guidance on Medicaid and CHIP coverage of “lawfully residing” children and pregnant women), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf>.
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- 47 42 C.F.R. § 457.10; 42 C.F.R. § 457.626(a)(3).
- 48 KFF, *Where Are States Today?* *supra* note 41, at Table 2.
- 49 Economic Opportunity Act Amendments of 1966, Pub. L. No. 89-794, § 211, 80 Stat. 1451, 1463 (1966).
- 50 Section 10503 of the Patient Protection and Affordable Care Act (ACA) established the Community Health Center Fund. Though the fund is named for community health centers, its funds are available for use by four types of health centers: (1) community health centers, (2) health centers for the homeless, (3) migrant health centers, and (4) health centers for residents of public housing.
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- 52 HRSA, Find Shortage Areas: MUA/P by State and County, <https://data.hrsa.gov/> (last visited Jun. 30, 2019).
- 53 U.S. Gen. Acct. Office, Pub. No. GAO/HES-00-39, Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success (2000), www.gao.gov/new.items/he00039.pdf.
- 54 *Id.* at Fig. 3-7 and 3-8.
- 55 *Id.* at Fig. 3-7.
- 56 *Id.* at Fig. 3-10.
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Appendix: CMS Guidance and Additional Resources

CMS Guidance and Federal Reports

A. Abortion

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2. 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>.

B. Family planning

1. CMS, Dear State Health Official (July 2, 2010) (SMDL #18-005 and ACA #4), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf> (Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans).
2. CMS, Dear State Medicaid Director (April 16, 2014) (SMDL #14-003 and ACA #31), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf> (Re: Family Planning and Family Planning Related Services Clarification).
3. CMS, Dear State Health Official (June 14, 2016) (SHO #16-008), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf> (Re: Medicaid Family Planning Services and Supplies).
4. CMS, Frequently Asked Questions Medicaid Family Planning Services and Supplies (Jan. 11, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11117.pdf>.

C. Pregnancy

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2. CMS, Dear State Health Official (SHO #09-006 and CHIPRA #2) (May 11, 2009), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO051109.pdf>, (outlining state CHIPRA options for pregnancy coverage).
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D. Preventive Services

1. CMS, Dear State Medicaid Director, (SMD #13-002 and ACA #25) (Feb. 1, 2013), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-002.pdf> (Re: Affordable Care Act Section 4106 Preventive Services).
2. Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* (July 19, 2011), <http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx>.
3. U.S. Dep’t of Labor, *Frequently Asked Questions about Affordable Care Act Implementation (Part XII)* (Feb. 20, 2013), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf>.

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5. Women's Preventive Services Initiative, *Recommendations for Preventive Services for Women* (2017), <https://www.womenspreventivehealth.org/final-report/>.

NHeLP Resources

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