



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



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

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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
NBCCEDP	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).