



Presumptive Eligibility and Abortion

By Fabiola Carrión and Courtney Mendoza

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Introduction – What is Presumptive Eligibility?

Presumptive eligibility (P.E.) allows a patient to receive immediate Medicaid coverage if that individual is likely to be found eligible based on income, household size, and if applicable, pregnancy status.¹ It serves a dual purpose of providing expedited access to care while setting potentially qualified individuals into the path of enrolling into Medicaid. Presumptive eligibility could be life-saving for the patient since it helps to provide immediate assistance rather than having to delay care while waiting for confirmation of coverage. Although it is helpful to all patients, presumptive eligibility is especially useful to those who need time-sensitive services like prenatal care and abortions.

Presumptive eligibility should not be confused with “Emergency Medicaid,” which is usually offered during emergency situations, including labor and delivery, to individuals who would generally not qualify for Medicaid.

How does Presumptive Eligibility work?

When an individual goes to an entity qualified to enroll people in P.E., this person responds to questions pertaining to income, household size, and possibly citizenship and immigration status.² The application form varies according to state law and qualified entity. Either the applicant can start filling out the regular Medicaid application or the state or qualified P.E. entity may create a separate P.E. application. Based on the individual’s responses, the qualified P.E. entity calculates whether the patient will likely be eligible for coverage. This entity then notifies the patient in writing and orally of its decision, and alerts the state Medicaid agency of its P.E. determination. Upon the

¹ See CMS, *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (Jan. 2014). <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>.

² *Id.* While questions regarding attestation for citizenship, immigration status, or state residency are allowed, presumptive eligibility determinations cannot be held up pending verification of such status. Verification of citizenship and immigration status is, however, required before a final eligibility determination can be made.

qualified entity's finding of presumptive eligibility, the individual can receive care immediately.³

Qualified P.E. entities may include community and rural health centers, physicians, hospitals, local health departments, and family planning agencies.⁴ In this sense, presumptive eligibility becomes an effective way to empower trusted community institutions to identify, enroll, and support Medicaid-eligible individuals.

Presumptive Eligibility coverage begins on the day a qualified entity makes the preliminary determination that a person is eligible.⁵ It ends the day the individual is enrolled in Medicaid or on the last day of the month following the month in which the presumptive determination was made, whichever comes first.⁶ Eligibility must be made effective no later than the third month before the month of application if the patient received Medicaid services during that period and would have been eligible for Medicaid at the time those services were provided.⁷ States are not required to make such a retroactive adjustment if they determine that such adjustment would be administratively burdensome.⁸

What are the different types of Presumptive Eligibility?

Presumptive eligibility is available for a range of patients and services. Pregnancy P.E. and Hospital Presumptive Eligibility ("H.P.E.") can both apply to pregnant individuals. This issue brief focuses on these two programs because of their implication to abortion care. In addition, P.E. programs exist for children, breast or cervical cancer patients, and for patients seeking family planning services.⁹ States can also offer presumptive eligibility to parents and caretakers, former foster children, and other adults covered by the state's Medicaid program.¹⁰

³ *Id.* Individuals do not need to verify their exact income when applying for P.E. coverage since the determination is made based on the applicant's description of family circumstances.

⁴ See Elena Tyler Broaddus, *Presumptive Eligibility for Pregnant Women*, State Health Policy Monitor (Dec. 2008), <https://nashp.org/wp-content/uploads/sites/default/files/Presumptive%20Eligibility%20Monitor.pdf>.

⁵ 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.

⁶ *Id.*

⁷ 42 C.F.R. § 435.915.

⁸ See CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

⁹ See 42 U.S.C. § 1396r-1a(b)(2) (children), 1396r-1b(b)(1) (certain breast or cervical cancer patients), 1396r-1c(b)(1) (family planning services).

¹⁰ 42 C.F.R. § 435.1103.

Presumptive eligibility began in 1986 when Congress established it as a state option to improve access to timely care for pregnant individuals.¹¹ Since then, thirty states and the District of Columbia have created presumptive eligibility programs for pregnant individuals.¹² Presumptive eligibility for pregnant individuals covers only “ambulatory prenatal care.”¹³ In contrast, other P.E. programs cover all services to which applicants would be entitled if ultimately found eligible for coverage.¹⁴ Another important distinction is that while other P.E. programs only allow a person to apply for presumptive eligibility once per calendar year, pregnant individuals can apply for P.E. once per pregnancy, meaning that an individual can apply for pregnancy P.E. more than once a year.¹⁵

Since the enactment of the Affordable Care Act, states must allow hospitals to provide presumptive eligibility; however, states retain the authority to ensure that hospitals are following their state-specific eligibility policies and procedures.¹⁶ Hence, any hospital participating in Medicaid can make presumptive eligibility determinations as long as they are qualified and they seek permission from their state.¹⁷ Hospitals are able to make P.E. determinations for all Medicaid-eligible groups including pregnant individuals, children, parents and caretaker relatives, former foster care children, individuals seeking specific services like family planning services, adults above 133 percent of the Federal Poverty Level if covered by the state, and certain individuals seeking treatment for breast or cervical cancer.¹⁸ When a state does not have a P.E. program for pregnant individuals, that pregnant individual can still qualify for Hospital Presumptive Eligibility (H.P.E.) if they apply at a qualified hospital and are eligible based on income and household size.¹⁹ However, according to CMS, the pregnant individual who qualifies for H.P.E. can only receive services related to ambulatory prenatal care. In addition, H.P.E.

¹¹ 42 U.S.C. §1396r-1.

¹² See Kaiser Family Found., *Presumptive Eligibility in Medicaid and CHIP* (Jan. 1, 2019), <http://www.kff.org/health-reform/state-indicator/presumptive-eligibility-in-medicaid-chip/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited July 8, 2019).

¹³ 42 C.F.R. § 435.1103(a).

¹⁴ See 42 U.S.C. § 1396r-1a(a) (children), 1396r-1b(a) (certain breast or cervical cancer patients), 1396r-1c(a) (family planning).

¹⁵ See CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

¹⁶ 42 C.F.R. § 435.1110. Even if a state is not using P.E. in other settings, hospitals that accept Medicaid patients have the unique authority to make presumptive Medicaid eligibility determinations for all the populations that are MAGI-eligible. See CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

¹⁷ 42 U.S.C. § 1396a(a)(47)(B).

¹⁸ 42 U.S.C. § 1396r-1a. See also, CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

¹⁹ See CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

is not limited to hospital patients.²⁰ Hospitals can assist with PE determinations for family members and may also enroll eligible individuals from the broader community.²¹

How are providers reimbursed under Presumptive Eligibility?

Providers who make a determination that a patient is eligible for P.E. will be reimbursed for services provided during the P.E. period, even if the individual is later found not eligible for full-scope Medicaid.²² Medicaid is generally the payer of last resort, which means that Medicaid only pays for covered care and services if there are no other sources of payment available or only to the extent that Medicaid payments exceed the amount for which a third party, such as a private insurer, would be liable.²³ If the state Medicaid agency determines that another insurance program is likely liable for a prenatal claim, it may return the claim to the provider noting that another insurer could be legally responsible for payment.²⁴

What services can a pregnant individual receive under Presumptive Eligibility?

Under pregnancy P.E., pregnant individuals are entitled to only “ambulatory prenatal care.”²⁵ Hospital P.E. provides that a patient is entitled to the same benefits that a person enrolled in Medicaid in the same eligibility group would receive.²⁶ As such, pregnant individuals – whether they apply for Hospital P.E. or Pregnancy P.E. – can only receive ambulatory prenatal care.

²⁰ See CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

²¹ See CMS, *Medicaid and CHIP FAQs*, *supra* note 1.

²² See CMS, *Medicaid and CHIP FAQs*, *supra* note 1. (“There is no recoupment for Medicaid services provided during a PE period resulting from erroneous determinations made by qualified entities. Payment for services covered under the state plan (as well as federal financial participation) is guaranteed during a PE period; without such a guarantee, providers could not rely on the PE determination.”)

²³ 42 U.S.C. § 1396a(a) (25).

²⁴ See CMCS, Medicaid Provisions in Recently Passed Federal Budget Legislation Bipartisan Budget Act of 2018 – Third Party Liability in Medicaid and CHIP (June 1, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060118.pdf>.

²⁵ 42 U.S.C. § 1396r-1(a).

²⁶ 42 C.F.R. § 435.1110(a) (States “must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under ... 42 C.F.R. § 435.1103 [limiting pregnancy PE coverage to ambulatory prenatal care].”). Pregnant individuals seeking H.P.E. are only subject to ambulatory prenatal care.

States decide the services that will be included as ambulatory prenatal care in their state Medicaid Plans.²⁷ Thus, each state has some flexibility to decide the services included under ambulatory prenatal care in its State Plan. For instance, Connecticut defines “ambulatory prenatal care” to include “doctor visits, prescription drugs, immunizations, and lab and x-ray services.”²⁸ New Mexico’s Human Services Department establishes that “ambulatory prenatal care” includes “amniocentesis, sonograms, lab work, pregnancy-related prescriptions, pre-decision counseling, and miscarriages.”²⁹

What is the relationship between Presumptive Eligibility and abortion coverage?

According to the Hyde Amendment, federal funding of abortions can only be used for circumstances of rape, incest, or life endangerment of the pregnant individual.³⁰ States, however, may fund abortions *beyond* the Hyde Amendment with their own state funds.³¹ Sixteen states have gone beyond these circumstances to allow greater protections for low-income individuals by using state funding to cover abortions.³²

Only two states clearly establish that presumptive eligibility covers abortions. California explicitly includes all outpatient abortions under its P.E For Pregnant Women Program.³³ In New York, pregnant individuals under the P.E. program can also receive

²⁷ 42 U.S.C. § 1396r-1(d)(2). “[A]mbulatory prenatal care...is included in the care and services covered by a State plan.” No other federal law or statute defines the standard “ambulatory prenatal care.”

²⁸ Conn. Gen. Assembly, File No. 432, S.B. No. 659, An Act Replacing Expedited Eligibility For Pregnant Women With Presumptive Eligibility Under The Social Security Act, OLR Bill Analysis, <https://www.cga.ct.gov/2008/FC/2008SB-00659-R000432-FC.htm>.

²⁹ New Mexico Human Servs. Dep’t, Med. Assistance Div., Presumptive Eligibility and Presumptive Eligibility Plus Training Manual (June 2014), Pages 21-22, 43, <http://www.nashp.org/wp-content/uploads/2015/11/NM%20-%20202.pdf>.

³⁰ Consolidated Appropriations Act of 2016, Pub. L. No. 114-113, §§ 506-507, 129 Stat. 2242, 2649, <https://www.congress.gov/114/plaws/publ113/PLAW-114publ113.pdf>.

³¹ Pub. L. No. 114-113, § 507(b)-(c), 129 Stat. 2242, 2649. See also Guttmacher Inst., State Funding of Abortion Under Medicaid, <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicare> (last visited Aug. 27, 2019).

³² See Guttmacher Inst., State Funding of Abortion Under Medicaid, <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicare> (last visited Aug. 27, 2019). Maine must implement funding by March 2020.

³³ Cal. Dep’t of Health Care Servs., *Presumptive Eligibility for Pregnant Women Program Patient Fact Sheet* (Nov. 2016), <http://files.medi-cal.ca.gov/pubsdoco/publications/masters-other/PE4PW/presumpatfact.pdf>.

full Medicaid services, including abortion.³⁴ On the flipside, Indiana is the only state that explicitly excludes abortions in its definition of ambulatory prenatal care.³⁵

In Appendix 1, we list states that are covering abortions under Medicaid. We also detail the coverage of their presumptive eligibility programs.

Recommendations

Presumptive eligibility was created to provide immediate coverage to certain individuals who appear to be eligible for Medicaid. Rather than delaying care until a full eligibility determination is made or foregoing care all together, patients such as pregnant individuals can get timely health services through presumptive eligibility. Below are measures that states and advocates can advance to make sure that presumptive eligibility covers abortions:

1. States should adopt a comprehensive definition of the term “ambulatory prenatal services” that explicitly recognizes abortion care.
2. States should cover abortion under pregnancy P.E. and H.P.E. to the same extent they cover abortion for Medicaid enrollees, keeping in mind that a number of states use state-only funding to provide abortion coverage beyond that which is federally funded as required by the Hyde Amendment.
3. Section 1115 of the Social Security Act allows the U.S. Secretary of Department of Health and Human Services to waive some requirements of the Medicaid Act so that states can develop a demonstration project to test, pilot, or experiment with novel approaches to improving medical coverage and access for low-income people, so long as the demonstration project achieves the objectives of the Medicaid Act.³⁶ Thus, states can choose to apply for a § 1115 waiver to cover services beyond ambulatory prenatal care when that coverage is associated with a proposal that is seeking to implement something that is novel or experimental.

³⁴ N.Y. Comp. Codes R. & Regs. tit. 18, § 360-3.7(d)(9). See also, N.Y. Dep’t of Health, Changes in Federal Poverty Levels for Medicaid Presumptive Eligibility Programs, New York State Medicaid Update (Nov. 2013), https://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-11.htm#fed.

³⁵ 405 Ind. Admin. Code 2-3.2-5.

³⁶ 42 U.S.C. § 1315 (giving the Secretary authority to waive Medicaid requirements in § 1396a to enable states to implement an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act)]. With such a waiver, states could provide full-scope Medicaid services during the presumptive eligibility period.

4. State advocates should encourage hospitals, abortion clinics, and other providers qualified to determine PE eligibility to enroll individuals seeking abortion into pregnancy P.E. and H.P.E. and bill Medicaid for abortion services in the same way they would bill for existing Medicaid enrollees.

State	Extent of abortion coverage	Does it have Pregnancy PE?	Does it have a P.E. 1115 project?
AK	Most “medically necessary” abortions – includes mental and physical health. ⁱ	No.	No.
AZ	“Medically necessary” abortions – determined by serious physical conditions and severe mental illness; ⁱⁱ Excludes abortion counseling.	No.	Yes. AZ covers all state plan services for pregnant individuals. ⁱⁱⁱ
CA	All abortions prior to fetal viability without requiring medical justification; After fetal viability, all abortions necessary to protect the life/health of the pregnant individual. ^{iv}	Yes	No.
CT	“Medically necessary/therapeutic” abortion – determined by conditions deleterious to a woman’s physical and/or psychological health, including depression. ^v	Yes	No.
HI	All “induced/intentional termination of pregnancy” and related services. ^{vi}	No.	No.
IL	All abortion that is legal under Illinois law. ^{vii}	Yes.	No.
ME	All abortion services that are not federally approved. ^{viii}	No.	No.
MD	“Medically necessary” abortions with physician certification for physical and mental health. ^{ix}	No.	Yes. MD covers full Medicaid State plan benefits for pregnant individuals with incomes up to 250% FPL. ^x
MA	“Medically necessary” abortion with physician certification “if it is reasonably necessary to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity” and there are no other adequate options. ^{xi}	No.	Yes. MA covers full MassHealth Standard benefits for pregnant individuals with incomes up to 200% FPL. ^{xii}
MN	“Therapeutic” (medically necessary) abortion for preserving the physical and mental health of pregnant individuals. ^{xiii}	No.	Yes. MN covers full Medical Assistance plan benefits for pregnant individuals with incomes up to 278% FPL. ^{xiv}
MT	“Medically necessary” abortion to avoid “physical and emotional complications” and avoid aggravating	Yes, it covers ambulatory prenatal care (defined as protecting and insuring the health of the	No.

	“pre-existing physical and psychological conditions.” ^{xv}	pregnant individual <i>and</i> the fetus) for pregnant individuals up to 159% FPL. ^{xvi}	
NJ	“Elective/induced abortions,” and medically necessary, physician-certified abortion determined by physical, emotional, or psychological health, as well as age and family circumstance. ^{xvii}	Yes.	No.
NM	Abortion coverage where “necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient,” as well as in cases of ectopic pregnancy. ^{xviii}	Yes, it covers ambulatory prenatal care, which includes tests, labs, pregnancy-related prescriptions, pre-decision counseling, and miscarriages. ^{xix}	No.
NY	“Medically necessary” abortion for individuals at up to 100% of the FPL only. ^{xx}	Yes, it covers ambulatory prenatal care, defined as “all outpatient Medicaid services necessary to promote a healthy birth outcome” ^{xxi} ; Includes medically necessary abortion for pregnant individuals at up to 100% of the FPL only. ^{xxii}	No.
OR	“Medically necessary” abortion, requiring a physician’s opinion due to “specified medical problems that may be caused or aggravated by the pregnancy” and necessary to protect the individual’s physical health. ^{xxiii}	No.	No.
VT	“Medically necessary” abortion, which includes those “necessary in the light of all factors, physical, emotional, psychological, familial, the patient’s age, relevant to the health-related well-being of the patient.” ^{xxiv}	No.	No.
WA	All “voluntary” abortions”. ^{xxv}	No.	No.

ENDNOTES

- ⁱ State of Alaska, Dep't of Health and Social Servs., Div. of Public Assistance, FAMILY MEDICAID ELIGIBILITY MANUAL, http://dpaweb.hss.state.ak.us/manuals/fam-med/5735/5735_hospital_presumptive_eligibility.htm. See *Alaska v. Planned Parenthood of the Great Northwest*, 436 P.3d 984 (Alaska 2019), <https://public.courts.alaska.gov/web/appellate/opinions/sp-7334.pdf> (holding that a 2013 and 2014 statute and regulation unconstitutionally created a more restrictive “medically necessary” definition for Medicaid abortion coverage).
- ⁱⁱ *Simat Corp v Arizona Health Care Cost Containment Sys.*, 56 P.3d 28 (2002) (holding that Arizona must fund medically necessary abortions under Medicaid; however, Arizona’s state Medicaid agency still has not been providing this coverage in practice). See Guttmacher Institute, State Funding of Abortion Under Medicaid (July 1, 2019), <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicare> (last visited July 8, 2019).
- ⁱⁱⁱ CMS, Arizona Waiver Approval Letter (Jan. 18, 2019), <https://www.azahcccs.gov/Resources/Downloads/WaiverAnd%20ExpenditureAuthoritiesAnd%20STCs.pdf>.
- ^{iv} Cal. Dep't of Health Care Servs., MEDI-CAL PROVIDER MANUAL, Abortions Chapter, Page 1; Cal. Health & Safety Code § 123466 (West). See *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d 779 (Cal. 1981).
- ^v *Doe v. Maher*, 515 A.2d 134 (Conn. Super. Ct. 1986).
- ^{vi} Hawaii Dep't of Human Servs., Med-QUEST Div., Memo No. FFS M15-12, Revised Guidelines for Submittal and Payment of Induced/Intentional Termination of Pregnancy (ITOP) Claims (Sept. 28, 2015), <https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/ffs-memos/2015/FFS-1512.pdf>.
- ^{vii} H.B. 40, 100th Leg. (Ill. 2017), Section 10, amending 305 ILCS 5/5-5 (“Notwithstanding any other provision of this Code, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.”).
- ^{viii} “H.P. 594,” 129th Maine Legislature, Reg. Sess. 2019, <http://legislature.maine.gov/bills/getPDF.asp?paper=HP0594&item=1&snum=129>. The state Medicaid agency (MaineCare) must comply by March 1, 2020.
- ^{ix} “H.B. 150,” Budget Bill FY 2018, Medical Care Provider Reimbursements (Md. 2017). “Medically necessary” for mental health conditions requires additional evidence that the condition carries serious effects or has substantial risks of serious/long-lasting effects on the pregnant individual.
- ^x CMS, Maryland HealthChoice Medicaid Section 1115 Demonstration Approval Letter (June 16, 2017), <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-ca.pdf>. Otherwise, abortion is never covered under HPE. Maryland Medical Care Program, *Abortion Services Fact Sheet* (Aug. 2017), https://mmcp.health.maryland.gov/Documents/Factsheet6_Abortion%20Services.pdf. See also Maryland Medicaid and Abortion, *Presumptive Eligibility*, <http://mdmedicaidabortion.org> (last visited July 8, 2019).
- ^{xi} 130 Mass. Code Regs. 450.105(A)(1)(a); 130 Mass. Code Regs. 433.455(A)(1-2); 130 Mass. Code Regs. 410.435; 130 Mass. Code Regs. 484.001(B); 130 Mass. Code Regs. 450.204. See *Moe v. Sec’y of Admin. & Fin.*, 417 N.E.2d 387 (1981) (holding does not mention medical necessity for mental health conditions).
- ^{xii} CMS, Massachusetts MassHealth Medicaid Section 1115 Demonstration Approval (Nov. 4, 2016), <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/1115-waiver-extension-approval-11-04-16.pdf>
- ^{xiii} *Women of Minn. v. Gomez*, 542 N.W.2d 17 (Minn. 1995).
- ^{xiv} CMS, Minnesota Approval Letter (Feb. 11, 2016), https://mn.gov/dhs/assets/pmap-waiver_tcm1053-277614.pdf.
- ^{xv} *Jeannette R. v. Ellery*, 1995 WL 17959705, No. BDV-94-811 (Mont. Dist. Ct. May 22, 1995).

- ^{xvi} Mont. Code § 53-6-101(3)(h); Mont. Admin. R. 37.86.202; See Montana Dep't of Public Health & Hum. Servs., PRESUMPTIVE ELIGIBILITY N2017 QUALIFIED ENTITY REFERENCE GUIDE (UPDATED JUNE 15, 2017), <http://medicaidprovider.mt.gov/manuals/presumptiveeligibilitymanual#617397409-definitions>.
- ^{xvii} N.J. Admin. Code § 10:54-5.43(b); N.J. Admin. Code § 10:52-2.15(d); N.J. Admin. Code § 10:54-5.43(d); N.J. Admin. Code § 10:66-2.16(c). See *Right to Choose v. Byrne*, 91 N.J. 287, 450 A.2d 925 (1982).
- ^{xviii} N.M. Admin. Code 8.310.2.12(O).
- ^{xix} New Mexico Human Servs. Dep't, Med. Assistance Div., PRESUMPTIVE ELIGIBILITY AND PRESUMPTIVE ELIGIBILITY PLUS TRAINING MANUAL, Pages 21-22, 43 (June 2014), <http://www.nashp.org/wp-content/uploads/2015/11/NM%20-%20202.pdf>. See N.M. Admin. Code 8.291.400.13(F).
- ^{xx} N.Y. Social Services Law § 365-a(2), (5)(b); N.Y. Comp. Codes R. & Regs. tit. 18, § 505.2(e). See *Hope v. Perales*, 83 N.Y.2d 563, 571-72, 634 N.E.2d 183, 184 (1994).
- ^{xxi} N.Y. Dep't of Health, MEDICAID REFERENCE GUIDE at 165 (June 2010), https://www.health.ny.gov/health_care/medicaid/reference/mrg/mrg.pdf.
- ^{xxii} N.Y. Comp. Codes R. & Regs. tit. 18, § 360-3.7(d)(9). See also N.Y. Dep't of Health, MEDICAID REFERENCE GUIDE, Page 789 (June 2010), https://www.health.ny.gov/health_care/medicaid/reference/mrg/mrg.pdf. The regulation lists a maximum of 185% of the FPL, contradicting the 200% FPL limit stated in the reference guide, so it is unclear which FPL limit is applied in practice.
- ^{xxiii} Reproductive Health Equity Act, H.B. 3391, 79th Leg. (Or. 2017), Sections 2, 5, 8 (codified at OR LAWS 2017 Ch. 721, § 8) (prohibiting a “public body” from “depriv[ing] a consenting individual of the choice of terminating the individual’s pregnancy” or “[i]nterfer[ing] with or restrict[ing], in the regulation or provision of benefits, facilities, services or information, the choice of a consenting individual to terminate the individual’s pregnancy”).
- ^{xxiv} Vermont Dep't of Health Access, Abortion Certification 219B (June 11, 2014), <http://dvha.vermont.gov/for-providers/219b-abortion-certification-r10-10-part2.pdf>. See *Doe v. Celani*, No. S81-84CnC (Vt. Super. Ct., Chittenden Cnty., May 26, 1986).
- ^{xxv} Wash. Rev. Code § 9.02.160.