



Reproductive Health in Medicaid

Leonardo Cuello, cuello@healthlaw.org
Iowa Initiative
October 18, 2010

"Securing Health Rights for Those in Need"

NHeLP

- National non-profit law firm committed to improving healthcare access and quality for low-income individuals
- Offices in Washington D.C., Los Angeles, and North Carolina
- Comprehensive analysis of health care reform law was released in June 2010 – see website!
- Visit our website at: www.healthlaw.org



Today's Presentation

- Medicaid Basics
 - Eligibility
 - Application
 - Services generally
- Family Planning Services
 - Medicaid coverage
 - Services and protections
 - Family planning expansions
 - Other: Pregnancy, Breast and Cervical Cancer, “Refusals”



What Is Medicaid?

- Medicaid is the largest public health insurance program in the country, currently insuring over 60 million people over the course of a year
- Medicaid is a Federal program, but it is funded jointly by Federal and State governments, and it is almost entirely implemented by States
 - States have tremendous flexibility in how they implement Medicaid
- Medicaid is a critical program for low income women, and access to and expansion of women's health services in Medicaid are essential to improving women's health and independence



Eligibility: 4 Basic Requirements

1. State Residency
2. Immigration Status
3. Fit into a “Category”
4. Income and Asset limits



(1) State Residency

- Since Medicaid programs are run by States, individuals must be a resident of one and only one state for Medicaid purposes
- This is defined as where an individual ‘lives with intent to remain’
- There are no minimum required time limits
- State residency is totally distinct from the concept of immigration ‘resident’ status – State residency just means: where is your address?



(2) Immigration Status

- U.S. Citizens and certain qualified immigrants can be eligible for full Medicaid
- Qualified immigrants are only eligible after 5 years in qualified status (but option to cover kids and pregnant women)
- Qualified immigrants include: Legal permanent residents; Asylees/refugees; Women (and children) self-petitioning through VAWA, and many other groups
- Non-qualified immigrants can be eligible for Emergency Medicaid if they would otherwise be eligible for Medicaid and have an emergency medical condition
- Note: The immigrant status of family members is not relevant to an individual's eligibility



(3) Fit into a “Category”

- Medicaid historically only offered coverage to individuals who fit into one of the program's categories
- Starting 2014, health reform creates a catch-all category for uncovered individuals up to 133% of FPL
- Note that states participating in Medicaid have certain mandatory categories they must cover, and others that are optional



(3) Fit into a “Category”

- Some traditional categories that are especially important to women include:
 - Pregnancy
 - Breast and Cervical Cancer Treatment
 - Some parents with dependent children
 - Disability, Elderly, or needing Home & Community Based Services
 - Children
 - **Family Planning (new, optional)**



(4) Income & Asset Limits

- Income is the earnings/benefits a household receives every month
- Assets are the total resources in bank accounts, property, IRAs, etc., of a household
- Each Medicaid category has different maximum limits for income and assets
- The new catch-all category has a 133% FPL income limit, and no asset limit
 - Also new MAGI counting rules in reform



Application for Medicaid

- Individuals must apply for Medicaid with their State of residence, and enrollees will be periodically 're-determined' for eligibility
- Individuals who are denied must receive notices, with the right to appeal
- "Presumptive Eligibility" is a special process, important for women, whereby individuals can be pre-determined to be eligible and can therefore begin receiving services before their application is fully processed and approved



Medicaid Services

- States are required to provide certain Mandatory Services, and can also provide some Optional Services
- In addition, different categories of enrollment have different benefits packages
- Furthermore, State have flexibility to restrict access to services using tools like medical necessity requirements, drug formularies, and prior authorization processes
- There is a special protection for children and teens known as EPSDT, which requires that individuals get all medically necessary services up to age 21



Family Planning & Medicaid

- Family Planning is a Mandatory Medicaid service, accessed by millions of women
 - Family planning matching rate is 90% FFP (Fed \$)
- Medicaid has special rules for Family Planning to make sure it is accessible to women
- Nonetheless, in some States the benefit does not include enough services, and in others there are problematic barriers to the services



Medicaid FP Services

- States have wide discretion around what services meet the requirement to provide family planning
- Contraceptive Supplies are covered by *most* (but not all) states
 - OTC methods are covered by *most* states (w/ a script)
- Emergency Contraception is covered by *most* states, w/ a script, and in some cases with monthly limits
- Sterilization services can be covered, with some strict conditions to ensure valid consent



Medicaid FP Expansions

- States may, with permission from CMS, run Family Planning “waiver” programs. These are special Medicaid programs that allow States to provide family planning services to women who would not otherwise be eligible for Medicaid
- Health reform has created a new optional category of eligibility for States to cover women in need of family planning services, without having to get a waiver
 - The benefits package only covers family planning
 - The income limit is up to state pregnancy level limit



Medicaid & Pregnancy

- Coverage for pregnant women is mandatory category of eligibility for states
 - States must set the income limit at 133% FPL or higher, and many states do apply the maximum income limit of 185% of FPL
- States are allowed to provide some extra benefits to pregnant women, and have special limits on cost-sharing they can apply
- Coverage includes 60+ days post-partum



Medicaid & Breast/Cervical Cancer

- In 1990, the CDC began a National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide screenings to low-income uninsured women
- However, there was no broad program in place to provide subsequent treatment to women who were screened and detected to have a problem
- In 2000, a new optional category of Medicaid was created to provide coverage to women in need of treatment
 - Known as: BCCPT – Breast and Cervical Cancer Prevention Treatment program



Medicaid & Refusal Clauses

- Refusal clauses are state or federal laws or regulations that protect medical providers from liability when they fail to provide expected services, typically for religious or moral reasons
- Refusal clauses lead to women being denied access to information or services, and ultimately result in women getting sub-standard medical care
- NHeLP's "Standards of Care Project" is devoted to ensuring that the right of a patient to receive proper care is not reduced by the personal beliefs of providers



NHeLP

www.healthlaw.org

Leonardo Cuello, cuello@healthlaw.org

