

Issue Brief # 2

Indiana Law Threatens Medicaid Services

June 17, 2011 Update*

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On May 10, 2011, Indiana Governor Mitch Daniels signed House Bill 1210, prohibiting any state agency from entering into a contract with or making a grant to any entity that performs abortions or maintains or operates a facility in which abortions are performed and in which state or federal funds are expended, even when the abortion services are provided with non-government funds.

[\[1\]](#)

The law terminates and withdraws all appropriations for any existing contracts or grants made to such an entity.

[\[2\]](#)

Hospitals and ambulatory surgery centers are exempted from the law.

[\[3\]](#)

This issue brief describes why the Indiana law violates key Medicaid provisions that are meant to promote broader access to important, and in some cases life-saving, health services for low-income women.

Background

Proponents of the law prominently focused on abortion, both in legislative dialogue and media campaigns around the law. Abortion access is significantly diminished by this law; however, the vast majority of services impacted are basic women's health services relied on by millions of women in Indiana every day.

While the text of the law singles out abortion services, the main impact of this law will be to block thousands of women from getting basic medical services such as pap smears, STD screening and treatment, family planning services, and cancer screenings, especially in rural areas where women already face substantial barriers accessing these services. Of course, the law also reduces the availability and accessibility of safe, legal abortion services. All providers who perform abortions or maintain a facility in which abortions are performed will be denied federal or state funding under this law, and one of the largest entities to be effected, and the clear target of the law, is Planned Parenthood of Indiana (PPIN).

PPIN and the American Civil Liberties Union (ACLU) have filed a lawsuit challenging the law. The state responded with a motion to dismiss that continues to focus on abortion, including incorrectly alleging that Medicaid does not cover abortion services. [\[4\]](#) This lawsuit is pending before a federal District Court in Indiana.

At the federal level, the Indiana state Medicaid office submitted a State Plan Amendment (SPA) incorporating the law's restrictions into the state's Medicaid program. On June 1, 2011 the Department of Health and Human Services (DHHS) denied the SPA, stating that the proposed changes would violate important Medicaid provisions including "freedom of choice" (discussed below) and would inappropriately exclude qualified health care providers (such as PPIN) from providing services that are funded under the program, including family planning services. [\[5\]](#) If Indiana is dissatisfied with this determination it can petition for reconsideration within 60 days of receipt of the letter.

[\[6\]](#)

Recent Developments

Department of Justice enters case for Planned Parenthood. The U.S. Department of Justice (DOJ), on behalf of the United States, filed a brief in support of Plaintiffs on June 17, 2011 alleging that the Indiana law violates federal law by creating a policy that encourages women to

avoid abortion in contradiction to the longstanding policy created by Congress to allow Medicaid beneficiaries to receive any type of covered services from any qualified provider of that service, especially for family planning services.

[\[7\]](#)

The DOJ brief also notes the inappropriate argument made by Indiana that states may operate a non-compliant Medicaid program so long as they are willing to lose federal funding.

[\[8\]](#)

DOJ correctly asserts that a state “operating a Medicaid program in open violation of federal law is not in the public interest.”

[\[9\]](#)

Republican Senators oppose funding. In a letter dated June 9, 2011, 28 Republican Senators expressed disappointment and concern at the denial of Indiana’s SPA application. In this letter the Senators assert that Indiana has the right to exclude providers from participating in Medicaid for *any* reason under state law and urges the agency not to eliminate the entirety of Indiana’s federal Medicaid match over this issue.

[\[10\]](#)

Discussion

1. Family Planning Services and Supplies

PPIN's Medicaid-reimbursed family planning services include the diagnosis and treatment of sexually transmitted diseases, health education and counseling necessary to make informed choices and understand contraceptive methods, pregnancy testing and counseling, provision of contraceptive pills and supplies, screening and testing of individuals at risk for HIV, and pap smears. [11] In 2010, PPIN provided services to over 9,300 Medicaid patients in the State. [12] By removing all federal and state funding, the Indiana law denies enrollees coverage for *all* of these Medicaid-covered services from this provider.

This defunding scheme violates an important Medicaid provision designed to ensure that women can seek family planning services and supplies from any Medicaid provider they choose. Under Federal law, state Medicaid programs *must* cover “family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies.”

[13]

Furthermore, the federal Medicaid Act recognizes the intimate nature of family planning services and that women require these services over much of their life-span. Women enrolled in Medicaid have the right to choose their family planning providers regardless of whether they receive health care through a fee-for-service or managed care organization system. This right is known as “freedom of choice.”

[14]

For decades, DHHS has recognized that “[t]he purpose of the free choice provision is to allow [Medicaid] recipients the same opportunities to choose among available providers of covered health care and services as are normally offered to the general population.” [15] This federal statement reaffirmed what many courts had already found, for example, a federal district court in 1977 stated that the requirement “reflects an attempt by the Congress to make medical services available to the needy as they are available to the more affluent of the society.”

[16]

DHHS has again reaffirmed this longstanding view in its letter to Indiana, stating that “Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a provider’s scope of practice.”

[17]

The letter also emphasized the special status given to family planning providers by the Medicaid Act under section 1396a(23)(B), which states that “enrollment of an individual eligible for medical assistance in a primary care case management system, a Medicaid managed care organization, or a similar entity

shall not restrict the choice of the qualified person from whom the individual may receive [family planning services and supplies]

” (emphasis added).

[18]

As a result of the situation in Indiana, the Centers for Medicare and Medicaid Services (CMS) also issued an informational bulletin to states on the freedom of choice requirement. In the bulletin, CMS referenced “longstanding federal law” as a reminder to states of the freedom of choice requirement.

[\[19\]](#)

Specifically, the bulletin reiterates that excluding an otherwise qualified provider based on the scope of services (scope of practice) the provider offers is impermissible, emphasizing that, unless freedom of choice has been waived, Medicaid beneficiaries may obtain medical services “from any institution, agency, community pharmacy, or person, qualified to perform the service or services required ... who undertakes to provide him such services.”

[\[20\]](#)

Freedom of choice of providers for family planning services and supplies may not be restricted unless the state has submitted to CMS and been approved for a section 1115 demonstration project (also known as a waiver), and Indiana does not have permission to waive this requirement. [\[21\]](#) By denying a woman’s ability to get any Medicaid-covered services from PPIN, this law violates the important Medicaid freedom of choice provision.

PPIN is a qualified, enrolled Medicaid provider in the state, entitling it to reimbursement for the Medicaid services that it provides, including for family planning services and supplies which account for the vast majority of its services. PPIN is an entity that provides some abortion services, and as a result of the law, PPIN will lose *all* current and future funding from Medicaid, the Federal Preventive Health Services Block Grant, and Titles V and XX of the Social Security Act.

In sum, the Indiana law illegally undermines the Medicaid Act provisions designed to promote the health and well-being of women of childbearing age. PPIN provides comprehensive reproductive health care in its 28 health centers in Indiana. Only four of these centers provide abortion services, but this law will terminate public funding to *all* 28 health centers. This will be especially detrimental for women living in rural parts of the state for whom a PPIN health center (including one that does not perform abortions) may be their only source of care for basic women’s health services.

2. Legal Abortion Services

Since 1977, Congress has prohibited Medicaid funding of abortions. However, there are narrow exceptions allowing Medicaid funding of abortions in certain dire circumstances: when abortion is necessary to save the life of the woman and when the pregnancy resulted from an act of rape or incest. [\[22\]](#) In those circumstances, Medicaid coverage of abortion is mandatory. [\[23\]](#) In addition, states may choose or may be required by the state constitution or a state court order to cover abortion services using state-only funding. Indiana is required by court order to cover abortions that pose a serious and irreversible risk to the woman's health.

[\[24\]](#)

Therefore, a woman who is enrolled in Indiana's Medicaid program is entitled to abortion services when continuing the pregnancy will endanger her life, pose serious risk to her physical health, or when the pregnancy resulted from rape or incest.

Under the new law, however, no entity, except hospitals and ambulatory surgical centers, that provides abortion services or maintains or operates facilities in which abortions are performed will be eligible for any federal or state funding. The vast majority of abortions are performed in a clinic setting; non-specialized clinic providers performed a quarter of all abortions in 2005. [\[25\]](#) Non-hospital clinic settings also improve accessibility to abortion services, as they are often easier to locate and charge less than other providers.

[\[26\]](#)

Excluding these clinic-based providers from the Medicaid program severely limits women's ability to obtain abortion services. The only foreseeable outcome is that this new law will result in women being illegally denied Medicaid abortion services because, although the woman will technically have Medicaid coverage for abortion services, there will be no Medicaid provider available to perform the service.

If only hospitals and ambulatory surgery centers can provide publicly-funded abortions, it is likely that only women in emergency or acute health situations will be able to obtain them. Other pregnancies such as those that are harmful to a woman's health or that are caused by rape or incest will likely not be determined eligible for admission to the hospital or ambulatory surgical center, leaving those women with no alternatives for obtaining the Medicaid-covered abortion service to which they are entitled. Moreover, services obtained in hospitals and surgical centers are more costly both to patients and to the Medicaid program. [\[27\]](#) Requiring women to seek services in these more expensive settings increases the costs to government programs and unnecessarily takes away health resources that should be used for only acute and emergent care.

Poor women in rural parts of a state are already disadvantaged because of inadequate access to abortion providers, in any clinic setting. [\[28\]](#) Without easy access to hospitals and ambulatory surgical centers, however, women in rural Indiana now face the very real possibility of being unable to access any abortion provider whatsoever, even when their life circumstances and physical well-being depend on it.

Poor women also already face significant barriers in accessing abortion services as a result of restrictions on public funding for abortions. This law goes a step further by restricting access to those abortions lawfully provided for in the Medicaid program, significantly reducing the availability of services and access to providers who can provide women with safe, legal abortion services.

Conclusion

This law is now in effect in Indiana, and Medicaid enrollees have been notified via the Indiana Medicaid agency website that they may need to seek new providers for family planning services and supplies. Other states considering restrictions on state payments to entities that perform abortions include North Carolina, Oklahoma, and Texas.

Advocates should be prepared to defend the important Medicaid provision ensuring freedom of choice for women in choosing providers for family planning services and supplies.

Laws like this also significantly undermine a woman's ability to access the abortion services to which she is legally entitled. By denying public funding to most entities capable of performing abortions, women are left with only hospitals and ambulatory surgery centers as available abortion providers. Federal law has prohibited public funding for abortions in most circumstances, but in the case of rape, incest, and life endangerment, an exception has long been maintained. This law, however, severely narrows the circumstances in which women falling within this exception can exercise their rights.

[1] Ind. Code § 5-22-17-5.5(b) (2011).

[2] *Id.* at § 5.5(c).

[3] *Id.* at § 5.5(a).

[4] Brief of Defendant at ¶¶ 1-3, *Planned Parenthood of Indiana, Inc. v. Comm’r of the Ind. State Dep’t of Health*, No. 1:11-cv-0630 (S.D. Ind. May 10, 2011). The state’s brief mainly focuses on explorations of when biological life begins and whether the fetus can feel pain based on the abortion restrictions included in the statute.

[5] See Letter from Donald M. Berwick, Admin., Dep’t of Health & Human Servs., to Patricia Casanova, Director, Office of Medicaid Policy and Planning (June 1, 2011) (on file with NHeLP-NC). Under federal law, states have some flexibility in determining providers eligible to participate in Medicaid, but unless the state has obtained special permission from DHHS to restrict provider participation, providers may only be excluded from Medicaid for reasons related to fraud or criminal activities, medical license revocation, or if the provider has been convicted of certain crimes. See 42 U.S.C. § 1320a-7.

[6] See 42 C.F.R. § 430.18.

[7] U.S. Statement of Interest at 21, *Planned Parenthood of Indiana, Inc. v. Comm’r of the Ind. State Dep’t of Health*, No. 1:11-cv-0630 (S.D. Ind. May 10, 2011).

[8] *Id.* at 21-22.

[9] *Id.*

[10] See Letter from Orrin G. Hatch et al., to Donald Berwick, Admin., Dep't of Health & Human Servs. (June 9, 2011) (on file with NHeLP-NC).

[11] Brief of Plaintiff at 5, *Planned Parenthood of Indiana, Inc. v. Comm'r of the Ind. State Dep't of Health*, No. 1:11-cv-0630 (S.D. Ind. May 10, 2011).

[12] *Id.* at 6.

[13] 42 U.S.C. § 1396d(a)(4)(C). States are required to establish procedures for identifying individuals who are sexually active and thus eligible for family planning services. See CMS, State Medicaid Manual § 4270.B. The federal financial participation for costs associated with providing family planning services (including administrative costs) is 90 percent, with the state covering the remaining 10 percent.

See
42 C.F.R. § 433.10(c)(1).

[14] 42 U.S.C. §§ 1396a(a)(23), 1396n(b). In managed care delivery systems, enrollees typically must obtain all but emergency care from a provider within the managed care system.

[15] CMS, State Medicaid Manual §§ 2100-02 (Aug. 1985).

[16] *Rush v. Parham*, 440 F. Supp. 383, 389 (N.D. Ga. 1977).

[17] See Letter from Donald M. Berwick, *supra* note 5.

[18] 42 U.S.C. § 1396a(23)(B) (referencing 1396d(a)(4)).

[19] See Center for Medicaid, CHIP and Survey and Certification Informational Bulletin from

Cindy Mann, Director CMCS (June 1, 2011) (on file with NHeLP-NC).

[20] 42 U.S.C. § 1396a(23).

[21] 42 U.S.C. § 1396n(b) (freedom of choice may not be waived under Section 1915(b) waivers). Section 1115 waivers typically include the use of mandatory, risk-based managed care programs. A number of these waivers also extend Medicaid eligibility to population groups that were previously uninsured. For additional discussion, see Jane Perkins & Michele Melden, *Section 1115 Medicaid Waivers: An Advocate's Primer* (National Health Law Program, 1994).

[22] This restriction, commonly known as the Hyde Amendment, has been attached to appropriations bills on an annual basis since 1976. Thus its citation varies, but the provision is usually included in the Labor-HHS Appropriations bill or any continuing resolution or omnibus bill that includes funding for the Departments of Labor and HHS. The most recent reauthorization of the Hyde Amendment can be found in the Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, §§ 507, 508, 123 Stat. 3034, 3150 (2010). See CMS, State Medicaid Manual § 4430 (citing § 440.230(c) and stating that “States have received Federal matching funds in expenditures for medically necessary abortions.”)

[23] *Id.* See also *Harris v. McRae*, 448 U.S. 297 (1980); *Williams v. Zbaraz*, 448 U.S. 358 (1980).

[24] *Humphreys v. Clinic for Women, Inc.*, 796 N.E.2d 247 (Ind. 2003). Please note that although abortion services necessary for the preservation of physical health must be a covered medical service for women enrolled in Indiana’s Medicaid program, they are not eligible for federal reimbursement and therefore are not Medicaid services.

[25] Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 Persp. on Sexual and Reprod. Health 1 (2008).

[26] *Id.*

[27] See Jones et al., *supra* note 12.

[28] *Id.* at 6 (finding that in 2000, approximately 87 percent of U.S. counties lacked an abortion provider, and the proportion of women of childbearing age living in those counties was 34 percent).