



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



Chapter VI:

Access to Care

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

A. Refusal Clauses/Religious Exemptions

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

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

1. Federal Refusal Clauses

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

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

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

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

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

2. State Refusal Clauses

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

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

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

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

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

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

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

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

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

3. Institutional Restrictions

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

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

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

ADVOCACY TIP:

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

B. Non-Discrimination Protections Under ACA § 1557

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

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

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

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

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

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

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

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

C. Language Access for People with Limited English Proficiency

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

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

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

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

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

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

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

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

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

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

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

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

ADVOCACY TIP: State Language Access Protections

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

D. Public Charge and Immigration-Related Barriers and Fears

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

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

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

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

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

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

E. Access for Women with Disabilities

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

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

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

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

1. Provider Attitudes and Physical Accessibility

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

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

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

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

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

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

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

F. Transportation

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

1. Non-Emergency Medical Transportation (NEMT)

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

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

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

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

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

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

ADVOCACY TIP: Transportation for Pregnant Women

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

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

2. Emergency Transportation

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

Endnotes

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

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

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

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

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

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

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

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

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

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