What makes Medicaid, Medicaid? -- Access

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Key takeaways

- Under current law, states have tremendous flexibility in designing their Medicaid programs to determine low-income people eligible and enroll them in coverage.
- Medicaid operates efficiently by ensuring that low-income people are enrolled into coverage when they need it.
- Medicaid coverage is designed to provide continuous coverage for pregnant women and newborns.
- Medicaid ensures that beneficiaries can get to their medical and specialty care appointments through transportation assistance.
- Medicaid contains protections designed to get beneficiaries who need prescription medication access to their treatment quickly
- Medicaid gives beneficiaries the right to access the providers they need to treat their health conditions.

Discussion

States have tremendous flexibility when deciding how to administer their Medicaid programs. Congress has established a broad array of optional populations whom states can cover in Medicaid, as well as a minimum baseline of populations who must be enrolled.[1] States also have many choices as to how they operate their eligibility and enrollment processes. States routinely change their eligibility and enrollment systems and processes.[2] States also have flexibility in covering services for beneficiaries. States can contract with providers directly, or

offer access to Medicaid services through managed care arrangements.[3] States determine how much to pay their providers or Medicaid managed care plans to deliver services and frequently adjust payment amounts to ensure that they have contracted with the right mix of providers.[4]

Low-income Americans often face urgent health care problems and need to get into coverage quickly to ensure that they can get the health care services that they need. In addition, low-income individuals face serious risks when their coverage status changes and leaves them one emergency away from tragedy. Medicaid includes a series of special protections to promote access to coverage and continuity of coverage to solve these problems. Medicaid is designed to include many protections that ensure that beneficiaries get the health care services they need when they need them. These protections are critical in ensuring that Medicaid provides the best benefit to individuals enrolled in coverage, and the best value to the country.

This issue brief highlights select Medicaid protections designed to ensure access to coverage and care, their importance for low-income populations, and the potential harmful impact under proposals to cap or cut Medicaid spending. These protections include:

- The right to enroll in Medicaid promptly;
- Point-in time eligibility
- Retroactive coverage
- Coverage during the postpartum period
- Automatic eligibility for babies born to parents on Medicaid
- Prohibition on illegal eligibility conditions
- Assurance of transportation to medical appointments
- Access to prescription drugs
- Guarantees that beneficiaries will have access to the providers they need.

1. Medicaid provides access to coverage.

Getting into coverage quickly without unnecessary delays is crucial to low-income Americans. By 2016, applicants could enroll online or by telephone in almost every state, and 37 states made eligibility determinations within 24 hours of application.[5] Without this, low-income Americans are less likely to get the care that they need, and more likely to have worse health outcomes while incurring bills and debt they are ill-equipped to pay.[6] When low-income Americans do get care they need while uninsured, the health system—and especially safety-net providers and hospitals—are often called on to absorb the cost of delivering care.[7] Medicaid attempts to address these concerns by including protections that require state

Medicaid programs to process applications quickly and enroll people in coverage promptly. Limiting Medicaid enrollment to certain times could leave Medicaid-eligible Americans without access to health care coverage when they need it most, and it would subject them to bankruptcy and financial strain if they were forced to pay for services out-of-pocket. Only Medicaid utilizes an application and enrollment system which ensures access to coverage for low-income people. The special rules for enrollment in Medicaid are fundamental to keeping the program operating efficiently.

a. Medicaid ensures prompt enrollment.

In recognition of the need for prompt access, the Medicaid Act grants Medicaid-eligible Americans the right to apply for the program without delay.[8] Furthermore, the Medicaid Act requires that Medicaid "shall be furnished with reasonable promptness to all eligible individuals."[9] In other words, the law ensures that low-income Americans who need health care are able to apply and enroll in the program quickly at any time of the year, without being subject to an annual enrollment period. Low-income Americans have higher incidence of acute health and mental health care conditions that require quick access to care.[10] Thus, the reasonable promptness protection is vital to ensuring that the program operates efficiently.

In addition, ensuring that low-income Americans can enroll in coverage quickly benefits the entire health care system. First, prompt access to necessary coverage means that low-income Americans are more likely to get care.[11] As a result, providers are less likely to have to absorb the costs of providing care to low-income, uninsured patients.[12] Second, because low-income Americans are more likely to get care when they have coverage, they are more likely to treat their health conditions earlier, before they progress to the point of requiring more invasive and expensive interventions.[13] Encouraging people to get care quickly helps the health care system to operate more efficiently.

Capped funding schemes, such as a block grant, would undo this important protection by allowing states to cap enrollment of individuals who are eligible for Medicaid coverage. When Oregon implemented a cap on its Medicaid Expansion program before the ACA, the outcomes were bleak for those who did not get Medicaid: they were less likely to use health care services (including primary and preventive care in addition to acute care), they spent more for the care they did receive and were more likely to incur medical debt (including more bills sent to collection), and they self-reported worse physical and mental health status than those who got Medicaid.[14] Requiring more low-income Americans to wait to enroll in Medicaid is likely to lead to similarly poor outcomes.[15]

b. Medicaid provides for retroactive and point-in-time eligibility.

The Medicaid Act also operates efficiently for low-income Americans by ensuring they can get coverage when they need it. The Marketplace, like most commercial insurance, effectuates enrollment on a date one to two months subsequent to application.[16] Medicaid enrollees often have urgent medical needs and cannot afford to wait for months, and also lack the means to pay for their care in the interim.[17] To solve these problems, Medicaid uses a unique "point-in-time" eligibility system which makes enrollment effective as of the date of application, even if the application is not processed immediately.[18] Furthermore, since a medical event may render an individual unable to apply for coverage for some amount of time, in most circumstances Medicaid actually offers retroactive coverage. Generally, Medicaid will pay for any bills for health care treatment during the three months *prior to* the month of application if the individual would have qualified for Medicaid during that retroactive period.[19]

These provisions are crucial to Medicaid recipients because it helps ensure they receive care and protects them from overwhelming medical bills. Recent studies suggest that low-income Americans are more likely to suffer accidents, including car accidents and unintentional house fires, that require immediate medical attention.[20] Medicaid's retroactive and point-in-time eligibility protections mean that low-income Americans can focus on getting the health care services they need to treat and illness or injury, not rushing to apply for coverage in hopes of avoiding medical bills and debt. Importantly, these provisions also protect the health care system, as providers and health systems have a source of payment for care that otherwise would be uncompensated.[21] Thus, this provision not only protects low-income Americans from medical bills they cannot afford, but it also makes an investment in the health care safety net by ensuring that health care providers get paid for the care they deliver.

2. Medicaid guarantees access to care.

Medicaid's service package is a critical component to effective coverage for low-income people.[22] However, health coverage is only as good as the individual's access to health care services and providers. Medicaid is designed to include many protections that ensure that beneficiaries get more than a coverage card.[23] Medicaid ensures that beneficiaries have access to a range of services specifically designed for their needs. These include services that have not historically been available in commercial insurance, such as occupational therapy, behavioral health, prenatal care, and long term services and supports.[24] These protections are critical in ensuring that Medicaid provides the best benefit to individuals enrolled in coverage, and the best value to the country.

a. Medicaid ensures that beneficiaries have access to coordinated primary and specialty care.

Medicaid beneficiaries have unique health care needs. Low-income Americans tend to have worse health than their higher-income counterparts. They are more likely to have chronic health conditions and disabilities, to have multiple co-occurring health conditions, and to experience acute illnesses. Medicaid provides the mix of primary and specialty care that can ensure the care low-income Americans need.[25]

Not only that, but Medicaid is designed to ensure that those services are delivered in a coordinated fashion to so that beneficiaries' care is efficient and organized. For example, Medicaid is at the forefront of using patient-centered medical homes to coordinate care delivery for beneficiaries.[26] Patient-centered medical homes are designed to serve beneficiaries with multiple health needs, provide easy access to providers through extended office hours and phone consultations, coordinate prescriptions across multiple providers, and encourage shared decision making between providers and patients.[27] Patients who are part of a patient-centered medical home model tend to use services more efficiently and report better health outcomes.[28] This model has been shown to be particularly effective at ensuring that people with chronic conditions receive the care they need in a coordinated and efficient manner.[29]

b. Medicaid ensures low-income Americans have transportation to their care.

Lack of transportation poses a serious barrier to health care. The barrier is especially acute for low-income Americans who tend to have fewer transportation options and more significant health care needs. By one estimate, nearly 3.6 million adults miss or delay needed care each year due to difficulties with transportation.[30] Under the Medicaid Act, all states must perform administrative functions necessary for the proper and efficient operation of their Medicaid programs.[31] CMS has long interpreted this provision to require states to ensure that enrollees have access to necessary transportation to and from Medicaid providers.[32] This requirement ensures that Medicaid beneficiaries are able to access the health care services Medicaid provides, in keeping with the very purpose of the Medicaid program.[33]

Research suggests that providing Medicaid beneficiaries with transportation not only improves health outcomes, but can also save Medicaid programs' money. Transportation barriers are associated with significantly reduced medication adherence.[34] Medication adherence can improve control of chronic conditions, reducing costly hospitalizations or emergency department visits. Thus, offering transportation assistance to needy individuals with common chronic conditions, like asthma, diabetes, and heart disease, can actually save more than the transportation benefit costs.[35] Similarly, improving access to prenatal visits through

transportation saves an estimated $367 per childbirth for pregnant women with limited transportation options, primarily by reducing premature births.[36]

3. Medicaid ensures access to providers.

Health coverage is only as good as the individual's access to health care providers who can deliver services that people need. Beneficiaries must be able to find a provider who accepts Medicaid and who has the right training and expertise. Because some health care services—such as reproductive health and behavioral health services—are sensitive, beneficiaries also need to be able to choose a provider who is a good fit for their needs. Medicaid has protections aimed at preserving beneficiaries' choice of provider and ensuring that there are enough providers with the right experience participating in the program.

a. Medicaid protects low-income Americans' right to have access to a range of providers who deliver the care they need.

To have true access, Medicaid beneficiaries must be able to access the range of providers who are qualified to deliver the care that they need. Finding a provider who is the right fit is more than just a matter evaluating providers' credentials and education. Particularly for low-income Americans with medically complex conditions, or multiple chronic conditions, it means finding a provider with the experience and knowledge to manage a multifaceted treatment plan. When consumers are able to choose their providers, they experience greater patient satisfaction and higher quality care.[37] For low-income Americans who need sensitive services that are sometimes stigmatized, such as mental health care and substance use disorder services, finding a provider with whom they feel comfortable is especially important.[38]

The Medicaid Act contains explicit protections to ensure that, regardless of the beneficiaries' need, they will be able to find a provider who accepts Medicaid. For this reason, Medicaid regulations require state Medicaid programs to make available information about participating providers—whether in fee-for-service programs or in managed care.[39] These requirements ensure that Medicaid beneficiaries know which providers are available to them and can locate providers to make appointments when they need care.

Of course, public information about providers is not enough. Medicaid programs must ensure that there are a sufficient number of providers participating in the program to deliver the services that beneficiaries need. When a state delivers services on a fee-for-service basis, federal regulations require Medicaid programs to monitor access to care on a regular basis in the following areas: primary care services (including those provided by a physician, FQHC, clinic, or dental care); physician specialist services; behavioral health services (including

mental health and substance use disorders); pre- and post-natal obstetric services including labor and delivery; home health services; any other services where the state has recently reduced payment rates; and any other services for which the state or CMS has identified an access issue.[40] The state must establish a mechanism for beneficiaries and providers to notify the state of access problems of potential problems so that the state can investigate further.[41]

Similarly, when states contract with Medicaid managed care plans to deliver services they must take steps to ensure that those plans contract with "a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."[42] States must set standards for their Medicaid managed care plans that ensure the plans provide access to adult and pediatric primary care; OB/GYNs; adult and pediatric behavioral health providers (mental health and substance use disorders); adult and pediatric specialists; hospitals; pharmacies; and pediatric dentists.[43] In addition, whenever a beneficiary needs a service that is not available from one of the providers in a plan's network, Medicaid rules require the plan to allow the beneficiary to see an out-of-network provider to receive that service.[44] Thus, Medicaid contains protections that ensure that beneficiaries will have access to the care they need.

b. Medicaid ensures that beneficiaries can choose the right provider for family planning services.

To get effective family planning services, people must divulge personal and sometimes sensitive information to their health care providers. Beneficiaries are more likely to obtain reproductive health services they need, such as family planning, when they can choose a provider with whom they are comfortable.[45] Choice also ensures that beneficiaries can find a provider who offers the particular contraceptive method that is best for them.[46] Giving beneficiaries a choice is particularly important since, in many states, providers have the right to refuse to provide certain family planning services due to a moral or ethical objection.[47] In addition, there may be times when—for their own safety or wellbeing—beneficiaries must seek these services confidentially, which is facilitated by provider choice.[48]

In recognition of the importance of choice in this context, Congress required state Medicaid programs to allow beneficiaries to receive family planning from the provider of their choice, even if they are enrolled in a managed care plan that otherwise limits their provider choice.[49] Interpreting this provision, the Seventh Circuit Court of Appeals concluded that a state Medicaid program may restrict an individual's right to choose their family planning provider only if it determines that the providers who are available are not "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner."[50]

Enabling Medicaid beneficiaries to choose the provider who delivers their family planning services enhances their health outcomes and allows them to maintain confidentiality.

Conclusion

With an array of optional benefits and services, as well as optional eligibility categories, states can design their Medicaid programs to best suit the needs of residents. This flexibility, however, is threatened by proposals to cap federal Medicaid funding. States will lose billions of dollars in federal Medicaid funding under per capita caps, which will invariably lead to cuts in services. These cuts will threaten access to coverage, care, and providers by low-income and vulnerable populations, such as persons with chronic conditions, children, pregnant women, older adults, and persons with disabilities. The impact of these cuts will reach far beyond Medicaid enrollees as communities experience the long-term effects of children with untreated medical conditions and an aging population facing institutionalization because they lack access to home and community-based care.

ENDNOTES

[1] 42 U.S.C. § 1396a(a)(10)(A)(i) (mandatory populations); *id.* § 1396d(a)(10)(A)(ii) (optional categories).
[2] *See, e.g.,* ROBIN RUDOWITZ, *ET. AL.,* MEDICAID REFORMS TO EXPAND COVERAGE, CONTROL COSTS AND IMPROVE CARE: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2015 AND 2016 at 5-8 (2016), http://files.kff.org/attachment/report-medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016.
[3] 42 USC § 1396u-2(a).
[4] *See* RUDOWITZ, *ET. AL., supra,* note 2 at 35-41, 49-51.
[5] TRICIA BROOKS *ET AL*., KAISER FAMILY FOUND., MEDICAID AND CHIP ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES AS OF JANUARY 2016: FINDINGS FROM A 50-STATE SURVEY 2 (2016), http://files.kff.org/attachment/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey.
[6] *See, e.g.,* Amy Finkelstein *et al., The Oregon Health Insurance Experiment: Evidence from the First Year,* 127 Q. J. ECON. 1057 (2012) (when Oregon gave Medicaid to some low-income residents but not others, those who went without coverage were less likely to get care, were more likely to have medical bills and debt, and reported worse health and mental health status).
[7] David Dranove *et al., Uncompensated Care Decreased At Hospitals In Medicaid Expansion States But Not At Hospitals In Nonexpansion States,* 35 HEALTH AFF. 1471 (2016) (expanded Medicaid coverage associated with decreases in uncompensated care).
[8] 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.
[9] 42 U.S.C. § 1396a(a)(8); *see also Wilson v. Gordon*, 822 F.3d 934, 954 (6th Cir. 2016) (in NHeLP co-counseled case, finding that plaintiffs were likely to succeed on their "reasonable promptness" claim because the fact that the federal government was delayed in transmitting information to the state about Medicaid applicants did not excuse the state from processing applications promptly).
[10] *See, e.g.,* Erica S. Spatz *et al., Geographic Variation in Trends and Disparities in Acute Myocardial Infarction Hospitalization and Mortality by Income Levels, 1999-2013,* 3 JAMA CARDIOLOGY 255 (2016) (lower income Americans more likely to be hospitalized for and die from heart attack); Jennifer A. Pellowski *et al., A pandemic of the poor: social disadvantage and the U.S. HIV epidemic,* 68 AM. PSYCH. 197 (2013) (HIV most prevalent among people living below the poverty line); Juliet Addo *et al., Socioeconomic Status and Stroke: An Updated Review,* 43 STROKE 1186 (2012) (incidence of stroke three times higher for low-income Americans); Jitender Sareen *et al., Relationship Between Household Income and Mental Disorders,* 68 ARCH. GEN. PSYCHIATRY 419 (2011) (low-income Americans more likely to experience mental illness and attempt suicide).
[11] *See* Finkelstein *et al., supra* note 6.
[12] *See, e.g.,* Dranove *et al., supra* note 7; *see also* Sayeh Nikpay *et al., Early Medicaid Expansion In Connecticut Stemmed The Growth In Hospital Uncompensated Care,* 34 HEALTH AFF. 1170 (2015).
[13] *See generally* INST. OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002).
[14] *See* Finkelstein *et al., supra* note 6.
[15] *See, e.g.,* INST. OF MEDICINE, *supra* note 13, at 87 (after summarizing research on the consequences of uninsured individuals delaying and forgoing care, concluding: "uninsured adults receive health care services that are less adequate and appropriate than those received by patients who have either public or private health insurance, and they have poorer clinical outcomes and poorer overall health than do adults with private health insurance").
[16] 45 C.F.R. § 155.410(f).
[17] *See* Finkelstein *et al., supra,* note 6; *see also* sources cited *supra*, note 10.
[18] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.
[19] *Id*.

[20] *See, e.g.,* Samantha L Turner *et al., Risk Factors Associated with Unintentional House Fire Incidents,*

Injuries and Deaths in High-Income Countries, 42 INJURY PREVENTION 174 (2017); Sam Harper *et al., Trends in Socioeconomic Inequalities in Motor Vehicle Accident Deaths in the United States, 1995-2010,* 182 AM. J. EPIDEMIOLOGY 606 (2015).

[21] *See* Dranove *et al., supra,* note 7; Nikpay *et al., supra,* note 12.

[22] *See generally,* WAYNE TURNER *ET AL.,* NAT'L HEALTH LAW PROG., WHAT MAKES MEDICAID, MEDICAID? SERVICES (2017), http://www.healthlaw.org/publications/browse-all-publications/what-makes-medicaid-medicaid-services.

[23] 42 U.S.C. § 1396a(a)(8) (requiring Medicaid programs to provide prompt access to medical assistance); *see B.E. v. Teeter*, No. C16-227-JCC, 2016 WL 3033500 at *5 (W.D. Wash. May 27, 2016) (finding Medicaid program's policy of delaying treatment for hepatitis C until disease reached advanced stages was likely to violate Medicaid Act); *see also Allen v. Mansour*, 681 F. Supp. 1232, 1238 (E.D. Mich. 1986) (finding two year waiting period for liver transplant unreasonable).

[24] *B.E.,* 2016 WL 3033500 at 3-4, 7-8.

[25] *See id.*

[26] Peter J. Cunningham, *Many Medicaid Beneficiaries Receive Care Consistent With Attributes Of Patient-Centered Medical Homes*, 34 HEALTH AFF. 1105 (2015), http://content.healthaffairs.org/content/34/7/1105.short#aff-1; *see also* Mary Takach, *About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations*, 31 HEALTH AFF. 2432 (2012), http://content.healthaffairs.org/content/31/11/2432.short.

[27] *See* Cunningham, *supra*, note 26 at 1106.

[28] *See, e.g.,* KEVIN GRUMBACH & PAUL GRUNDY, OUTCOMES OF IMPLEMENTING PATIENT CENTERED MEDICAL HOME INTERVENTIONS 1 (2010) ("Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization."), http://3ww.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf.

[29] *See, e.g.,* Jeanne Van Cleave *et al, Care Coordination Over Time in Medical Homes for Children With Special Health Care Needs,* 135 PEDIATRICS 1018, 1024 (2015) (effectiveness for children with special health care needs), http://pediatrics.aappublications.org/content/pediatrics/135/6/1018.full.pdf; Audrey L. Jones *et al., Usual Primary Care Provider Characteristics of a Patient-Centered Medical Home and Mental Health Service Use,* 30 J. GEN. INTERNAL MED. 1828 (2015) (effectiveness for individuals with behavioral health care needs), https://link.springer.com/article/10.1007/s11606-015-3417-0.

[30] PAUL HUGHES-CROMWICK & RICHARD WALLACE, ALTARUM INST., COST BENEFIT ANALYSIS OF PROVIDING NON-EMERGENCY MEDICAL TRANSPORTATION 3 (2005), http://www.trb.org/Main/Blurbs/156625.aspx.

[31] 42 U.S.C. § 1396a(a)(4)(A); *see also* 42 C.F.R. §§ 431.53, 440.170(a); HEW, MEDICAID ASSISTANCE MANUAL § 6-20-00, at 2 (1978) The Medicaid Assistance Manual, though superseded in many instances by the State Medicaid Manual, contains important statements of early agency policy. Courts continue to cite the Medical Assistance Manual with favor, while others have not accorded it great weight.

[32] 42 C.F.R. § 431.53. Note that several courts have found that the regulation is not enforceable under 42 U.S.C. § 1983. *See, e.g., Harris v. James*, 127 F.3d 993, 1112 (11th Cir. 1997)

[33] 42 U.S.C. § 1396a (the primary goal of the program is to provide medical assistance to certain needy individuals and furnish them with rehabilitation and other services to help them "attain or retain capability for independence or self-care").

[34] Timothy E. Welty *et al.*, *Effect of Limited Transportation on Medication Adherence in Patients with Epilepsy*, 50 J. AM. PHARM. ASSOC. 698 (2010); Ramzi G. Salloum *et al.*, *Factors Associated with Adherence to Chemotherapy Guidelines in Patients with Non-small Cell Lung Cancer*, 75 LUNG CANCER 255 (2012).

[35] HUGHES-CROMWICK & WALLACE, *supra,* note 30.

[36] Richard Wallace *et al.*, *Cost-Effectiveness of Access to Nonemergency Medical Transportation*, 1956 TRANSPORTATION RESEARCH RECORD 86, 93 (2006); Talia McCray, *Delivering Healthy Babies: Transportation and Healthcare Access*, 15 PLANNING PRACTICE & RESEARCH 17 (2000).

[37] *See, e.g.,* JEANNE M. LAMBREW, "CHOICE" IN HEALTH CARE: WHAT DO PEOPLE REALLY WANT? 3 (2005), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2005/sep/choice--in-health-care--what-do-people-really-want/lambrew_853_choice_ib-pdf.pdf.
[38] *See, e.g.,* Jay Scharf *et al., Dropout and Therapeutic Alliance,* 47 PSYCHOTHERAPY 637 (2010) (mental health services); Petra S. Meier, *et al., The Role of the Therapeutic Alliance in the Treatment of Substance Misuse,* 100 ADDICTION 304 (2005) (substance use disorder services).
[39] 42 C.F.R. § 440.204 (fee-for-service Medicaid); *id.* § 438.10(h) (Medicaid managed care).
[40] *Id.* § 440.204(b)(5).
[41] *Id.* § 440.204(b)(7).
[42] *Id.* § 438.207(b)(2).
[43] *Id.* § 438.68(b)(1).
[44] *Id.* § 438.206(b)(4).
[45] JUDITH SOLOMON, PROTECTING MEDICAID BENEFICIARIES' FREEDOM TO CHOOSE PROVIDERS (2016).
[46] Jennifer Frost & Kinsey Hasstedt, *Quantifying Planned Parenthood's Critical Role In Meeting The Need For Publicly Supported Contraceptive Care*, Health Aff. Blog, Sep. 8, 2015, http://healthaffairs.org/blog/2015/09/08/quantifying-planned-parenthoods-critical-role-in-meeting-the-need-for-publicly-supported-contraceptive-care.
[47] *See, e.g.,* NAT'L HEALTH LAW PROG., HEALTH CARE REFUSALS AND CONTRACEPTION: UNDERMINING QUALITY CARE (2012), http://www.healthlaw.org/issues/reproductive-health/health-care-refusals/health-care-refusals-and-contraception-undermining-quality-care; RENEE SCHWALBERG *ET AL.,* KAISER FAMILY FOUND., MEDICAID COVERAGE OF FAMILY PLANNING SERVICES: RESULTS OF A NATIONAL SURVEY 41-44 (2013), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-coverage-of-family-planning-services-results-of-a-national-survey-report.pdf.
[48] SCHWALBERG *ET AL., supra,* note 47, at 40-41; JULIE LEWIS *ET AL.,* CONFIDENTIALITY PROTECTIONS - IMPLICATIONS ON ACCESS TO SEXUAL AN REPRODUCTIVE HEALTH CARE (2016), http://www.healthlaw.org/issues/reproductive-health/Webinar-Confidentiality-Protections.
[49] 42 U.S.C. § 1396a(a)(23); *see* CMS, SMD # 16-005 (Apr. 19, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf; *see also, e.g.,* USHA RANJI *ET AL*., KAISER FAMILY FOUND., MEDICAID AND FAMILY PLANNING: BACKGROUND AND IMPLICATIONS OF THE ACA (2016), http://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca.
[50] *Planned Parenthood v. Com'r of Dep't Health*, 699 F. 3d 962, 968 (7th Cir. 2012).