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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 people and newborns
- Medicaid ensures that beneficiaries can get to their health 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.

Introduction

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 people living in the United States often face urgent health care problems and need to access 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 health care emergency away from financial collapse. 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, including preventative services that can reduce higher Medicaid expenses in the future.

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

- Prompt enrollment in Medicaid
- Retroactive and point-in-time eligibility
- Coordination of primary and specialty care services
- Assurance of transportation to health care
- Right to access to a range of health care providers
- Freedom to choose the right provider for family planning services

Medicaid provides access to coverage

Getting coverage quickly and without unnecessary delays is crucial to the health and safety of low-income people living in the United States. As of January 2023, all states accept applications online, forty-eight states offer online accounts that make it easier to submit and access coverage information, and forty-eight states report being able to make eligibility determinations within twenty-four hours of application.[5] Without prompt access to coverage, low-income individuals are less likely to get the care that they need and more likely to have worse health outcomes while incurring bills and debt they cannot pay.[6] When low-income

people do get care they need while uninsured, the health system—and especially safety-net providers and hospitals—often 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 only certain times of the year could leave Medicaid-eligible individuals 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. Medicaid utilizes an application and enrollment system that ensures access to coverage for low-income people. The special rules for enrollment in Medicaid are fundamental to keeping the program operating efficiently.

Medicaid ensures prompt enrollment

In recognition of the need for prompt access, the Medicaid Act grants Medicaid-eligible individuals the right to apply for the program "without delay."[8] Further, the Medicaid Act requires that Medicaid coverage "shall be furnished with reasonable promptness to all eligible individuals."[9] In other words, the law ensures that low-income individuals 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 people have higher incidence of acute physical and mental health 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 individuals can enroll in coverage quickly benefits the entire health care system. First, prompt access to necessary coverage means that low-income individuals 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 individuals are more likely to get care when they have coverage, they are more likely to seek preventative care and 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 and, by treating conditions at their onset, can reduce Medicaid expenses in the long term.

Capped funding schemes, such as block grants, would undo this important protection by allowing states to cap enrollment of individuals who are eligible for Medicaid coverage. For example, when Oregon implemented a cap on its Medicaid Expansion program prior to the passage of the Affordable Care Act (ACA), the outcomes were bleak: individuals who were locked out of Medicaid because of the cap were less likely to use health care services (including primary care, preventive care, and 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 reported worse physical and mental health statuses than those who were able to enroll in Medicaid.[14] If funding cuts were implemented, states might impose waiting periods for enrollment, which would likely cause similarly negative outcomes in access to care and health status.[15]

Medicaid provides for retroactive and point-in-time eligibility

The Medicaid Act also guarantees that low-income people can get Medicaid coverage when they need it. Most private health insurance plans, including those purchased on the "Marketplace" or "Exchange," enroll consumers in a health plan one to two months after they apply.[16] Medicaid enrollees often have urgent medical needs, and they lack the means to pay for care while they wait for their health coverage to start.[17] To solve this problem, Medicaid uses a unique "point-in-time" eligibility system, which makes enrollment effective on the date of application, even if the application is not processed immediately.[18] Further, because a medical event can render an individual unable to apply for coverage for some amount of time, Medicaid will offer retroactive coverage in most circumstances. Generally, Medicaid will pay for health care services during the three months prior to the month of application if the individual would have qualified for Medicaid during those prior three months.[19]

These provisions are important to Medicaid recipients because it helps ensure that they receive care and it protects them from overwhelming medical bills. Studies suggest that low-income people in the United States are more likely to experience 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 people can focus on getting the health care services they need to treat their illness or injury, and not stress about immediately applying 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 individuals from medical bills they cannot afford, but it also makes an investment in the health care system by ensuring that health care providers get paid for the care they deliver.

Medicaid guarantees access to care

Medicaid's service package is a critical component of ensuring that low-income people have access to effective health care coverage.[22] 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 private insurance plans, 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 benefits to individuals enrolled in coverage, and that the program is cost-effective.

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

Medicaid beneficiaries have unique health care needs. Low-income people living in the United States tend to have worse health than their higher-income counterparts. They are more likely to have chronic health conditions, multiple co-occurring conditions, and to experience acute illnesses. Low-income people are also more likely to have disabilities and lack access to the supports and services they need to equally participate in their communities. Medicaid provides a mix of primary, specialty, and long-term care that can ensure that the health needs of low-income people are met.[25]

Medicaid is also designed to ensure that the delivery of services is coordinated, such that the beneficiary's care is efficient and organized, and the potential for positive health outcomes is maximized. For example, Medicaid is at the forefront of using "patient-centered medical homes" (PCMHs), which is a health care delivery model in which a primary care provider works with a care team to coordinate all aspects of patient care.[26] PCMHs 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 PCMHs 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]

Medicaid ensures that low-income individuals have transportation to health care

Lack of transportation poses a serious barrier to health care. By one study, nearly 5.8 million adults miss or delay needed care each year due to difficulties with transportation.[30] These barriers are especially acute for low-income people, and particularly those with functional impairments, who tend to have fewer transportation options and more significant health care needs.[31] Under the Medicaid Act, all states must perform administrative functions necessary for the proper and efficient operation of their Medicaid programs.[32] CMS has long interpreted

this provision to require states to ensure that enrollees have access to necessary transportation to and from Medicaid providers.[33] This requirement ensures that beneficiaries are able to access the health care services that Medicaid provides, in keeping with the core purpose of the program.[34]

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.[35] Medication adherence can improve control of chronic conditions, reducing costly hospitalizations or emergency department visits.[36] Thus, offering transportation assistance to low-income individuals with common chronic conditions, like asthma, diabetes, and heart disease, can actually save more than the transportation benefit costs.[37] Similarly, improving access to prenatal and postnatal visits through transportation reduces parent and infant mortality and helps prevent birth complications, including premature birth, which can significantly reduce health costs associated with pregnancy, childbirth, and postnatal care.[38]

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 they need. Beneficiaries must be able to find a provider who accepts Medicaid and who has the right training and expertise. Because many health care services—such as reproductive and sexual health and behavioral health services—are particularly dependent on trust and sensitivity in the patient-provider relationship, beneficiaries also need to be able to choose a provider who is culturally competent and a good fit for their individual needs. Medicaid has protections aimed at preserving beneficiaries' choice of provider and ensuring that there are providers with a wide range of expertise participating in the program.

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

In order to guarantee access to health care, a diversified set of qualified providers must be made available to Medicaid beneficiaries. Finding a provider who is the "right fit" is more than just a matter of evaluating a provider's credentials and education. Particularly for low-income individuals with medically complex conditions, or multiple chronic conditions, it means finding a provider with the experience, knowledge, and training to manage a multifaceted treatment plan in a culturally competent manner. When beneficiaries are able to choose their providers, they experience greater patient satisfaction and higher quality care.[39] For low-income individuals who need services that are sometimes stigmatized, such as mental health care or

substance use disorder services, finding a provider with whom they feel comfortable is especially important.[40]

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.[41] 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.[42] 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, Federally Qualified Health Center, clinic, or dental provider); 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 the Centers for Medicare & Medicaid Services (CMS) has identified as an access issue.[43] The state must also establish a mechanism for beneficiaries and providers to notify them of potential access problems so that the state can investigate further.[44]

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."[45] States must set standards for their Medicaid managed care plans to ensure that they provide access to adult and pediatric primary care; OB/GYNs; adult and pediatric behavioral health providers (for mental health and substance use disorders); adult and pediatric specialists; hospitals; pharmacies; pediatric dentists;[46] and providers of long-term services and supports.[47] 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.[48] Thus, Medicaid contains protections to ensure that beneficiaries will have access to the providers they need to improve and maintain their health.

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

To get effective family planning services, individuals often need to divulge personal and sometimes sensitive information to their health care providers. Beneficiaries are more likely to obtain the reproductive health services they need, such as family planning, when they can choose a provider with whom they are comfortable.[49] Choice also ensures that beneficiaries can find a provider who offers the particular contraceptive method that is best for them.[50] Giving beneficiaries a choice is particularly important because, in many states, providers refuse to provide certain family planning services due to a moral or ethical objection.[51] 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.[52]

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 provider choice.[53] Additionally, states cannot set unreasonable qualification standards or otherwise take action against family planning providers that could interfere with beneficiaries' access to those providers.[54] Qualified family planning providers can include individual providers, physician groups, outpatient clinics, and hospitals, even if they separately provide family planning services or the full range of legally permissible gynecological and obstetric care, including abortion services (as permitted by state and federal law), as part of their scope of practice.[55] This "freedom of choice" protection is critical to ensuring that Medicaid beneficiaries can choose a provider with whom they are comfortable, is familiar with their health history, and can provide immediate and time-sensitive care.

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 their residents. This flexibility, however, is threatened by proposals to limit federal Medicaid funding. If enacted, states will lose billions of dollars in federal Medicaid funding under per capita caps or block grants, which will invariably lead to cuts in services. These cuts will threaten access to coverage, care, and providers for low-income and underserved populations, such as people with chronic conditions, children, pregnant people, older adults, and people with disabilities. The impact of these cuts will reach far beyond Medicaid enrollees, as communities will experience the long-term effects of children who go without needed health care and an aging population that may face institutionalization because they lack access to home and community-based care.

Additional Resources

- For information on other aspects of Medicaid, see our entire series on What Makes Medicaid, Medicaid.

ENDNOTES

[1] 42 U.S.C. §§ 1396a(a)(10)(A)(i) (mandatory populations), 1396d(a)(10)(A)(ii) (optional categories).
[2] *See, e.g.,* Tricia Brooks et al., Kaiser Family Found., *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey* (Mar. 2021), https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2021-Findings-from-a-50-State-Survey.pdf; Kathleen Gifford et al., Kaiser Family Found., *A View from the States: Key Medicaid Policy Changes Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020*, at 8–14 (Oct. 2019), https://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes.
[3] 42 U.S.C. § 1396u-2(a).
[4] *See* Gifford et al., *supra* note 2, at 18–38 (delivery system and payment models), 70–75 (provider rates).
[5] Tricia Brooks et al., Kaiser Family Found., *Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision*, at 25–27 (Mar. 2023), https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf.
[6] *See* Robert Wood Johnson Found., *Medicaid's Impact on Health Care Access, Outcomes and State Economies*, at 1–2 (Feb. 2019), https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html.
[7] *See* David Dranove et al., The Commonwealth Fund, *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal* (May 2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_may_dranove_aca_medicaid_expansion_hospital_uncomp_care_ib.pdf; 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); *see also, e.g.*, Kevin Callison et al., *Medicaid Expansion Reduced Uncompensated Care Costs At Louisiana Hospitals; May Be A Model For Other States*, 40 HEALTH AFF., No. 3, at 529–535 (Mar. 2021), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01677.
[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 an 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 J. AM. MED. ASSOC. CARDIOLOGY 255 (2016) (lower income people living in the United States are 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 individuals); Jitender Sareen et al., *Relationship Between Household Income and Mental Disorders,* 68 ARCH. GEN. PSYCHIATRY 419 (2011) (low-income people more likely to experience mental health disorders and attempt suicide).

[11] ROBERT WOOD JOHNSON FOUND., *supra* note 6, at 1.

[12] *See, e.g.,* Dranove et al., *supra* note 7; Callison et al., *supra* note 7.

[13] *See generally* Prevention Inst. & The Cal. Endowment, *Reducing Health Care Costs Through Prevention* (Aug. 2007), https://www.preventioninstitute.org/sites/default/files/publications/HE_Health%20Care%20Reform%20Policy%20Draft_040511.pdf; Inst. of Medicine, *Care Without Coverage: Too Little, Too Late* (2002), https://pubmed.ncbi.nlm.nih.gov/25057604/.

[14] *See* Robert Wood Johnson Found., *supra* note 6, at 2; Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year,* 127 Q. J. ECON. 1057 (2012).

[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* Robert Wood Johnson Found., *supra* note 6, at 1; *see also, e.g.*, Finkelstein et al., *supra* note 14; Spatz et al., *supra* note 10; Pellowski et al. *supra* note 10; Sareen et al., *supra* note 10.

[18] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.

[19] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.

[20] *See, e.g.,* Samantha 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; Callison et al., *supra* note 7.

[22] *See generally* Wayne Turner et al., Nat'l Health Law Prog., *What Makes Medicaid, Medicaid? – Services* (Mar. 2023), 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 the Medicaid program's policy of delaying treatment for Hepatitis C until the 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, e.g., id.*

[26] Peter J. Cunningham, *Many Medicaid Beneficiaries Receive Care Consistent With Attributes Of Patient-Centered Medical Homes*, 34 HEALTH AFFAIRS 1105 (2015),

https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0141; *see also* Mary Takach, *About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations*, 31 HEALTH AFFAIRS 2432 (2012), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0447.

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

[28] *See, e.g.,* Kevin Grumbach & Paul Grundy, *Outcomes of Implementing Patient Centered Medical Home Interventions*, at 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), https://pubmed.ncbi.nlm.nih.gov/25963012/; 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] Mary K. Wolfe et al., *Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997–2017*, 110 AM. J. PUB. HEALTH, no. 6, at 815–22 (June 1, 2010).

[31] *Id.*

[32] 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.

[33] 42 C.F.R. § 431.53. Note that several courts have found that this regulation is not enforceable under 42 U.S.C. § 1983. *See, e.g., Harris v. James*, 127 F.3d 993, 1112 (11th Cir. 1997).

[34] 42 U.S.C. § 1396–1 (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.").

[35] Caroline Hensley et al., *Poverty, Transportation Access, and Medication Nonadherence*, 141 PEDIATRICS, no. 4, at 1–11 (Apr. 2018); 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).

[36] Jonathan Watanabe et al., *Cost of Prescription Drug-Related Morbidity and Mortality*, 52 ANNALS PHARMACOTHERAPY no. 9, at 829–37 (Sept. 2018) (The estimated annual medical costs of morbidity and mortality resulting from nonoptimized medication therapy, including medication nonadherence, is $528.4 billion, equivalent to 16% of total U.S. health care expenditures in 2016).

[37] Richard Wallace et al., *Cost-Effectiveness of Access to Nonemergency Medical Transportation: Comparison of Transportation and Health Care Costs and Benefits*, 1956 J.

TRANSP. RESEARCH BD. 86–93 (2006); Paul Hughes-Cromwick et al., Transp. Research Bd., Nat'l Acads. Sci., Eng'g, & Med., *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation* (Oct. 2005), https://nap.nationalacademies.org/catalog/22055/cost-benefit-analysis-of-providing-non-emergency-medical-transportation.

[38] *See, e.g.*, Joan Rosen Bloch, *Beyond bus fare: Deconstructing Prenatal Care Travel among Low-income Urban Mothers through a Mix Methods GIS Study*, 54 CONTEMP. NURSE, no.3, at 233–45 (June 2018); Talia McCray, *Delivering Healthy Babies: Transportation and Healthcare Access*, 15 PLANNING PRACTICE & RESEARCH 17 (2000).

[39] *See, e.g.,* Andrzej Kozikowski et al., *Choosing a Provider: What Factors Matter Most to Consumers and Patients?*, 9 J. PATIENT EXPERIENCE 1–9 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8785326/pdf/10.1177_23743735221074175.pdf; Jeanne M. Lambrew, *"Choice" in Health Care: What Do People Really Want?*, The Commonwealth Fund, at 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.

[40] *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).

[41] 42 U.S.C. § 1396a(23); *see also* 42 C.F.R. § 431.51.

[42] 42 C.F.R. §§ 447.203 (fee-for-service Medicaid), 438.10(h) (Medicaid managed care).

[43] *Id.* § 447.203(b)(5).

[44] *Id.* § 447.203(b)(7).

[45] *Id.* § 438.207(b)(2).

[46] *Id.* § 438.68(b)(1).

[47] *Id.* § 438.68(b)(2).

[48] *Id.* § 438.206(b)(4).

[49] *See, e.g.,* Debora Goldberg et al., *Patient perspectives on quality family planning services in underserved areas*, 4 PATIENT EXPERIENCE J., no. 1 at 54–65 (2017), https://pxjournal.org/cgi/viewcontent.cgi?article=1194&context=journal.

[50] Julie Solo & Mario Festin, *Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations*, 7 GLOBAL HEALTH SCI. & PRACTICE, no. 3, at 371–85 (Sept. 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6816811/; Jennifer Frost & Kinsey Hasstedt, *Quantifying Planned Parenthood's Critical Role In Meeting The Need For Publicly Supported Contraceptive Care*, HEALTH AFFAIRS, (Sep. 8, 2015), http://healthaffairs.org/blog/2015/09/08/quantifying-planned-parenthoods-critical-role-in-meeting-the-need-for-publicly-supported-contraceptive-care.

[51] *See, e.g.,* Usha Ranji et al., Kaiser Family Found., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, at 28 (Feb. 2022), https://files.kff.org/attachment/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey.pdf; Renee Schwalberg et al., Kaiser Family Found., *Medicaid Coverage of Family Planning Services: Results of a National Survey*, at 41–44 (2013), https://www.kff.org/wp-content/uploads/2013/01/medicaid-coverage-of-family-planning-services-results-of-a-national-survey-report.pdf.

[52] Schwalberg et al., *supra* note 51 at 40–41; *see* Andrew G. Corley et al., *Exploring and Monitoring Privacy, Confidentiality, and Provider Bias in Sexual and Reproductive Health Service Provision to Young People: A Narrative Review*, 19 INT'L J. ENVTL. RESEARCH & PUB. HEALTH, no. 11 (May 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9180733/; Anna W. Brittain et al., *Confidentiality in Family Planning Services for Young People*, 19 AM. J. PREVENTATIVE MED. 85–92 (Aug. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4579525/.
[53] 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51(a)(3); *see* CMS, Dear State Medicaid Director Letter # 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.
[54] CMS, *supra* note 53, at 2.
[55] *Id.*