



What Makes Medicaid, Medicaid? Services

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Key Takeaways

- Under current law, states have tremendous flexibility in designing their Medicaid programs with a wide array of optional services.
- Most Medicaid spending is on optional services and eligibility categories.
- Medicaid services address otherwise unmet health needs in vulnerable populations, such as persons with disabilities and children with complex medical conditions.
- Investments in services, such as maternity care, early detection and treatment of health conditions in children, treatment of chronic conditions, and prevention improve overall population health and help avoid more costly care and hospitalizations.
- Proposals to impose per capita caps and block grants in Medicaid would shift costs to the states and lead to drastic cuts in health services vital for persons who have no other way to obtain them.

Discussion

States have tremendous flexibility when deciding what Medicaid benefits and services they provide. Congress established a broad array of optional services that states can cover, as well as a minimum baseline of services that states must cover (see Appendix for a list of mandatory and optional services).¹ States routinely add, modify, or discontinue optional Medicaid services by amending their state plans; and can provide additional services through waiver programs and demonstration projects.² States can also require prior authorization or other utilization control measures to limit use of certain services and benefits. Studies have shown that these optional services account for 60 percent of state Medicaid spending.³

Because Medicaid beneficiaries are low income and often have unmet health needs, states developed their Medicaid services and benefits packages to address those needs. For example, Medicaid is the principle provider of nursing home care and in-home long term services and supports (LTSS). LTSS are critical for older adults and persons with disabilities, but are not typically covered by Medicare or private insurance.

This issue brief highlights select Medicaid services and their importance for low income populations, and the potential harmful impact to both mandatory and optional services under proposals to cap or cut Medicaid spending. These services include:

- Children’s health services
- Pregnancy-related care
- Family planning services and supplies
- Outpatient prescription drugs
- Non-emergency medical transportation
- Long term services and supports

1. Children’s health services

Children living in poverty have unique health care needs. These children face a number of challenges to their health and development – such as malnourishment and exposure to environmental toxins – that may result in regular developmental deficiencies in the population. Without aggressive intervention and case management, many of these children would never “catch-up” or attain their best possible function.

To address this deficit, children in Medicaid receive a special benefit known as **Early and Periodic Screening, Diagnostic and Treatment**, or “EPSDT.” EPSDT ensures that low-income children are periodically screened for health and developmental problems and referred for further diagnosis and treatment as needed. EPSDT also guarantees that children will receive access to all Medicaid services when needed to correct or ameliorate the conditions, irrespective of any limits in the coverage package for adults.

The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

Department of Health and Human Services, Centers for Medicare & Medicaid Services, *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014)

a. Required screenings

Federal law requires states to provide all Medicaid eligible children periodic screening, vision, and hearing services, at intervals that meet reasonable standards of medical practice.⁴ These screenings help identify a range of health and developmental issues in children, from Autism Spectrum Disorder (ASD), to hearing or vision loss, to signs of physical abuse. The following chart outlines these screenings.

Medical Screens	Additional required screens
<ul style="list-style-type: none"> • Health and developmental history; • Unclothed physical exam; • Immunizations; • Lab tests, including lead blood tests; and • Health education. 	<ul style="list-style-type: none"> • Vision, including eyeglasses; • Hearing, including hearing aids; and • Dental, including relief of pain, restoration of teeth and maintenance of dental health.

Checkups and screenings begin right away for newborns and continue on a frequent basis for infants and toddlers to help ensure early detection of problems. States establish a schedule for screenings and developmental assessments – a periodicity table. Most states base their periodicity tables, with some modifications, on a model developed by American Academy of Pediatrics through its [Bright Futures](#) program.

Research has shown that early access to Medicaid coverage during childhood results in better long term health and achievement for children as they grow into adulthood.

Any physical or mental illness or condition identified must be then be diagnosed and treated, even if the condition is identified outside a regular screening period.

b. Providing treatment

Medicaid not only screens and diagnoses illnesses or conditions in children; it also ensures that children are provided treatment as well. Medicaid programs are required to treat conditions that are detected in Medicaid eligible children.⁵ States must “arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment” that a child needs.⁶ For example, early detection and treatment of vision problems in children can affect school performance and avert long term medical and social consequences.⁷

EPSDT’s mandate to screen, diagnose, and “correct or ameliorate” health conditions in low income children has given generations of Americans the opportunity to grow and thrive. However, per capita cap/block grant proposal threaten this Medicaid success story. Cuts in federal funding shift costs onto states, which may balk at the cost of early interventions, such as screening for elevated blood lead levels or providing Applied Behavioral Analysis therapy to children with ASD.

Tragically, cuts to these core services will most affect low income children with the greatest health care needs.

2. Pregnancy-related care

Medicaid finances almost half of all births in the United States, and in eight states funds 60 percent or more of all births.⁸ Medicaid provides immediate coverage for infants born to women, who give birth while on Medicaid by automatically deeming those infants eligible and enrolling them until the infant’s first birthday.⁹ Research has shown that early access to Medicaid coverage during childhood results in better long term health and achievement for children as they grow into adulthood.¹⁰ Medicaid also provides pregnant women with access to

regular prenatal care during pregnancy, which can help reduce the risk of future health complications for infants, such as fetal alcohol spectrum disorders and neural tube defects.¹¹

Medicaid ensures that women of reproductive age have access to preconception care. These important services include screening and treatment for sexually transmitted infections; counseling and treatment for smoking, alcohol, and substance use; and treatment for chronic diseases such as diabetes, heart disease, obesity, and oral health problems.¹² For women who do become pregnant and continue their pregnancies, Medicaid provides comprehensive care, including prenatal care, labor and delivery, and prenatal screenings to help detect chromosome abnormalities, genetic disorders, and birth defects.¹³

Acknowledging that women may have post-pregnancy health needs, Medicaid pregnancy coverage continues through a postpartum period of at least 60 days.¹⁴ Finally, by providing 75 percent of all publicly funded family planning services, Medicaid provides valuable inter-conception care, which allows women to appropriately plan for and space out their pregnancies.¹⁵

Block grants and per capita cap proposals reduce the amount of federal funding available to states to provide essential health care for pregnant women. States struggling to fund their Medicaid budgets could reduce or eliminate services available to pregnant women. For example, states could eliminate services such as oral health care, which is currently provided to pregnant women on Medicaid in many states, but by state option.¹⁶ Poor oral health has been associated with preterm birth.¹⁷ Cuts in pregnancy-related services will have long term effects not only on low income women, but their children as well.

3. Family planning services

The Medicaid Act provides family planning services and supplies for individuals of childbearing age, including minors.¹⁸ The family planning benefit includes services to prevent or delay pregnancy and may also include infertility treatment.¹⁹ As with many other Medicaid benefit categories, states have some flexibility to determine which particular family planning services and supplies to offer, but must ensure that coverage is “sufficient in amount, duration, and scope to reasonably achieve its purpose.”²⁰

Federal Medicaid law contains several additional protections designed to ensure that Medicaid enrollees have access to comprehensive family planning services.

First, states must provide family planning services without any cost-sharing.²¹ Second, states must ensure that Medicaid enrollees are “free from coercion or mental pressure and free to choose the method of family planning to be used.”²² Given this requirement, CMS has recommended that states cover all FDA-approved contraceptive methods, including both prescription and non-prescription methods.²³ Third, Medicaid enrollees, including individuals who receive services through a managed care plan, have the right to receive family planning services from the qualified Medicaid provider of their choice.²⁴ Finally, states receive an enhanced federal reimbursement rate for costs attributable to offering, arranging, and furnishing family planning services and supplies, giving them an additional incentive to make these services widely available to enrollees.²⁵

In further recognition of the value of family planning services, federal Medicaid law gives states the flexibility to cover family planning and family planning related services for individuals who are not eligible for full-scope Medicaid coverage.²⁶ Family planning related services are medical, diagnostic, and treatment services provided pursuant to a family planning visit.²⁷ Such services include treatment for conditions routinely diagnosed during a family planning visit (such as a urinary tract or sexually transmitted infection), preventive services routinely provided during a family planning visit (such as the HPV vaccine), and treatment for complications.²⁸ Family planning expansion programs provide a critical source of coverage for individuals who are uninsured and for those seeking confidential access to family planning services, such as minors and domestic violence survivors.

However, proposals to radically alter Medicaid's current financing structure by imposing per capita caps and block grants will likely negatively impact family planning services. Under such proposals, the enhanced federal match for family planning could be eliminated. Without this additional incentive, family planning services will be forced to compete with other state spending priorities, and could be reduced in availability and scope.

4. Outpatient prescription drugs

Although it is an optional service, all states have elected to provide outpatient prescription drug coverage in their Medicaid programs.²⁹ In general, states can provide all prescription drugs which are approved for safety and effectiveness under the federal Food, Drug, and Cosmetic Act.³⁰ Prescribed drugs must be for medically accepted indications, including approved off-label uses.³¹ Congress established broad coverage requirements to help ensure full access to prescription drugs for low-income Medicaid enrollees.³²

States that elect to provide outpatient prescription drug coverage must cover all drugs approved by the U.S. Food and Drug Administration (FDA) that are offered by any manufacturer that agrees to provide rebates.³³ Rebate agreements allow Medicaid programs to purchase prescription drugs at a much lower cost than retail amounts.³⁴

Nevertheless, states have substantial discretion to use utilization control techniques to steer Medicaid beneficiaries toward or away from certain drugs, within limits.³⁵ Specifically, federal regulations require states to ensure that prescription drugs are provided in sufficient amount, duration, and scope to reasonably achieve their purpose.³⁶ In addition, states may place "appropriate limits" on drugs, as long as they take into account medical necessity or utilization control procedures.³⁷ States must ensure that drug coverage is designed in the "best interests" of Medicaid beneficiaries.³⁸ In addition, restrictions on outpatient prescription drugs must be reasonable.³⁹ States must also ensure that their utilization control policies are consistent with the requirements for behavioral health parity.⁴⁰

States have substantial discretion and flexibility to develop appropriate limits and reasonable restrictions on outpatient prescription drugs.

Medicaid formularies must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor or the state's drug use review board.⁴¹ If a state excludes an outpatient prescription drug from its formulary, the

state must permit coverage pursuant to a prior authorization program and on a case-by-case basis.”⁴²

Recently, some states resisted providing expensive new treatments for hepatitis C infection (HCV). The Centers for Medicare & Medicaid Services issued guidance reminding states of their obligation under federal law, “CMS is concerned that some states are restricting access to [HCV] drugs contrary to the statutory requirements [...] by imposing conditions for coverage that may unreasonably restrict access to these drugs.”⁴³ As a result, states have been updating their HCV treatment coverage to conform to Medicaid requirements for outpatient prescription drugs.⁴⁴

Under per capita caps and block grants, state Medicaid programs will likely limit or reduce access to prescription drugs. Persons with more costly treatment needs, such as people living with HIV/AIDS, would likely be the first to experience cuts.⁴⁵ For some conditions, like HIV/AIDS, disruptions in treatment can lead to drug resistance, whereby conventional therapies are no longer effective, leading to potentially deadly consequences. Moreover, while Medicaid enrollees currently have access to new FDA-approved medicines, under per capita caps and block grants, access to promising new therapies and cures will likely end for those with the fewest resources.

5. Non-emergency medical transportation

By one estimate, nearly 3.6 million adults miss or delay needed care each year due to difficulties with transportation.⁴⁶ Lack of transportation poses a serious barrier to care, especially for individuals with lower incomes who on average have fewer transportation options and more significant health care needs. Medicaid ensures that beneficiaries have access to non-emergency medical transportation (NEMT) to and from medical appointments.⁴⁷ States have the option to cover transportation as an administrative expense, as an optional medical service, or both.⁴⁸ Without these services, many enrollees would simply be unable to access health care, undermining the purpose of the Medicaid program.

Research shows that increasing access to NEMT can improve health outcomes and even save money. Transportation barriers can substantially reduce adherence to medications.⁴⁹ Better adherence can improve control of chronic conditions, reducing costly hospitalizations or emergency department visits. Thus, offering NEMT to individuals with common chronic conditions, like asthma, diabetes, and heart disease, can actually save more than the transportation benefit costs.⁵⁰ Similarly, improving access to prenatal visits through NEMT saves an estimated \$367 per childbirth for pregnant women with limited transportation options, primarily by reducing premature births.⁵¹

States have considerable flexibility regarding how to administer NEMT services. First, states may contract with transportation providers. The state Medicaid agency or a third party administrator may authorize and coordinate the services. Second, states may contract with managed care entities to cover transportation services for enrollees. Finally, states may use a transportation broker to “more cost-effectively provide non-emergency transportation services”

to enrollees who need access to services and have no other means of transportation.⁵² Currently, the majority of states use a broker for at least some Medicaid enrollees.⁵³

Despite data showing its cost effectiveness, NEMT is often the first service on the chopping block as states seek to reduce Medicaid expenditures. Several states have obtained CMS approval to waive NEMT services under § 1115.⁵⁴ Proposals to cut federal Medicaid funding through per capita caps and block grants could lead states to cut or eliminate NEMT. However, evidence shows that waiving NEMT likely perpetuates or even exacerbates longstanding health care disparities for historically underserved populations.⁵⁵

6. Long term services and supports

Medicaid is tailored to meet the needs of low-income populations and thus covers many vital services not covered by Medicare or most other insurance, including long term care. In fact, Medicaid pays for approximately two-thirds of the country's long term services and supports (LTSS), including nursing home care.⁵⁶ For individuals with both Medicare and Medicaid, Medicaid supplements Medicare, helping to fill in coverage gaps and ensure that older adults and people with disabilities have access to comprehensive care.

Long term services and supports include, but are not limited to:

- Institutional care – nursing facilities and intermediate care facilities for individuals with intellectual and developmental disabilities
- Personal care services – help with tasks of daily living, such as eating, bathing, and dressing, and also help preparing meals, managing medication, and housekeeping
- Private duty nursing – medical care in community settings
- Supported employment and other work opportunities
- Habilitation – learning key skills
- Adult day programs – providing for community interaction and care while supporting family members work
- Care planning and care coordination services – help beneficiaries and families navigate the health system and ensure that the proper providers and services are in place to meet beneficiaries' needs and preferences.

Providing care in a person's home is not only less expensive than providing care in an institutional setting, such as a nursing home, but also provides an enhanced quality of life and improved health outcomes.⁵⁷

States can use HCBS waivers to provide long-term services and supports outside of institutions.⁵⁸ These waiver programs allow states to waive certain Medicaid requirements and allow them to craft a program of eligibility and services that is not available to the broader Medicaid population, such as respite for family caregivers which is often used for errands or other tasks and is important to the ongoing caregiving relationship.

Medicaid per capita caps and block grants reduce federal funding for states and shift costs onto states. When faced with the need to control costs to adjust to reduced federal funds, state will likely target populations with higher costs which are often individuals with disabilities and older adults, especially those receiving LTSS. States would likely target a wide-range of critical, yet optional, LTSS that are extremely important to older adults and persons with

LTSS are cost-effective services, but also represent a significant portion of state Medicaid budgets. These critical services for people with disabilities and older adults are often the target of budget reduction efforts; sometimes leading to greater long-term costs through increased use of institutions.

disabilities, such as home attendants or incontinence supplies. States would also likely place strict limits on the amount and frequency of services these enrollees could access, which could endanger individual's health and ability to remain at home instead of more placements, such as nursing homes.

Moreover, the health care costs for the older adult population increase sharply as an increasing proportion of older adults surpass age 80. Under funding caps, federal funding is locked-in ahead of time, and states might not get additional support to address an increase in costs as the population ages.⁵⁹

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 turn Medicaid into a per capita cap or block grant program. States will lose billions of dollars in federal Medicaid funding under per capita caps and block grants, which will invariably lead to cuts in services. The prime targets for cuts are more costly services relied upon 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. For more than fifty years, Medicaid has brought much needed health services that would otherwise be unavailable to many, but per capita caps and block grants now threaten to roll back that success.

ENDNOTES

¹ 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17), and (21); 42 C.F.R. § 440.210.

² Robin Rudowitz, et. al., KFF & NAMD, *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 56 (Oct. 2016), available at <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>.

³ Republic leaders on the Senate Finance and House Energy and Commerce Committees asked MACPAC to review federal and state spending on optional Medicaid services and categories, see <https://energycommerce.house.gov/sites/repUBLICANS.energycommerce.house.gov/files/documents/114/letters/20170111MACPAC.pdf>. See Kaiser Comm. for Medicaid & the Uninsured, *Medicaid: An Overview of Spending on “Mandatory” vs. “Optional” Populations and Services* (June 2005) available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-an-overview-of-spending-on.pdf>.

⁴ 42 USC §§ 1396a(a)(10)(a), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). The Children’s Health Insurance Program (CHIP) is another important source of child health coverage. CHIP covers children in limited-income families whose incomes are not low enough to qualify for Medicaid. States can implement CHIP by expanding their Medicaid programs (and, thus, EPSDT), or by establishing a separate CHIP. Thus, CHIP benefits for children “can vary significantly from state to state in coverage of vision care services. In general, only Alabama, Arkansas, Colorado, Maine and West Virginia specifically mandate direct access to eye care professionals.” See Peter Shin and Brad Finnegan, George Washington Univ. Dep’t of Health Pol., Policy Brief – Assessing the Need for On-Site Eye Care Professionals at Community Health Centers 17 (Feb. 2009).

⁵ *Id.* at § 1396d(r)(5).

⁶ *Id.* at § 1396a(a)(43)(C); *O.B. v. Norwood*, 170 F. Supp. 3d 1186 (N.D. Ill.), *aff’d* 838 F.3d 837 (7th Cir. 2016).

⁷ See Jane Perkins and Catherine McKee, NHeLP, *Vision Services for Children on Medicaid a Review of EPSDT Services*, May 11, 2015, <http://www.healthlaw.org/publications/search-publications/vision-screening-epsdt#.WKcbRlf3Vp8>.

⁸ Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23-5 WOMEN’S HEALTH ISSUES e273, e275 (2013), <http://www.whijournal.com/article/S1049-3867%2813%2900055-8/pdf>; KAISER FAMILY FOUND., *BIRTHS FINANCED BY MEDICAID* (Oct. 2016), <http://kff.org/medicaid/state-indicator/births-financed-by-medicare>.

⁹ 42 U.S.C. § 1396a(e)(4); 42 C.F.R. § 435.117.

¹⁰ See, e.g., Michel H. Boudreaux et al., *The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program’s Origin*, 45 J. HEALTH ECON. 161 (2016); Sarah Miller et al., *The Long-Term Health Effects of Early Life Medicaid Coverage* (2016), <https://ssrn.com/abstract=2466691>.

¹¹ Nat’l Inst. of Child Health & Human Dev., *What is Prenatal Care and Why is it Important?*, <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx>.

¹² Alexandra Gates et al., Kaiser Family Found., *Coverage of Preventive Services for Adults in Medicaid* (Nov. 2014), <http://files.kff.org/attachment/coverage-of-preventive-services-for-adults-in-medicare-issue-brief>.

¹³ Centers for Medicare & Medicaid Services, *State Medicaid Manual*, § 4421. See also Usha Ranji et al., Kaiser Family Found., *State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings* (Nov. 2009), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8014.pdf>.

¹⁴ The postpartum period extends to the end of the month in which the 60th day after the end of the pregnancy falls. 42 U.S.C. § 1396a(e)(5-6); 42 CFR §§ 435.170, 440.210(a)(3).

¹⁵ 42 U.S.C. § 1396d(a)(4)(C), 42 C.F.R. § 441.20; Kaiser Family Found., *Women’s Health Insurance Coverage* (Oct. 2016), <http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet>.

¹⁶ MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, REPORT TO CONGRESS: COVERAGE OF MEDICAID DENTAL BENEFITS FOR ADULTS, APPENDIX 2A: STATE DENTAL BENEFITS POLICIES (June 2015), <https://www.macpac.gov/wp-content/uploads/2015/06/Medicare-Coverage-of-Dental-Benefits-for-Adults.pdf>.

¹⁷ Comm’n on Health Care for Underserved Women, Am. Coll. Of Obstet. Gynecol., *Committee Opinion: Oral Health Care During Pregnancy and Through the Lifespan* (2013), <http://www.acog.org/Resources-And->

[Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Oral-Health-Care-During-Pregnancy-and-Through-the-Lifespan.](#)

¹⁸ 42 U.S.C. § 1396d(a)(4)(C).

¹⁹ CMS, State Medicaid Manual § 4270; CMS, Dear State Health Official Letter 2 (June 13, 2016).

²⁰ 42 C.F.R. § 440.230(c).

²¹ 42 U.S.C. § 1396o(a)(2)(D); 42 C.F.R. § 447.56(a)(2)(ii).

²² 42 C.F.R. § 441.20.

²³ CMS, Dear State Health Official Letter 3 (June 13, 2016). In addition, CMS has made clear that states and managed care plans may not use utilization controls that “effectively deprive” enrollees of free choice of “equally appropriate” family planning services. *Medicaid and Children’s Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901, at 27,634 (May 6, 2016), <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. In particular, states and plans may not use step therapy or adopt policies that restrict a change in method. *Id.*; CMS, Dear State Health Official Letter 3 (June 13, 2016).

²⁴ 42 U.S.C. § 1396a(a)(23).

²⁵ *Id.* § 1396b(a)(5).

²⁶ *Id.* §§ 1396a(a)(10)(A)(ii)(XXI), 1396a(ii), 1396a(10)(G)(XVI). See also *id.* § 1315(a).

²⁷ *Id.* § 1396a(10)(G)(XVI); CMS, Dear State Health Official Letter (June 14, 2016); CMS, Dear State Medicaid Director Letter (April 16, 2014).

²⁸ See CMS, Dear State Health Official Letter (June 14, 2016); CMS, Dear State Medicaid Director Letter (April 16, 2014).

²⁹ 42 U.S.C. § 1396d(a)(12). 42 C.F.R. §§ 440.120(a), .90, .100.

³⁰ 42 U.S.C. § 1396r-8(k)(2)(A).

³¹ 42 U.S.C. § 1396r-8(d)(1)(B)(i).

³² H.R. Rep. 101-881, 101st Cong. 2nd Sess. 1990, 1990 U.S.C.A..A.N. 2017.

³³ 42 U.S.C. § 1396r-8(k)(2)(i).

³⁴ *Id.* § 1396r-8(a)(1).

³⁵ See 42 C.F.R. § 440.230(d).

³⁶ *Id.* § 440.230(b).

³⁷ *Id.* § 440.230(d).

³⁸ *Alexander v. Choate*, 469 U.S. 287, 303 (1985).

³⁹ 42 U.S.C. §§ 1396r-8(d)(1), (5); 42 C.F.R. § 440.230(d); *NB v. District of Columbia*, 34 F.Supp.3d 146, 153 (D.D.C.2014), rev. on other grounds, *NB v. District of Columbia*, 794 F.3d 31 (D.C.Cir.2015). See also 42 U.S.C. § 1396a(a)(17), “[a] State plan for medical assistance must ... include reasonable standards ... for determining eligibility for and the extent of medical assistance under the plan ... which are consistent with the objectives of this subchapter [of Medicaid],” and the implementing regulation requiring that each provided service, including prescription drugs, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b); *Detgen v. Janek*, 752 F.3d 627, 631 (5th Cir.2014). That requirement has been interpreted by the Supreme Court to include certain reasonable restrictions relating to costs, see Walsh, 538 U.S. at 666, 123 S.Ct. 1855 and *Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977), albeit budgetary considerations cannot be “the conclusive factor in decisions regarding Medicaid.” *Arkansas Med. Soc., Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir.1993); *Bontrager v. Indiana Family & Soc. Servs. Admin.*, 697 F.3d 604, 611 (7th Cir.2012); *Tallahassee Mem’l Reg’l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir.1997).

⁴⁰ Elizabeth Edwards, NHLP, *Health Parity and Addition Equity Act of 2008* (2014), <http://www.healthlaw.org/publications/issue-brief-mhpaea2008>.

⁴¹ 42 U.S.C. § 1396r-8(d)(4)(A). These are often called Pharmacy and Therapeutics (P&T) committees. See also National Academy for State Health Policy (NASHP), *State Experience in Creating Effective P&T Committees* (March 2006), http://www.nashp.org/sites/default/files/medicaid_pandt.pdf

⁴² 42 U.S.C. § 1396r-8(d)(4)(C); see also *Pharmaceutical Research and Mfrs. of America v. Meadows*, 304 F.3d 1197, 1207.1208 (11th Cir. 2006).

- ⁴⁴ Center for Health Law and Policy Innovation of Harvard Law School, *Hepatitis C: The State of Medicaid Access Preliminary Findings: National Summary Report* (Nov. 14, 2016), http://www.chlpi.org/wp-content/uploads/2013/12/HCV-Report-Card-National-Summary_FINAL.pdf.
- ⁴⁵ *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir.1989).
- ⁴⁶ 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>.
- ⁴⁷ 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. Some courts continue to cite the Medical Assistance Manual with favor, while others have not accorded it great weight.
- ⁴⁸ CMS, STATE MEDICAID MANUAL § 2113.
- ⁴⁹ 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).
- ⁵⁰ HUGHES-CROMWICK & WALLACE, *supra* note 46.
- ⁵¹ 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).
- ⁵² 42 U.S.C. § 1396a(a)(70); 42 C.F.R. § 440.170(a)(4); CMS, Dear State Medicaid Director Letter (March 31, 2006).
- ⁵³ Amelia Myers, National Council of State Legislatures, *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community* (2015), <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx#mix>.
- ⁵⁴ See Abbi Coursolle, David Machledt, and Catherine McKee, NHeLP, *Current Issues in NEMT* (Nov. 4, 2016) available at <http://www.healthlaw.org/issues/medicaid/current-issuesNEMT>.
- ⁵⁵ SUZANNE BENTLER *ET AL.*, U. IOWA PUBLIC POLICY CTR., NON-EMERGENCY MEDICAL TRANSPORTATION AND THE IOWA HEALTH AND WELLNESS PLAN 22 (2016), http://ir.uiowa.edu/ppc_health/132.
- ⁵⁶ Naomi Freundlich, RWJF, *Long-term Care: What are the Issues?* (2014), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf410654.
- ⁵⁷ See, e.g., Arpita Chattopadhyay, Yang Fan & Sudip Chattopadhyay, *Cost-efficiency in Medicaid Long-term Support Services: The Role of Home and Community Based Services*, SPRINGERPLUS (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3710567/>.
- ⁵⁸ See Elizabeth Edwards, NHeLP, *Helping Those on HCBS Waiting Lists: Positive Impacts of the ACA* (Feb. 14, 2017), <http://www.healthlaw.org/publications/search-publications/helping-those-on-hcbs-waiting-lists-positive-impacts-of-aca>.
- ⁵⁹ CONG. BUDGET OFFICE, OPTIONS FOR REDUCING THE DEFICIT: 2014-2023, 187 (2013), <https://www.cbo.gov/budget-options/2013/44687>.