



What Makes Medicaid, Medicaid?

– Services

Wayne Turner, Catherine McKee, Amy Chen, Abbi Coursolle,
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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 underserved or vulnerable populations, such as persons with disabilities and children with complex medical conditions.
- Investments in services, such as sexual and reproductive care, early detection and treatment of health conditions in children, treatment of chronic conditions, and prevention improve overall population health and help avoid costlier care and hospitalizations.
- Proposals to impose per capita caps and block grants on 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.

Introduction

States have tremendous flexibility when deciding what Medicaid benefits and services they choose to 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.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.

Because Medicaid beneficiaries are low income and often have unmet health needs, states developed Medicaid services to address those needs. For example, Medicaid is the primary 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 will highlight select Medicaid services, their importance for low-income populations, and the potential harmful impact under proposals to cap or cut Medicaid spending. These services include:

- [Children's health services](#)
- [Pregnancy-related care](#)
- [Family planning services](#)
- [Outpatient prescription drugs](#)
- [Non-emergency medical transportation](#)
- [Long-term services and supports](#)
- [Behavioral health services](#)

Children's health services

Children who live in low-income families 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 result in regular developmental drop-offs in the population. Without proactive intervention and case management, many of these children would never 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 their health 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.³ These screenings help identify a range of health and developmental issues in children, from Autism Spectrum Disorder (ASD), to hearing 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 • Health education 	<ul style="list-style-type: none"> • Vision, including eyeglasses • Hearing, including hearing aids • 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. Any physical or mental conditions identified by a screening must then be diagnosed and treated, even if the condition is identified outside a regular screening period.⁴ 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.⁵

b. Providing treatment

Medicaid not only screens and diagnoses health and mental health illnesses or conditions in low-income children, it also ensures that children are provided treatment as well. Medicaid programs are required to “correct or ameliorate physical and mental illnesses and conditions” that are detected in Medicaid eligible children.⁶ States must “arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment” that a child needs.⁷ For example, early detection and treatment of vision problems in children can affect school performance and avert long term medical and social consequences.⁸

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

Pregnancy-related care

Medicaid finances forty-two percent of all births in the United States, which is a six percent decrease from a forty-eight percent coverage in 2010; additionally, only two states fund sixty percent or more of all births.⁹ Medicaid provides immediate coverage for infants born to persons who are active on Medicaid by automatically deeming those infants eligible, enrolling them in the program, and maintaining their eligibility until the infant’s first birthday.¹⁰ 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.¹¹ Medicaid also provides pregnant people 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.¹²

Medicaid ensures that people of reproductive age have access to preconception care to help them become healthy if they choose to become pregnant, through services such as 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.¹³ For persons 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.¹⁴

Acknowledging that people whose pregnancies have ended may continue to have ongoing health needs related to their pregnancies, Medicaid pregnancy coverage continues through a postpartum period of at least sixty days.¹⁵ However, in 2022, Congress permanently extended a state option to cover postpartum individuals for twelve months after the end of the pregnancy. Over thirty states have taken that option so far with more are expected in the future.¹⁶ Finally, by providing seventy-five percent of all publicly funded family planning services, Medicaid provides valuable interconception care, which allows individuals to appropriately plan for and space out their pregnancies.¹⁷

Block grants and per capita cap proposals reduce the amount of federal funding available to states to provide essential health care for pregnant people. States struggling to fund their Medicaid budgets could reduce or eliminate services available to pregnant people. For example, states could eliminate services such as oral health care, which are currently provided to pregnant individuals on Medicaid in many states, but by state option.¹⁸ Poor oral health has been associated with preterm birth.¹⁹ Cuts in pregnancy-related services will have long term effects not only on low-income people, but their children as well.

Family planning services

The Medicaid Act provides family planning services and supplies for individuals who are able to birth children, including young people under the age of eighteen.²⁰ The family planning benefit includes services to prevent or delay pregnancy and may also include infertility treatment.²¹ 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.”²²

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.²³ 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.”²⁴ Given this requirement, CMS has recommended that states cover all FDA-approved contraceptive methods, including both prescription and non-prescription methods.²⁵ 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.²⁶ Finally, states receive an enhanced federal reimbursement rate (ninety percent) 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.²⁷

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.²⁸ Family planning related services are medical, diagnostic, and treatment services provided pursuant to a family planning visit.²⁹ 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.³⁰ 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 intimate partner violence (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 will be eliminated. Without this additional incentive, family planning services will be forced to compete with other state spending priorities, and will likely be reduced in availability and scope.

Outpatient prescription drugs

Although it is an optional service, all states have elected to provide outpatient prescription drug coverage in their Medicaid programs.³¹ In general, states can provide all prescription drugs which are approved for safety and effectiveness under the federal Food, Drug, and Cosmetic Act.³² Prescribed drugs must be for medically accepted indications, including approved off-label uses.³³ Congress established broad coverage requirements to help ensure full access to prescription drugs for low-income Medicaid enrollees.³⁴

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.³⁵ Rebate agreements allow Medicaid programs to purchase prescription drugs at a much lower cost.³⁶

Nevertheless, states have substantial discretion to use utilization control techniques to steer Medicaid beneficiaries toward or away from certain drugs, within limits.³⁷ Specifically, federal regulations require states to ensure that prescription drugs are provided in sufficient amount, duration, and scope to reasonably achieve their purpose.³⁸ In addition, states may place "appropriate limits" on drugs, as long as they take into account medical necessity or utilization

control procedures.³⁹ States must ensure that drug coverage is designed in the “best interests” of Medicaid beneficiaries.⁴⁰ In addition, restrictions on outpatient prescription drugs must be reasonable.⁴¹ States must also ensure that their utilization control policies are consistent with the requirements for behavioral health parity.⁴²

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.⁴³ If a state excludes an outpatient prescription drug from its formulary, the state must permit coverage of excluded drugs pursuant to a prior authorization program and on a case-by-case basis.⁴⁴

In the past, some states resisted providing expensive new treatments for hepatitis C infection (HCV). In response, 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.”⁴⁵ As a result, states have updated their HCV treatment coverage to conform to Medicaid requirements for outpatient prescription drugs.⁴⁶

Under per capita caps and block grants, state Medicaid programs will likely limit or reduce prescription drug benefits. Persons with more costly treatment needs, such as people living with HCV or HIV/AIDS, would likely be the first to experience cuts.⁴⁷ For some conditions, like HCV and 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.

Non-emergency medical transportation

In 2017, 5.8 million adults delayed needed care each year due to difficulties with transportation.⁴⁸ 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 healthcare needs. To better serve this population, state Medicaid programs ensure that beneficiaries have access to non-emergency medical transportation (NEMT) to and from medical appointments.⁴⁹ States have the option to cover transportation as an administrative expense, as an optional medical service, or both.⁵⁰ Without these services, many enrollees would simply be unable to access health care, undermining the purpose of the Medicaid program.

Increasing access to NEMT can improve health outcomes and even save money. Transportation barriers can substantially reduce adherence to medications.⁵¹ 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.⁵² Similarly, improving access to prenatal visits through NEMT leads to significant savings per childbirth for pregnant persons with limited transportation options, primarily by reducing premature births.⁵³

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.⁵⁴ In 2018, about two-thirds of all NEMT services were paid for through brokers or managed care companies.⁵⁵

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 § 1115.⁵⁶ Proposals to cut federal Medicaid funding through per capita caps and block grants would likely lead states to cut or eliminate NEMT. However, evidence shows that waiving NEMT perpetuates and may even exacerbate longstanding healthcare disparities for historically underserved populations.⁵⁷

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 is the largest payer of long-term services and supports (LTSS), paying for approximately forty-two percent of all of these services across the country.⁵⁸ 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 - assistance 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 - community interaction and care while supporting family members' work; and
- 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.⁵⁹

States use HCBS waivers to provide LTSS outside of institutions.⁶⁰ These waiver programs allow states to waive certain Medicaid requirements and allow them to craft a program of eligibility and services that are 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.

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.⁶¹

Medicaid per capita caps and block grants would reduce federal funding for states and shift costs onto states. When faced with the need to control costs to adjust to reduced federal funds, states 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 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.⁶²

Behavioral health services

The U.S. is in the midst of a behavioral health crisis, with mental health conditions and substance use disorders (SUD) affecting individuals of all walks of life. This crisis has been exacerbated by the COVID-19 pandemic. Between 2019 and 2021, the number of individuals experiencing anxiety or depression increased from eleven percent to over forty percent.⁶³ Similarly, the number of opioid-related overdose deaths rose thirty-two percent from 2019 to 2020, the year the pandemic began.⁶⁴

Medicaid represents a lifeline for millions of individuals with behavioral health conditions. Mental health conditions and SUD are particularly prevalent among low-income individuals, and individuals with chronic conditions are more likely to have a behavioral health condition if they are low-income.⁶⁵ Many low-income individuals with behavioral health conditions are eligible for health care coverage under the Affordable Care Act's Medicaid expansion. Medicaid is now the single largest source of payment for behavioral health services across the country and, primarily due to the program's open-ended funding mechanism, it has served as an important tool for states to respond to the overdose epidemic and other behavioral health emergencies.⁶⁶

The Medicaid program gives states significant authority to cover a wide array of behavioral health services, and many states have taken steps to ensure coverage of the full continuum of behavioral health care at parity with physical health services.⁶⁷ Medicaid programs may cover essential behavioral health services, such as emergency and crisis intervention services, intensive case management, assertive community treatment, peer support services, supported employment, housing-related activities and services, partial hospitalization, and intensive outpatient services. In addition, Medicaid programs are required to cover FDA-approved medications for opioid use disorders, including methadone and buprenorphine, and the overdose-reversal medication, naloxone.⁶⁸

If faced with funding cuts, however, states will likely make cuts to some of the less traditional, but effective, behavioral health services. States may also reduce the level of non-clinical services that are so vital for individuals with behavioral health conditions, such as peer support and housing-related services. These services are key components of the journey towards

improvements in mental health and avoiding unhealthy substance use, but states will likely prioritize clinical services if Medicaid cuts are implemented. States have also taken steps to fund proper coordination and integration of behavioral health services with physical health services, all efforts that would be in jeopardy under a per capita caps system.

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 costlier services relied upon by low income and vulnerable populations, such as persons with chronic conditions, children, pregnant people, 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.

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

² 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*, KFF and NAMD 56 (Oct. 2016), <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 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 can vary significantly from state to state.

⁴ CMS, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents 5* (June 2014), https://www.medicare.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

⁵ 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).

⁶ *Id.* § 1396d(r)(5).

⁷ *Id.* § 1396a(a)(43)(C); *O.B. v. Norwood*, 2014 WL 5335494.

⁸ See Jane Perkins & Catherine McKee, Nat'l Health Law Prog., *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>.

⁹ Kaiser Fam. Found., *Births Financed by Medicaid* (2020), <http://kff.org/medicaid/state-indicator/births-financed-by-medicare> (last visited March 18, 2023); 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>.

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

¹¹ 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 & Laura Wherry, *The Long-Term Effects of Early Life Medicaid Coverage* (2016), <https://ssrn.com/abstract=2466691>.

¹² Nat'l Inst. OF Child Health and Hum. Dev., What Is Prenatal Care And Why Is It Important?, <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx> (last visited March 18, 2023).

¹³ Alexandra Gates, Usha Ranji, & Laura Snyder, Kaiser Fam. Found., *Coverage of Preventive Services for Adults in Medicaid* (Nov. 2014), <http://files.kff.org/attachment/coverage-of-preventive-services-for-adults-in-medicaid-issue-brief>.

¹⁴ CMS, State Medicaid Manual, § 4421. *See also* Usha Ranji et al., Kaiser Fam. Found., *Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey* (May 2022), <https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/>.

¹⁵ The postpartum period extends to the end of the month in which the sixtieth day after the end of the pregnancy falls. 42 U.S.C. § 1396a(e)(5-6); 42 C.F.R. §§ 435.170, 440.210(a)(3).

¹⁶ Consolidated Appropriations Act, P.L. 117-328 § 5113 (2022). The twelve-month postpartum period begins on the first day occurring after the end of the sixty-day period and ends on the last day of the month in which the twelve-month period (beginning on the last day of the pregnancy) ends. 42 U.S.C. § 1396a(e)(16). *See also* Maggie Clark, Georgetown Univ. Health Policy Inst. Ctr. For Children and Families, Permanent Medicaid Postpartum Coverage Option, Maternal Health Infrastructure Investments in 2022 Year-End Omnibus Bill (Jan. 4, 2023), <https://ccf.georgetown.edu/2023/01/04/permanent-medicaid-postpartum-coverage-option-maternal-health-infrastructure-investments-in-2022-year-end-omnibus-bill/>.

¹⁷ 42 U.S.C. § 1396d(a)(4)(C), 42 C.F.R. § 441.20; Kaiser Fam. Found., *Women's Health Insurance Coverage* (Dec. 2022), <http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet>.

¹⁸ MACPAC, *Medicaid Coverage of Adult Dental Services* (Jan. 2021), <https://www.macpac.gov/wp-content/uploads/2021/01/Medicaid-Coverage-of-Adult-Dental-Services.pdf>.

¹⁹ Com. On Health Care for Underserved Women, Am. Coll. Of Obstet. Gynecol., Committee Opinion No. 569: Oral Health Care During Pregnancy and Throughout the Lifespan (2013), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan>.

²⁰ 42 U.S.C. § 1396d(a)(4)(C).

²¹ CMS, State Medicaid Manual § 4270; CMS, Dear State Health Official Letter (June 14, 2016) (SHO # 16-008) (guidance on Medicaid Family Planning Services and Supplies) [hereinafter SHO # 16-008], <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.

²² 42 C.F.R. § 440.230(c).

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

²⁴ 42 C.F.R. § 441.20.

²⁵ SHO # 16-008, *supra* note 21. 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.*; SHO # 16-008, *supra* note 21, at 3.

²⁶ 42 U.S.C. § 1396a(a)(23).

²⁷ *Id.* § 1396b(a)(5).

²⁸ *Id.* §§ 1396a(a)(10)(A)(ii)(XXI), 1396a(ii), 1396a(10)(G)(XVI). *See also id.* § 1315(a).

²⁹ *Id.* § 1396a(10)(G)(XVI); SHO # 16-008, *supra* note 21; CMS, Dear State Medicaid Director Letter (April 16, 2014) (SMDL # 14-003) (guidance on family planning and related services) [hereinafter SMDL # 14-003], <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-003.pdf>.

³⁰ SHO # 16-008, *supra* note 21; SMDL # 14-003, *supra* note 29.

³¹ 42 U.S.C. § 1396d(a)(12). 42 C.F.R. §§ 440.120(a).

³² 42 U.S.C. § 1396r-8(k)(2)(A).

³³ 42 U.S.C. § 1396r-8(d)(1)(B)(i).

³⁴ H.R. Rep. 101-881, 101st Cong. 2nd Sess. 1990, 1990 U.S.C.C.A.N. 2017.

³⁵ 42 U.S.C. § 1396r-8(k)(2)(A)(i).

³⁶ *Id.* § 1396r-8(a)(1).

³⁷ *See* 42 C.F.R. § 440.230(d).

³⁸ *Id.* § 440.230(b).

³⁹ *Id.* § 440.230(d).

⁴⁰ *Alexander v. Choate*, 469 U.S. 287, 303 (1985).

⁴¹ 42 U.S.C. §§ 1396r-8(d)(1), (5); 42 C.F.R. § 440.230(d). *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).

⁴² Elizabeth Edwards & Abbi Coursolle, Nat’l Health Law Prog., *Mental Health Parity in Medicaid: Overview of Requirements & the Right to Information* (April 1, 2021), <https://healthlaw.org/resource/mental-health-parity-in-medicaid-overview-of-requirements-the-right-to-information/>.

⁴³ 42 U.S.C. § 1396r-8(d)(4)(A). These are often called Pharmacy and Therapeutics (P&T) committees.

⁴⁴ 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).

- ⁴⁵ CMS, Medicaid Drug Rebate Program Notice No. 172, 2 (Nov. 5, 2015), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/state-releases/state-rel-172.pdf>.
- ⁴⁶ Ctr. for Health Law and Policy Innovation, *Hepatitis C: The State of Medicaid Access* (May 2021), https://stateofhepc.org/wp-content/uploads/2021/06/HCV_State-of-Medicaid-Access_May-2021-Progress-Report.pdf.
- ⁴⁷ *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989).
- ⁴⁸ Mary K. Wolfe, Noreen C. McDonald, G. Mark Holmes, *Transportation Barriers to Health Care in the United States: Findings from the National Health Interview Survey, 1997-2017*, 110 AM. J. PUB. HEALTH 815 (June 2020), <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.305579?journalCode=ajph>.
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- ⁵⁰ CMS, State Medicaid Manual § 2113.
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- ⁵⁴ 42 U.S.C. § 1396a(a)(70); 42 C.F.R. § 440.170(a)(4); CMS, Dear State Medicaid Director Letter (March 31, 2006) (SMD # 06-009) (guidance on NEMT), <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd06009.pdf>.
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