FEDERAL AND STATE PROGRAMS: HOW TO TURN CONSTRAINTS INTO INNOVATION

BHT IMPACT

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LETTER FROM THE AUTHOR

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If you're building, investing in, or supporting solutions in youth mental health, then understanding how Medicaid works for youth mental health is definitely part of the job. (Check out our latest article written by Caren Howard).

A lot of us enter this space out of passion and compassion, with a desire to help and serve those who need it most. Unfortunately, we also often enter this space without a good starting point of how Medicaid works in youth and how it applies to us as we try to make an impact. As a result, we all end up learning lessons once we start implementing solutions which are costly, time intensive, and deflating.

Before launching BHT Impact, we heard a lot of feedback around how many of you want to help youth covered by Medicaid but find it difficult to do so. It's complicated or too state specific or what's written feels like we all need a degree in public policy or the law.

Thankfully, many experts have started to create really strong Medicaid 101 courses, resources that explain specific policies, rules, changes, and more. We've gone ahead and compiled all those for you in the References section of this toolkit. Please use them, read them, and print out their 1-pagers because they are truly helpful.

What we did feel was missing though was something more practical. A toolkit that speaks directly to innovators to provide a foundation of knowledge, frameworks on how to identify patterns, and how to then understand how those patterns impact or can serve as the foundation of your solution. We want you to be able to design with the system in mind instead of avoiding it entirely or having it teaching you its limits the hard way.

So this toolkit is just the start of that journey. We hope it inspires you to not build around Medicaid but understand that its limitations can be opportunities for improvement for our youth who need it and for the individuals who serve and support them.

Notes:
We use common 101 terms in this toolkit and also provide you with a glossary at the end in case you need it!

All policy-related examples in this brief are presented for educational and informational purposes, to support research, learning, and nonpartisan analysis of innovation work in Medicaid.

TODAY'S TOOLKIT

- Role of Federal and State Governments
- EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) and CHIP (Children's Health Insurance Program)
- A Decision Flow Framework for Innovators
- How to Identify Opportunities for Innovations

FUTURE TOOLKITS

- Stakeholder Navigation
- Reimbursement and Billing
- Workforce and Staffing Models
- Program Design and Operations
- Tech Solutions: Advantages and Challenges
- Designing Effective Business Models
- Metrics & KPIs
- Lessons Learned, Tips & Tricks
- Tools and Templates

02

MEDICAID FEDERAL AND STATE ROLES

My guess is that when someone explains Medicaid roles to you, you're used to hearing Medicaid is state specific, Medicaid means 50 different operating systems, plus managed care contracts, plus state politics, plus provider shortages, plus policies, plus waivers, plus plus plus.

If I had to give you just a starting sentence to summarize Medicaid roles it would be this: Medicaid is federal rules + state implementation. In other words, federal rules set the foundation and the states build the house that the rest of us live and work in. Notice how the decorations look different in every house? Yeah, us too.

At the federal level (CMS), Medicaid is governed by the Social Security Act and federal regulations. Federal policy defines broad eligibility rules, core requirements, and important protections for youth.

At the state level, the specifics of those federal rules become clearer(ish). Each state adds details to those rules and requirements in the form of:

- What benefits look like in practice
- How mental health services are defined (e.g., is telehealth video, audio, synchronous, asynchronous?)
- How providers enroll
- How rates are set
- How utilization is managed
- And whether care is delivered through the state or given to a managed care organization

This is why people tell you "every state is different" because states do answer some of these questions differently. However, for youth mental health in Medicaid the federal rules and requirements matter a lot and how it shows up downstream to all the stakeholders you likely interact with is not the same for youth as it is for adults.

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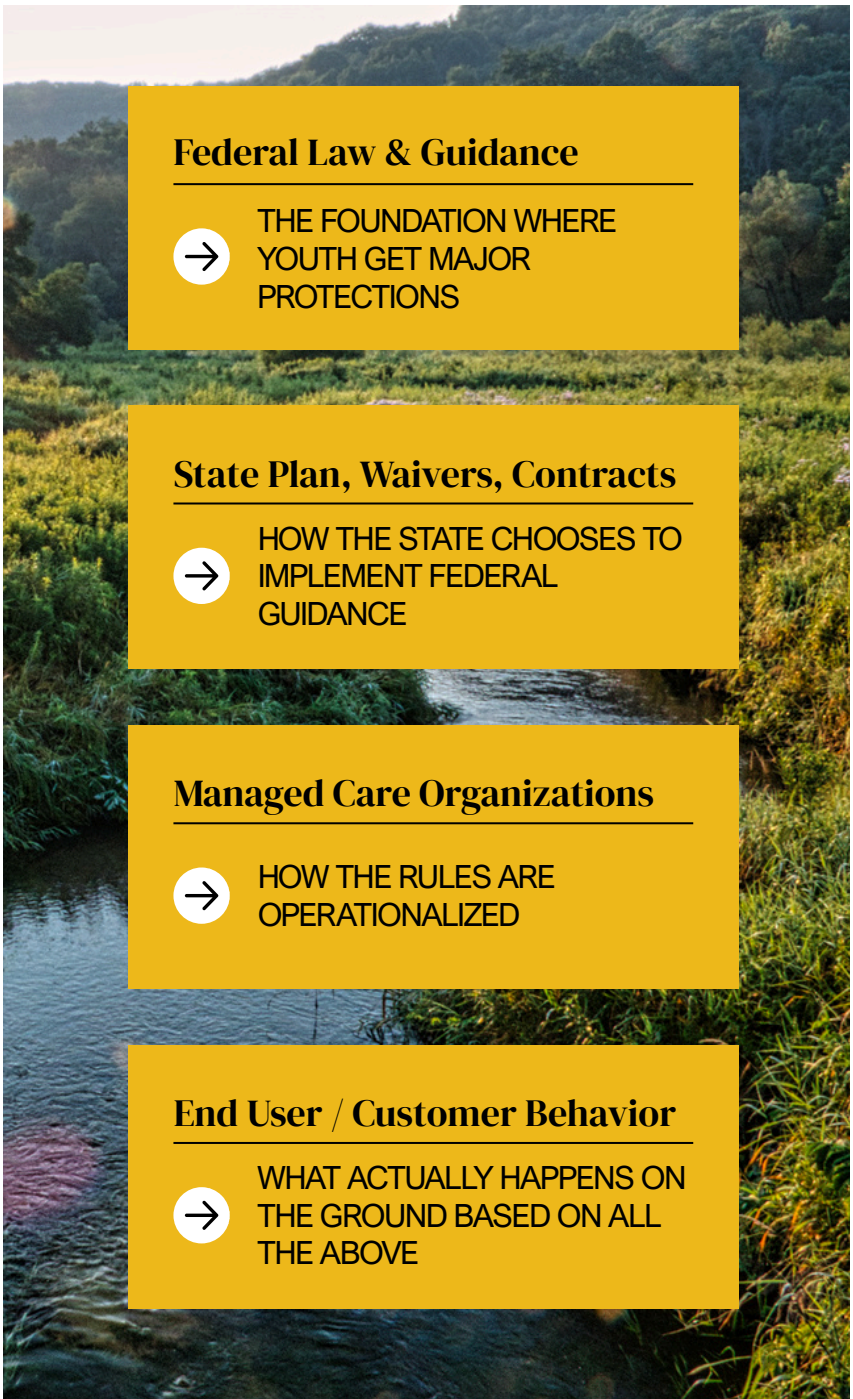
MEDICAID DECISION FLOW

If you're trying to understand why something is happening in Medicaid, it helps to think about the decision flow that happens. Often we see a consequence (e.g., a denial, a limitation, a service being "not covered," etc.) and this decision flow can also help you identify why that consequence is happening in the first place.



Why This Flow Matters

A lot of innovators I meet have no idea which layer is blocking them and if those blocks are solvable or not. As a result, they end up designing the wrong workaround, pitching the wrong value proposition (sometimes to the wrong stakeholder), designing their model around the wrong levers, and unfortunately end up giving up on something that's actually possible to solve.

Bringing it All Together with Examples.

For me, I learned this decision flow more when I saw examples play out. So, here is a long and short example that hopefully brings this to life and hopefully enables you to see parallels in the work you are doing.

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EXAMPLE: INTENSIVE IN-HOME THERAPY FOR A CHILD WITH SERIOUS BEHAVIORAL NEEDS

Intensive In-Home Therapy (IIHT) is a high-intensity service that is delivered in the home for kids with serious emotional or behavioral needs and who may be at risk for hospitalization, residential care, etc. The service is typically short-term and focuses on stabilization (3-6 months), it is family centered, and is available outside of traditional business hours so that it can be crisis responsive.

1. Federal laws and guidance (the foundation)

Federal Medicaid law says that for children under 21, EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) applies. That means if a child has a behavioral health condition and needs medically necessary treatment to "correct or ameliorate" that condition, the state must cover it, even if they don't cover the service for adults.

What does this mean for me? The service is *allowed* and potentially *required* if medically necessary. Time to move on to what the State is doing.

2. State plan + waivers (how the state implements)

This is where we enter the "it depends on the state" responses. In some states the service can be named explicitly or may not be named or defined clearly.

At this layer, the state Medicaid agency decides:

- "Intensive In-Home Therapy" is a named service (i.e., service that is named explicitly)
- Or is it delivered through:
  - an existing service category (e.g., rehabilitative services), or
  - a waiver (e.g., an 1115 or HCBS (Home and Community-Based Services) authority)

What does that mean for me? If your solution relates to the service, needs to collaborate with it, or is a technology that supports it, simply looking up the name of the service isn't sufficient. You'll need to do some research or talk to experts about what bucket that service may fall into (hint: think level of care, where it is delivered, who delivers it to help narrow down the list) or we need to proceed to the next layer, the MCOs.

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3. Managed care contracts (how MCOs operationalize it)

This is where you are likely used to feeling the friction. If the state uses managed care (most do), the state contracts with MCOs and says, in effect: “You must cover EPSDT services and the services defined in the state plan. You decide how to manage them within these rules.” However, two MCOs in the same state can treat the same service very differently.

Now the MCO decides that for Intensive In-Home Therapy, its broader category or waiver:

- How medical necessity is defined
- What documentation is required to prove it upfront + while service is being delivered
- How many hours per week are authorized (sometimes labeled as “units”)
- Whether a diagnosis is required up front and if so, which ones
- How often reauthorization is needed, if at all
- What provider types are allowed to bill for the service (e.g., MDs but maybe not NPs depending on the state or often NPs are allowed but paid at a different rate)

What does this mean for me? Think of how your solution interacts with any of the criteria required for the service: how it is defined, who delivers it, how it is paid for, etc. The more information you know here, the more you understand the simplicity or complications that your key stakeholders may face, one of which could be providers.

Note: “Managed care” isn’t only MCOs. Federal rules recognize multiple entity types (MCOs, PIHPs, PAHPs, PCCMs, etc.). Medicaid.gov lays out the taxonomy and our glossary has definitions. (Link)

Recently, several states have significantly increased their rates for youth mental health such as NY and NM. Check out state-specific websites as well as KFF’s 2025-2026 of Medicaid budgets and upcoming changes (Link)

Coverage Reality Check

When you see that a service is “covered,” immediately begin asking these questions:

- Who does the coverage apply to (e.g., ages, diagnoses, level of service)?
- What are the criteria that must be met?
- What are the CPT codes and how much do those codes pay?
- What staff are needed to meet the requirements? Can it only be certain provider types?
- Does it need to be prior-authorized?
- Does it exist in all regions or counties in the state?

Complaints to Constraints

When someone says: “Medicaid won’t pay for that,” or “Plans won’t allow it,” Try to translate the complaint into one of these specific constraints:

- Coverage?
- Rate?
- Workforce?
- Authorization?
- Data?
- Contracting?

Most Medicaid problems aren’t abstract. They’re concrete and solvable once you name them clearly.

4. Provider behavior (what happens in real life)

Even if federal law allows it, state rules support it, MCOs clarify and authorize it, the service still has to be deliverable in the real world. But what does it mean for a service to be realistically deliverable?

Providers have to ask:

- Do we see these types of patients?
- Can we hire staff who meet the requirements?
- Is the payment high enough to cover staff time, supervision, materials, and more? If not and I am still required to deliver the service, what is our approach?
- Are the documentation or authorization requirements manageable?

Sometimes providers struggle to offer a service, not because they aren't allowed to, but it is difficult to because of all these rules. This is typically where you hear people talk about administrative burden, workforce shortages, operational complexity, and low rates.

What does that mean for you? Often, this is where innovation also plays a huge role. What is your solution? What problems is it solving? And now that you have the whole cascade, where do those problems actually originate?

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EPSDT- POTENTIALLY POWERFUL BUT UNDERUSED

EPSDT stands for Early and Periodic Screening, Diagnostic, and Treatment.

EPSDT is the pediatric benefit in Medicaid that ensures youth under 21 get comprehensive preventive care and medically necessary services and it explicitly includes behavioral health. (More Info). It is considered to be powerful because, at the federal level, it creates an obligation for states to cover what is needed to "correct or ameliorate" conditions for youth (*Even More Info*).

Specifically, EPSDT includes:

1. **Screening:** youth are entitled to preventive screening and assessment
2. **Diagnostic:** if a screening shows a concern, diagnostic services must be available
3. **Treatment:** if a youth needs medically necessary treatment services, the state must cover them. Note that this is true even if it isn't covered for adults or explicitly listed in the state plan, it has to fit within Medicaid's allowable service categories. (More Info Again)

Note: In 2024, CMS reinforced and clarified EPSDT expectations in the 2024 State Health Official letter and in related EPSDT guidance materials. (Link to Letter)

MEDICAL NECESSITY

Medical necessity does not have a universal definition. States and MCOs define and operationalize it differently. There is often a hierarchy of rules and criteria used: federal or state rules, third-party guidelines (e.g., CASII, ESCII, CALOCUS-CASII, etc.) and/or criteria developed internally by the plan. Depending on the extent to which third party criteria are used, understanding medical necessity criteria for a specific health plan can take some digging.

Why EPSDT is a big deal for youth behavioral health

As most of us know, adult behavioral health is talked about in units of time: 6 hours in a day, 15 minute office visits, and more.

However, since youth behavioral health often requires solutions that don't fit into those time-bound buckets, EPSDT supports those solutions by supporting the system using earlier intervention (before something becomes a crisis), family-centered approaches, community or school-based services, and services that address functioning and development instead of just symptom reduction.

Why it's underused in practice

Many experts will share that EPSDT is one of the strongest legal tools Medicaid has for supporting children's behavioral health. but it is still tough to get solutions implemented in the system. This is where intention and implementation can be at odds and some factors to be aware of:

1. Budget Predictability for States and Managed Care Organizations

- EPSDT expands what states must cover for youth which could result in the ability to use more services (utilization) and therefore less predictable spending and budget forecasting.
- Even when the federal government matches funds, states still carry budget risk and so states implement service definitions and utilization limits to make spending more predictable and manageable.
- Health plans are under similar pressure. They are paid a fixed amount per youth member, are required to manage appropriate utilization accordingly, and are not significantly rewarded or incentivized for expanding access or driving quality.

2. EPSDT is legally strong but operationally vague

- EPSDT requires coverage of services that are medically necessary to "correct or ameliorate" but it does not give specifics of how many hours, days, delivered by who, or in what setting.
- This results in different rules and requirements even within a state across MCOs. For the provider, this could mean more documentation or justification to prevent audit and compliance risk and sometimes more denials and appeals.
- The economic value of early screening and prevention is still vague and under proven for youth behavioral health. As a result, there are typically more guardrails in place because the value is seen years later, often not measured, and with a lack of clarity around which industry stakeholders are receiving the benefit.

3. Full implementation would likely overload the system

- As we know, EPSDT disproportionately benefits youth who are in low-income families, have disabilities, or are involved in child welfare or justice systems.
- Implementation of EPSDT without guardrails would surface how under-resourced our youth systems are while highlighting the inability to provide appropriate support

We share this, not to suck the hope out of you (but we get that sometimes it does!), but to help you understand that innovation and opportunities are in these complexities. It is precisely why Medicaid needs innovation and exactly the nuances we hope to keep sharing with you all.

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HOW CHIP COMES INTO PLAY

My first exposure to CHIP was as a column of member enrollment data and I'm sure many of you have heard about it with varying degrees of familiarity. As a primer, **CHIP stands for Children's Health Insurance Program** and is for youth who are in families who make too much money to qualify for Medicaid but not enough to afford commercial insurance.

States can implement CHIP using 3 different approaches and each approach has downstream implications on youth, families, and other key stakeholders.

States can run CHIP as:

- **Medicaid Expansion CHIP**: CHIP youth are basically covered through Medicaid and the benefits, delivery systems, and involvement of managed care mirrors Medicaid as well.
- **Separate CHIP Program:** Operates more like a standalone insurance product where the benefits are standardized, utilization is managed more tightly, and EPSDT doesn't apply in the same way it does in Medicaid
- **Combination approach:** Some youth in the state can be in either option which creates variability that is tough to see from the outside.
- (More Info) (Behavioral Health in CHIP)

What CHIP Typically Covers in Behavioral Health

Similar to other health plans, CHIP has to cover all of the standard services that we are familiar with in ways that are comparable to physical health (parity). But, since CHIP doesn't have the same EPSDT requirements if it operates as a separate CHIP program, the end program looks a lot more like a typical mental health insurance plan that we are used to (i.e., outpatient therapy, medication management, limits on how many visits you can have covered, etc.). It also means that CHIP can include premiums or copays which we all know changes engagement and follow-through with solutions.

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YOUTH MEDICAID, EPSDT, CHIP, ETC. WHAT DOES THIS MEAN FOR ME?

You don't have to deliver therapy or run clinical programs for Medicaid and CHIP to have a big impact on your solutions. These systems and programs define what gets adopted, paid for, and scaled even for technology, data, workflow solutions, and more.

1. Solutions can be found within the constraints

Whether you're building care delivery, software, or infrastructure, Medicaid and CHIP set real boundaries around the following:

- what users are allowed to do,
- what data must exist,
- what workflows are acceptable,
- and what outcomes matter.

We all know at this point to not assume frictionless adoption and if your approach is to find the friction, need, and leverage in the system's constraints, then you are on the right path to creating, testing, and/or improving your solution.

2. EPSDT tells you where opportunity exists even if you're not delivering care

EPSDT shapes documentation requirements, care coordination and planning, prior authorization rules, and more.

If your innovation makes any of the below easier than EPSDT is likely upstream or downstream to your solution in some way:

- document requirements for rules, regulations, medical necessity, and more
- bringing together workflows that fall under different stakeholders
- leveraging data to analyze the relationships screening or functional change and value
- support family-centered or school-based care
- standardize variability or creating systems that balance variability with standardization in a provider-friendly compliance framework

3. CHIP can be a stepping stone from traditional insurance

As mentioned in section 5, CHIP is often closer to commercial insurance in structure. So, if your solution works in commercial insurance, you can certainly test it with CHIP (depending on how the state implements it!). However, if your solution breaks with cost-sharing or relies on the expansion of services and definitions that EPSDT provides, entering CHIP will expose those flaws quite quickly. Think of CHIP as a stress test – it works in CHIP, it can move into other states, other payers, or adjacent markets.

4. Understanding your customer gets you in the door, delivering improvement keeps you there.

Plans, states, and providers don't like an innovation because it is a "cool tool." Over and over again, I have seen a great solution lose to an easier workflow, the newest tool fails because they didn't consider operational fit, and the most needed innovations never get used because they forgot to understand how the financial side of their customer's business actually works.

Getting to know the users and customers of your solution (note: not always the same people, see #5!) is critical. Understand that they want:

- Fewer claims denials, audits, staff hours lost, and missed appointments
- Solutions that fit into existing processes, reduce clicks and rework, respect the reality of documentation and reporting requirements, and don't overpromise on value or implementation ease
- Pricing and fees that fit into how they bill and operate, not just with MCOs but with states and federal governments too. (e.g., selling to a CCBHC? Check out what PPS rates are!)

If you take the time to understand the 4 layer decision flow (section 3!), who has to deal with what, and then design your solution and operating model to consider those components, you will outperform all of these other flashier solutions that require systems to change how they function.

5. You are designing for users and customers, and not just one.

The “user” of most youth mental health innovations is typically a child, guardian, caregiver, front line staff member, coordinator, or more.

The “customer” of your innovation is typically someone totally different: clinic CEOs, MCOs, and sometimes even the state.

In youth mental health your users and customers also have upstream “impactors.” Impactors can be federal and state governments, policies, waivers, or more which create rules and requirements that affect how your users and/or customers deliver or receive your solutions. Root your value stories and business models in a deep understanding of these to build credibility and strong relationships, as well as a design and operating model that your users and customers can actually work with.

Remember that these also change over time. Our solutions all need time and use in the system to demonstrate value and so who your users and customers are to begin with may evolve to include larger systems and organizations. Be sure to continuously evaluate to whom and how you are delivering value.

6. Understanding the system is a competitive advantage

Most innovators underestimate or don’t dive into how Medicaid and CHIP impacts their solutions. Our hope is that by bringing you along on this learning journey we can help you:

- ask better questions,
- design fewer dead ends,
- and build credibility faster

You don’t need to become an expert or memorize this information but you do need to understand how the system works, how (and who) it breaks, and who it impacts. In my experience, the innovators that don’t underestimate this initial work learn lessons faster and shape their solutions more accurately before critical time and resource investments have been made.

07

IF YOU JUST SCROLLED THROUGH THE PAGES, HERE'S WHAT TO SKIM!

Phew, that was a lot. Honestly, I don't blame you if you didn't read the whole thing but I hope you use this as a reference or to find information quickly. If you are scrolling pages and skim nothing else, here's the essentials playlist:

EPSDT

→ EPSDT gives youth stronger coverage protections than adults. The opportunity often exists but implementation is where it gets constrained.

Medicaid has Layers

→ Federal law → State rules → Managed care → Provider reality.

If you don't know which layer is blocking you, you'll design the wrong solution.

The Innovation Must Fit the Economics

→ Great ideas fail when they ignore reimbursement mechanics, compliance risk, and workflow reality. If your solution reduces friction instead of adding it, it has a chance to scale.

Constraints Reveal Opportunity

→ Most "Medicaid can't do that" complaints translate to something specific: rate, authorization, workforce, documentation, or data.
Name the constraint clearly, and you'll find the leverage point.

Know the Difference Between Your User and Customer

→ Your user isn't your customer. And your customer answers to payment rules, compliance risk, and operational burden. If you ignore that, your innovation won't stick.

APPENDIX

REFERENCES + HELPFUL LINKS

EPSDT and CHIP Basics

- Medicaid.gov EPSDT overview - the cleanest official baseline (Link)
- Medicaid FAQ on EPSDT Services - details what EPSDT must cover, including mental-health-related screening and treatment services. (Link)
- MACPAC: Access to behavioral health services for children/adolescents in Medicaid/CHIP - credible, structured view of access barriers (Link)
- Children and Youth Behavioral Health on Medicaid.gov - federal Center for Medicaid & CHIP Services resource page with links and good practice info on children's behavioral health coverage. (Link)
- CHIP benefits guidance - helpful for innovators conflating Medicaid and CHIP (Link)
- CMS SHO 24-005 (EPSDT best practices) - the most important recent federal guidance for kids (Link)
- KFF on school-based behavioral health and Medicaid guidance - good real-world application area + KFF is an excellent resource in general (Link)
- SAMHSA's Behavioral Health Resources for Children & Families – broader behavioral health tools and materials, including Medicaid/CHIP parity and programming. (Link)

Medicaid Program & Coverage Basics

- Medicaid.gov Managed Care overview - clear explanation of capitation (Link)
- 42 CFR Part 438 - for when someone says "plans can't do that" and you want the actual regulatory framework (Link to eCFR)
- InsureKidsNow: Mental Health - simple federal guide on Medicaid & CHIP covering essential mental/behavioral health services for kids/teens. (Link)

EPSDT Policy & State Guidance

- **CMS State Health Official Letter on EPSDT Best Practices (2024)** – the most recent comprehensive guidance CMS issued to states on meeting EPSDT requirements, including behavioral health. (Link)
- **CMS Historic EPSDT Guidance (2024)** — announcement reinforcing EPSDT requirements and implementation strategies tied to federal law and the Bipartisan Safer Communities Act. (Link)
- **SPHVS EPSDT State Behavioral Health Guidance (2025)** – a practical resource outlining how states can expand behavioral health services under EPSDT, including mobile crisis, peer support, and integrated care. (Link)
- **KFF on Medicaid & School-Based Behavioral Health** – explains how EPSDT can extend to prevention, screening & treatment through school settings even without formal diagnoses. (Link)

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REFERENCES + HELPFUL LINKS

Data, Research & Analysis

- **Commonwealth Fund – Medicaid's Role in Mental Health & SUD** - fresh data on how Medicaid covers youth with depression, substance use disorders, and co-occurring conditions. (Link)
- **MACPAC: Access to Behavioral Health Services for Children & Adolescents Covered by Medicaid/CHIP** - policy paper with recommendations and access challenges. (Link)
- **UW Family Medicine Report on Medicaid Reimbursement** - state Medicaid coverage and reimbursement for behavioral health professionals (2025). (Link)

State & Local Examples (Useful for Case Studies)

(These aren't comprehensive resources on their own, but great for demonstrating variation and actual implementation in states.)

- **Alabama EPSDT & Behavioral Health Services** – state example of Medicaid mental health services and EPSDT implementation. (Link)
- **Utah Medicaid Behavioral Health Services Overview** – shows how a state Medicaid program describes covered behavioral health services, case management, inpatient, therapy, and crisis services. (Link)
- **EPSDT Material from California (Medi-Cal)** – example of how EPSDT is operationalized with no cost services through age 21. (Link)

APPENDIX

GLOSSARY OF TERMS

- **Administrative Burden:** The documentation, billing, authorization, reporting, and compliance workload required to receive Medicaid reimbursement.
- **Appeal:** A formal request to reconsider a denied service, authorization, or claim.
- **Audit:** A review conducted by a state or managed care entity to ensure compliance with Medicaid rules and billing requirements.
- **Capitation:** A fixed per-member-per-month payment made to a managed care plan to cover enrolled members' services.
- **Carve-In:** When behavioral health services are included within the same managed care contract as physical health services.
- **Carve-Out:** When behavioral health services are managed under a separate contract or entity from physical health services.
- **CCBHC (Certified Community Behavioral Health Clinic):** A federally recognized clinic model that receives enhanced reimbursement to provide comprehensive behavioral health services.
- **CHIP (Children's Health Insurance Program):** A public insurance program for children whose family income is too high for Medicaid but too low to afford private insurance.
- **CMS (Centers for Medicare & Medicaid Services):** The federal agency that oversees Medicaid and issues guidance to states.
- **Compliance Risk:** The risk of failing to meet federal, state, or plan requirements, which may result in penalties or repayment.
- **Cost Sharing:** Premiums, copayments, or deductibles required from enrollees/patients.
- **CPT Codes (Current Procedural Terminology Codes):** Standardized billing codes used to describe medical and behavioral health services.
- **Denial:** A refusal to authorize or pay for a requested service
- **Diagnostic Services:** Services used to evaluate a condition following screening or referral.
- **EPSDT (Early and Periodic Screening, Diagnostic, and Treatment):** The Medicaid benefit requiring comprehensive preventive and medically necessary services for individuals under age 21.
- **Fee-for-Service (FFS):** A payment model in which providers are reimbursed for each individual service delivered.
- **HCBS (Home and Community-Based Services):** Services provided in home or community settings instead of institutional settings.
- **HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems):** A standardized national patient experience survey required by CMS that measures patients' perceptions of hospital care. Results are publicly reported and used in certain value-based payment programs to influence hospital reimbursement.
- **Level of Care:** The intensity and setting of services provided (e.g., outpatient, intensive in-home, residential).
- **Managed Care:** A Medicaid delivery model in which states contract with organizations to manage services for enrolled members.

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GLOSSARY OF TERMS

- **Managed Care Organization (MCO):** A private entity contracted by a state to administer Medicaid benefits.
- **Medical Necessity:** The criteria used to determine whether a service qualifies for coverage.
- **Medicaid State Plan:** A document outlining how a state administers its Medicaid program.
- **Mandatory Benefits:** Services federal law requires states to cover.
- **Optional Benefits:** Services states may choose to cover.
- **PAHP (Prepaid Ambulatory Health Plan):** A managed care entity covering a limited set of outpatient services.
- **Parity:** Mental health parity refers to the legal requirement that health insurance plans cover mental health and substance use disorder services in a manner that is comparable to coverage for physical health services. Under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), plans that offer mental health benefits cannot impose more restrictive limits than they do for medical/surgical benefits
- **PCCM (Primary Care Case Management):** A model where primary care providers coordinate care but do not assume full insurance risk.
- **PIHP (Prepaid Inpatient Health Plan):** A managed care entity covering specific inpatient services.
- **PMPM (Per Member Per Month):** A fixed monthly payment per enrolled Medicaid member.
- **Prior Authorization:** Approval required before certain services can be delivered and reimbursed.
- Provider Enrollment: The process by which clinicians or organizations become authorized to bill Medicaid.
- **Reauthorization:** Approval required to continue services beyond an initial authorization period.
- **Rehabilitative Services:** A Medicaid service category used to restore or improve functioning.
- **Serious Emotional Disturbance (SED):** A designation for youth with significant functional impairment due to a mental health condition.
- **Social Security Act:** The federal law that created Medicaid and defines its structure, authority, and core requirements. Medicaid is authorized under Title XIX of the Act (added in 1965). State Medicaid Agency
- **Utilization:** The amount or frequency of services used.
- **Utilization Management:** Processes used to review and control service use.
- **Value-Based Care:** Payment models that link reimbursement to quality or outcomes rather than service volume.
- **Waiver:** Federal approval allowing a state to modify certain Medicaid rules.
- **Workforce Shortage:** Insufficient availability of qualified providers to meet service demand.
- **1115 Waiver:** Federal authority allowing states to test new Medicaid approaches not otherwise permitted under standard rules.