THE DECISION FLOW GUIDE: FEDERAL, STATE, MCO, AND PROVIDERS

BHT IMPACT

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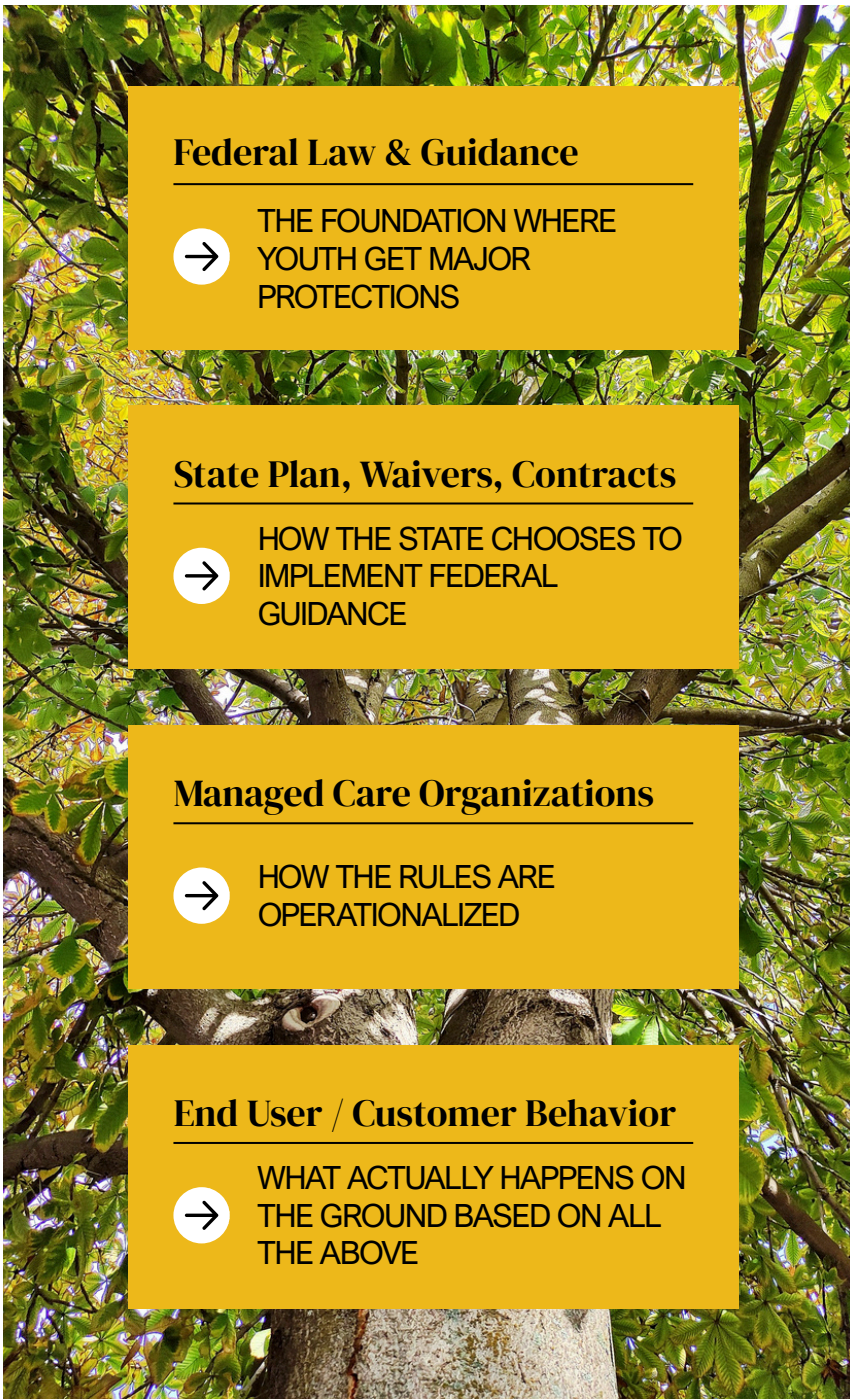
Published: February 2026

BHT Impact is a fiscally sponsored project of Moore Impact, a 501(c)3 public charity.

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?

02

EXAMPLE: SCHOOL-BASED MENTAL HEALTH

Federal level: EPSDT supports screening and early identification

State level: The state may or may not explicitly allow billing in school settings.

Managed Care level: Plans may require parental consent documentation, specific types of providers, or limits on who can initiate screening

Provider level: Schools may not have school therapists enrolled in Medicaid, lack billing infrastructure, or staff may not have time to document everything properly