

Medicaid is often understood as the United States' health insurance program for low-income people, although its reach extends more broadly. As of November 2022, 84.8 million people were covered by Medicaid, or approximately one in four Americans. Many different people are covered by Medicaid: low-income families, pregnant women, children with complex health care needs, individuals living with disabilities, older adults, and single adults below certain incomes.

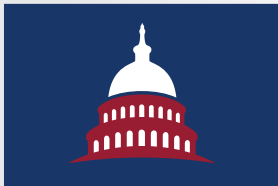
Unlike Medicare, which is entirely federally administered, Medicaid operates as a partnership between the federal government, the states, and the territories. Medicaid is run by state and territory Medicaid agencies, according to broad parameters set by Congress and the federal government. The program is also jointly financed, with the federal government and state/territorial governments each paying a portion of the programs' costs.

This state-federal structure results in considerable variation across the country's 56 Medicaid programs. Generally, federal law sets a "floor" of benefits and services that must be covered by Medicaid programs, as well as general requirements like statewideness and comparability of services. Some states and territories have chosen to build on this floor extensively, covering additional eligibility groups, services, and providers; states and territories also have flexibility in the financing structures they use to cover these services. This complexity can make it difficult to understand the Medicaid program. Exploring the drivers of Medicaid policymaking, however, can help us start to unpack why programs look so different and how that variation impacts Medicaid members.

### Understanding Medicaid Policymaking: Priorities and Constraints

How do policymakers decide who and what to cover through their Medicaid programs?

**First, it's helpful to understand who sets Medicaid policy.**



**Federal policymakers, including Congress and leaders from federal agencies, can encourage, mandate, or restrict coverage of certain eligibility groups, services, and providers through Medicaid.** In the 2018 SUPPORT for Patients and Communities Act, for example, Congress mandated that all Medicaid programs cover medications for opioid use disorder.



**Federal judges can mandate policy changes.** The 1999 Supreme Court ruling in Olmstead v. LC, for example, requires Medicaid agencies to rebalance their long-term care systems towards home- and community-based services.



**State governors, budget offices, and Medicaid Directors can set policy directions.** For example, a Governor may direct their Medicaid agency to focus on improving maternal health outcomes, or a Medicaid Director may be passionate about improving mental health outcomes for kids.



**State legislatures can pass bills requiring certain Medicaid policy changes.** For example, some state legislatures have passed laws requiring their Medicaid programs to cover certified community behavioral health clinics.



**Medicaid members, providers, and advocacy organizations can urge certain policy changes.** For example, many substance use disorder advocates have encouraged Medicaid agencies to cover the overdose reversal drug naloxone without cost-sharing.

# Why Did They Do It That Way?

## Medicaid: The More You Learn



While each of these stakeholders influence the direction of policy, Medicaid policymakers are subject to a set of constraints that limit the feasibility of different policy priorities. Common constraints in Medicaid include:

- ✓ **The state or territory budget.** For many states and territories, Medicaid is the second largest area of general fund spending, after education. Unlike the federal government, almost all states and territories are subject to balanced budget requirements in each budget cycle. This means that many Medicaid priorities do not get enacted because of budget concerns.
- ✓ **Medicaid agency administrative capacity.** Medicaid agencies need staff to enroll providers, set reimbursement rates, apply for authorities through the federal government, and conduct eligibility processes. Agencies with less staff may not be able to pursue initiatives and waiver authorities that can be more administratively burdensome, such as 1115 demonstration waivers.
- ✓ **Statutory and regulatory restrictions.** Congress and the Centers for Medicare and Medicaid Services (CMS), the federal regulator of Medicaid, set restrictions on the populations and benefits that Medicaid programs can cover. For example, Medicaid programs generally cannot cover people who are incarcerated. Some agencies pursue waivers from the federal government to mitigate these restrictions in pursuit of their program goals.
- ✓ **Provider availability.** Medicaid is a health insurer, not a service provider. Even if Medicaid covers a certain benefit, if there aren't providers in the state or territory to deliver the benefit, members won't have access to the benefit.
- ✓ **Political feasibility.** Different policymakers have different values around the health care system. For example, policymakers may prioritize expanding coverage, advancing market-based approaches, reducing total state spending, or enhancing benefits for certain eligibility groups.

How might this play out in states and territories? In 2021, Congress gave Medicaid programs a new option to extend postpartum coverage in Medicaid to 12 months. In order to take up this option, however, a Medicaid agency may need to request approval and an appropriation from their legislature. If the legislature does not approve this cost increase, the agency would not be able to take up the option, even if the Medicaid Director and Governor's Office are in favor of the policy. Similarly, a Medicaid agency may want to expand coverage to doulas to improve birth outcomes. If there isn't a robust network of doulas in the state or territory, however, coverage of the benefit would not result in real access for Medicaid members.

## Implementing Medicaid Policy

Setting a policy is just the first step in changing how Medicaid members experience care. After a Medicaid Director decides to, or is directed to, focus on a certain policy goal, they typically then must:



**Define the actual policy that will be implemented,** including the services that will be covered, the type of provider that will be covered, and/or the reimbursement rate these providers will be paid.



**Develop a fiscal impact statement** with their budget office. A fiscal impact statement estimates how the proposed policy change will impact revenue and expenditures for the state or territory.



**Decide on which federal authority** (e.g., state plan option, waiver, etc.) and administrative vehicle (managed care organization, directly paying providers, etc.) they will use to deliver the service. These factors are detailed below.



**Consider whether they need state legislative approval** to enact the policy change, and if so, pursue this approval.



**Go through a public comment process,** and potentially revise the policy based off of these comments.



**Seek approval from CMS** to make the policy change. This could look like getting approval of a State Plan Amendment (SPA) or negotiating a waiver.

## Why Did They Do It That Way?

### *Medicaid: The More You Learn*



Let's say that a Governor directs a Medicaid agency to focus on improving health care access for individuals who are re-entering communities from jail or prison. The Medicaid Director may decide to focus the policy intervention on providing Medicaid coverage (and Medicaid-covered services like case management and substance use medication) 30 days before an individual is released from prison and develop a corresponding fiscal impact statement.

Then, the Medicaid Director needs to decide which federal authority and administrative vehicles they'll pursue to deliver these services. To provide services to individuals re-entering from incarceration, the Medicaid Director could:

- ✓ **Use a state plan option.** State plan options are generally easier to get approved through the federal government. However, they are also typically more limited in scope. Because of the federal "inmate exclusion" on using Medicaid funds for incarcerated individuals, a state plan option would limit the Medicaid agency to providing services only after the individual has left a jail or prison.
- ✓ **Apply for an 1115 demonstration project waiver.** 1115 demonstration waivers allow the federal government to waive certain statutory restrictions, so they are the most flexible federal authority. For example, [California received federal approval](#) in 2023 to provide services to incarcerated individuals 90 days before they are released through an 1115 waiver. However, 1115 waivers also require significant agency staff time and resources to negotiate with CMS, have lengthy approval processes which can delay policy implementation, and typically require Medicaid agencies to conduct robust evaluations on the demonstration, which can be costly.
- ✓ **Contractually require their managed care organizations to offer these services.** Managed care organizations (MCOs) have more flexibilities than Medicaid agencies, so the Medicaid Director could require their MCOs to provide certain services to members before they are released from incarceration. This option is [only available in states and territories who use managed care delivery systems](#) and requires sophisticated contract management.

These different federal authorities allow the Medicaid agency to deliver different sets of benefits to Medicaid members. For example, an incarcerated person living in a state or territory with an approved 1115 waiver may receive case management, medications, and behavioral health care before they are released from prison, while an incarcerated person living in a state or territory that uses a state plan option would have to wait until they are released to enroll in Medicaid.

The Medicaid Director also needs to figure out how their agency will deliver this care. This could look like contracting with a managed care organization to deliver a set of services, such as case management, substance use medications, and other behavioral health treatment. Alternatively, the agency could directly pay providers (fee-for-service) to deliver this care. Many agencies use a [mix of these delivery systems](#), carving certain benefits, like behavioral health or pharmacy, into or out of managed care. This has real impacts on how members experience care: a Medicaid member may have a different set of covered benefits, in-network providers, and customer support services depending on if they are in a fee-for-service or managed care delivery system.

After making these choices, the Medicaid Director may need to seek legislative approval and go through a public comment process. They would also need to get formal CMS approval to deliver the services by negotiating a waiver or submitting an amendment to their state plan. All of these steps have to occur before Medicaid members experience a change in their care – meaning that the Medicaid policymaking process can often take years to go from conception to implementation.

### *The Result? Variability, Variability, Variability*

The state-federal partnership at the core of the Medicaid program leads to significant variability across states and territories. These differences are driven by the priorities of state and territory policymakers (including the Medicaid Director, the Governor and their health policy leads, and the legislature), input from advocates and Medicaid members, and jurisdiction-specific constraints like budget, administrative capacity, provider availability. Variability is also driven, however, by how states and territories choose to implement certain policies, including the federal authorities and delivery systems they use.

This variability has real impacts on how Medicaid members experience care. A low-income adult who does not have children, for example, is eligible for Medicaid in some states but not others. Benefit packages vary significantly between states and territories: a Medicaid member can access dental benefits in some states but not others. This variability also allows states and territories to experiment with many different models of health care delivery; some states [recently received approval](#) to fund short-term housing through the Medicaid program. These waivers will provide important data on the relationship between housing and health.

Medicaid is a cornerstone of the US health care system, currently covering approximately one in four Americans. Understanding this program is challenging, however, due to the complex web of state and federal policies that interact to produce 56 different programs. Examining priorities, constraints, and policy implementation can help us understand why Medicaid policymakers make the choices they make, and why Medicaid programs look the way they do.

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**Medicaid covers  
ONE IN FOUR  
Americans today.**