Chapter 2:

Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

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Key Points

- The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement mandates that states provide Medicaid beneficiaries age 21 and younger access to any treatment, including residential treatment, for physical or mental conditions. Residential treatment services for youth may be provided in a psychiatric residential treatment facility (PRTF), qualified residential treatment program (QRTP), or in other residential settings that do not meet the requirements of a PRTF or QRTP.
- Federal law prohibits Medicaid payments for services provided to beneficiaries residing in an institution for mental disease, however there are several exceptions, including the psych under 21 benefit. The benefit allows states to cover medically necessary services delivered in PRTFs, a psychiatric hospital, or a psychiatric unit of a general hospital to beneficiaries under age 21.
- Lack of a single federal data source and other data limitations make it difficult to conduct comprehensive analysis of how Medicaid-enrolled children utilize residential treatment services.
- Identifying available residential treatment when needed is challenging due to the lack of easily attainable and specific information about the facilities serving Medicaid beneficiaries, such as their bed availability and specialty area.
- States may seek out-of-state placement for children if in-state placement cannot be found. In-state PRTFs may deny admission due to the child's diagnosis or functional or behavioral health characteristics, or to reserve beds for out-of-state patients to secure higher payment rates.
- Access to services along the continuum of behavioral health care, in particular home- and community-based behavioral health services, also affects access to residential behavioral health treatment. MACPAC previously found that intensive home- and community-based behavioral health services can help children with significant mental health conditions remain in their communities and avoid residential placement, but are often unavailable or difficult to access.
- MACPAC will continue to explore work that focuses on addressing the behavioral health needs of children with Medicaid coverage across the continuum of care.

CHAPTER 2: Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

Medicaid supports a wide range of behavioral health services for children, including residential treatment programs when determined medically appropriate (MACPAC 2021). Federal laws are in place to ensure that children with Medicaid receive appropriate access to behavioral health services. The Americans with Disabilities Act of 1990 (ADA, P.L. 101-336) prohibits discrimination against individuals with disabilities, including Medicaid beneficiaries with serious mental illness (SMI), and requires that services such as necessary mental health treatment be provided in the most integrated setting appropriate. Under the U.S. Supreme Court's ruling in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), states must provide treatment for individuals with disabilities, including SMI and serious emotional disturbance (SED), in community-based settings if the individuals do not oppose such services and if such placement is appropriate and can be reasonably accommodated by the state.[1] Intensive home- and community-based behavioral health services can help children and adolescents with significant mental health conditions remain in their communities and avoid unnecessary residential treatment. However, for children who need more intense care or pose a safety risk to themselves or their families, it is important that they can access residential treatment when appropriate (SAMHSA 2025b).

Residential treatment services for children are behavioral health interventions intended to provide intensive clinical treatment to children with SED or co-occurring conditions such as substance use disorder (SUD) (SAMHSA 2019). Residential treatment settings for children include psychiatric residential treatment facilities (PRTFs); qualified residential treatment programs (QRTPs) for children in foster care; residential programs such as SUD programs; and therapeutic boarding schools, wilderness camps, therapeutic ranches, boot camps, group homes, and other congregate care settings (Herbell and Ault 2021, Teich and Ireys 2007). Although the literature is limited, some research finds that individuals with disabilities experience barriers to treatment, such as inaccessible treatment facilities and communication difficulties (Clemans-Cope and Lynch 2025).

The 2021 U.S. Surgeon General's Advisory on Protecting Youth Mental Health described the ongoing youth mental crisis as an urgent public health issue and highlighted the consequences of mental health challenges, including poor health outcomes and the potential for future disability (HHS 2021). A Centers for Disease Control and Prevention analysis of Youth Risk Behavior Survey data indicated that from 2013 to 2023, certain indicators, such as experiencing persistent feelings of sadness or hopelessness and seriously considering attempting suicide, worsened (CDC 2024).[2] In addition, visits to emergency departments (EDs) by children for mental health-related issues increased (Hoge et al. 2022, ISPN 2022). For example, mental health-related ED visits in the United States increased 24 percent for children age 5 to 11 and 31 percent for those age 12- to 17-years-old between March 2020 and October 2020, compared to the same period in 2019 (Leeb et al. 2020). ED boarding also increased (MHPC 2025, Snow et al. 2025). ED boarding of children who need behavioral health treatment occurs when these patients remain in the ED, sometimes for prolonged periods, while awaiting needed behavioral health treatment. In 2017, about 12 percent of mental health encounters in the ED resulted in boarding in children's hospitals compared to 16 percent in 2023 (Snow et al. 2025). During the same time period, the median length of stay for boarding increased from 3 to 4 days, with a range of 2 to 589 days (Snow et al. 2025). ED boarding may cause patients to experience increased stress and delay mental health treatment that could mitigate the need for an inpatient stay (The Joint Commission 2021).[3]

In 2022, approximately one in four noninstitutionalized Medicaid-enrolled youth age 12- to 17-years-old reported experiencing a major depressive episode in their lifetime, and one in seven experienced a major depressive episode with severe role impairment (SHADAC 2024).[4] One study found that major depressive episodes and other mood, disruptive, and psychotic disorders were predictive of admission to

residential treatment for Medicaid-enrolled children (Rose and Lanier 2017). Other factors associated with admission for children were a trauma-associated behavioral health diagnosis, one or more antipsychotic drug prescriptions, a history of prior placement in a residential facility, a history of physical or sexual abuse, high levels of aggressive behaviors, family dysfunction including parental substance use, being older (with highest admission rates among adolescents), being male, and being Black (Wulczyn et al. 2015, Connor et al. 2004).

In response to the ongoing behavioral health crisis for children, the challenges in finding timely treatment when needed, and the health consequences of not being able to find timely treatment, MACPAC examined access to and use of appropriate residential treatment. This chapter describes the findings from this work. Although few children with Medicaid coverage require residential treatment services, the families of children that do require this level of treatment often experience barriers in finding an appropriate placement. This chapter begins with an overview of Medicaid coverage of residential behavioral health treatment, how children are referred to residential treatment, the use of residential services, the use of out-of-state placements, and barriers to appropriate access to residential treatment.

Medicaid Coverage of Residential Treatment Services

Children with behavioral health needs eligible for treatment under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements have a statutory right to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act (the Act), if that treatment or service is medically necessary. Residential treatment services for children are behavioral health interventions intended to provide intensive clinical treatment for children with SED or co-occurring conditions such as SUD. Medicaid-enrolled children access this intensive level of care in PRTFs, QRTPs for children in foster care, and other settings that are not defined in federal law (e.g., therapeutic boarding schools, boot camps) (Appendix 2A).

Early and Periodic Screening, Diagnostic, and Treatment

EPSDT requirements entitle Medicaid beneficiaries age 21 and younger to any treatment, including residential treatment, that is necessary to correct or ameliorate physical or mental conditions. EPSDT is designed to identify health issues early in the life course to promote early intervention and treatment, including for behavioral health. Identification of health needs often occurs through regular screenings and assessments at each well-child visit from birth through adolescence based on a state's periodicity schedule (CMS 2022). For example, screenings may address conditions including developmental delays, autism, depression, and suicide risk in adolescence. States must ensure availability of Medicaid coverable (under Section 1905(a) of the Act), medically necessary services to treat conditions identified during screening and diagnostic visits. Many residential facilities do not accept Medicaid, which limits the available treatment options for beneficiaries (BPC 2025).

The EPSDT requirement applies to children enrolled in the State Children's Health Insurance Program (CHIP) through Medicaid-expansion CHIP but not those in separate CHIP. However, several states with separate CHIP coverage have elected to provide EPSDT to beneficiaries in that program. In addition, in 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) required coverage of behavioral health services in CHIP. The Centers for Medicare & Medicaid Services (CMS) urges states to "leverage a comprehensive array of Medicaid providers...in meeting EPSDT coverage obligations" (CMS 2022).

Institution for mental disease exclusion

Federal law defines an institution for mental disease (IMD) as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (§ 1905(i) of the Act).

The term "institution for mental disease" is broad and has meaning only within the context of the Medicaid program; IMDs are not identified as a specific type of provider by other payers, state licensure agencies, or accrediting bodies. The definition encompasses several different types of facilities, including inpatient SUD and mental health treatment facilities as well as residential SUD and mental health programs (MACPAC 2019). The term "mental diseases" includes diseases listed as mental disorders in the *International Classification of Diseases*, with the exception of mental retardation, senility, and organic brain syndrome.

Since its inception in 1965, Medicaid has largely prohibited payments for services provided to beneficiaries residing in IMDs. The exclusion was designed to ensure that states and local governments retained their historical responsibility for funding inpatient psychiatric care (MACPAC 2019). The IMD exclusion applies to facilities with more than 16 beds and is one of the few instances in which no Medicaid federal financial participation (FFP) is available for any medically necessary and otherwise covered services for certain Medicaid beneficiaries receiving treatment in a specific setting (MACPAC 2019, CMS 2012).

Exceptions to the IMD exclusion for children younger than age 21

The Social Security Amendments of 1972 (P.L. 92-603) allowed an exemption to the IMD exclusion for children younger than age 21, commonly referred to as the "psych under 21" benefit (§§ 1905(a)(16), 1905(h), and paragraph (B) following the last numbered paragraph of § 1905(a) of the Act).[5] This optional benefit allows states to provide coverage for services delivered in PRTFs, a psychiatric hospital, or a psychiatric unit of a general hospital. Although this is an optional benefit, states must cover it if an assessment under EPSDT determines that the level of service is medically necessary. If the state lacks a facility to meet the assessed need, the state Medicaid program must pay for placement in an out-of-state facility (CMS 2012).

Section 1115 demonstrations also permit states to receive FFP for services provided to children with SED and adults with SMI during short-term stays in psychiatric hospitals or residential treatment settings that qualify as IMDs. FFP for services provided to children younger than 21 is limited to settings that qualify under the "Psych Under 21" benefit and to QRTPs that comply with restraint and seclusion requirements (CMS 2021). States must commit to improving connections to community-based care following stays in acute care settings, ensure a continuum of care is available to address the needs of beneficiaries with SED or SMI, provide a full array of crisis stabilization services, and promptly engage beneficiaries in treatment (CMS 2018). States may also use Section 1115 SMI/SED demonstrations to receive FFP for services delivered to Title IV-E beneficiaries (i.e., children in foster care) in a QRTP that is an IMD (CMS 2019).[6]

States may also use demonstration authority to waive the IMD exclusion and receive FFP for SUD treatment services delivered to beneficiaries during short-term IMD stays. Demonstration approval and funding are contingent on states pursuing efforts to meet specified milestones, such as providing access to all levels of care, ensuring the use of evidence-based patient placement criteria, and improving transitions between levels of care. States that receive waivers are expected to maintain a statewide average IMD length of stay of 30 days or less for individuals with SUD, and they cannot use FFP to pay for room and board (MACPAC 2024).

PRTFs

PRTFs are non-hospital-based facilities that have an agreement with a state Medicaid agency to provide the psych under 21 benefit (Appendix 2A). PRTFs must be accredited by one of the following: The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or any other accrediting organization with comparable standards that is recognized by the state (42 CFR 441.151).

Before admission to a PRTF, a child's health care team is required to certify that community resources do not meet the treatment needs of the child, treatment of the child's psychiatric condition requires an inpatient level of care under the direction of a physician, and services can be reasonably expected to improve the child's condition or prevent regression. Emergency admissions must be certified within 14 days of admission (42 CFR 441.152). The team must include a physician with competence in the diagnosis and treatment of mental illness (42 CFR 441.153). During

their admission, a child must receive active treatment specified in an individualized plan of care that must be reviewed at least every 30 days. The individualized plan of care must be based on a diagnostic evaluation, be developed by an interdisciplinary team of licensed mental health providers, outline treatment objectives, prescribe specific therapies and activities, and include post-discharge plans to ensure continuity of care with the child's family, school, and community (42 CFR 141.154-156).

PRTFs, like all health care facilities receiving any federal support, are required to protect and promote the rights of all residents, including the right to be free from any restraint or involuntary seclusion imposed for discipline, convenience, or retaliation (42 CFR 441 and 42 CFR 483). PRTFs are permitted to use restraint or seclusion only to ensure the safety of the resident or others during an emergency safety situation (42 CFR 483.356). Restraint or seclusion must be ordered by a physician or licensed practitioner and must not exceed four hours for residents age 18 to 21, two hours for residents age 9 to 17, or one hour for residents younger than age 9 (42 CFR 483.358). Staff must document the use of restraint or seclusion in the resident's record, notify the parent or guardian, monitor the safety and condition of the resident, and conduct a post-incident debriefing within 24 hours (42 CFR 483.358-370).

QRTPs

Enacted as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), the Family First Prevention Services Act (FFPSA) made substantial reforms to the child welfare system, including placing restrictions on the use of federal funding for congregate care. The FFPSA generally restricts the availability of Title IV-E foster care maintenance payments to 14 days unless the child is placed in a QRTP, a newly defined category of group homes (Appendix 2A).[7]

QRTPs provide time-limited trauma-informed treatment for children in foster care with behavioral health disorders. For a QRTP to receive Title IV-E payment on behalf of a child, the child must be assessed by a qualified individual not associated with the public agency or the residential program within 30 days of placement. Within 60 days of placement, the court must consider the assessment to determine if the placement in the residential facility is necessary and approve the placement (ACF 2018).

Title IV-E funds may be used to pay QRTPs for maintenance costs, which include room and board, supervision, case management, and allocated indirect costs for children who are eligible. Title IV-E does not reimburse the cost of any treatment services received by any child regardless of the child's IV-E eligibility. Medicaid may reimburse for clinical, therapeutic, and rehabilitation services, depending on the state's Medicaid plan, as long as the QRTP is not an IMD or has been exempted from the IMD exclusion (e.g., under a Section 1115 SMI/SED demonstration). If the QRTP claims FFP for state plan services authorized under Section 1915(i), it must meet the home- and community-based setting requirements in accordance with 42 CFR 441.710(a)(1) and (2). QRTPs may also claim FFP for Section 1915(i) services if the facility meets the state's requirements for Section 1915(i) participants in addition to federal home- and community-based settings requirements.

QRTPs with more than 16 beds are likely to be subject to the IMD exclusion as they are facilities that are "primarily engaged in providing diagnoses, treatment or care of persons with mental diseases including medical attention, nursing care, and related services" (42 USC § 1396d(i)). If the QRTP is an IMD, FFP is available only if the facility meets one of the exceptions described above; that is, it must comply with PRTF standards or the state must use a Section 1115 SMI/SED demonstration to receive FFP for services delivered to children in foster care who reside in a QRTP that is an IMD (CMS 2019). State Medicaid agencies must review each QRTP to determine whether it is an IMD (CMS 2019).

Other types of residential facilities

Other residential settings include public or private congregate or group care settings that do not meet the requirements of a PRTF or QRTP. These placement settings may be state licensed and can take the form of group homes, therapeutic boarding schools, therapeutic wilderness programs, boot camps, ranch programs, and other treatment settings. No federal laws define residential programs, and there are no uniform or commonly recognized definitions for program types (Huefner 2018, Kutz 2008).[8] Although

states typically regulate publicly funded programs, some do not license or regulate private or faith-based programs that operate behavioral health facilities (GAO 2008, GAO 2007). Although state regulations for licensing and regulating programs may vary, some states have used the American Society of Addiction Medicine criteria for patient placement to help ensure appropriate placement for SUD (O'Brien et al. 2021).

Some states permit Medicaid-enrolled providers to bill for clinical, therapeutic, or rehabilitative service components within these other types of children's residential facilities. For example, CMS approved a Maine state plan amendment in 2011 to establish a reimbursement methodology for private non-medical institutions, which include children's residential care facilities (CMS 2024a). These institutions receive FFP on a per diem basis for each child, which covers all staffing required by state law but excludes room and board (Maine DHHS 2025, 2021). Typically, room and board and non-treatment supports and services may be paid with Title IV-E dollars for eligible children subject to the time limits imposed by the FFPSA or with state or local general funds for children who are not Title IV-E eligible (CHCS 2020).

Referrals to Residential Treatment

Children with behavioral health needs may be referred to residential treatment providers from several sources, including providers, parents, and various child welfare agencies. Children may also be referred for residential care from EDs, mobile crisis response providers, urgent care, and home- and community-based service providers following a crisis or exacerbation in symptoms. In addition, in certain circumstances, courts may refer children who are involved in the child welfare system for placement in PRTFs or QRTPs if they have behavioral health needs that cannot be met in the community.[9]

In some cases, the lack of home- and community-based behavioral health services leads parents to relinquish custody of children to the child welfare or juvenile justice systems to obtain and pay for needed care (Gross et al. 2025, MACPAC 2021, GAO 2003). Parents may take such action when intensive home- and community-based behavioral health services are unavailable or inaccessible and when a family experiences a financial crisis due to the loss of income resulting from a parent or caregiver having to provide intensive supervision to ensure the safety of children and other family members (Herbell and Graaf 2023, GAO 2003). Between February 2017 and February 2019, an estimated 25,000 children were placed in foster care likely through custody relinquishment (Gross et al. 2025).[10]

Some states permit parents to enter a binding agreement with the state or local child welfare agency rather than relinquish custody. The agency assumes custody of the child for a specified period of time to provide the child access to residential treatment, typically after a family has exhausted private insurance benefits. Children who are voluntarily placed and are eligible for Title IV-E automatically become eligible for Medicaid (42 CFR 435.135). Federal foster care payment (under Title IV-E) for the children under voluntary placement agreements may not exceed 180 days unless there has been a judicial determination that such placement is in the best interest of the child (42 USC §§ 672(d)-(g)).

Use of Residential Treatment Services

No single federal data source systematically collects and analyzes the use of residential treatment by Medicaid-enrolled children age 0 to 21, which makes understanding their use of these services challenging (Lanier et al. 2024). In addition, federal regulations do not require that states collect and report information on the use of residential treatment in settings other than PRTFs for Medicaid and CHIP-covered children.

National estimates

Researchers use disparate data sources and methodologies to assess use of residential treatment services by children enrolled in Medicaid, including those involved in the child welfare system, in the absence of a single national data source. For example, a 2018 analysis examining children's behavioral health services and expenditures from 2005 to 2011 found that roughly 4 percent of children age 0 to 18 had a claim for residential services (Pires et al. 2018).

Another study of claims data found that in 2019, less than 0.1 percent of children age 3 to 17 enrolled in Medicaid with behavioral health conditions used residential treatment services (Radel et al. 2023).[11] A third study, using data from the National Survey on Drug Use and Health, found that in 2023 about 5 percent of noninstitutionalized youth age 12 to 17 with Medicaid and CHIP coverage received residential services, had been hospitalized, or received other inpatient treatment for a mental health condition (SAMHSA 2024b).

Prior analyses of Medicaid claims data have demonstrated that a small percentage of Medicaid-enrolled children use residential treatment (Pires et al. 2018). Studies in selected states have found that male, older age, and Black children have a disproportionately high use of residential treatment (Rose and Lanier 2017, Wulczyn et al. 2015, Connor et al. 2004). In addition, child welfare-involved youth represent a small share of the Medicaid population but a disproportionate share of admissions to residential behavioral health treatment settings, including through custody relinquishment and the use of voluntary placement agreements (Hill 2017).

According to national data from the Adoption and Foster Care Analysis and Reporting System, 4 percent of children in foster care reside in group homes, and 5 percent reside in an institution such as a residential treatment facility, child care institution, maternity home, nursing home, or hospital (ACF 2024, 2023).[12] Data from the Adoption and Foster Care Analysis and Reporting System do not, however, provide information by facility type or distinguish whether Medicaid-covered services are provided to children in those settings.

State estimates

Data from states indicate varied trends in the extent to which Medicaid- and CHIP-enrolled children are accessing residential treatment services. These data provide insight into trends within states but are not comparable across states due to differences in data collection methods and definitions of residential care settings. The use of residential care in North Carolina has declined since the COVID-19 public health emergency. The use of PRTFs among children age 5 to 18 who are enrolled in North Carolina's Medicaid program declined from a high of 1,213 in 2018 to 1,020 in 2022. Since 2018, less than 0.2 percent of Medicaid-enrolled children age 5 to 18 were admitted to a PRTF in North Carolina (North Carolina DHHS 2025). In Utah, the percentage of children with Medicaid using residential care has fluctuated in recent years, rising from 1.3 percent in 2022 to 2.9 percent in 2023 before declining to 2.0 percent in 2024 (Utah DHHS 2025). In one state, the number of children receiving care in group homes increased from 600 to 900 between 2020 and 2024, as there has been a shift away from other types of congregate settings.

Some state reports show disproportionate use of residential services by children in foster care. For example, children in foster care in North Carolina made up 26 to 42 percent of PRTF placements, depending on the year, despite making up less than 1 percent of children in the state (Lanier et al. 2024). In addition, 27 percent of children in residential treatment in Virginia in 2019 were in foster care at the time of admission (Virginia DBHDS 2021a).

Utilization data limitations

Data limitations make conducting a comprehensive claims analysis of residential treatment services by children difficult. PRTFs are assigned a specific place of service code, making it easier to identify claims associated with this provider type compared to others. Identifying QRTPs and other residential provider types is challenging, as they may not have a specific place of service code assigned by their respective state Medicaid agency. Without specific place of service codes, it is difficult to differentiate claims submitted for services delivered in a facility that is not a PRTF from those delivered in office-based settings. An analysis of PRTF-only claims would likely be of limited generalizability, as one study found that the majority of children receive residential treatment in non-PRTF settings (Brown et al. 2010).

Demographic data

Limitations in available national and state data prevent reporting detailed information about the characteristics of Medicaid-enrolled children using residential

treatment. For example, stakeholders indicate that a lack of data on Medicaid beneficiaries who are referred for, admitted to, denied admission to, and discharged from residential treatment facilities has made it difficult to understand the scope and trends in these measures. Stakeholders also noted similar difficulties reporting on children who are in overstay—that is, children who were admitted to residential treatment and received treatment and are ready to be discharged to the community but for whom appropriate placement has not been identified and secured.

In addition, published national studies and literature do not report on the demographic characteristics or provide data on health conditions or needs of children enrolled in Medicaid who use residential treatment services. Although several states collect some data on use of residential treatment services for their own analytic and programmatic purposes, the data collected vary. For example, among the sample of five states in our analysis, only one reported collecting data on Medicaid-enrolled children who received residential treatment by county.[13]

Facility information

Some information to identify the number and locations of certain residential treatment facilities is publicly available, but a lack of easily attainable and specific information about the facilities serving Medicaid beneficiaries, such as their bed availability and specialty area, make it difficult for families, providers, and states to find placements.

Number of facilities. In fiscal year (FY) 2025, there are 341 PRTFs in 34 states (CMS 2025). CMS reports that nationwide, the number of PRTFs declined from 372 in 34 states in FY 2021 to 344 in 34 states in FY 2023 before increasing slightly in 2024 (346) (CMS 2025).[14] The number of PRTFs increased from FY 2021 to FY 2025 in six states: Colorado, Louisiana, Missouri, Oklahoma, Oregon, and Utah (as of May 2025). The number of PRTFs decreased by five or more from FY 2021 to FY 2025 in two states, New York (16 PRTFs to 11) and Pennsylvania (89 to 66) (CMS 2025). Other states had smaller or no decreases. Some stakeholders attribute declines in the number of residential facilities nationwide to closures during the COVID-19 public health emergency. After the public health emergency, some states could not reopen closed facilities, and some facilities reduced bed capacity.

Each state maintains a list of licensed QRTPs, but no publicly available database or repository includes, for example, the number of beds in each facility, the demographic and clinical profile of the children served by each facility, the total number of beds by state, or the number of children placed in out-of-state QRTPs under the Interstate Compact on the Placement of Children.[15]

Other types of information. No national or regional bed registries list complete information on all residential facilities (i.e., PRTFs, QRTPs, and other facilities) and their respective areas of expertise (e.g., the populations or conditions they treat). Although CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) maintain lists of facilities, they may be insufficient to meet state needs. CMS's Quality, Certification, and Oversight Reports website primarily provides information about state survey agency findings from health and safety surveys of PRTFs (Howard 2024).[16] It also provides information such as address, phone number, accreditation type, and ownership type but does not provide information about areas of expertise or treatment modalities. CMS does not independently verify the accuracy of the information from states (Howard 2024).

Assessment and Admissions

Federal PRTF and QRTP requirements direct that the need and appropriateness for admission be assessed to ensure that children are served in the least restrictive setting. Although the goal for the assessments is shared, federal requirements specify different approaches for PRTFs and QRTPs. No federal regulations govern the admissions process or certification of need for other types of residential treatment providers.

Assessment

Federal PRTF rules require a certification of need of services. The rules stipulate that a team that includes a physician with competence in diagnosis and treatment of mental illness, preferably child psychiatry, specify that resources available in the community do not meet the treatment needs of the child, that the child's condition requires inpatient care under the direction of a physician, and that the inpatient services can be reasonably expected to improve the child's condition or prevent further regression (42 CFR 441.152-153). PRTF rules do not require the use of a validated assessment tool before certifying the need for care in a PRTF.

Federal QRTP requirements call for an assessment of the appropriateness of a QRTP placement within 30 days of the placement. A qualified individual (e.g., trained professional or licensed clinician) who is not an employee of the state and who is not connected to or affiliated with any placement setting in which children are placed by the state must use an age-appropriate, evidence-based, validated, functional assessment tool to document the need for residential treatment (ACF 2018).

Evaluation of admission decisions

There is no federal requirement for CMS or states to audit the clinical appropriateness of admissions or denials of admission to PRTFs, QRTPs, or any other residential facility type for children with behavioral health needs. Most of the states in our study collect some data on denials of admission to residential treatment facilities. The most common reasons for denied admission included being older age; having current or previous child welfare or juvenile justice involvement; having a history of aggressive or sexualized behaviors or elopement; and having co-occurring conditions, including SUD, intellectual and developmental disabilities (I/DD), or autism. Some PRTFs may also deny admission due to co-occurring medical conditions. One state reported that it does not have any policies that forbid or limit facilities from denying admission to children; a facility could have an open bed and still deny placement from child welfare, youth court, or a community provider. In contrast, one state that has been involved in reforming its children's behavioral health delivery system reported that facilities must accept referred children and that denials of admission must be approved by the state.

Out-of-State Placement

Out-of-state placements may be necessary if in-state facilities lack the capacity to admit children or the expertise to address their behavioral health needs or deny admission. For example, in-state PRTFs may deny admission due to the child's diagnosis or functional or behavioral health characteristics or to reserve beds for out-of-state patients to secure higher payment rates. States typically make multiple attempts to find an appropriate in-state residential setting before making an out-of-state placement to provide the psych under 21 benefit. For example, a Medicaid official in one state reported having to make between 40 and 60 referrals to facilities before being able to find a placement, and that some facilities do not provide timely responses about denials or acceptances. A Medicaid official in another state reported that the state requires in-state denials before authorizing treatment in out-of-state PRTFs. If a state sends a beneficiary out of state, the state must ensure that the receiving PRTF is certified (CMS 2013).

Frequency

There is no single national data source for understanding the frequency of out-of-state placements or the circumstances surrounding that placement, length of stay, the outcomes of the placement, or transitions upon discharge (CMS 2017). The Medicaid State Operations Manual specifies that PRTFs must submit annual attestation statements to each state Medicaid agency with which they have an established provider agreement. The statement must include information on the number of Medicaid beneficiaries receiving the psych under 21 benefit in the facility, the number of such individuals from out of state, and a list of states from which it has ever received Medicaid payment for the psych under 21 benefit (CMS 2024b). State survey agencies, which are responsible for certifying PRTF compliance with

Medicaid participation requirements, must input this information into the Automated Survey Process Environment reporting system.

Data from some states indicate that out-of-state placements have increased in recent years. For example, the number of Montana children placed in out-of-state PRTFs increased from 174 in state fiscal year (SFY) 2023 to 198 in SFY 2024 (Montana DPHHS 2024). Similarly, Montana's out-of-state placement report for SFY 2024 showed the overall number of children who received residential treatment (not just in PRTFs) outside the state increased from 239 in SFY 2023 to 254 in SFY 2024.[17] In North Carolina, of the children placed in PRTFs, the percentage placed out of state increased from 27 percent in 2016 to 44 percent in 2022 (Lanier et al. 2024, North Carolina DHHS 2023). Still another state included in our study indicated that it makes few out-of-state placements but that there has been an increase in out-of-state children coming to the state for residential treatment services.

Some states are working to minimize out-of-state placements. For example, Montana tries to place the child in the lowest level of care in state and requires denials from the two in-state PRTFs before it places children out of state (Montana DPHHS 2024). Utah officials similarly reported focusing resources on placing children in state and avoiding out-of-state placements. North Carolina officials reported working with facilities to create specialized placements to keep children in in-state facilities, but the parents and guardians can decide to send children out of state. The state is also working to address the availability of community-based wraparound services so children can stay in a family-based setting.

PRTF capacity and expertise

PRTF capacity and expertise are key factors in determining whether a beneficiary is placed out of state for treatment. Nationally, the number of residential treatment centers for children declined by 61 percent from a little less than 800 in 2010 to about 300 in 2022 (Dziengelski 2024). Similarly, the number of PRTFs declined by 21 percent, from more than 400 in 2010 to less than 350 in 2023 (Dziengelski 2024). Some states experienced high rates of decline: PRTFs declined by more than 30 percent in 12 states from 2010 to 2023, faster than the national rate of decline for all residential treatment facilities (Dziengelski 2024). In 2024, 14 states did not have any PRTFs (CMS 2024c). Data from states reflect these national trends. For example, in North Carolina, the number of PRTFs decreased from 33 in 2018 to 27 in 2023, and the total number of licensed beds declined from 450 to 339 (North Carolina DHHS 2023). Officials from Utah reported closures of PRTFs, short-term crisis centers, and longer-term residential centers.

Some children are placed in out-of-state PRTFs when in-state facilities lack staff with expertise to address their behavioral health needs. Finding appropriate residential treatment options can be challenging for children with more complex needs, such as those with I/DD, SUD, sexualized behaviors, eating disorders, aggression, and more than one behavioral health diagnosis. Other demographic characteristics of populations struggling to access appropriate residential care include age, location, language, sexual orientation, and race. Specifically, Ohio officials reported difficulty finding placements for adolescent boys; Montana officials reported a lack of facilities accepting children younger than age 12; and Utah officials reported that children in rural counties may have additional barriers to finding facilities near their homes, limiting their families' involvement in their care.

Although out-of-state placements are made to secure residential treatment for children who need it, the placements do not guarantee the quality or receipt of needed care. For example, a Medicaid official in one state shared that sometimes the PRTFs receiving children from out of state find that they cannot adequately treat the complexity of the children. Some of those children subsequently present in crisis in an ED or become involved in the juvenile justice system. In addition, sending states sometimes find it difficult to monitor and oversee the care being provided to their beneficiaries in out-of-state facilities because they often must rely on information and reports from the receiving state (Larin 2024). Some state Medicaid officials reported that out-of-state placements can make it difficult for children to maintain connections with family and transition back to their respective states of residence.

Payment for out-of-state beneficiaries

States set payment rates for residential facilities, including the rates for out-of-state facilities, which can be higher than those for in-state facilities. One state in which PRTFs primarily serve out-of-state children reported that payments for such Medicaid beneficiaries are an estimated three to four times greater than payments for in-state children.

The need for residential care for certain children who cannot be served in their home states, combined with higher out-of-state payment incentives, creates a dynamic that may exacerbate the need for out-of-state placement. Under EPSDT, states must find a residential placement for a child requiring that level of care even if there is insufficient in-state PRTF capacity. In such situations, states must cover out-of-state care, paying the higher rate for care to out-of-state facilities. Facilities may be more willing to accept out-of-state children due to their higher Medicaid payments, which could lead to a lack of available in-state residential beds or denials by in-state facilities. No federal rules govern provider decisions to accept children from outside the state to access higher reimbursement rates. Similarly, some states do not have rules that prevent facilities from denying care or holding beds for out-of-state Medicaid beneficiaries.

Continuum of Care

Access to residential treatment for behavioral health care is affected by access to services along the continuum of behavioral health care, in particular home- and community-based behavioral health services. State and federal officials, beneficiary advocates, researchers, and other stakeholders identified the availability of and access to home- and community-based behavioral health as critical to addressing the behavioral health needs, including the need for residential treatment, of children with Medicaid. The lack of intensive community-based services can also prevent residential treatment facilities from being able to discharge residents when appropriate, which can limit bed availability for other individuals in need of residential care. Researchers have previously noted the benefits of a system of care approach, or care continuum, in preventing the need for residential treatment for youth with SMI or SED and maintaining connections with their communities and families while receiving treatment for their mental health needs (Stroul et al. 2021).

Previous MACPAC work found that intensive home- and community-based behavioral health services, which can help children with significant mental health conditions remain in their communities and avoid residential placement, are often unavailable or difficult to access (MACPAC 2021). In addition, researchers have documented that many children and adolescents may receive treatment in a residential setting, be discharged, but then be readmitted within approximately three months (D'Aiello et al. 2021). Factors affecting access to home- and community-based behavioral health services include the systemic complexity brought on by the multiagency nature of serving children with substantial behavioral health needs and barriers to using certain Medicaid authorities designed to serve these children (MACPAC 2021). The Commission recommended that the Secretary of the Department of Health and Human Services direct CMS, SAMHSA, and the Administration for Children and Families to issue joint subregulatory guidance and provide education and technical assistance to states on improving access to home- and community-based behavioral health services. MACPAC also recommended that the Secretary examine options to use existing federal funding to support state activities to improve access (MACPAC 2021).

States are engaged in a variety of efforts to increase the capacity of or enhance the intensity of available home- and community-based behavioral health services. For example, some states are using the targeted case management benefit to increase the provision of coordinated services, such as respite care for children with behavioral health conditions to prevent caregiver burnout, which can lead to out-of-home placement.[18] States also use targeted case management to provide warm hand-offs between providers.[19]

One state in our study permits community providers to offer and receive Medicaid payment for services delivered concurrently with residential treatment to ensure a successful transition back to the child's home and community. Concurrent service delivery may include, for example, permitting Medicaid payment for home- and community-based behavioral health services and residential treatment while a child is

on therapeutic leave from an institutional setting.[20] This state also increased reimbursement rates for many home- and community-based behavioral health services. A few states introduced new Medicaid-covered home- and community-based behavioral health services such as family-centered treatment to help children transition back to the community. One state reported that it developed and was implementing a prepaid inpatient health plan to increase availability of home- and community-based behavioral health services to reduce reliance on in- and out-of-state residential treatment facilities. Two states described efforts to expand mobile crisis and stabilization services for children and families.[21]

Barriers to Appropriate Residential Treatment

Our work surfaced numerous factors affecting appropriate access to residential treatment for Medicaid-covered children in need of that level of care.

Availability of home- and community-based behavioral health services

Addressing the lack of home- and- community-based behavioral health services for children is one of the most pressing issues facing the Medicaid program. Insufficient access to home- and community-based behavioral health providers to serve Medicaid beneficiaries can have both upstream and downstream effects on access to residential treatment. The lack of community-based treatment alternatives for youth with SMI, SED, and other mental or behavioral health concerns may result in placement of children who may not need a residential level of care into such treatment. Such placements may in turn reduce bed availability for those children who do. Home-and community-based behavioral health services can help to reduce the need for and use of residential treatment. Greater access to intensive home- and community-based behavioral health services may also allow for earlier intervention and shorten residential lengths of stay. In addition, with more home- and community-based behavioral health services available, facilities may be able to more quickly transition children out of the facility—for example, to partial hospitalization, intensive outpatient programs, or back into their communities—as soon as they can be safely treated in a less restrictive setting. Freeing up these beds may help with other beneficiaries' access to residential care when needed. Additionally, some states use in lieu of services to increase access to behavioral health services such as crisis stabilization and partial hospitalization, which may help reduce the need for residential care (NCSL 2023).

Federal policy limitations

States and stakeholders identified the IMD exclusion and prohibition on FFP for room and board as federal policies that pose barriers to appropriate residential treatment. The IMD exclusion is a long-standing policy established to advance deinstitutionalization efforts, provide care in the community, and prevent shifting the cost of psychiatric institutional care from the states to the federal government (MACPAC 2019). Although the IMD exclusion means that certain facilities are not accessible to Medicaid beneficiaries, unless states use non-Medicaid funds to support their stay, nearly all states are making payments for services provided in IMD settings via various exemptions and authorities. These exemptions and authorities include statutory exemptions related to older adults and children, Section 1115 demonstrations, a state plan option, and managed care arrangements under certain conditions (MACPAC 2019).

States that include QRTPs with more than 16 beds (i.e., QRTPs that are IMDs) in Section 1115 SMI/SED demonstrations may receive FFP for services provided to children residing in those QRTPs. States with Section 1115 SMI/SED demonstrations generally must achieve a statewide average length of stay of 30 days or less in participating IMDs (CMS 2019). However, states and stakeholders described 30 days as sometimes insufficient to treat behavioral health needs, and CMS will consider state requests for an exemption of up to two years from this requirement (CMS 2021). Some stakeholders indicated that the intersection of federal IMD, PRTF, and QRTP coverage policy is complex and confusing and is an area in which additional guidance would be useful.

Information on facility and bed availability

States have indicated that it can be difficult to find needed information to identify, in real time, facilities that may be able to serve children (North Carolina DHHS 2023, Morrisette 2021, Virginia DBHDS 2021b). As noted earlier, there is no single source of information on facility availability or areas of expertise. There is limited reporting on the facility waitlists that help parents and providers understand bed availability. A 2024 article focused on SUD and residential addiction treatment for youth, particularly for OUD, noted that approximately 40 percent of facilities surveyed did not have bed availability, nor did they have a waitlist. Of those facilities that did have a waitlist, the average time until a bed became available was 28 days. Approximately 57 percent of facilities with waitlists accepted Medicaid (King et al. 2024). The process of finding a residential placement for a child who requires it can take several hours to several days, which, in the case of children in crisis in an ED, can lead to longer stays in the ED than are needed.

Some state and federal agencies have taken steps to facilitate finding facilities and, in some cases, available beds. However, gaps remain. For example, to address challenges in identifying available and appropriate beds in residential facilities, North Carolina launched the Behavioral Health Statewide Central Availability Navigator, which monitors daily bed availability in inpatient, residential, and other settings.[22] However, the state notes that even with the bed registry, specialized care for sexualized behavior, autism spectrum disorder, co-occurring I/DD, and SUD is often unavailable (North Carolina DHHS 2023). Virginia's Office of Children's Services hosts a web-based directory of providers, but it does not provide a comprehensive source of information about bed availability, types of residential settings, or residential facilities with particular specialties (Virginia DBHDS 2021b). SAMHSA maintains a website, FindTreatment.gov, which allows users to search for behavioral health treatment facilities based on criteria such as location and acceptance of Medicaid, but it does not provide bed availability (SAMHSA 2025a).[23] Moreover, in a March 2025 report, the U.S. Department of Health and Human Services Office of the Inspector General described finding inaccurate or incomplete information (e.g., addresses, facility treatment approaches) for several facilities (OIG 2025).

In some cases, the lack of accessible residential treatment beds can lead to an out-of-state placement. Such placements can occur if in-state facilities lack the staff or expertise to address certain behavioral health conditions or if facilities decline an in-state placement in favor of an out-of-state placement due to financial incentives. Although these placements may help with access to treatment, it can be difficult for states to monitor the care of beneficiaries they have placed out of state and for beneficiaries to maintain connections to their communities in their home states.

Assessment requirements

States and stakeholders expressed concern that the processes by which children are assessed and admitted to residential treatment are fragmented and vary by agency involvement, facility type, and provider. This lack of uniformity in assessing children's need for residential behavioral health care could lead to the inappropriate use of this restrictive setting or its inconsistent use among different populations (e.g., children in foster care versus children who are not in foster care) (National Council 2023).

Some state officials expressed concern that many EDs lack psychiatric staff to evaluate children's behavioral health needs.[24] Thus, EDs may precipitously refer children to residential treatment because they are not aware of the full array of home- and community-based behavioral health services available in the community or the processes for referring children and families to local behavioral health agencies or providers. Some stakeholders viewed the lack of a follow-up assessment after the initial referral to residential care, the PRTF certification of need standard, and inconsistent requirements related to the use of validated assessment tools to document the need for residential care as areas in need of improvement to better prevent inappropriate residential placements.

Data

The lack of a single national source of data on the number, type, and characteristics of children accessing residential treatment services limits what

can be known about beneficiaries using the services and their access. Without this information, it is difficult to determine what areas are most in need of improvement, if particular subgroups experience greater or particular types of barriers, and how interventions to address access concerns should be designed or targeted. Although some states are already collecting data, data collection varies by state.

Workforce issues

Difficulty hiring, training, and retaining clinical and direct care staff makes it challenging for states to operate facilities at their full licensed residential bed capacity. Two stakeholders interviewed reported that residential treatment facilities do not have the fiscal resources necessary to recruit, train, and retain clinical and direct care staff with proficiency to treat and manage children with co-occurring conditions, particularly autism and I/DD. One state official reported that it has thousands of licensed residential care beds across several facility types, such as PRTFs and QRTPs, but those facilities lack sufficient staff (e.g., awake overnight staff). Another state official reported that residential facilities closed because of a lack of sufficient staff and that the costs of operating a partially occupied facility were higher than the reimbursement received. Officials in three states named reasons for workforce shortages, including competition for staff as facilities reopened after COVID-19 closures, risk of injury to staff, and low wages for direct care staff compared to other industries. A provider noted that maintaining a workforce trained in evidence-based practices is costly and requires initial and ongoing investments to maintain fidelity to the selected evidence-based model. As staff depart, the facility must continually invest in training new providers.[25]

Looking Ahead

Addressing the behavioral health needs of children with Medicaid coverage will require an approach that addresses barriers along the continuum of care. Improving access to appropriate residential treatment requires addressing residential care-specific concerns (e.g., lack of information on available bed and facility expertise information) as well as improving access to home- and community-based behavioral health services. MACPAC's examination of these issues will continue and will include analysis of the considerations affecting access to home- and community-based behavioral health services for children as well as additional topics related to safety and quality of appropriate residential treatment services.

Endnotes

[1] SMI describes a diagnosable mental, behavioral, or emotional disorder (e.g., bipolar disorder and schizophrenia) experienced by someone older than age 18 that substantially interferes with their life and ability to function. SED has the same definition except that it used only for children (SAMHSA 2024a).

[2] The Centers for Disease Control and Prevention conducts the annual Youth Risk Behavior Survey of high school students regarding their health behaviors and experiences, including those related to behavioral health, sexual behavior, and experience with violence (CDC 2024).

[3] These stays consume ED resources, exacerbate ED crowding, delay treatment for other ED patients, and affect ED payment (Morrisette 2021).

[4] Severe role impairment is defined by the level of problems reported in four major life activities or role domains: (1) ability to do chores at home, (2) ability to do well at school or work, (3) ability to get along with family, and (4) ability to have a social life (SHADAC 2024).

[5] In addition to the psych under 21 benefit, states may pay for services in IMDs under Section 1115 demonstration authority, a state plan option and a limited exception for pregnant women under the Substance Use-Disorder Prevention that Promotes Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271), and through managed care arrangements under certain circumstances (MACPAC 2019).

[6] Title IV-E provides partial federal reimbursement to states, territories, and tribes for the cost of providing foster care, adoption assistance, and guardianship assistance for eligible low-income children who have been removed from their homes. As part of the Bipartisan Budget Act of 2018 (P.L. 115-123), the Family First Prevention Services Act expanded the allowable uses of Title IV-E funds to include certain foster care prevention services and kinship navigator programs (CRS 2014).

[7] The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence (42 USC § 675(4)).

[8] The International Work Group for Therapeutic Residential Care's 2016 consensus statement noted that a 2014 definition of therapeutic residential care "offered a useful starting point." "'Therapeutic residential care' involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection of children and youth with identified mental or behavioral health needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources" (Whittaker et al. 2016). Researchers often define the facilities in developing the scope of their work. For example, noting the lack of a single definition, the U.S. Government Accountability Office defined a wilderness therapy program as a program that places youth in different natural environments, including forests, mountains, and deserts. Some wilderness therapy programs may include a boot camp element, but boot camps are also independent of wilderness programs. The U.S. Government Accountability Office defined a boot camp as a residential treatment program in which strict discipline and regime are dominant principles (GAO 2007). Therapeutic boarding schools combine educational components with therapy in a residential setting (Golightley 2020). Some of these facilities may also provide step-down care upon discharge from inpatient treatment or a PRTP or QRTP. If the facilities are community based, they may also provide treatment to prevent higher levels of care.

[9] Such placements may occur if the child welfare agency files a petition with the court for an out-of-home placement order after substantiating abuse or neglect and a finding of imminent harm or after prevention services and supports have been deemed unsuccessful. The court may place the child with kin; in foster care or therapeutic foster care; or in a QRTP, PRTF, or other congregate care setting, depending on the child's needs. Section 473(b)(1) of the Act requires that Title IV-E-eligible youth be considered to be receiving cash assistance. Section 1902(a)(10)(A)(i)(I) of the Act makes those cash assistance recipients eligible for Medicaid (42 CFR 435.135).

[10] This figure includes data on children from the Adoption and Foster Care Analysis and Reporting System for the 50 states, the District of Columbia, and Puerto Rico (Gross et al. 2025).

[11] The data include children with Medicaid or CHIP coverage for full or comprehensive benefits who were enrolled for at least six consecutive months.

[12] The U.S. Department of Health and Human Services Administration for Children and Families Children's Bureau maintains the Adoption and Foster Care Analysis and Reporting System. State and tribal Title IV-E agencies must report Adoption and Foster Care Analysis and Reporting System case-level information on all children in foster care and children who have been adopted with Title IV-E agency involvement (ACF 2025).

[13] This state maintains a data dashboard with this information.

[14] The count of PRTFs refers to the number of such providers for which CMS has survey records in the agency's online survey and certification reporting system.

[15] The Interstate Compact on the Placement of Children is a statutory agreement between all 50 states, the District of Columbia, and the U.S. Virgin Islands. The agreement governs children being placed in the custody of a state, being placed for private or independent adoption, or under certain circumstances being placed by a parent or guardian in a residential treatment facility from one state into another state (APHSA 2024).

[16] The website pulls data from the Automated Survey Process Environment and Certification reporting system used by state survey agencies to document their required health and safety surveys of PRTFs.

[17] The state placed these children in PRTFs or therapeutic group homes. Medicaid covers the cost of care for the majority of the children placed out of state, but care for some children is covered by another state agency, such as the state's Department of Corrections or the Child and Family Services Division (Montana DPHHS 2024).

[18] Respite care, in which another caregiver comes to the child's residence (in-home respite care) or the child is supervised and cared for in the community (out-of-home respite), is associated with reductions in out-of-

home placement in residential and child welfare settings, reductions in some areas of caregiver stress, and lower incidences of negative behaviors by the children (Bruns and Burchard 2010).

[19] For example, some states engage targeted case management coordinators to help beneficiaries establish care with community-based behavioral health providers after a call to a mobile crisis responder.

[20] Therapeutic leave is a short-term absence from a facility prescribed as part of the youth's individualized treatment program and acclimates the youth to community treatment and the family environment before discharge.

[21] Such services typically send trained providers to a caller's home or foster home within 60 to 90 minutes to address behavioral health challenges and to begin developing a plan of care that focuses on maintaining the youth in their home or current foster care placement.

[22] The state launched the Behavioral Health Statewide Central Availability Navigator in 2023.

[23] The 21st Century Cures Act (P.L. 114-255) required that SAMHSA develop and maintain an online, searchable behavioral health treatment services locator that includes providers' names, locations, contact information, and services provided (OIG 2025). SAMHSA also makes available a written directory of the facilities that are included at https://findtreatment.gov. The providers listed on the website and in the directory are public and private providers of behavioral health services that responded to the National Substance Use and Mental Health Services Survey (SAMHSA 2025a).

[24] A 2018 survey of Medicare-enrolled hospitals found that 30 percent of rural and 57 percent of urban hospitals had a psychiatrist on staff or available for consultation (Ellison et al. 2022).

[25] Residential treatment providers may offer a variety of evidence-based treatments to children in their care.

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APPENDIX 2A: Comparison of Federal Regulations for Children's Residential Provider Types

TABLE 2A-1. Comparison of Federal Regulations for Children's Residential Provider Types

Topic	Psychiatric residential treatment provider	Qualified residential treatment provider	Other residential providers
Service definition	A non-hospital facility that can provide inpatient psychiatric hospital services. Designed to offer a short-term, intense, focused mental health treatment program.	Type of child care institution as defined under the Family First Prevention Services Act (P.L. 115-123). Provides short-term, trauma-informed treatment. May also provide a placement and treatment for prenatal, postpartum, or parenting youth; a supervised independent living setting; and a placement for youth who have been or are at risk of becoming sex trafficking victims.	No federal regulations or requirements. Provider types typically include therapeutic boarding schools, wilderness programs, ranches, and boot camps; terms may vary by state. Programs vary but typically offer clinical, therapeutic, and rehabilitative services to youth.
Licensing and accreditation	Must be accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state.	Must be licensed by the state as a CCI (42 USC § 672). Must be accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or another U.S. Department of Health and Human Services-approved organization.	No federal regulations or requirements.
Facility size	No size limit.	Publicly owned QRTPs can be no more than 25 beds to meet the statutory definition of a CCI (42 USC § 672). If more than 25 beds, they cannot claim Title IV-E funds. No size limit for private QRTPs.	No size limit unless the facility intends to seek Medicaid reimbursement (see Medicaid reimbursement row).

TABLE 2A-1. (continued)

Topic	Psychiatric residential treatment provider	Qualified residential treatment provider	Other residential providers
Age of eligible children	No minimum age. Maximum age is 21. Upon turning 22, individuals must be transitioned to community services or non-Medicaid inpatient services.	No minimum age. Maximum age depends on a state's age of foster care eligibility.	No federal regulations or requirements.
Length of stay	No length of stay limitation.	If longer than 30 days, requires an assessment. Within 60 days, requires review by the court. If an extended placement is necessary (6 to 12 months, depending on age), must submit documentation to the Children's Bureau, Administration for Children and Families in the U.S. Department of Health and Human Services.	No federal regulations or requirements.
Medicaid reimbursement	Provide care under the optional "Psych Under 21" benefit. May claim Medicaid for the total cost of care, including room and board. PRTFs must meet the conditions of participation, including limiting restraint and seclusion (42 CFR 441.150 et seq.). If the youth's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen determines this service is necessary, it can be funded under Medicaid's EPSDT requirement, even if the service is not included in the state plan.	If they are not IMDs, QRTPs may claim Medicaid for behavioral health treatment and other medical costs, excluding room and board. Title IV-E pays maintenance costs, including room and board. QRTPs that are IMDs may not claim Medicaid, unless they also meet the requirements of a PRTF or they are covered under their state's Section 1115 SMI/SED demonstration. State Medicaid agencies determine whether a QRTP is an IMD. If billing Medicaid for allowable services under a Section 1915(i) state plan amendment, the QRTP must meet the home- and community-based setting requirements in accordance with 42 CFR 441.710(a)(1) and (2).	If they are not IMDs, other residential providers may claim Medicaid for behavioral health treatment and other medical costs, excluding room and board. Other residential providers that are IMDs may not claim Medicaid.

TABLE 2A-1. (continued)

Notes: CCI is child care institution. QRTP is qualified residential treatment program. PRTF is psychiatric residential treatment facility. IMD is institution for mental disease. SMI is serious mental illness. SED is serious emotional disturbance.

Source: MACPAC analysis of Baxter et al. 2023.