Report to Congress on Medicaid and CHIP

MARCH 2026

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

Report to Congress on Medicaid and CHIP

MARCH 2026

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Advising Congress on
Medicaid and CHIP Policy

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March 12, 2026

The Honorable JD Vance
President of the Senate
The Capitol
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The Honorable Mike Johnson
Speaker of the House
The Capitol
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the March 2026 *Report to Congress on Medicaid and CHIP*. This report includes a recommendation to help promote the home- and community-based services workforce (HCBS) as well as chapters on behavioral health in Medicaid and the State Children's Health Insurance Program (CHIP), Medicaid for justice-involved youth, and Medicaid for children in foster care.

Chapter 1 includes a recommendation aimed at bolstering the HCBS workforce by requiring states to report hourly wages paid to HCBS workers to help states set effective HCBS payment rates. Workforce shortages reduce Medicaid's ability to serve people with long-term care needs in the home or community. Many states are exploring ways to use Medicaid rate setting to expand the HCBS workforce and reduce worker turnover. Under this recommendation, states would gain access to more robust wage data, including comparison data from neighboring states, as a way to promote the HCBS workforce.

Chapter 2 focuses on behavioral health in Medicaid and CHIP. The Commission has had a long-standing interest in examining behavioral health service use and spending in Medicaid, given the program's role as a major source of coverage for behavioral health services in the United States. However, analyzing behavioral health spending and utilization data in Medicaid and CHIP at a national level has historically been challenging. Behavioral health services do not have a standardized definition or well-defined set of procedure codes, provider taxonomies, or care settings, making it difficult to identify these services in medical claims. The chapter includes findings from the Commission's analytic work to measure utilization and spending for Medicaid and Medicaid-expansion State Children's Health Insurance Program (M-CHIP) enrollees with behavioral health conditions.

Chapter 3 looks at the role of Medicaid in supporting justice-involved youth. Medicaid has historically played a limited role in the care of incarcerated youth, but in recent years, federal Medicaid policy has shifted to focus on improving health care transitions for justice-involved youth as they reenter the community. The chapter includes findings from the Commission's work on state efforts to improve care transitions for justice-involved youth who return to the community. It begins by providing an overview of the demographics and health needs of these youth, then reviews the federal Medicaid policy for eligible incarcerated individuals. It concludes with findings from interviews with selected states on their efforts to implement these requirements and challenges in implementation.

Medicaid and CHIP Payment
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Chapter 4 provides an overview of how Medicaid meets the needs of children in child welfare. Children and youth in the child welfare system represent a small but highly vulnerable segment of the Medicaid-enrolled population. The chapter includes background information about children and youth in foster care, their health status, and health care utilization. Next, it highlights key federal requirements for child welfare and Medicaid state agencies. The chapter concludes with selected considerations for states in providing health care access to children in foster care based on MACPAC's review of seven states.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy, and we hope this report will prove useful to Congress as it considers future policy development affecting these programs. This document fulfills our statutory mandate to report each year by March 15.

Sincerely,

Verlon Johnson, MPA

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MACPAC

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Executive Summary: March 2026 *Report to Congress on Medicaid and CHIP*

MACPAC's March 2026 *Report to Congress on Medicaid and CHIP* contains four chapters of interest to Congress: (1) a recommendation to support the home- and community-based services (HCBS) workforce, (2) behavioral health in Medicaid and the State Children's Health Insurance Program (CHIP), (3) Medicaid for justice-involved youth, and (4) Medicaid for children in foster care.

CHAPTER 1: Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

Chapter 1 includes a recommendation to support the HCBS workforce by requiring states to report hourly wages paid to HCBS workers to help states set effective HCBS payment rates. Workforce shortages reduce Medicaid's ability to serve people with long-term care needs in the home or community. Many states are exploring ways to use Medicaid rate setting to expand the HCBS workforce and reduce worker turnover. Wages comprise the largest share of HCBS payment rates, and states use a variety of data sources for wages and other rate components. However, existing data have significant limitations. For example, these data are not specific to Medicaid job classes, and may not be available across labor markets.

Under this recommendation, states would gain access to more robust wage data, including comparison data from neighboring states, as a way to promote the HCBS workforce.

In this chapter, we make the following recommendation:

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

CHAPTER 2: Behavioral Health in Medicaid and the State Children's Health Insurance Program

In Chapter 2, we focus on behavioral health in Medicaid and CHIP. The Commission has had a longstanding interest in examining behavioral health service use and spending in Medicaid, given the program's role as a major source of coverage for behavioral health services. However, analyzing behavioral health spending and utilization data in Medicaid and CHIP at a national level has historically been challenging.

Behavioral health is an umbrella term that includes mental health and substance use disorders (SUD). Behavioral health services do not have a standardized definition or well-defined set of procedure codes, provider taxonomies, or care settings, making it difficult to identify these services in medical claims. The chapter includes findings from the Commission's analytic work to measure utilization and spending for Medicaid and Medicaid expansion State Children's Health Insurance Program (M-CHIP) enrollees with behavioral health conditions.

This chapter uses Transformed Medicaid Statistical Information System (T-MSIS) data to update MACPAC's analyses of behavioral health service use and spending for calendar year 2023. In addition, this chapter expands the scope of conditions to separately identify enrollees with an intellectual or developmental disability. In 2023, almost 27 million Medicaid and M-CHIP enrollees had a behavioral health condition, nearly 23 million had a mental health condition, and around 10 million had an SUD. Approximately 6 million enrollees had co-occurring mental health and SUD conditions.

CHAPTER 3: Medicaid for Justice-Involved Youth Transitions to the Community

Chapter 3 looks at the role of Medicaid in supporting justice-involved youth who are young people who have had contact with the criminal justice system, such as through arrest, incarceration, or probation. The transition from incarceration to the community is a critical period for justice-involved youth. Medicaid has historically played a limited role in the care of these youth, but in recent years federal Medicaid policy has shifted to focus on improving health care transitions for justice-involved youth as they reenter the community.

The chapter includes findings from the Commission's work on state efforts to improve care transitions for justice-involved youth who return to the community. It begins by providing an overview of the demographics and health needs of these youth, then reviews the federal Medicaid policy for eligible incarcerated individuals. It concludes with findings from interviews with selected states on their efforts to implement these requirements and challenges in implementation.

This chapter provides background on juvenile justice settings, detention rates and lengths of stay, then summarizes the demographic characteristics and health needs of youth who are incarcerated or transitioning from incarceration. Next, the chapter describes federal Medicaid policy for these youth, including recent changes to smooth health care transitions for youth leaving correctional settings. The chapter then explores how state Medicaid agencies are approaching transition periods and describes state-reported efforts to implement new federal Medicaid policy, as well as potential barriers to accessing health services that are specific to these youth.

CHAPTER 4: Access to Care for Medicaid-Enrolled Youth in Foster Care

The final chapter of the March report provides an overview of how Medicaid meets the needs of children in child welfare. Children and youth in the child welfare system represent a small but highly vulnerable segment of the Medicaid-enrolled population. Children involved in the child welfare system, specifically those in foster care, have disproportionately high rates of acute and chronic physical conditions, behavioral health issues, developmental delays, and oral health concerns.

The chapter includes background information about children and youth in foster care, their health status, and health care utilization. Next, it highlights key federal requirements for child welfare and Medicaid state agencies. The chapter concludes with selected considerations for states in providing health care access to children in foster care based on MACPAC's review of seven states.

The Commission has previously called for improvements to access and use of Medicaid services for the child welfare population. Additionally, improved collaboration among Medicaid, child welfare, and other agencies is critically important, given that the majority of these children are eligible for Medicaid-financed services and care coordination.

Chapter 1:

Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

Recommendation

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

Key Points

- Medicaid is the nation's largest payer of HCBS for individuals with intellectual or developmental disabilities, older adults, and individuals with physical disabilities.
- All states report HCBS worker shortages as the demand for HCBS outpaces growth in the HCBS workforce.
- Findings from our compendium, state interviews, and technical expert panel identified HCBS wage levels as a key driver of HCBS workforce shortages and acknowledged the important role of Medicaid payment policy in determining the wages that providers pay.
- To advance the statutory goals of efficiency, economy, quality, and access, states should adhere to the following payment principles:
  - ensure that HCBS payment rates promote an adequate workforce and efficient use of resources;
  - take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs; and
  - review HCBS payment rates for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing.

CHAPTER 1: Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a homelike setting in the community. Medicaid is the nation's largest payer of HCBS for individuals with intellectual or developmental disabilities (I/DD), older adults, and individuals with physical disabilities, accounting for about 60 percent of total HCBS spending (MACPAC 2024a, O'Malley Watts et al. 2022a).

The limited availability of HCBS workers is one of the key HCBS access challenges that the Commission highlighted in its June 2023 report to Congress (MACPAC 2023). Although many factors that affect the HCBS workforce are outside of Medicaid's purview, many states are exploring ways to use Medicaid payment policy to expand the number of HCBS workers and reduce worker turnover.

Through federal and state policy reviews, stakeholder interviews, and a technical expert panel (TEP), staff conducted analytic work to better understand the role of payment policy in addressing HCBS workforce shortages. Three payment principles surfaced through these analyses:

- HCBS payment rates should promote an adequate workforce and efficient use of resources;
- states should take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs; and
- HCBS payment rates should be reviewed for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing.

Our research also determined that the rate setting principles cannot be achieved without robust HCBS payment data, which are limited. Based on these findings, the Commission recommends:

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

To provide context for this recommendation, the chapter begins with background on Medicaid HCBS and the ongoing workforce shortage. The chapter then describes current challenges in developing payment approaches that can support the HCBS workforce. The chapter concludes with a discussion of the identified payment principles, the recommendation, and supporting rationale.

Background

Medicaid is the nation's largest payer of HCBS for individuals with I/DD, older adults, and individuals with physical disabilities (MACPAC 2023). In calendar year (CY) 2021, total federal and state Medicaid spending on HCBS was $82.5 billion and financed care for more than 2.5 million individuals (MACPAC 2025a).

States have considerable flexibility in the design of their HCBS programs. Nearly all HCBS are optional benefits, and all states choose to cover some HCBS.[1] States use a wide range of pathways to authorize these services, including Medicaid state plan, Section 1915(c) waiver, and Section 1115 demonstration authorities, or some combination of these authorities (Appendix 1A).

States also have considerable flexibility to set HCBS payment rates and define many other parameters of HCBS in their state, including the types of services covered, how benefits are delivered, the populations served, and the criteria used to determine eligibility. As a result, variation exists in HCBS spending by state and subpopulation. In CY 2021, HCBS spending per person for individuals with I/DD ($55,339) was more than 50 percent higher than for individuals with physical disabilities who were younger than 65 ($36,605) and twice as high as for HCBS users 65 and older ($26,544) (MACPAC 2025a).[2] In fiscal year 2020, HCBS spending per state resident ranged from $151 in Alabama to $1,082 in New York (Murray et al. 2023).

HCBS Workforce

In 2023, there were approximately 3.6 million HCBS workers nationwide (PHI 2024a).[3] Different data sources define HCBS workers in varying and often overlapping ways. HCBS workers may be defined as direct care workers (DCWs), direct support professionals (DSPs), or independent providers, and these larger classifications may in turn include personal care aides, home health aides, and even nurses.

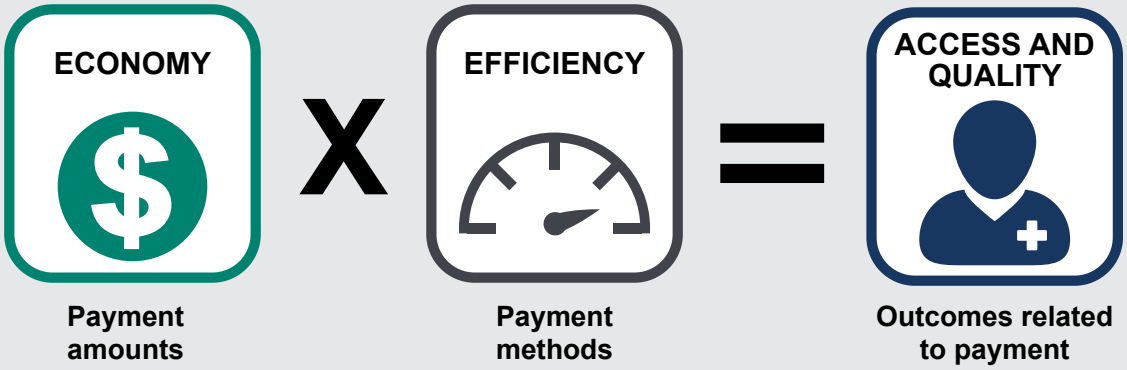
Most HCBS workers are employed by HCBS provider agencies, but approximately 1.2 million HCBS workers (42 percent) were employed as independent providers through Medicaid-funded self-direction programs (PHI 2024a). According to the 2021 American Community Survey, HCBS workers are predominantly female (84 percent) and Black or Hispanic (53 percent), and more than half of HCBS workers (58 percent) receive some kind of public assistance (PHI 2024a).

All states report HCBS worker shortages as growth in demand for HCBS outpaces growth in the HCBS workforce (Burns et al. 2023). Although the number of HCBS workers grew by an average of 4 percent per year between 2008 and 2020, the number of Medicaid HCBS participants grew by an average of 10 percent per year during that period. The ratio of home care workers to Medicaid HCBS participants began declining in 2013, and preliminary estimates suggest further declines occurred in 2020 (Kreider and Werner 2023). In addition to challenges in recruiting HCBS workers, states also face challenges retaining them. HCBS workers have a high turnover rate of approximately 40 to 60 percent each year (PHI 2023).

The COVID-19 public health emergency (PHE) further exacerbated HCBS workforce capacity challenges, making it difficult for states to maintain access to services. For example, a 2022 survey found that nearly all states reported workforce shortages in one or more HCBS settings (O'Malley Watts et al. 2022b). In addition, two-thirds of the 41 states that responded to a similar survey in 2021 reported a permanent closure of at least one Medicaid HCBS provider during the pandemic (O'Malley Watts et al. 2021). A 2021 survey of providers of community-based I/DD services found that 77 percent turned away new referrals, 58 percent discontinued certain programs or services, and 84 percent delayed programs due to staffing shortages (ANCOR 2021).

The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2), in response to the PHE, introduced a new source of federal funding through a temporary increase in the federal medical assistance percentage (FMAP) specific to states' HCBS spending. Workforce initiatives were among the most common uses of the one-time infusion of federal funding (CMS 2023); all states and the District of Columbia submitted spending plans to the Centers for Medicare & Medicaid Services (CMS) indicating intentions to use enhanced funding under ARPA to support workforce recruitment and retention activities. Many state spending plans also indicated intentions to use ARPA funding to support workforce training initiatives (CMS 2023). States generally had until March 31, 2025 to spend their ARPA funding (CMS 2023), although CMS granted additional extensions to about half of states through as late as September 30, 2026 (MACPAC 2025b). According to a 2023 survey conducted by the National Academy for State Health Policy, at least 22 states planned to sustain increased Medicaid payment rates for DCWs. However, states had to identify state funding to maintain payment rate increases or other workforce enhancement strategies (Teshale et al. 2023).

FIGURE 1-1. MACPAC Provider Payment Framework



Source: MACPAC 2015.

HCBS Payment Policies

MACPAC's provider payment framework is the starting point for assessing how Medicaid payment policies can be used to address HCBS workforce challenges. The framework describes the statutory goals of Medicaid payment policy and their relationship to each other (MACPAC 2015):

- **Economy** is defined as a measure of what is spent on provider payments. The most basic measure of economy is the rate that providers are paid for a particular service.
- **Access and quality** are defined as measures of what is obtained as a result of provider payments. Access measures include potential access (e.g., whether a provider is available), realized access (e.g., use of services), and beneficiary perceptions and experiences about their care.
- **Efficiency** is defined as a measure that compares what is spent (economy) to what is obtained (access and quality). To identify opportunities to improve efficiency, it is helpful to compare payment rates and outcomes across states. States with the highest payment rates and the lowest access and quality outcomes have the greatest opportunity to improve efficiency by changing payment methods to get better outcomes for the same level of spending.

To promote access and quality goals, states can improve payment rates (a measure of economy) or change payment methods and other conditions of payment to achieve more efficiency (Figure 1-1).

States can establish different payment methodologies for each covered Medicaid service. The payment methodologies must be set forth in the Medicaid state plan or another authority. States can set different payment rates for certain classes of providers as defined by the state (42 CFR 447.201, § 1902(a)(30)(A) of the Social Security Act (the Act)), and although federal requirements may specify additional requirements for certain provider types (e.g., institutional providers or federally qualified health centers (FQHCs)), no such standards apply to fee-for-service (FFS) methodologies for HCBS.

States must comply with certain federal public notice and transparency requirements for any changes to statewide reimbursement methods or rates (42 CFR 447.205). As part of this process, states must ensure that reductions to rates or rate restructurings do not cause access to care concerns or provide a justification if they anticipate access to care concerns (42 CFR 447.203(c)(1) and (c)(2)). CMS oversees these requirements and may take compliance action as a result of this discovery (42 CFR 447.203(c)(5) and (6)).

The CMS 2024 Ensuring Access to Medicaid Services final rule (often referred to as the "access rule") created additional Medicaid payment requirements (CMS 2024a). The rule requires that FFS rates paid by fee schedule be published on a publicly accessible website no later than July 2026 (42 CFR 447.203). State Medicaid agencies must implement other transparency requirements within the same timeline, including a comparative payment rate analysis and disclosure (42 CFR 447.203(b)(3)). The rule additionally includes specific reporting requirements for a subset of HCBS. For Section 1915(c) waivers, states must document new measures of HCBS payment rate adequacy (42 CFR 441.302(k) and 42 CFR 441.311(e)) beginning in 2028. These require that states report to CMS annually on the proportion of Medicaid payments for furnishing homemaker services, home health aide services, personal care, and habilitation services spent on compensation for direct care workers. Compensation, as described in the regulation, includes worker wages as well as other forms of compensation, such as personnel benefits. Beginning in 2030, states must also ensure that this proportion as reported is at or above 80 percent of total payments for homemaker, home health aide, and personal care services (42 CFR 441.302(k)(3)).

The CMS 2024 Managed Care Access, Finance, and Quality final rule (often referred to as the "managed care rule") includes new requirements for a payment rate analysis for certain HCBS (homemaker, home health aide, personal care, and habilitation services), effective for rating periods beginning on or after July 9, 2026 (CMS 2024b). The analysis must show the total amount each managed care plan paid for all codes billed for these services compared to what would have been paid under the state's Medicaid FFS rates (42 CFR 438.207(b)(3)(ii)).

HCBS payment rates and rate components

HCBS can be delivered through FFS or managed care. Under an FFS model, the state pays providers directly for each service provided to a Medicaid beneficiary. In FFS, Medicaid HCBS payments must be consistent with the statutory goals of efficiency, economy, quality, and access (§ 1902(a)(30)(A) of the Act). Under a managed care model, the state pays a fixed amount (usually per member per month), to the managed care plan to provide the HCBS and other services specified in the plan's contract with the state. Managed care plans generally have the flexibility to negotiate payment rates with providers, unless a specific amount is required (e.g., under a state directed payment that requires use of a minimum fee schedule).

Like for all other Medicaid services, states set applicable FFS rates for HCBS. As with other services, CMS has broad authority to review rate methodologies as part of the state plan amendment or waiver application process. CMS may not approve rates when the rate methodologies do not comply with the efficiency, economy, quality, and access standards required by Section 1902(a)(30)(A) of the Act.

Authorities used to cover FFS HCBS are subject to different requirements, but most have requirements around public notice, public comment, and rate transparency to grant visibility into the state's rate-setting process. Section 1915(c) waiver authority requires notice of rate changes consistent with general federal payment methodology requirements but also at waiver amendment or renewal (42 CFR 447.205, 42 CFR 441.304(e)). If CMS finds a state out of compliance with these requirements, it may result in compliance action or disapproval of the waiver. Section 1915(i) state plan amendments similarly require a description of the payment methodology in the state's submission to CMS.

CMS guidance on FFS rate setting for HCBS supports states' compliance with federal regulatory and statutory standards and provides information on several kinds of rates, including fee schedules, negotiated market price rates, tiered rates, bundled rates, and cost reconciliation (CMS 2016). Guidance also covers prospective and retrospective payment methods. Federal language does not prescribe which kind of rate states should use.

- **Fee schedules.** Rates are set prospectively, per unit, and for a specific period of time, and rates are fixed.
- **Negotiated market prices.** Rates are based on those available in a free market and are subject to negotiation between payer and provider.
- **Tiered rates.** Rates are fixed and vary by characteristics of the individual, provider, or both.

- **Bundled rates.** Rates are set prospectively for a specific period of time for a specified group of services to be delivered in tandem.
- **Cost reconciliation.** Interim rates are paid and updated according to provider cost reports.

State payment rates may be diverse to reflect the variability among HCBS types as well as the adjustment factors employed in rates, which may include acuity, provider costs, geographic variation, or other factors.

- **Acuity.** Rates vary based on beneficiary characteristics, such as diagnosis or service needs.
- **Provider costs.** Rates vary based on provider characteristics reported to the state, such as capital costs or other differences among providers within a class.
- **Geographic variation.** Rates vary based on urban or rural differences or along state borders to reflect differences in health care markets' costs.

Managed care. States may cover HCBS under managed LTSS (MLTSS) programs using different Medicaid managed care authorities (§§ 1932(a), 1915(a), 1915(b), 1115 of the Act). The many intersections between HCBS authorities (§§ 1905(a), 1915(c), 1915(i), 1915(j), 1915(k), and 1115 of the Act), managed care authorities and contracts, and diverse beneficiary populations make managed care programs operating HCBS vary widely state to state (Appendix 1B).

States pay Medicaid managed care plans per member per month capitation payments to provide all covered benefits required in their contract. Federal regulatory standards and oversight govern states' development of capitation rates. State capitation rates for managed care plans must be actuarially sound, which means that they are sufficient to cover all reasonable, appropriate, and attainable costs for the services covered and according to established standards (42 CFR 438.4 and 438.5). CMS reviews states' managed care contracts and actuarial certifications for each rating period, or the period for which the rates are established prospectively (42 CFR 438.7). Managed care plans subsequently establish payment rates to providers who deliver HCBS waiver services to enrolled participants.

States may use FFS data and experience in setting capitation rates if no other acceptable base data are available (42 CFR 438.5). Base data for capitation rate setting must be drawn from the Medicaid population's actual experience, including comparable populations. Although managed care plans generally have the flexibility to negotiate their own payment rates with providers, states can require the plans to pay providers according to specific rates or methods under the directed payment option (42 CFR 438.6(c)). For example, states can establish a minimum fee schedule (e.g., a state's FFS fee schedule) and require their plans to pay at least that amount to their contracted providers.

Data sources and inputs

FFS payment rate setting requires robust data to generate initial rates for new programs and to update or revise payment rates. States have broad flexibility in identifying appropriate base data and setting HCBS payment rates within federal frameworks, and CMS has similarly broad authority to review and provide oversight of state rate-setting methods. HCBS payment rate development and maintenance typically involves identifying assumptions for each rate component. Rate components include:

- **Worker salary and wages**, such as wage rates, direct and indirect time, supervisory time, paid time off, training time, and staff-to-client ratios, generally the largest component of HCBS payment rates;
- **Employee-related expenses**, such as employee-related taxes, fees, and employee benefits such as health insurance and retirement contributions;
- **Transportation and fleet vehicle expenses**, such as expenses related to ownership, maintenance, and operation of agency vehicles and mileage paid to employees for use of their own vehicles; and
- **Administration, program support, and overhead**, including all other operational expenses.

TABLE 1-1. Wage Data Sources Used for Fee-for-Service Home- and Community-Based Services Rate Development in Section 1915(c) Waivers

Wage data source	Home-based services		Day services		Round-the-clock services	
	States	Percentage of total	States	Percentage of total	States	Percentage of total
Total states in analysis	**31**	**100%**	**37**	**100%**	**33**	**100%**
BLS	23	74	28	76	25	76
State wage data	9	29	8	22	9	27
Provider survey data	3	10	3	8	3	9

Notes: BLS is Bureau of Labor Statistics. Home-based services, day services, and round-the-clock services refer to home- and community-based services (HCBS) taxonomy categories. Some states use more than one wage source during payment rate development. States excluded from analysis do not operate fee-for-service HCBS through Section 1915(c) waivers or did not indicate the wage source used in HCBS rate development in their Section 1915(c) waiver.

Source: Milliman 2023 analysis for MACPAC of Section 1915(c) waiver applications approved as of August 2023.

Assumptions for each rate component vary considerably based on the type of service and acuity of the population. Participants in our interviews and TEP cited wage data as one of the most important data inputs, both because of the substantial contribution of wages to overall payment rates and because wage data themselves are composites of other costs (e.g., overtime, administrative tasks, supervision, and more).

Our review of 47 state Medicaid programs' Section 1915(c) waivers revealed varied sources for wage assumptions when developing HCBS payment rates (Table 1-1) (MACPAC 2024b). In some cases, state waiver application language included consideration of several sources but did not specify the exact wage source used for HCBS payment rate development.

According to an analysis of states' Section 1915(c) waiver applications, the majority of states use Bureau of Labor Statistics (BLS) wage data as the foundation for building the wage component of the rate. BLS wages are reported by Standard Occupational Classification (SOC); year; and region, state, or metropolitan area, pending availability of data. BLS data reflect national wage data for more than 800 occupations in about 400 industries and are derived from the Occupational Employment Statistics Survey, BLS Modeled Wage Estimates, or the U.S. Census Bureau's Current Population Survey (BLS 2024a).

Despite their widespread use in HCBS rate setting, there is notable variability in the SOC codes because BLS wage data reflect standard market-wide labor and wage categories rather than Medicaid HCBS worker classifications. BLS, for example, does not report wages for a single DSP-specific SOC (BLS 2023a). Our interviews and TEP revealed that states often blend BLS SOC code data to reflect different HCBS worker roles and service-specific requirements. States use varying methodologies to blend SOC data.

Beyond BLS, states employ other widely available sources for HCBS worker wage inputs in rate setting, including published cost indices, national survey data, or state-collected data. In waiver applications, states cited the use of a variety of price indices, including the Consumer Price Index; federal market basket indices for LTSS, including nursing facilities or home health services; the Medicare Economic Index; and others. Additionally, more than half of states are participating in the National Core Indicators State of the Workforce surveys, which collect information from provider agencies about worker wages, benefits, and turnover rates among the aging and disability population as well as the I/DD population (NCI-AD 2024, NCI-IDD 2024). However, no state in our Section 1915(c) waiver reviews reported the use of National Core Indicators survey data in their rate-development efforts.

State data. States also implement or leverage other local data collection activities. States may use program data to establish tiered rate structures based on functional or clinical assessments or other data sources (CMS 2016). Some states may use state employment trend data or state compensation studies as inputs for building HCBS rates (MACPAC 2024b). States also may field provider surveys to obtain data on a variety of provider costs, including administrative overhead, capital costs, or other expenses (CMS 2016).

In some cases, states require routine provider cost reporting. Cost reporting may support multiple types of rate models and may be used to provide effective oversight of HCBS programs. From a federal perspective, cost reporting is not required. However, when it is in place, CMS may impose certain standards (e.g., the waiver application must describe audit protocols and standards) (CMS 2019).

Among the 47 states' Section 1915(c) waivers in our review, 10 states list cost reports as a data adjustment source in FFS HCBS rate setting. Notably, cost reporting can be onerous for both providers and states. Participants in our TEP discussed challenges with cost reporting given (1) the technical capacity of agency providers to comply with cost reporting requirements, (2) the variability in costs across different types and sizes of HCBS providers, (3) the variability in engagement from different provider types or agencies, and (4) the state agency capacity level to address these challenges and obtain consistent and accurate provider data.

Access rule. Once implemented, the 2024 access rule will provide CMS additional data related to workforce, payment rates, and wages. Beginning in 2028, states must report annually on the percentage of payments directed toward compensation for DCWs for homemaker, home health aide, personal care, and habilitation services. States will be required to publish average hourly FFS HCBS payment rates for those services beginning in 2026. Though states may need to calculate average wage rates for each service to satisfy the existing HCBS data reporting requirements, the access rule does not require states to report average wage rates to CMS. The access rule additionally does not require CMS to share compensation data across states or make compensation data public.

State policy inputs. Apart from historical data sources at the state or federal level, state payment rates may further reflect state policy decisions in rate components. These may include state minimum wage laws; mandatory staffing ratios included in rate models; licensure or supervisory requirements set forth in state law; licensure and training costs; and capital investments, including health information technology costs. These costs are likely reflected in other data such as historical trend data, index data, and cost reporting, but states may benchmark rates to known policies to ensure payment rates are adequate to support providers' compliance.

Fiscal integrity requirements

The financial accountability assurance in the Section 1915(c) authority is one of the main federal levers CMS has for ensuring oversight of state HCBS rates and implementation. Described in 42 CFR 441.302(b), state agencies must assure financial accountability for Medicaid funds paid for waiver programs, including compliance with audit or other oversight activities undertaken by CMS.

In Section 1915(c) waiver applications and renewals, a state must specify how it makes payments for services covered by the waiver, ensures program integrity, and complies with applicable requirements concerning payments and federal financial participation. In its review of an initial waiver application or a waiver renewal, CMS applies the following review criteria (CMS 2019):

The rate-setting method used for each waiver service is described, and variation between providers of the same service is described;

- the rate-setting methodology for self-directed services, if applicable, is described;
- the entity (or entities) responsible for rate determination is identified, and oversight of the rate determination process is described;
- the year rates were set and last reviewed are provided;
- the agency's public comment process for rate determination methods is included;

- the process for making payment rate information available to waiver participants is described;
- the state's rate-review methods and processes are described; and
- for concurrent HCBS-managed care authorities, the capitation rate methodology should be referenced but is reviewed through standard capitation rate review processes at CMS.

Federal policy does not require waiver applications or other HCBS authorities to indicate the source of wage data. CMS conducts reviews of rate determination methods at the time of initial and renewal applications in tandem with other financial accountability reviews and monitoring.

Methods for maintaining and updating rates

Rate reviews range from internal rate reviews, which are limited to refreshing key rate inputs within the existing rate methodology through indexing or rebasing, to comprehensive external rate evaluations, also called rate studies (Box 1-1).

Federal HCBS rate review requirements vary by HCBS authority; however, CMS does not prescribe a specific type of rate review for any HCBS authority. CMS technical guidance instructs states operating HCBS through Section 1915(c) waiver authority to review rates at least every five years (CMS 2019). No other HCBS authorities have a specific provision requiring a rate review or indicating a frequency for review (Appendix 1C).

Current Challenges

Findings from our compendium, state interviews, and TEP identified wage levels as a key driver of workforce shortages and acknowledged the important role of Medicaid payment policy in determining the wages that providers pay. Wages for HCBS workers typically lag behind other industries, such as fast food or retail, that employ workers with similar training and can often pay similar or higher wages for less demanding work (PHI 2024b, ASPE 2024). Because many HCBS providers rely on Medicaid funding, the wages they pay are linked to the wage assumptions used to develop Medicaid payment rates. As a result, rate setting is a primary tool that states use to promote an adequate workforce and efficient use of resources.

Our analyses also identified aligned rate assumptions and regular rate reviews as key payment policy levers that can be used to address HCBS workforce challenges. However, lack of consistent HCBS wage data presents a barrier to developing, monitoring, and maintaining appropriate rates and underlying wage components.

Variations in HCBS rates influence workforce participation

There is substantial variation in service definitions and associated rates across HCBS models and programs. The MACPAC compendium on Medicaid payment policies for HCBS provided under Section 1915(c) waiver authority found 253 unique, state-defined services that fit into three major HCBS service categories (MACPAC 2024b). Findings from our

BOX 1-1. Rate- Review Definitions

Indexing. Any payment rate methods that account for changes in cost over time by linking certain trend factors to payment rates. These trend factors can include price indices, provider cost data, wage data, or minimum wage floors.

Rebasing. Periodic recalculation of payment rates according to new or updated data such as provider cost reports or more recent wage data.

Rate studies. Comprehensive external rate evaluations. Unlike indexing and rebasing, rate studies may result in changes to the underlying rate methodology.

interviews and TEP indicate that variation in rates, and how the rate ultimately relates to wages, may lead HCBS workers to participate in delivery models or programs that offer the highest wage, which in turn may affect beneficiary access.

Some variations in rates between similar services may reflect differences in patient acuity and the scope of services provided to one population versus another. For example, individuals with I/DD receiving habilitation services may require more specialized care than older adults receiving personal care services. Rate variations may also reflect administrative complexity. States typically cover HCBS through multiple authorities, which can include multiple Section 1915(c) waiver programs, state plan authorities, and concurrent managed care authorities. These programs may offer similar, but distinct, types of services to different populations through different provider types in unique combinations or scope. Ultimately, this may lead to variance in workforce, service descriptions, or service requirements across programs, which creates challenges in aligning rates across them where appropriate. Additionally, states generally develop and expand or alter their HCBS programs over time, which means that the authorities used to provide services may not be on the same renewal schedule. States may update rates for one program without making corresponding adjustments to other waivers or HCBS authorities.

Rate variations may also reflect the landscape of competing provider and beneficiary advocate groups. A single association typically does not represent all HCBS providers, nor does an organization advocate for all beneficiaries receiving HCBS in a state. As a result, influential associations and advocacy groups may secure rate increases with state legislatures that are specific to the providers or beneficiaries they represent.

Variations in payment rates or wage components may skew workforce participation in ways that may undermine statewide access goals. For example, in one state we interviewed, comparably low rates for independent workers caused HCBS workers to switch from self-direction to agency employment to obtain higher wages, which in turn led to disruptions in beneficiary care. In another state, higher rates for services provided to I/DD populations drew workers from other agencies and made it more difficult for older adults with physical disabilities to access care. Variations in county or state minimum wage laws also led workers to cross borders to secure higher wages.

States may encourage workforce participation according to population need or policy goals. For example, we heard from one state that employed consistent wage assumptions for setting rates for similar types of work across different services. Other states have adopted strategic rate variations across the LTSS system more broadly by reducing rates for residential placement to encourage community integration and rebalance care. Across our interviews and TEP, we heard the importance of considering how rate variations across LTSS and the commercial market may influence HCBS workforce participation. States may also consider opportunities to reduce wage competition across state geographies, such as imposing locality adjustments to HCBS rates.

Rate studies, rebasing, and indexing offer opportunities to review and improve rates

FFS rates for HCBS, like all other Medicaid services, are set by the state, and CMS has the authority to review rate methodologies as part of the process required to approve new state authorities and policies (42 CFR Parts 430 and 447). Federal requirements governing HCBS rate reviews vary by HCBS authority. For most HCBS authorities, no federal provision requires a rate review or indicates a specific frequency for review. CMS technical guidance instructs states operating HCBS through Section 1915(c) waiver authority to review rates at least every five years, and there is considerable flexibility to determine how to do this review (CMS 2019). As a result, Section 1915(c) rate review approaches vary.

Of the 47 states and the District of Columbia included in our review of Section 1915(c) rate methodologies, 33 states (69 percent) conducted rate studies that reviewed all components of an HCBS rate (MACPAC 2024b).[4] In 10 states (21 percent), no rate study was identified, but the states regularly rebased or indexed components of the rate. Moreover, we also found that rate study methodology and outputs were not always publicly available (MACPAC 2024b). Federal policy does not require waiver applications or other

HCBS authorities to indicate the source of wage data for building HCBS rates, and in our review, we found that not all states indicated the wage data source in their waiver application even if they described the rate methodology (Table 1-1).

Our interviews and TEP indicated the value of rate reviews in ensuring that rates account for a changing policy and financial environment. In particular, experts identified rate studies as an important tool in establishing rates that promote an adequate workforce. As discussed above, rate studies offer a comprehensive and global opportunity to evaluate HCBS rate methodologies within the context of HCBS authorities, the Medicaid payment environment, and the health care ecosystem as a whole.

Using detailed cost, wage, and service delivery information in rate studies also provides a benchmark for state legislators, providers, consumer advocates, and other stakeholders to understand the cost of services and funding needs, which can support efforts to right-size variation across services and programs. Our review of Section 1915(c) rate methodologies found substantial variability in the public documentation of rate study processes and results. Of the 33 states that conducted rate studies for one or more Section 1915(c) waivers, we identified public documentation of rate studies for 27 states. In many states, the publicly available rate study documentation was limited to a PowerPoint presentation or other similar documentation that did not include details about specific rate assumptions.

Rate studies additionally provide an opportunity to ensure that rates and their underlying wage components are comprehensive and reflect the full range of worker inputs necessary to provide care. Some inputs that may not be reflected in rates include but are not limited to the range of professional skills and responsibilities associated with the various HCBS worker types and needed to deliver a given service as well as the time HCBS workers spend conducting critical program support and supervisory tasks beyond delivering services to participants. Rate reviews may also consider language, cultural, and geographic dynamics associated with providing HCBS. For example, language and translation services, travel, and culturally appropriate meals may increase the costs of delivering care.

Compensation for indirect non-billable activities can be built into HCBS rates through productivity or other rate adjustments. Productivity adjustments refer to the practice of covering hours when staff must perform non-billable activities that prevent them from performing direct services.[5] Employers can calculate the number of productive hours spent on non-billable tasks and apply an adjustment rate to an HCBS worker's hourly base wage (CMS 2016). States may also use local payment rate adjustments or code modifiers to reflect additional indirect costs.

Rate studies require considerable time and resources to complete and implement across a variety of stakeholders, including Medicaid agency staff, state legislatures, and health care stakeholders. For example, providers completing related cost surveys often require training and technical assistance because these reports are not routinely collected by Medicare or other payers. Additionally, when rate studies are conducted, fiscal barriers such as state budget constraints may prevent the resulting rate recommendations from being implemented. These could include the timing of state budgeting processes or legislative reluctance to provide repeated rate increases. Budget constraints can be especially acute in the FFS context. Research participants indicated that legislatures are often more amenable to approving rate increases for managed care organizations (MCOs) than for FFS due to the requirement in federal law mandating actuarial soundness in MCO rates. FFS payment rates have no such federal regulatory requirement. However, implementing rate study recommendations may also create unintended effects. For example, to ensure that a rate increase identified by a rate study can be funded without exceeding their budgets, states may implement utilization limits or program waiting lists.

Our interviews and TEP identified indexing and rebasing as less-intensive mechanisms for updating rates. In our interviews, we heard about state efforts to index or regularly inflate key rate components (e.g., wages). We also learned about instances in which rebasing allowed a state to adapt rates to evolving provider costs, including increasing workforce costs. One state shared that they make automatic rate updates based on a review of state and federal wages and inflation data, biennial wage components and inflation updates, and regional variance factor updates every six years.

The state also recently added a new "competitive workforce factor" to help close the gap between assumed wages for HCBS workers and competing non-HCBS workforce sectors.

Our TEP highlighted that established inflationary adjustments or rebasing processes create predictability for providers and other stakeholders, particularly default inflationary adjustments that require no further legislative or policy action. For example, a state plan may describe a standard inflationary adjustment that can be frozen or avoided only through a subsequent state plan amendment. This approach allows stakeholders to count on the increase unless additional action is taken.

A standard and predictable inflationary or rebasing adjustment aligns HCBS payment structures with other Medicaid rate-setting models. Annual increases are common for other Medicaid payment rates, such as state-mandated inflationary adjustments for institutional providers like hospitals and nursing facilities. In a similar vein, federal regulations require annual actuarial certifications for Medicaid managed care programs. Incorporating inflationary adjustment or rebasing processes into the payment rate through legislative or Medicaid agency action makes the basis for payment rate changes more visible and transparent to stakeholders.

Automated indexing or rebasing adjustments remain subject to states' fiscal climates and may rely on scarce budget resources. Additionally, indexing can have the unanticipated effect of putting rate structures on autopilot and can stifle the system's ability to evolve over time, as this process does not require states to reevaluate payment rates or address system issues. State stakeholders flagged that applying a trend factor without periodically re-examining underlying rate assumptions can also exacerbate disparities across service types. Additionally, depending on how tightly rate development is linked to cost reporting, inflationary increases could create a compounding effect of progressively larger increases. Our findings ultimately emphasized that indexing and rebasing are effective interim rate review options, but because the policy and program environment continues to evolve, they do not substitute for periodic comprehensive assessments of rate structures and reimbursement policy. In weighing the benefits and challenges of rate studies, participants in our TEP noted that a key decision for states may be identifying the appropriate periodicity for rate studies and other means of adjusting rates. A strategic cadence of rate reviews could promote the inclusion of relevant rate assumptions and updated data without overwhelming the system with administrative or fiscal burdens.

Robust wage data are the foundation for payment rates that promote an adequate HCBS workforce

Based on our research, we found consistent evidence that robust wage data are a necessary input in states' formulation of effective HCBS payment rates. Wage data are a critical input to rate development because of the substantial contribution of wages to overall payment rates and because wage data themselves are composites of other costs (e.g., overtime, administrative tasks, supervision). Historical wage data alone are not sufficient to develop payment rates that address workforce shortages, as these wage levels reflect existing workforce structures and budget constraints. However, accurate, current, and robust wage data provide states with a critical starting point for HCBS rates that promote adequate workforce participation at the time of initial rate model development and in periodic rate reviews to reevaluate payment rates. Despite this need, key gaps exist in available wage data. Addressing these gaps could provide states with another important tool in implementing payment rates that facilitate access to Medicaid HCBS.

States often lack the wage data needed to build appropriate payment rates. Unlike other areas of health care, where consistent, robust data on wages are readily available, the same is not true for HCBS wage data. As described above, our review of payment policies used in Section 1915(c) waivers found that most states use wage data from the BLS to develop Medicaid wage assumptions (Table 1-1).[6] However, the BLS does not offer a single reliable data source for HCBS worker wages. BLS SOC wage data reflect the workforce serving individuals in the health care system, without regard to whether those wages are ultimately paid through the Medicaid program or another payer. Thus, wage data reflect a multi-payer market across all designated fields, rather than one specific to Medicaid. Industries are grouped according to an established hierarchy of sectors, subsectors,

and industry designations. This approach necessarily includes non-Medicaid workers in Medicaid-relevant job classifications and subsumes Medicaid-majority fields (e.g., residential facilities for individuals with IDD) into larger groupings. For example, although the BLS provides data on some HCBS worker types, including personal care aides, home health aides, and a variety of nursing and medical support professionals, no SOC code exists for DSPs (BLS 2023a). In the absence of an appropriate SOC, states often blend different occupational codes that approximate HCBS worker roles and service-specific requirements (Table 1-2).

Other sources of wage data include state-level wage data, average wages from provider surveys, provider cost reports, minimum wage levels, market rates, and stakeholder feedback. States may use provider-submitted cost reports or provider surveys to support rate development or rate reviews. However, there are several challenges associated with state cost reporting as described above, including the technical capacity of providers to comply, variability in costs across providers, the level of effort to engage stakeholders to produce complete and accurate cost data, and the required oversight of cost reporting at the state agency.

Findings from our TEP reflect the lack of necessary historical wage data and the importance of accessing such data in the future. Multiple state participants noted that granular data are a tool that states could wield to set payment rates reflecting accurate wages. Recognizing that state budgets may constrain rate updates, state and federal representatives additionally noted the value of wage data in demonstrating the need for rate adjustments to key stakeholders, including state legislatures and CMS.

New data are not sufficient. The 2024 access rule includes several provisions to create more consistency and transparency in HCBS wage data (CMS 2024a). Beginning in July 2026, states will be required to publish the average FFS hourly payment rate for personal care, home health aide, homemaker, and habilitation services on a publicly available and accessible website every two years. Additionally, beginning in July 2028, states will be required to collect and report to CMS data regarding the percentage of Medicaid payments for certain HCBS—personal care, home health aide, homemaker, and habilitation—spent on compensation for DCWs. CMS selected homemaker, home health aide, and personal care services because they are services for which CMS asserts that the vast majority of payments should be composed of compensation for DCWs.

Although the access rule provisions offer the potential for increased availability of wage and payment information, they do not require states to report the wage data needed to build adequate payment rates. Additionally, although the data collected through the access rule will allow CMS to compare payment rates and wage-to-payment ratios across state Medicaid programs, the compensation data are not required to be shared among states or made public. Furthermore, the access rules' broad definition of DCWs—which includes diverse job classes like DSPs and nurses—creates the potential for confounded data that conflate diverse worker wages.

Wage data reporting is not required. The access rule requires states to produce data on hourly HCBS rates for each of the specific services listed above and data on the proportion of HCBS rates for the same set of services that account for DCW compensation. To calculate the ratio of compensation to overall payment required by the access rule, states will need to collect and aggregate data on worker wages across each service. However, states are not required to report or publish data on wage levels. States having access to these average wage data across various job classes and service categories would support their building of appropriate rates.

Wage data are not available across labor markets. States can benefit from wage data from other states and across labor markets. HCBS rate and wage information sharing is particularly relevant for states that may compete with one another for HCBS workers—for example, in markets along a border. Robust state-specific wage data could help states identify instances in which rates are set in such a way that provides incentives for HCBS workers to travel across state lines to receive higher payments for the same or similar services. States may then work to adjust rates to reduce workforce shortfalls. The access rule, however, does not require CMS to share worker compensation data publicly. In response to concerns about lack of public reporting, CMS noted that certain BLS wage data are already publicly available and that states are not limited to the reporting requirements finalized in the access rule.

TABLE 1-2. Home- and Community-Based Services–Related Standard Occupational Classifications Reported in Bureau of Labor Statistics Wage Data

SOC	Job description	Example industries	Entry-level education requirement	2023 mean annual wage
Home health aides and personal care aides	Support individuals who are elderly or who have disabilities or chronic conditions, including by assisting with activities of daily living. Home health aides and personal care aides may provide medication or collect vital signs under supervision of a nurse or another practitioner.	Home health care services, residential facilities, continuing care retirement communities, and assisted living facilities for the elderly	High school diploma or equivalent	$33,530
Licensed practical nurses or licensed vocational nurses	Provide basic medical care to people who are ill, injured, or convalescing or who have disabilities. Duties may vary by setting (e.g., in the home versus a hospital), and scopes of practice may vary by jurisdiction.	Home health care services	Non-degree postsecondary training	$59,730
Nursing assistants	Provide or assist with basic care or support under the direction of onsite nursing supervision. May provide activities of daily living assistance or monitor health status.	Continuing care retirement communities and assisted living facilities for the elderly, home health care services	Non-degree postsecondary training	$39,610
Occupational therapy aides and assistants	Help occupational therapists provide treatment or perform procedures or fulfill support tasks such as preparing treatment rooms.	Home health care services	High school diploma or associate's degree	$65,450

Notes: SOC is Standard Occupational Classification, which is a standard used by federal agencies to classify workers into 1 of 867 detailed occupational groups. Example industries reflect the home- and community-based services–related Bureau of Labor Statistics–classified industries with the highest levels of employment of that SOC.

Sources: BLS 2024b and 2023b.

Job definitions are broad. States rely on wage data from each HCBS job class to build appropriate payment rates. As described above, our review of 1915(c) waiver documents found 253 distinct services for which states must set effective payment rates. The access rule, however, does not disaggregate wage data according to job class. The rule requires states to report for each service type for all DCWs. Additionally, CMS defines DCWs broadly, inclusive of all of the following job classifications (CMS 2024a):

- nurses (including registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists);
- licensed nursing assistants providing HCBS under the supervision of a nurse;
- DSPs;
- personal care attendants and home health aides; and
- any other individuals providing "services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration."

As a result of this broad definition of DCWs, access rule data will not account for the vast wage variations that may occur across different HCBS job classes (Table 1-2). For example, average wages for nurses, who receive a high level of training and are responsible for a clinical scope of practice, may differ considerably from average wages for other HCBS job classes that fall under CMS's DCW definition that require less training. In 2023, the mean annual wage for home health aides and personal care aides was $33,530 compared to $59,730 for licensed practical nurses or licensed vocational nurses (Table 1-2). Including wages across all of these job classes may produce results that misrepresent the wage experience of the majority of HCBS workers. In its response to comments on the notice of proposed rulemaking, CMS acknowledged the concern that higher-wage job classes (such as nurses) might overshadow other job classes in the data (CMS 2024a). CMS indicated that states interested in examining workforce issues at a more granular level may choose to disaggregate data for state use, but the access rule does not explicitly require them to do so.

Payment Principles

For Medicaid to achieve its potential, it is important for policymakers to design payment policies that advance the statutory goals of efficiency, economy, quality, and access. MACPAC has developed an overarching provider payment framework for assessing whether payments are consistent with these goals, which has guided the Commission's development of principles for HCBS payment policy (MACPAC 2015). MACPAC's analysis demonstrates the importance of setting rates at a level that accounts for patient and workforce needs (economy) and ensuring that rates reflect the broader payment and wage context (efficiency). The following payment principles reflect these findings and offer a conceptual framework for states to use to improve their HCBS workforce.

HCBS payment rates should promote an adequate workforce and efficient use of resources. Though by no means the only factor, MACPAC's research finds that wage levels are a key driver of workforce levels, and Medicaid payment policy plays a key role in determining the wages that providers pay. States should leverage HCBS payment policy to address HCBS workforce shortages.

States should take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs. MACPAC's research suggests that variation in HCBS rates, and subsequently in HCBS wages, may lead HCBS workers to participate in delivery models or programs that offer the highest wage. This may in turn affect beneficiary access. For example, in one state we interviewed, comparably low rates for independent workers caused HCBS workers to switch to agency employment to obtain higher wages, which created disruptions in beneficiary care.

Our analysis found substantial variation in service definitions and associated rates across HCBS models and programs. The MACPAC compendium on Medicaid payment policies for HCBS provided under Section 1915(c) waiver authority found 253 unique, state-defined services that fit into three major HCBS service categories (MACPAC 2024b). Although rate variations may reflect differences in patient acuity and the scope of services provided to one population

versus another, rate variations may also reflect administrative complexities. As noted above, states typically cover HCBS through multiple authorities often on different renewal timelines, which may lead to programs with varying service descriptions, provider requirements, provider types, or populations. This can create challenges in aligning rates across programs. Furthermore, because CMS reviews HCBS rates for each program individually, states may update rates for one Section 1915(c) waiver without making corresponding adjustments to other waivers or HCBS authorities.

HCBS payment rates should be reviewed for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing. Rate reviews are an important tool to help ensure that payment rates are adequate and account for a changing policy and financial environment. Rate studies, in particular, offer a comprehensive and global opportunity to evaluate HCBS rate methodologies within the context of HCBS authorities, the Medicaid payment environment, and the health care ecosystem as a whole. However, rate studies require substantial time and resources to complete and implement across a variety of stakeholders, including Medicaid agency staff, state legislatures, and health care stakeholders.

Other, less-intensive mechanisms for reviewing and updating rates include but are not limited to indexing and rebasing. Our analysis surfaced state efforts to index or regularly inflate key rate components such as wages as well as instances in which states have used rebasing to adapt rates to increasing workforce costs. Generally, established inflationary adjustments or rebasing processes create predictability for providers and other stakeholders.

States should identify the appropriate periodicity and mechanism for rate reviews to ensure that data and rate assumptions are updated regularly without creating undue administrative or fiscal burdens. States may also choose to align rate reviews across HCBS programs to promote consistency in rate setting or stagger rate reviews across programs to minimize system burden.

Commission Recommendation

The lack of consistent HCBS payment data presents a barrier to states looking to apply the payment principles listed above. The Commission therefore recommends that HHS improve the data available to help policymakers to identify payment rates and underlying wage levels that address the HCBS workforce shortage and support increased access to HCBS services.

Recommendation 1.1

The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

Rationale

Section 1902(a)(30)(A) of the Act requires states to set sufficient payment rates that are consistent with efficiency, economy, and quality of care. Section 2402(a)(3)(B)(iii) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires states to allocate resources for HCBS in a manner that is responsive to the changing needs and choices of beneficiaries receiving HCBS. Additionally, Section 2402(a)(3)(B)(iii) of the ACA requires states to oversee and monitor HCBS system functions to assure a sufficient number of qualified direct care workers to provide self-directed personal assistance services (CMS 2024a). Substantial and growing workforce shortages threaten states' ability to comply with these requirements.

Our findings indicate that a key tool for promoting an adequate workforce are payment rates that reflect appropriate wage components. Developing appropriate wage components for rates requires that states have access to robust and current wage data. Existing wage data are often piecemeal and do not provide a clear baseline for states to build upon to establish HCBS payment rates that promote workforce participation and retention. As the most robust and commonly used wage data source, state-specific BLS wage data provide a federal resource on HCBS wages. Yet BLS data are simultaneously broader and narrower than what states need to effectively set HCBS payment rates. BLS wage data reflect the entire workforce serving individuals in the home and community. As a result, BLS wage data include information beyond wages paid to Medicaid HCBS workers alone. Although this can provide valuable information to states looking to understand broader market wages, states still lack the data needed to assess the workforce in the Medicaid context specifically. BLS's broad lens also results in the exclusion of some Medicaid-specific service types and worker classifications that are rarely found outside the Medicaid HCBS sector, such as DSPs. BLS's limitations therefore introduce challenges in state rate setting, as we heard from states and other interview and TEP participants.

The provisions finalized in the 2024 access rule offer the potential to improve transparency and data availability in HCBS payment. The access rule clarifies the importance of payment transparency for HCBS and justifies the inclusion of "special considerations for LTSS, specifically HCBS" given the substantial workforce shortage in this industry and its strong tie to beneficiary access issues (CMS 2024a). Consistent with prior practice, CMS should release a reporting template, which would promote further standardization among the data reported by states.

However, the provisions included in the access rule do not sufficiently fill identified gaps in wage data that states need for rate setting. First, the provisions require states to report average hourly HCBS payment rates and the percentage of the rate that accounts for DCW compensation but not the average wage paid to the worker. As discussed above, historical wage data are a crucial input to developing appropriate HCBS rates, and these data are not readily available today. Second, although the HCBS workforce at all levels can benefit from additional payment transparency, CMS's broad definition of DCWs that includes nurses and other clinical staff types may confound the payment and wage reporting data that the access rule produces. The consolidation of compensation data for nurses and licensed nursing assistants alongside DSPs, personal care attendants, and home health aides in particular may produce results that misrepresent the average wage experience of many HCBS workers. Average wages for nurses, for example, may differ substantially from average wages for other HCBS job classes that fall under CMS's DCW definition.

Promoting state reporting of wage data helps ensure that the HCBS payment reporting requirements included within the access rule fill gaps in the existing data available to states to build appropriate HCBS rates. The recommendation would direct CMS to require that states disaggregate compensation to also report average wage base data by meaningful subclassifications, such as distinct workforce categories and geographic subcategories. Disaggregating the data in this manner will improve the data's accuracy and usability. The access rule requires that all data be disaggregated by service type, aligned by regulatory service definitions referenced in the access rule. CMS, in consultation with states, may leverage guidance or templates to ensure that comparable services and workers are classified and reported in a similar way under these requirements.

To further ease the burden on states, data collection and reporting methodology should align with and build upon existing reporting requirements where possible, most notably the aforementioned provisions of the access rule. To calculate the ratio of compensation to overall payment for each service already required by the access rule, states will need to collect and aggregate data on wages across all worker categories and geographies. With advance planning, and in consultation with states, CMS can implement this proposed requirement through templates or operational guidance intended to minimize additional state burden. The wage data included in our recommendation align closely with existing reporting requirements in current regulation and slated to begin

in 2028. Additionally, CMS should require states to report descriptive statistics for each service to reflect the breadth and variation in wages due to seniority, raises, bonuses, or other factors. CMS could include the proposed data reporting requirements in its access rule reporting template and provide guidance and definitions for state reporting.

Both our TEP participants and CMS indicated the importance of more granular data. Responding to comments requesting further data disaggregation in the access rule, CMS noted, "We agree that some of the granular data elements suggested by commenters could provide States with valuable insights into their own programs and workforce needs" (CMS 2024a). CMS encouraged states to consider additional data collection activities as useful. Although it is important to note that budget constraints often make rate adjustments challenging, TEP participants stressed that improved data offer state legislatures and CMS more clarity regarding how states can comply with their statutory requirement to set sufficient rates (§ 1902(a)(30)(A) of the Act).

In CMS's response to comments on the proposed rule, the agency cited transparency as a key objective of the proposed and final provisions: "Gathering and sharing data about the amount of Medicaid dollars that are going to the compensation of workers is a critical step in understanding the ways we can enact policies that support the direct care workforce and thereby help advance access to high quality care for Medicaid beneficiaries" (CMS 2024a). The importance of wage transparency is especially relevant given that states compete with one another for HCBS workers. However, the access rule does not require that the wage data collected be made public (CMS 2024a). The recommendation directs CMS to make wage data public to ensure that all state Medicaid agencies and relevant stakeholders can access the same information pertinent to HCBS payment rates.

Implications

Federal spending. The Congressional Budget Office anticipates no impact on federal spending attributable to the recommendation.

States. As a result of this recommendation, state Medicaid agencies will be equipped with granular wage data and the ability to compare wage rates across states and other HCBS marketplaces. These data can support states to identify payment rates that address HCBS workforce shortages and adjust rates as feasible. States can also use these data to justify rates to state legislatures. Although this recommendation would require states to conduct additional data reporting activities, it should not require substantial state effort beyond that required for compliance with the regulatory provisions effected by the access rule. Additionally, to the extent that states are already engaging in piecemeal and laborious data collection efforts to determine historical HCBS wages, such as through cost reports, this change could reduce existing administrative burden by potentially eliminating the need for those ad hoc activities.

Beneficiaries. This policy would not have a direct effect on beneficiaries. However, the goal of this recommendation is to support states to set payment rates in a manner that addresses workforce shortages and increases beneficiary access to HCBS. Over time, state efforts to adjust payment rates in a manner that attracts more HCBS workers may result in increased access to HCBS among beneficiaries.

Plans. This policy would not have a direct effect on managed care plans. However, any changes that states make to HCBS payment rates could affect the rates that managed care plans pay to HCBS providers, particularly if a state requires plans to pay at least the state plan rate through a directed payment arrangement. Ultimately, any payment changes should be reflected in the capitation rate that the plans receive.

Providers. This recommendation is expected to have a marginal effect on providers. Providers will need to report wage information under the current access rule provisions. In some states, providers may report more granular data under this recommendation than under the access rule alone; however, the data would already be collected, and the marginal level of effort to report at a disaggregated level should be minimized. Furthermore, as a result of increased availability of

historical wage data, state Medicaid agencies may choose to adjust payment rates to achieve a more robust HCBS workforce. Over time, payment rate adjustments and resulting wage changes would impact providers in diverse ways. Wage changes could impact the level of provider participation in the HCBS market and frequency of provider turnover as well as shift provider participation from one service area, region, or state to another. At the agency level, wage changes could allow HCBS providers to adjust the amount of the payment rate used to cover patient care versus administrative and operational needs.

Endnotes

[1] States are required to cover home health services under Section 1905(a)(7) of the Social Security Act; all other HCBS are optional for states.

[2] Section 1915(c) waivers are the most commonly used authority for HCBS and accounted for 43 percent of HCBS spending in fiscal year 2021 (Murray et al. 2023).

[3] The 458,590 nursing assistants who provide care to individuals in nursing homes are excluded from this analysis. Additionally, due to data inconsistencies across states, the Paraprofessional Healthcare Institute analysis likely excludes many independent providers (PHI 2024a).

[4] Four states (Arizona, New Jersey, Rhode Island, and Vermont) were excluded from our review of Section 1915(c) waiver rate-setting methodologies because HCBS in these states is authorized though Section 1115 demonstration authority instead.

[5] Activities that may be eligible for productivity adjustments include but are not limited to conducting beneficiary assessments, transporting beneficiaries, traveling between clients, recordkeeping, and program development.

[6] BLS is an agency of the U.S. Department of Labor that provides a wide range of data and analyses in the field of labor economics and statistics, including wage data by occupational category. The BLS reports wages according to the SOC system, which classifies workers into nearly 900 occupational categories for collecting, calculating, or disseminating data. These categories reflect occupations with similar job duties and in some cases similar skills, education, or training.

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APPENDIX 1A: Home- and Community-Based Services Statutory Authorities

TABLE 1A-1. Home- and Community-Based Services Statutory Authorities

Type of authority	Authority	Description
Waiver	Section 1915(c)	Allows states to modify Medicaid requirements to target HCBS benefits to specific populations, cap the number of beneficiaries who receive benefits, or create waiting lists for people who cannot be served under the cap.
	Section 1115	Broad authority that allows states to test new delivery models and is not specific to HCBS. Allows states to target HCBS benefits to specific populations.
State plan	Section 1905(a)(24)	Allows states to cover personal care services but does not allow participants using self-direction to manage their individual service budgets.
	Section 1915(i)	Allows states to offer HCBS to people who need less than an institutional level of care. States can use this authority to target certain populations for HCBS.
	Section 1915(j)	Allows states to provide individuals with the option to self-direct personal assistance services, including hiring relatives. States may also provide individuals with the authority to manage their own individual service budget.
	Section 1915(k) Community First Choice Option	Provides states with a 6 percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services.

Notes: HCBS is home- and community-based services.

Sources: Sections 1115, 1905(a)(7), 1905(a)(24), 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act; 42 CFR 440.70(b).

APPENDIX 1B: Managed Long-Term Services and Supports

TABLE 1B-1. Selected Managed Long-Term Services and Supports Program Design Characteristics

MLTSS program characteristics	Description
Managed care authorities	State options include: • Section 1115 waiver authority. • A combination of Section 1915(a) and Section 1915(c) waiver authorities. • A combination of Section 1915(b) and Section 1915(c) waiver authorities. • A combination of Section 1932(a) state plan amendment and Section 1915(c) waiver authorities.
Contract types	• Comprehensive managed care program that includes LTSS and non-LTSS benefits (some states limit enrollment to populations eligible for LTSS; others include all populations). • Plan that provides only LTSS benefits. • Single comprehensive plan that covers Medicare and Medicaid benefits for individuals who are dually eligible for Medicare and Medicaid, such as fully integrated dual eligible special needs plans.
Populations covered	• Almost all state MLTSS programs cover older adults and individuals with physical disabilities. • Most states exclude individuals with intellectual or developmental disabilities. • Some states exclude children. • Some states cover individuals with traumatic brain injuries.
Mandatory or voluntary enrollment	• Many states mandate that beneficiaries in eligible populations enroll. • Some states give beneficiaries the option of enrolling in an MLTSS plan or continuing to receive LTSS on a fee-for-service basis.
Geographic reach	Statewide or only offered in certain regions.
Inclusion of institutional coverage	• Most state MLTSS programs cover both HCBS and institutional care. • A few states focus their MLTSS programs on beneficiaries currently receiving HCBS, and they have delayed including current nursing facility residents, or they limit their plans' risk for institutionalized beneficiaries.

TABLE 1B-1. (continued)

MLTSS program characteristics	Description
Number of plans participating	State decisions on number of plans affect beneficiary choice and administrative complexity.
Types of plans participating	States can contract with for-profit, non-profit, or public entities.
Payment policies	States can make different decisions regarding payment incentives—for example, to promote home- and community-based services.
Integration with Medicare benefits	States can align Medicaid MLTSS with Medicare Advantage dual-eligible special needs plans to integrate care for beneficiaries who are dually eligible for Medicare and Medicaid.

Notes: HCBS is home -and community-based services. LTSS is long-term services and supports. MLTSS is managed long-term services and supports.

Source: MACPAC 2018 analysis of Lewis et al. 2018, Dobson et al. 2017, Libersky et al. 2016, and Saucier et al. 2012.

APPENDIX 1C: Managed Long-Term Services and Supports

TABLE 1C-1. Federal Requirements for Home- and Community-Based Services Payment Rates

HCBS authority	Description of rate methodology	Rate review	Network adequacy	Stakeholder engagement
1915(c) fee-for-service	A description of the rate-setting method used for each waiver service must be included in the waiver application, including the basis for any variation, the rate methodology for self-directed services, and the entities responsible for rate determination.	Required a minimum of every five years. States must describe their rate review process, including when rates were initially set and last reviewed, how the state measures sufficiency and compliance with Section 1902(a)(30)(A) of the Social Security Act, rate review methods used, and frequency of rate review activities.	Rate review must ensure that rates are adequate to maintain an ample provider base and ensure quality of services.	State must describe how the Medicaid agency solicited public comment on rate determination methodologies.
State plan	State plan language must include a description of the policy and methods used to set payment rates.	No specific provision; however, state descriptions of the policy and methods used to develop payment rates must be approved by the Centers for Medicare & Medicaid Services.	States must do the following: • Develop and implement a medical assistance access monitoring review plan. • Submit an access review with any state plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances in which changes could result in diminished access. • Have ongoing mechanism for beneficiary and provider input on access to care.	States must provide public notice of changes in statewide methods and standards for setting payment rates. Additional state-specific requirements may apply.

TABLE 1C-1. (continued)

HCBS authority	Description of rate methodology	Rate review	Network adequacy	Stakeholder engagement
State plan (continued)			• Address any access deficiencies within a predetermined time period.	
Managed care	No federal requirement for specific services.	Rate reviews for individual services are not required. Capitation rates reflecting all services included under managed care are updated annually to account for changes in program costs and utilization. MCOs negotiate payment rate changes directly with providers unless a state chooses to implement a state directed payment arrangement.	States monitor MCO performance to ensure MCOs meet the following federal requirements: • Covered services must be accessible to MCO enrollees to the same extent that such services are accessible to other state residents with Medicaid who are not enrolled with the MCO. • MCOs must have sufficient network adequacy (sufficient number, mix, and geographic distribution of providers) to meet the expected enrollment in the service area. • States may also develop state-specific performance requirements related to performance adequacy.	There are no federal requirements for the release of capitation rates for public comment. Although MCOs must each have a member advisory committee when states implement managed care long-term services and supports, review of payment rate development under managed care is not a specific responsibility of this committee.

Notes: HCBS is home -and community-based services. MCO is managed care organization.

Source: MACPAC 2018 analysis of Lewis et al. 2018, Dobson et al. 2017, Libersky et al. 2016, and Saucier et al. 2012.

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on January 30, 2026.

Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

1.1 voting result	#	Commissioner
Yes	15	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Johnson, Karl, Killingsworth, McFadden, Nardone, Snyder
No	2	Ingram, McCarthy

Chapter 2:

Behavioral Health in Medicaid and the State Children's Health Insurance Program

Behavioral Health in Medicaid and the State Children's Health Insurance Program

Key Points

- In this chapter, MACPAC used 2021 to 2023 data from the Transformed Medicaid Statistical Information System (T-MSIS) to describe behavioral health spending and utilization among Medicaid and Medicaid-expansion State Children's Health Insurance Program (M-CHIP) enrollees in calendar year 2023. Behavioral health includes services that address mental health and substance use disorders (SUDs).
- In 2023, almost 27 million Medicaid and M-CHIP enrollees (27.6 percent) had behavioral health conditions, nearly 23 million (23.1 percent) had mental health conditions, and around 10 million (10.6 percent) had SUDs. Approximately six million enrollees (6.0 percent) had co-occurring mental health and SUD conditions.
- In addition, this chapter separately identifies enrollees with intellectual and developmental disabilities (I/DD). In 2023, there were nearly six million enrollees (6.0 percent) with I/DD and around two million (2.2 percent) with co-occurring mental health and I/DD conditions.
- In 2023, total Medicaid service-related spending for enrollees with behavioral health conditions was nearly $370 billion, accounting for more than half of overall service-related spending. Spending per enrollee for individuals with any behavioral health condition ($13,723) was more than twice that of the overall Medicaid and M-CHIP population ($6,582).
- Anxiety and depressive disorders were the most common mental health conditions among all full-benefit enrollees, while serious mental illness was associated with the highest spending per enrollee.
- More than 16 million enrollees who were not eligible for both Medicaid and Medicare with behavioral health conditions used behavioral health services (excluding prescription drugs), and 14.3 million used behavioral health drugs in 2023, accounting for $79.8 billion and $15.5 billion, respectively, in behavioral health spending.
- Most non-dually eligible Medicaid enrollees with behavioral health conditions who used behavioral health services received care in non-hospital outpatient settings (63.8 percent), which accounted for about one-third of total behavioral health spending. Enrollees with SUDs relied more heavily on inpatient and emergency department care than enrollees with a mental health condition; nearly half received inpatient care (49.2 percent), and one-quarter used emergency departments (24.9 percent).
- In 2023, more than 17 percent of children and youth younger than age 21 enrolled in Medicaid or M-CHIP had behavioral health conditions, and their spending on behavioral health services represented half of their total service-related spending. More than one-third of non-dually eligible adults younger than age 65 had behavioral health conditions, and their behavioral health spending accounted for more than a quarter of their total service-related Medicaid spending.
- Behavioral health services accounted for the majority of spending on adults with I/DD (61.3 percent) and co-occurring mental health and I/DD conditions (63.6 percent).

CHAPTER 2: Behavioral Health in Medicaid and the State Children's Health Insurance Program

"Behavioral health" is an umbrella term that includes mental health and substance use disorders (SUDs). Mental health conditions may include anxiety disorders, mood disorders, personality disorders, and schizophrenia. SUD conditions include opioid use disorder (OUD), alcohol use disorder, and other drug use disorders. Behavioral health conditions are prevalent in the United States, affecting one in three adults in 2024, according to the Substance Abuse and Mental Health Services Administration (SAMHSA 2025). Eight percent of adults younger than age 65 reported having both a mental illness and an SUD in 2024 (SAMHSA 2025).

The Commission has had a long-standing interest in examining behavioral health service use and spending in Medicaid, given the program's role as a major source of coverage for behavioral health services in the United States (CMS 2026, IHME 2025, MACPAC 2015). However, analyzing behavioral health spending and utilization data in Medicaid and the State Children's Health Insurance Program (CHIP) at a national level has historically been challenging. Behavioral health services do not have a standardized definition or well-defined set of procedure codes, provider taxonomies, or care settings, making it difficult to identify these services in medical claims. To analyze behavioral health use in Medicaid, MACPAC has typically relied on the National Survey on Drug Use and Health (NSDUH), which is the primary source of national estimates of mental health and SUD status and service utilization in the United States. However, NSDUH data do not include information on spending, and estimates of utilization resulting from the NSDUH can differ substantially when compared to claims analyses. For example, MACPAC's analysis of medications for opioid use disorder (MOUD) treatment rates using 2021 NSDUH data found that only 24 percent of enrollees with OUD received MOUD in the past year, while our analysis of Transformed Medicaid Statistical Information System (T-MSIS) data found that more than 70 percent of enrollees with OUD received MOUD in the same time period (MACPAC 2025a). This is likely because NSDUH relies on self-reported data rather than diagnoses or claims for OUD-related services and therefore tends to identify more enrollees with OUD.[1]

With the exception of the Commission's work on MOUD, MACPAC has not used Medicaid claims data to publish estimates of behavioral health services use or spending since the June 2015 report to Congress, which presented descriptive analyses of utilization and spending for children and adults with behavioral health conditions (MACPAC 2015).[2] This chapter uses T-MSIS data to update MACPAC's analyses of behavioral health service use and spending for calendar year 2023. In addition, this chapter expands the scope of conditions to separately identify enrollees with intellectual or developmental disabilities (I/DD). Though I/DD conditions are not classified as behavioral health conditions given differences in age of onset and etiology, individuals with I/DD often have co-occurring mental health conditions and behavioral support needs (Pouls et al. 2022, NIH 2021).

The chapter begins by providing an overview of Medicaid enrollees with behavioral health conditions and behavioral health benefits in Medicaid. Then, we outline the methodology and limitations for this analysis and discuss key findings from our T-MSIS analysis on utilization and spending among Medicaid and CHIP enrollees with behavioral health conditions, including enrollees with I/DD conditions.

Overview of Behavioral Health Prevalence and Coverage in Medicaid

In 2020, nearly 4 in 10 adults younger than age 65 enrolled in Medicaid reported having a behavioral health condition (Saunders and Rudowitz 2022). Often, behavioral health conditions begin in childhood or adolescence. In 2024, around 20 percent of adolescents age 12 through 17 had either a major depressive episode (MDE) or an SUD in the past year, with the vast majority experiencing an MDE rather than having an SUD (SAMHSA 2025).

Mental health disorders

Medicaid covers nearly one-third of adults with mental health disorders (Saunders et al. 2025). In 2023, 35 percent of adults younger than age 65 enrolled in Medicaid reported having a mental illness, and 10 percent reported having a serious mental illness (SMI).[3] About 60 percent of adult Medicaid enrollees who reported having any mental illness received mental health treatment in 2023, similar to rates in the privately insured population (Saunders et al. 2025).

The most common mental health diagnoses for children and youth are anxiety disorders, conduct disorders, and depressive disorders (CDC 2025). In 2024, more than 15 percent of adolescents had a MDE in the past year, and nearly 19 percent had moderate or severe symptoms of generalized anxiety disorder (SAMHSA 2025). Among all youth age 12 through 18 enrolled in Medicaid, around 16 percent received mental health services in 2022 (CMS 2025a).

SUD

Medicaid covers around one-fifth of adults with an SUD and an even greater share (40 percent) of youth and adults younger than age 65 with OUD (MACPAC 2025a, Saunders et al. 2025). In 2022, 9 percent of adults younger than age 65 and roughly 1 percent of youth age 12 through 18 enrolled in Medicaid received SUD treatment services (CMS 2025a).

I/DD

Medicaid provides health coverage to millions of people with I/DD conditions such as autism spectrum disorder or Down syndrome. Historically, limited data on the I/DD population in Medicaid have inhibited precise estimates of Medicaid enrollees with I/DD (MACPAC 2024). Our current analysis estimates that approximately 6 percent of the Medicaid population had an I/DD condition in 2023, and 2 percent of the Medicaid population had co-occurring I/DD and mental health conditions (Table 2-2). Many people with I/DD conditions without formal behavioral health diagnoses require behavioral health supports, indicating a need to study behavioral health service use among individuals with I/DD (Barth et al. 2020).

Medicaid coverage and delivery of behavioral health services

There is no federal, standardized definition for coverage of behavioral health services, and state definitions and coverage of behavioral health services vary widely.

Mandatory and optional services

Behavioral health services for children younger than age 21 enrolled in Medicaid are covered under the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, if the services are considered medically necessary. The EPSDT requirement mandates that states provide Medicaid enrollees age 21 and younger access to any treatment for physical or mental conditions listed in Section 1905(a) of the Social Security Act (P.L. 74-271) if that treatment or service is medically necessary (MACPAC 2025b). This requirement applies regardless of whether such services are covered under the state plan or the enrollee receives care through a managed care or fee-for-service (FFS) delivery system (CMS 2022). The EPSDT requirement applies to children enrolled in Medicaid-expansion CHIP (M-CHIP) but not those in separate CHIP. However, several states with separate CHIP coverage have elected to provide the EPSDT benefit to enrollees in that program (MACPAC 2025b). States with separate CHIP are required to provide behavioral health services to CHIP enrollees, regardless of whether their benefit package includes EPSDT.[4]

For adults enrolled in Medicaid, federal law requires coverage of certain behavioral health services, while leaving others optional for states. All state Medicaid programs are required to cover certain behavioral health services for adults, such as medically necessary inpatient hospital services, outpatient hospital services, federally qualified health center (FQHC) services, and physician services. Behavioral health services considered optional include clinic services, case management, certified community behavioral health clinic services, and prescription drugs (CMS 2025b).[5, 6] Prescription drugs used to treat behavioral health conditions can include antidepressants, antianxiety agents, antipsychotic or antimanic agents, and anticonvulsants.[7]

Medicaid's role in the coverage and financing of SUD treatment varies considerably across states. All state Medicaid programs offer some form of SUD services. As of October 2020, states are required to cover certain types of SUD treatment under the MOUD benefit mandate.[8] A review conducted by MACPAC in April 2018 found that the largest gaps in SUD coverage exist for residential SUD treatment (MACPAC 2018).

Settings for behavioral health care

Medicaid enrollees receive behavioral health services in various care settings, such as inpatient, outpatient, and residential. Inpatient settings may include public or private psychiatric inpatient hospitals, a psychiatric unit or medical unit of an acute care hospital, or other inpatient settings. Outpatient settings may include office-based settings such as a private therapist's office, a day treatment program, an outpatient mental health center, or a community health center such as an FQHC. Residential settings may include a psychiatric residential treatment facility (PRTF) or an SUD residential facility.

Certain inpatient and residential settings, referred to in the Medicaid statute as "institutions for mental diseases" (IMDs), are subject to particular restrictions. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases. Subdivision (B) following section 1905(a) of the Social Security Act prevents states from receiving federal financial participation for services delivered to individuals younger than age 65 residing in an IMD, with some exceptions. This statutory feature of Medicaid, also referred to as the "IMD exclusion," has existed since the program's inception to maintain state and local responsibility for funding psychiatric institutions and to promote access to community-based alternatives. The payment exclusion generally applies to all physical and behavioral health services delivered to patients residing in an IMD, whether they are furnished inside or outside of the facility.

Despite the IMD exclusion, states have multiple ways to pay for services delivered to enrollees in IMDs. First, the statute provides an exception for older adults as well as children and youth in certain circumstances. Under what is commonly referred to as the "psych under 21 benefit," states can cover services for enrollees younger than age 21 who are receiving care in a PRTF, a psychiatric hospital, or a psychiatric unit of a general hospital. Second, for adults younger than age 65, states may choose to cover services in IMDs, including under Section 1115 demonstrations, a state plan option for enrollees with SUDs, or as an in-lieu-of service or setting in managed care.[9] Although the IMD exclusion limits the settings in which enrollees can receive behavioral health treatment, states can receive federal financial participation for services delivered to enrollees in non-IMD settings, such as inpatient and residential facilities with fewer than 16 beds.

Delivery systems

States that deliver behavioral health services through managed care may carve out specific services to FFS. In 2024, 42 states and the District of Columbia offered behavioral health services through Medicaid managed care, and 8 states offered behavioral health services through FFS (Kaye et al. 2025).[10] Managed care arrangements in state Medicaid programs fall under two categories: (1) comprehensive risk-based managed care offered through managed care organizations and (2) limited-benefit plans that provide only a subset of services such as behavioral health (MACPAC 2020).[11]

FFS carve outs are a way for states to offer and pay for behavioral health services separately for certain subpopulations, such as those with SMI. Because of the wide range of behavioral health services, enrollees may ultimately receive some services under managed care (e.g., psychiatrist visits), while others are delivered through FFS (e.g., prescription drugs). As a result of these varying arrangements, this chapter stratifies spending by the type of claim (i.e., FFS or managed care encounter) regardless of the individual's enrollment in a managed care organization.

Methodology

MACPAC calculated service use and spending in calendar year (CY) 2023 for enrollees in Medicaid and M-CHIP with behavioral health conditions by analyzing enrollment, claims, and managed care encounter data from T-MSIS for CYs 2021through 2023.[12] In this analysis, MACPAC defined a behavioral health service as any service-related claim or encounter that includes a primary or secondary behavioral health–related diagnosis code. Service-related claims and encounters exclude capitation payments and FFS supplemental payments. The methodology for identifying enrollees with behavioral health (i.e., mental health and SUD conditions) and I/DD conditions is adapted from the Centers for Medicare & Medicaid Services' Physical and Behavioral Health Integration algorithm, SUD Data Book, Chronic Conditions Data Warehouse, and the Milbank Memorial Fund's *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending* (Sinha et al. 2024; CMS 2024a, 2024b, 2023; Hula et al. 2023).[13] Refer to Appendix 2A for more detailed information on the methodology.

Throughout this chapter, enrollees with behavioral health conditions refer to enrollees with a mental health condition, an SUD condition, or both, regardless of the presence of an I/DD condition. We include enrollees with I/DD conditions only when highlighting that specific population or enrollees with co-occurring mental health and I/DD conditions. We exclude full-benefit dually eligible enrollees from select measures related to utilization and care settings because Medicare is the primary payer for most behavioral health services for this population. When Medicaid or CHIP is a secondary payer, there may be no record in the Medicaid claims data of the enrollee receiving the service. Please refer to the table or figure notes for details on the populations included.

Calculating spending

In the analysis presented in this chapter, we report federal and state service-related spending (i.e., total payments reflected in FFS claims and managed care encounters) in comparison to total Medicaid spending (i.e., FFS payments and capitation payments made to managed care plans).[14] Table 2-1 compares service-related spending with total Medicaid spending. Among all full-benefit enrollees in 2023, total Medicaid spending was 16.1 percent higher than service-related spending. However, when we limit the population to enrollees with behavioral health conditions, total Medicaid spending is 5.1 percent lower than service-related spending, which may be an indication that enrollees with behavioral health conditions use more services than the average Medicaid enrollee in managed care.[15]

TABLE 2-1. Total Spending on Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees and Those with Behavioral Health Conditions by Expenditure Type, CY 2023 (billions)

Expenditure type	Total spending for all enrollees	Total spending for enrollees with BH conditions
FFS payments to providers	$292.7	$168.2
Capitation payments to managed care plans	462.1	182.6
Managed care payments to providers	349.6	201.0
Total Medicaid spending (FFS plus capitation)	**754.9**	**350.8**
Total service-related spending (FFS plus encounters)	**642.3**	**369.2**
Percentage difference between total Medicaid spending and total service-related spending	**16.1%**	**5.1%**

Notes: CY is calendar year. BH is behavioral health. FFS is fee for service. This table includes spending for full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees in CY 2023. Spending includes federal and state funds. The sum of spending across expenditure types may not equal the total due to rounding.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Limitations

Using claims data to identify behavioral health conditions and estimate use and spending is subject to certain data limitations. Enrollees with mental health or SUD conditions who did not seek or receive treatment covered by, billed to, or paid for by Medicaid or M-CHIP cannot be identified in T-MSIS data. As a result, using claims data to estimate the prevalence of behavioral health conditions can result in an underestimate. Also, because claims data do not capture functional assessments that inform the diagnosis of behavioral health conditions and are particularly important for identifying SMI, the figures presented in this report may differ from those reported using other data sources. Enrollees with I/DD conditions often use behavioral health services but may not have a documented behavioral health diagnosis. Because this analysis focuses on enrollees who use behavioral health services with an identified behavioral health condition, it may undercount behavioral health service use among enrollees with I/DD conditions.

States may make other payments to certain providers (e.g., disproportionate share hospital (DSH) payments, certain types of managed care state directed payments) that are paid on a lump-sum basis and not tied to a specific individual or service-related claim. Because the spending associated with these FFS supplemental payments and managed care state directed payments are not accounted for in our T-MSIS claims analysis, the data we present in this chapter likely understate actual spending for these individuals and services.

As mentioned above, our analysis defined behavioral health services as any service-related claim or encounter that includes a primary or secondary behavioral health–related diagnosis code. As a result of this approach, the behavioral health spending and utilization data in our analysis do not include behavioral health prescription drugs, as prescription drug claims do not capture diagnosis codes.

Medicaid and CHIP Enrollees with Behavioral Health Conditions

This analysis found that more than one-quarter of enrollees in Medicaid and M-CHIP had a behavioral health condition in 2023 (Table 2-2). Characteristics of enrollees with behavioral health conditions varied from the overall Medicaid population and differed by condition type. Despite enrollees with behavioral health conditions representing one-quarter of enrollment, their total Medicaid service-related spending accounted for more than half of overall service-related spending (Table 2-1). Furthermore, service-related spending per enrollee for individuals with any behavioral health condition was more than double than that of the overall Medicaid population (Table 2-3). More than half of service-related spending on enrollees with behavioral health conditions was via managed care encounter payments (Table 2-4).

The prevalence of behavioral health conditions among Medicaid enrollees and associated spending varied (Tables 2-5 through 2-7). Although per-enrollee spending was similar for enrollees with mental health conditions versus SUDs, enrollees with co-occurring mental health and I/DD conditions had more than double the amount of per-enrollee spend.

Characteristics of enrollees with behavioral health conditions

In 2023, almost 27 million (27.6 percent) of the 98 million individuals enrolled in Medicaid and M-CHIP had a behavioral health condition (Table 2-2). For prevalence of behavioral health conditions by state, please refer to Table 2B-1 in Appendix 2B. Overall, Medicaid enrollees were age 21 through 64 (47.1 percent), were female (53.4 percent), were eligible through an adult-related (i.e., new adult group and other adults) pathway (42.0 percent), resided in urban areas (83.2 percent), and identified as white, non-Hispanic (39.1 percent). Compared with the overall Medicaid population, a larger share of enrollees with behavioral health conditions were age 21 through 64 (63.2 percent), were female (56.9 percent), were eligible through an adult-related pathway (51.1 percent), and identified as white, non-Hispanic (51.7 percent). Enrollees with behavioral health conditions also represented a larger share residing in a rural area (20.7 percent versus 16.8 percent) and a larger share dually eligible for Medicaid and Medicare (15.1 percent versus 10.8 percent) than the overall Medicaid population. Enrollees with behavioral health conditions were predominantly individuals with mental health conditions; as a result, enrollee characteristics are similar across these two groups.

Approximately 10 million (10.6 percent) Medicaid enrollees had an SUD in 2023 (Table 2-2). Compared with the overall Medicaid population, a larger share of enrollees with an SUD were adults age 21 through 64 (85.9 percent versus 47.1 percent) and were eligible through the new adult group (46.0 percent versus 26.7 percent). Enrollees with an SUD also represented a larger share of male enrollees (49.2 percent versus 46.5 percent) and a smaller share of enrollees who identified as Hispanic (18.7 percent versus 29.1 percent) than the overall Medicaid population. Nearly six million enrollees were diagnosed with co-occurring mental health and SUD conditions. Although enrollees with behavioral health conditions were predominantly in an adult-related eligibility group, enrollees with co-occurring mental health and SUD conditions represented a larger share enrolled in the blind or disabled eligibility group (22.0 percent) compared with blind or disabled enrollees with behavioral health conditions (16.1 percent) or the overall Medicaid population (8.3 percent).

TABLE 2-2. Characteristics of Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Behavioral Health or Intellectual or Developmental Disability Conditions, CY 2023

Selected characteristics	All enrollees	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	Any I/DD	MH and I/DD
Total (millions)	**97.6**	**26.9**	**22.5**	**10.3**	**5.9**	**5.5**	**2.1**
Age							
0–20	44.8%	28.3%	33.1%	5.2%	6.5%	77.8%	66.8%
21–64	47.1	63.2	58.8	85.9	86.3	20.1	29.9
65+	8.0	8.6	8.1	8.9	7.2	2.2	3.3
Gender							
Male	46.5	43.1	40.5	49.2	43.8	64.9	65.1
Female	53.4	56.9	59.5	50.8	56.2	35.1	34.9
Eligibility group							
Aged	7.3	8.0	7.6	8.0	6.7	2.1	3.2
Blind or disabled	8.3	16.1	17.0	17.7	22.0	33.8	42.1
Children	35.2	19.3	22.5	3.4	4.1	50.0	36.5
Total foster care[2]	1.1	2.0	2.3	0.7	0.9	3.3	5.3

TABLE 2-2. (continued)

Selected characteristics	All enrollees	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	Any I/DD	MH and I/DD
New adult group[3]	26.7%	32.7%	29.4%	46.0%	43.0%	2.6%	4.8%
Other adults	15.3	18.3	17.0	23.6	22.6	1.3	2.1
M-CHIP	6.0	3.6	4.2	0.5	0.6	6.9	6.0
Dual status[4]							
Full dual	10.8	15.1	15.0	16.1	16.6	11.4	16.3
Medicaid only	89.2	84.9	85.0	83.9	83.4	88.6	83.7
Geographic location[5]							
Urban	83.2	79.3	79.2	78.7	78.1	82.6	79.9
Rural	16.8	20.7	20.8	21.3	21.9	17.4	20.1
Race and ethnicity[6]							
White, non-Hispanic	39.1	51.7	52.3	54.3	58.5	43.6	52.6
Black, non-Hispanic	19.5	18.3	17.5	19.8	17.5	18.8	17.4
API, non-Hispanic	5.7	2.6	2.4	2.1	1.3	3.2	2.0
AIAN, non-Hispanic	1.3	1.6	1.5	2.2	2.1	1.1	1.1
Multiracial, non-Hispanic	2.1	2.2	2.3	1.9	2.1	2.4	2.5
Hispanic, all races	29.1	22.7	23.2	18.7	17.6	29.6	23.9

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. M-CHIP is Medicaid-expansion State Children's Health Insurance Program. API is Asian and Pacific Islander. AIAN is American Indian and Alaska Native. This table includes all full-benefit enrollees in Medicaid and M-CHIP covered in CY 2023 and excludes those with missing or unknown age, gender, eligibility group, dual status, geographic location, or race and ethnicity, who comprise less than 3 percent of the population. Because behavioral health categories are not mutually exclusive, some enrollees appear in more than one group.

[1] Counts of enrollees with an SUD or with co-occurring mental health and SUD conditions exclude children age 0 through 12.

[2] Total foster care includes youth currently and formerly in foster care. Youth currently in foster care are defined as individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Social Security Act. Youth formerly in foster care are defined as individuals younger than age 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care.

[3] The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

[4] Full-benefit dually eligible enrollees receive the full range of Medicaid benefits offered in a given state, in addition to their Medicare benefits. Medicaid pays Medicare premiums and may also pay the cost sharing for their Medicare services.

[5] Urban or rural location is classified based on enrollee zip codes using the 2010 Rural-Urban Commuting Area code classification scheme from the U.S. Department of Agriculture. Refer to Appendix 2A for more information.

[6] The Transformed Medicaid Statistical Information System (T-MSIS) data element for race and ethnicity is unusable or unreliable in many states. Therefore, we used the T-MSIS analytic file race and ethnicity imputation companion file for more complete enrollee race and ethnicity information. For more information regarding the race and ethnicity imputation file, refer to Appendix 2A.

Source: MACPAC, 2025, analysis of 2021–2023 T-MSIS data.

Nearly 6 percent of Medicaid enrollees had an I/DD condition in 2023, and around 2 million (2.2 percent) had co-occurring mental health and I/DD conditions (Table 2-2). Compared with the overall Medicaid population, a larger share of individuals with co-occurring mental health and I/DD conditions were children and youth age 0 through 20 (66.8 percent), were male (65.1 percent), and identified as white, non-Hispanic (52.6 percent). Although individuals with I/DD represented a larger share of enrollees in the child eligibility group than the overall population (50.0 percent versus 35.2 percent), individuals with co-occurring mental health and I/DD conditions represented a larger share of enrollees in the blind or disabled eligibility group (42.1 percent versus 8.3 percent).

Overall spending for enrollees with behavioral health conditions

In 2023, Medicaid service-related spending (FFS and encounter payments) on enrollees with behavioral health conditions was nearly $370 billion, accounting for more than half of overall service-related spending for all Medicaid enrollees (Table 2-1). Spending per enrollee for individuals with any behavioral health condition ($13,723) was more than twice that of the overall Medicaid population ($6,582). Per-enrollee spending was highest for individuals with co-occurring mental health and I/DD conditions ($34,604) (Table 2-3). For more information on state spending on enrollees with behavioral health conditions, please refer to Tables 2B-2 and 2B-3 in Appendix 2B.

Per-enrollee service-related spending was highest for enrollees age 65 and older across all condition categories (Table 2-3). Although spending per enrollee was higher for adults age 21 through 64 than for children and youth across all condition categories, this difference was particularly large for individuals with I/DD. Spending per enrollee for adults with I/DD was about five times that of children with I/DD.

Per-enrollee service-related spending was highest for enrollees eligible through the aged or blind or disabled pathways compared with other eligibility groups across all condition categories (Table 2-3). Similarly, per-enrollee service-related spending was higher across all condition categories for enrollees dually eligible for Medicare and Medicaid compared with enrollees with Medicaid only.

TABLE 2-3. Overall Per-Enrollee Service-Related Spending among Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Behavioral Health or Intellectual or Developmental Disability Conditions by Selected Characteristics, CY 2023

Selected characteristics	All enrollees	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	Any I/DD	MH and I/DD
Total	**$6,582**	**$13,723**	**$14,469**	**$15,583**	**$19,797**	**$24,974**	**$34,604**
Age							
0–20	3,317	7,164	7,217	11,282	13,932	12,510	15,684
21–64	7,855	14,463	15,863	15,224	19,414	65,627	69,736
65+	17,349	29,957	34,105	21,582	29,661	96,498	99,826
Gender							
Male	6,566	14,815	15,971	16,338	21,850	23,846	32,942
Female	6,598	12,896	13,447	14,854	18,195	27,058	37,699
Eligibility group							
Aged	18,486	31,257	35,243	22,726	30,701	96,906	100,205
Blind or disabled	25,402	30,305	31,756	28,640	32,227	50,800	57,736
Children	2,530	5,415	5,456	8,848	11,291	7,475	10,243
Total foster care[2]	8,204	12,153	12,355	18,113	21,412	20,086	22,155

TABLE 2-3. (continued)

Selected characteristics	All enrollees	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	Any I/DD	MH and I/DD
New adult group[3]	$4,977	$10,078	$10,639	$12,611	$16,240	$18,464	$19,440
Other adults	4,617	8,758	9,274	10,247	12,946	30,898	33,168
M-CHIP	1,755	4,386	4,416	7,070	9,321	6,498	8,603
Dual status[4]							
Full dual	18,911	27,422	30,327	18,917	23,095	78,512	85,272
Medicaid only	5,082	11,283	11,661	14,943	19,142	18,092	24,765
Geographic location[5]							
Urban	6,548	14,036	14,820	15,988	20,481	25,264	35,409
Rural	6,750	12,521	13,127	14,087	17,356	23,597	31,403
Race and ethnicity[6]							
White, non-Hispanic	7,835	13,977	14,846	14,882	18,389	31,125	38,943
Black, non-Hispanic	6,670	15,004	16,042	17,465	23,755	23,260	34,857
API, non-Hispanic	6,283	16,295	17,207	16,521	23,318	27,301	42,706
AIAN, non-Hispanic	9,106	17,826	19,249	22,067	28,972	22,984	34,782
Multiracial, non-Hispanic	5,213	11,089	11,439	14,965	18,721	16,997	23,466
Hispanic, all races	4,976	11,690	12,051	14,770	19,187	17,337	25,406

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. M-CHIP is Medicaid-expansion State Children's Health Insurance Program. API is Asian and Pacific Islander. AIAN is American Indian and Alaska Native. This table includes CY 2023 spending for all full-benefit enrollees in Medicaid and M-CHIP and excludes those with missing or unknown age, gender, eligibility group, dual status, geographic location, or race and ethnicity, who comprise less than 3 percent of total spending. Because behavioral health categories are not mutually exclusive, some enrollees appear in more than one group. Spending includes federal and state funds.

[1] Spending amounts on enrollees diagnosed with an SUD or co-occurring mental health and SUD conditions exclude children age 0 through 12.

[2] Total foster care includes youth currently and formerly in foster care. Youth currently in foster care are defined as individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Social Security Act. Youth formerly in foster care are defined as individuals younger than age 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care.

[3] The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

[4] Full-benefit dually eligible enrollees receive the full range of Medicaid benefits offered in a given state, in addition to their Medicare benefits. Medicaid pays Medicare premiums and may also pay the cost sharing for their Medicare services.

[5] Urban or rural location is classified based on enrollee zip codes using the 2010 Rural-Urban Commuting Area code classification scheme from the U.S. Department of Agriculture. Refer to Appendix 2A for more information.

[6] The Transformed Medicaid Statistical Information System (T-MSIS) data element for race and ethnicity is unusable or unreliable in many states. Therefore, we used the T-MSIS analytic file race and ethnicity imputation companion file for more complete enrollee race and ethnicity information. For more information regarding the race and ethnicity imputation file, refer to Appendix 2A.

Source: MACPAC, 2025, analysis of 2021–2023 T-MSIS data.

Across race and ethnicity groups, the highest per-enrollee spending among enrollees with behavioral health conditions was for those who identify as American Indian and Alaska Native, non-Hispanic ($17,826), who represented 1.6 percent of enrollees with a behavioral health condition (Tables 2-2 and 2-3). Within each race and ethnicity group, per-enrollee costs for Asian or Pacific Islander, non-Hispanic; Hispanic; and Black, non-Hispanic, enrollees with behavioral health conditions were more than double the overall per-enrollee average for their group.

In 2023, managed care payments to providers accounted for more than half (54.5 percent) of service-related spending on enrollees with behavioral health conditions (Table 2-4). The share of spending attributable to managed care payments was highest for enrollees with any SUD (62.0 percent) and co-occurring mental health and SUD conditions (60.8 percent). Conversely, FFS spending was highest for individuals with any I/DD condition (68.8 percent) and co-occurring mental health and I/DD conditions (70.7 percent).

TABLE 2-4. Overall Spending by Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Behavioral Health or Intellectual or Developmental Disability Conditions, CY 2023 (billions)

Population	Total service-related spending		Fee-for-service spending		Managed care payments to providers	
	Dollars	% of total enrollee spending	Dollars	% of service-related spending	Dollars	% of service-related spending
All Medicaid enrollees	$642.3	100.0%	$292.7	45.6%	$349.6	54.4%
Any BH	369.2	57.5	168.2	45.6	201.0	54.4
Any MH	326.0	50.8	153.2	47.0	172.8	53.0
Any SUD	160.3	25.0	61.0	38.0	99.4	62.0
MH and SUD	117.2	18.2	46.0	39.2	71.2	60.8
I/DD	137.5	21.4	94.6	68.8	42.9	31.2
MH and I/DD	72.4	11.3	51.1	70.7	21.2	29.3

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. This table reports CY 2023 spending by delivery system (fee for service and managed care), which does not correspond directly to enrollment; enrollees in either delivery system may generate spending in both categories. Spending includes federal and state funds. This table includes spending for all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees. Spending amounts on enrollees diagnosed with an SUD or co-occurring mental health and SUD conditions exclude children age 0 through 12. Because enrollees may have more than one behavioral health condition, percentages in the total enrollee spending column will sum to more than 100 percent. However, percentages in the fee-for-service and managed care spending columns sum to 100 percent within each row, as they reflect the distribution of total spending for each population by payment type.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Prevalence and spending by specific behavioral health conditions

Behavioral health conditions varied widely in prevalence and associated spending among Medicaid enrollees. Anxiety and depressive disorders were among the most common mental health conditions, while SMI was associated with the highest spending per enrollee (Table 2-5). Enrollees with co-occurring mental health and I/DD conditions were also associated with high service-related spending per enrollee (Table 2-7).

Mental health conditions

Among enrollees with a mental health condition, the most prevalent conditions were anxiety disorders (55.6 percent) and depressive and mood disorders (45.8 percent) (Table 2-5). However, total service-related spending per enrollee was highest for enrollees with SMI ($24,240) and conduct disorders ($23,351).

TABLE 2-5. Prevalence and Overall Service-Related Spending among Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Mental Health Conditions by Selected Mental Health Conditions, CY 2023

Mental health conditions	Number of enrollees (millions)	Total service-related spending (billions)	Total spending per enrollee
With a mental health condition	**22.5**	**$326.0**	**$14,469**
Specific conditions			
Attention deficit hyperactivity disorder	4.3	45.8	10,634
Adjustment disorder	4.2	61.3	14,537
Anxiety disorders	12.5	189.2	15,105
Conduct disorders	1.5	34.8	23,351
Depressive and mood disorders	10.3	185.4	17,939
Other mental health disorders	1.3	25.9	19,888
Serious mental illness[1]	5.0	120.5	24,240
Suicide or self-harm	1.7	38.1	22,747

Notes: CY is calendar year. This table includes CY 2023 enrollment and spending for all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees. Spending includes federal and state funds. Because enrollees can have multiple mental health conditions, prevalence estimates for specific conditions are not mutually exclusive, and the sum of enrollees or spending across conditions may be greater than the totals. Total spending per enrollee indicates the total service-related spending (fee for service plus encounter spending) divided by the number of enrollees with that condition.

[1] Although not a diagnostic term, "serious mental illness" 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.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

SUD conditions

Most enrollees with an SUD had a tobacco use disorder (62.1 percent) (Table 2-6). Further, one in four Medicaid enrollees had an alcohol use disorder (25.2 percent). Total service-related spending per enrollee ranged from $16,902 (drug use disorders—cannabis) to $20,629 (drug use disorders—stimulants).

I/DD conditions

In 2023, approximately 5.5 million Medicaid enrollees had an I/DD condition, of which 2.1 million had co-occurring I/DD and mental health conditions with overall spending of more than $72 billion (Tables 2-2 and 2-7). The most prevalent co-occurring mental health conditions for individuals with I/DD were attention deficit hyperactivity disorder (42.9 percent), anxiety disorders (42.9 percent), and depressive and mood disorders (28.6 percent). Of those three co-occurring conditions, service-related spending per enrollee was highest for those with I/DD and depressive and mood disorders ($46,122). Among all enrollees with co-occurring I/DD and mental health conditions, service-related spending per enrollee was highest for enrollees with I/DD and SMI ($69,506).

Behavioral Health Service Use and Spending in Medicaid and CHIP

More than 16 million Medicaid enrollees who are not eligible for both Medicaid and Medicare with behavioral health conditions used behavioral health services (excluding prescription drugs), and 14.3 million used behavioral health drugs in 2023, accounting for $79.8

TABLE 2-6. Prevalence and Overall Service-Related Spending among Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Substance Use Disorder Conditions by Selected Substance Use Disorder Conditions, CY 2023

SUD conditions	Number of enrollees (millions)	Total service-related spending (billions)	Total spending per enrollee
With an SUD condition	**10.3**	**$160.3**	**$15,645**
Specific conditions			
Alcohol use disorders	2.6	50.6	19,369
Tobacco use disorders	6.4	112.0	17,416
Drug use disorders—opioids	2.3	44.8	19,268
Drug use disorders—cannabis	1.9	32.6	16,902
Drug use disorders—stimulants	1.8	36.9	20,629

Notes: CY is calendar year. SUD is substance use disorder. This table includes CY 2023 enrollment and spending for all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees. Spending includes federal and state funds. Total spending per enrollee indicates the total service-related spending (fee for service plus encounter spending) divided by the number of enrollees with that condition. Spending amounts on enrollees diagnosed with specific SUD conditions do not exclude children age 0 through 12 because of data limitations. Because enrollees can have multiple SUD conditions, prevalence estimates for specific conditions are not mutually exclusive, and the sum of enrollees or spending across conditions may be greater than the totals. This table highlights SUD conditions with the highest prevalence among Medicaid enrollees.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

billion and $15.5 billion, respectively, in behavioral health spending (Table 2-8 and Figure 2-1). Patterns of utilization and spending for behavioral health services and prescription drugs among Medicaid enrollees varied by condition category.

Behavioral health service use by care setting

Most non-dually eligible Medicaid enrollees with behavioral health conditions who used behavioral health services (excluding prescription drugs) received care in outpatient settings (63.8 percent), which accounted for about one-third of total behavioral health spending (Table 2-8). In contrast, fewer enrollees used inpatient care (29.7 percent), which accounted for 27.6 percent of spending. Approximately 15 percent of enrollees received services in FQHCs (14.8 percent) and community mental health center (CMHCs) (16.0 percent), and these settings represented 3.2 percent and 8.0 percent of spending, respectively. Although almost one-quarter of enrollees used telehealth, spending on telehealth services remained below 5 percent of total behavioral health spending. Because enrollees with a mental health condition comprise a large share of enrollees with behavioral health conditions, their utilization and spending by care setting largely align with these trends.

TABLE 2-7. Prevalence and Overall Service-Related Spending among Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Co-Occurring Intellectual or Developmental Disability and Mental Health Conditions by Mental Health Conditions, CY 2023

Co-occurring mental health conditions	Number of enrollees (millions)	Total service-related spending (billions)	Total spending per enrollee
With an I/DD and a mental health condition	**2.1**	**$72.4**	**$34,604**
Specific conditions			
Attention deficit hyperactivity disorder	0.9	19.1	20,168
Adjustment disorder	0.5	13.6	28,572
Anxiety disorders	0.9	33.2	39,027
Conduct disorders	0.4	19.4	46,361
Depressive and mood disorders	0.6	29.2	46,122
Other mental health disorders	0.2	8.3	39,247
Serious mental illness[1]	0.4	30.6	69,506
Suicide/self-harm	0.2	8.0	49,908

Notes: CY is calendar year. I/DD is intellectual or developmental disabilities. This table includes CY 2023 enrollment and spending for all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees. Spending includes federal and state funds. Because enrollees can have multiple mental health conditions, prevalence estimates for specific conditions are not mutually exclusive, and the sum of enrollees or spending across conditions may be greater than the totals. Total spending per enrollee indicates the total service-related spending (fee for service plus encounter spending) divided by the number of enrollees with that condition. Other mental health disorders include disorders that do not meet the criteria for the conditions listed in this table.

[1] Although not a diagnostic term, "serious mental illness" 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.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Enrollees with an SUD relied more heavily on inpatient and emergency department care than enrollees with a mental health condition (Table 2-8). Nearly half received inpatient care (49.2 percent), and one-quarter used emergency departments (24.9 percent). Inpatient care accounted for a larger share of total spending among enrollees with an SUD (39.8 percent) than among those with a mental health condition (26.9 percent). In contrast, enrollees with an SUD were less likely to receive care in an outpatient setting (57.5 percent) or via telehealth (20.4 percent) compared with enrollees with a mental health condition (66.6 percent and 26.3 percent, respectively). Enrollees with co-occurring mental health and SUD conditions were more likely to receive care in an emergency department (27.2 percent) compared to enrollees with mental health conditions (12.3 percent).

TABLE 2-8. Total Behavioral Health Service Use and Spending among Non-Dually Eligible Users in Medicaid and Medicaid-Expansion State Children's Health Insurance Program with Behavioral Health Conditions by Care Setting, CY 2023

Care setting	Any BH		Any MH		Any SUD		MH and SUD	
	BH users (millions)	BH spending (billions)	BH users (millions)	BH spending (billions)	BH users (millions)	BH spending (billions)	BH users (millions)	BH spending (billions)
Total	**16.1**	**$79.8**	**14.2**	**$74.9**	**6.0**	**$36.6**	**4.1**	**$31.7**
Share of users and spending by care setting								
CMHC	16.0%	8.0%	17.6%	8.2%	15.4%	6.7%	20.4%	7.1%
Emergency department	13.2	1.0	12.3	1.0	24.9	1.7	27.2	1.7
FQHC	14.8	3.2	15.6	3.2	15.0	2.8	17.9	2.8
Inpatient	29.7	27.6	27.2	26.9	49.2	39.8	49.7	40.3
Outpatient hospital	10.3	1.8	10.0	1.8	14.6	2.1	15.6	2.0
Outpatient	63.8	33.6	66.6	33.8	57.5	25.0	64.3	24.1
SUD residential	1.6	2.6	1.4	2.3	4.2	5.6	4.8	5.4
Telehealth	24.2	4.6	26.3	4.7	20.4	3.1	26.1	3.3
Other settings	25.6	17.8	25.9	18.2	35.3	13.1	40.9	13.3

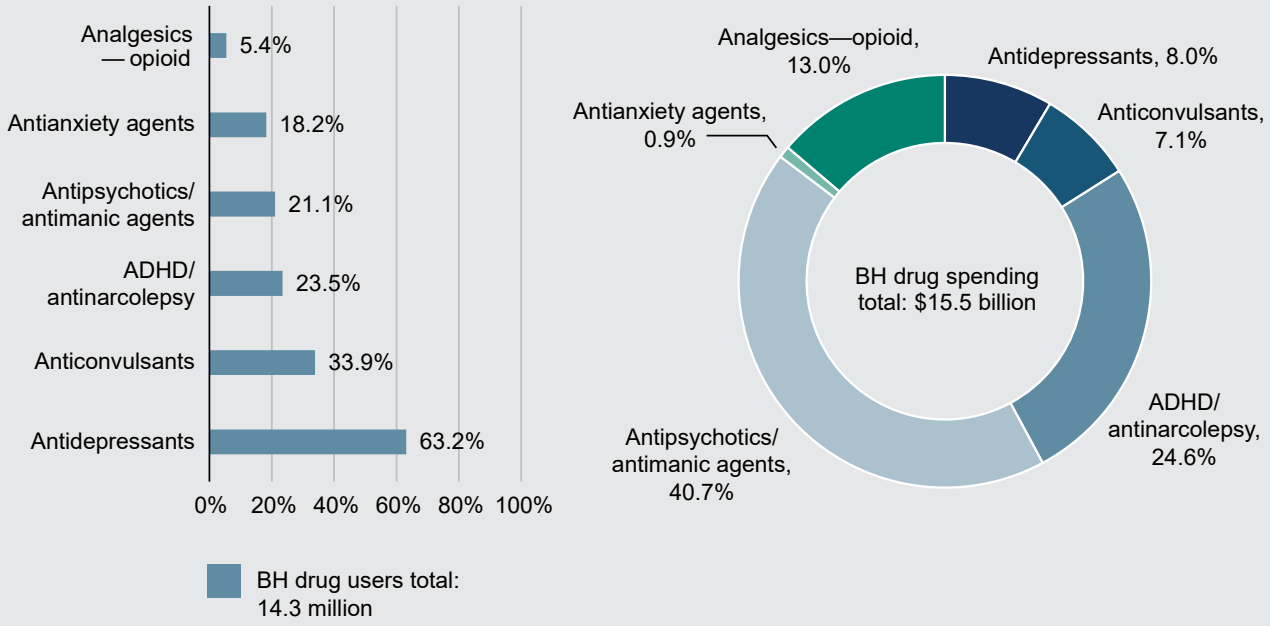
Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. CMHC is community mental health clinic. FQHC is federally qualified health center. This table includes CY 2023 behavioral health–related utilization and spending, excluding prescription drugs, for non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees with behavioral health conditions. Spending includes federal and state funds. User counts and spending amounts for enrollees diagnosed with an SUD or co-occurring mental health and SUD conditions exclude children age 0 through 12. Total behavioral health spending on enrollees with a behavioral health diagnosis represents spending on services with a primary or secondary behavioral health diagnosis code. Because enrollees can receive services in multiple care settings, user percentages sum to more than 100. Behavioral health spending percentages across care settings will sum to 100.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Behavioral health drug use and spending

Among non-dually eligible enrollees with behavioral health conditions who used behavioral health drugs in 2023, antidepressants were the most commonly used drug group (63.2 percent of users), though antidepressants accounted for a relatively smaller share of behavioral health drug spending (8.0 percent) (Figure 2-1). Approximately one-third of users used anticonvulsant drugs (33.9 percent), which accounted for 7.1 percent of behavioral health drug spending. The drug group that represented the largest share of spending was antipsychotics or antimanic agents (40.7 percent), though the share of users was much smaller (21.1 percent).

FIGURE 2-1. Behavioral Health Drug Use and Spending among Non-Dually Eligible Users in Medicaid and Medicaid-Expansion State Children's Health Insurance Program with Behavioral Health Conditions by Drug Group, CY 2023



Notes: CY is calendar year. ADHD is attention deficit hyperactivity disorder. BH is behavioral health. This figure includes CY 2023 behavioral health drug utilization and spending for non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees with behavioral health conditions. Because enrollees can use multiple behavioral health drugs, user percentages sum to more than 100. Spending includes federal and state funds. The percentages for spending on behavioral health drugs across all drug groups will sum to 100.

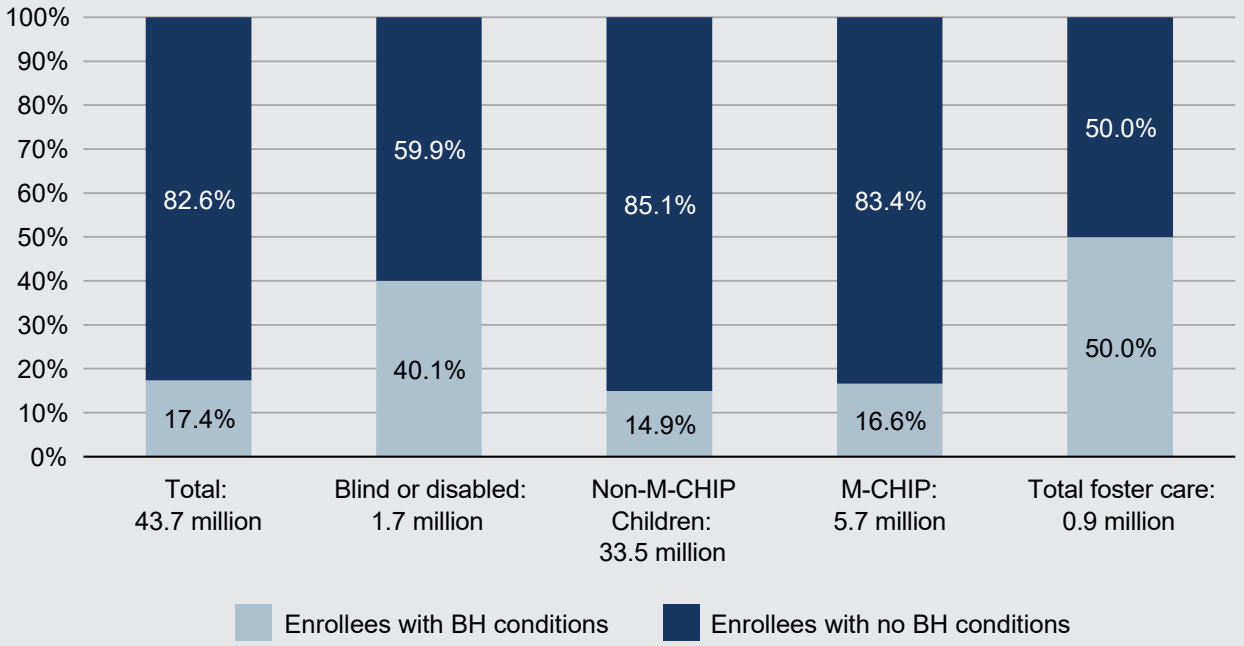
Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Children and Youth in Medicaid and CHIP with Behavioral Health Conditions

More than 17 percent of children and youth younger than age 21 enrolled in Medicaid or M-CHIP had a behavioral health condition in 2023 (Figure 2-2). Behavioral health conditions were more prevalent among children and youth in the foster care eligibility group; those identifying as white, non-Hispanic; and those residing in a rural area (Figures 2-2 through 2-4).

Spending on behavioral health services represented half of total service-related spending for children and youth with behavioral health conditions in 2023 (Table 2-9). Nearly three-quarters of children and youth with behavioral health conditions used at least one behavioral health service (Figure 2-5). Almost three-quarters of children and youth received behavioral health services in outpatient settings, which accounted for more than 40 percent of their total behavioral health spending (Figure 2-6). More than half of child and youth enrollees with behavioral health conditions used attention deficit hyperactivity disorder drugs, which represented the largest share of behavioral drug spending (Figure 2-7).

FIGURE 2-2. Behavioral Health Prevalence among Children and Youth in Medicaid and Medicaid-Expansion State Children's Health Insurance Program by Eligibility Group, CY 2023



Notes: CY is calendar year. M-CHIP is Medicaid-expansion State Children's Health Insurance Program. BH is behavioral health. This figure includes non-dually eligible, full-benefit enrollees in Medicaid and M-CHIP younger than age 21 in CY 2023 and shows the eligibility groups only with the largest number of child and youth enrollees; as a result, the sum across eligibility groups will not equal the total. This figure excludes 4.3 percent of enrollees younger than age 21 who belong to adult-related pathways. Non-M-CHIP children include enrollees eligible for Medicaid through a child-related eligibility pathway who are not in a blind or disabled or foster care eligibility group. Total foster care includes individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Social Security Act and also includes individuals younger than age 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care.

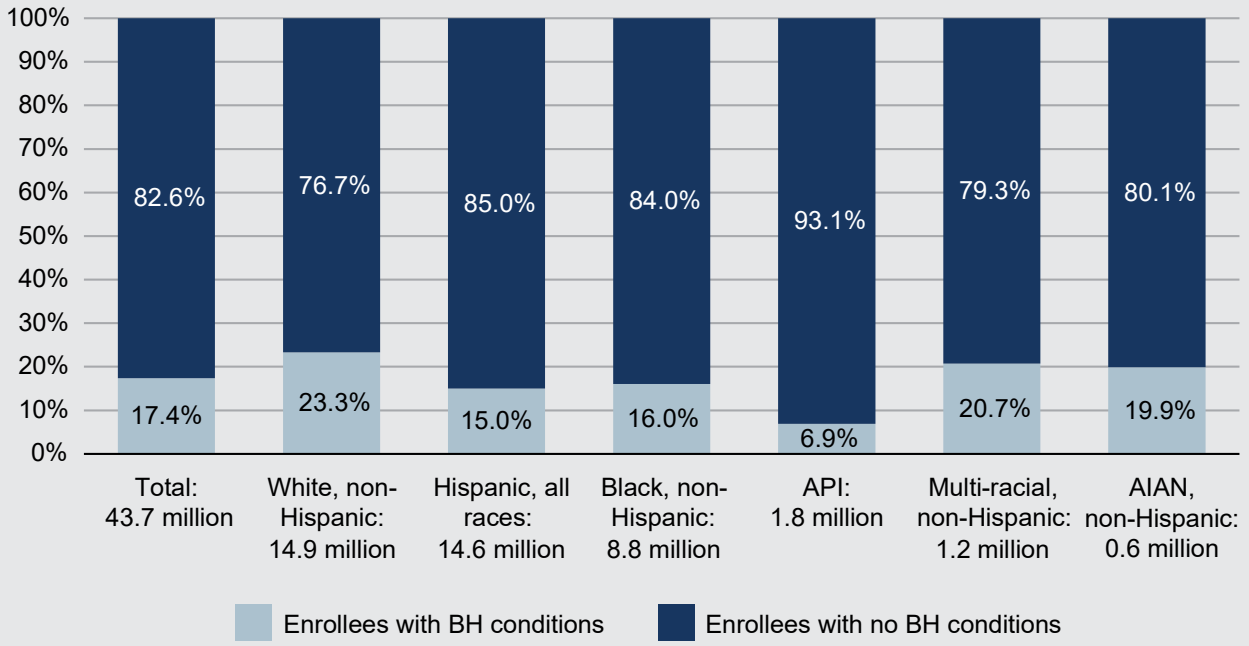
Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Prevalence of behavioral health conditions among children and youth

Behavioral health conditions were most prevalent among children and youth in the foster care and blind or disabled eligibility groups, with 50.0 percent and 40.1 percent of enrollees, respectively, having a behavioral health condition in 2023 (Figure 2-2). By comparison with these groups, the prevalence of behavioral health conditions in M-CHIP was lower (16.6 percent), similar to the overall rate among all children and youth age 0 through 20 who are in a non–M-CHIP child-related eligibility group (17.4 percent).

Children and youth who identified as white, non-Hispanic, had the highest prevalence of behavioral health conditions in 2023 (23.3 percent), while those who identified as Asian or Pacific Islander, non-Hispanic, had the lowest prevalence (6.9 percent) (Figure 2-3). Hispanic and Black, non-Hispanic, enrollees had slightly lower rates of behavioral health conditions compared with the overall group of child enrollees (15.0 percent and 16.0 percent versus 17.4 percent, respectively), while American Indian and Alaska Native, non-Hispanic, and multiracial enrollees had slightly higher rates (19.9 percent and 20.7 percent, respectively).

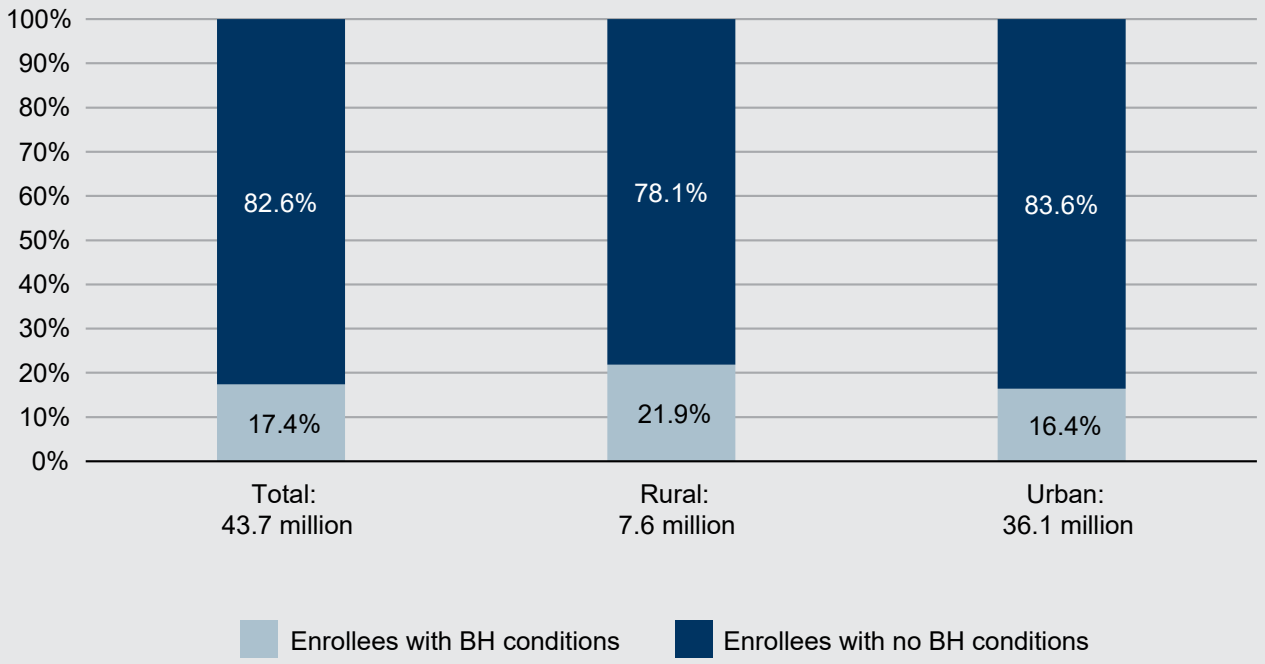
FIGURE 2-3. Behavioral Health Prevalence among Children and Youth in Medicaid and Medicaid-Expansion State Children's Health Insurance Program by Race and Ethnicity, CY 2023



Notes: CY is calendar year. API is Asian and Pacific Islander. AIAN is American Indian and Alaska Native. BH is behavioral health. This figure includes non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees younger than age 21 and excludes enrollees with missing or unknown race or ethnicity, who represent less than 5 percent of the population. The sum across racial and ethnic groups may not equal the total.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

FIGURE 2-4. Behavioral Health Prevalence among Children and Youth in Medicaid and Medicaid-Expansion State Children's Health Insurance Program by Geographic Location, CY 2023



Notes: CY is calendar year. BH is behavioral health. Urban or rural location is classified based on enrollee zip codes using the 2010 Rural-Urban Commuting Area code classification scheme from the U.S. Department of Agriculture. Refer to Appendix 2A for more information. This figure includes non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees younger than age 21 and excludes enrollees with missing zip codes, who represent less than 0.5 percent of the population.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

In 2023, a larger share of child and youth enrollees residing in rural areas had a behavioral health condition (21.9 percent), compared with enrollees residing in urban areas (16.4 percent) (Figure 2-4).

Spending patterns among children and youth

In 2023, spending on behavioral health services represented nearly half of total service-related spending for children and youth with behavioral health conditions (Table 2-9). Percentages referenced in this section are derived from table data. Total behavioral health spending reflects services only and excludes spending on behavioral health drugs, while total service-related spending includes drug spending. Spending per enrollee on behavioral health services was highest for those with co-occurring mental health and SUD conditions ($11,163) and lowest for those with mental health conditions ($4,760).

Although enrollees age 13 through 17 comprised the largest share of behavioral health–related spending of those with a mental health condition (35.6 percent), behavioral health–related spending per enrollee was similar across age groups for enrollees with a mental health condition (approximately $5,000 per enrollee) (Table 2-9). In contrast, there was more substantial variation by age within the other condition categories. For those with SUD conditions, enrollees age 13 through 17 had the highest per-enrollee spending on behavioral health–related services ($12,674), which was more than double that of enrollees age 18 through 20 ($6,087). In addition, the share of behavioral health service spending on enrollees age 13 through 17 (69.7 percent) was higher than enrollees age 18 through 20 (48.1 percent). Older child and youth enrollees (age 18 through 20) with I/DD conditions had the highest per-enrollee behavioral health spending ($13,705). Two-thirds of spending for enrollees with mental health and SUD conditions was on behavioral health–related services, and an even higher proportion was spent on behavioral health–related services for those age 13 through 17 (76.7 percent of total spending).

TABLE 2-9. Overall and Behavioral Health–Related Spending among Children and Youth in Medicaid and Medicaid-Expansion State Children's Health Insurance Program with Behavioral Health or Intellectual or Developmental Disability Conditions by Age and Condition Category, CY 2023

Age groups	Total enrollees (millions)	Total spending (billions)	Total spending per enrollee	Total BH users (millions)	Total BH spending (billions)	Total BH spending per BH user
BH conditions	**7.6**	**$54.3**	**$7,137**	**5.6**	**$26.5**	**$4,712**
0–5	0.4	3.7	9,802	0.3	1.6	4,977
6–12	2.7	18.3	6,752	2.2	9.4	4,304
13–17	2.9	21.7	7,427	2.2	11.4	5,301
18–20	1.6	10.5	6,626	1.0	4.2	4,240
MH conditions	**7.5**	**53.6**	**7,190**	**5.5**	**26.4**	**4,760**
0–5	0.4	3.7	9,802	0.3	1.5	4,995
6–12	2.7	18.3	6,752	2.2	9.4	4,305
13–17	2.9	21.5	7,473	2.1	11.4	5,354
18–20	1.5	10.0	6,780	0.9	4.1	4,391
SUD conditions	**0.5**	**6.0**	**11,223**	**0.4**	**3.6**	**9,169**
0–5	–	–	–	–	–	–
6–12	–	–	–	–	–	–
13–17	0.2	3.3	14,780	0.2	2.3	12,674
18–20	0.3	2.7	8,716	0.2	1.3	6,087
I/DD conditions	**4.3**	**53.2**	**12,457**	**3.4**	**22.7**	**6,682**
0–5	1.5	16.2	11,078	1.2	5.9	5,041
6–12	1.8	19.6	10,666	1.5	8.9	6,068
13–17	0.7	11.7	16,107	0.6	5.4	9,191
18–20	0.2	5.7	23,229	0.2	2.6	13,705

TABLE 2-9. (continued)

Age groups	Total enrollees (millions)	Total spending (billions)	Total spending per enrollee	Total BH users (millions)	Total BH spending (billions)	Total BH spending per BH user
MH and SUD conditions	**0.4**	**$5.3**	**$13,863**	**0.3**	**$3.5**	**$11,163**
0–5	–	–	–	–	–	–
6–12	–	–	–	–	–	–
13–17	0.2	3.0	17,598	0.2	2.3	14,892
18–20	0.2	2.3	10,812	0.2	1.2	7,564
MH and I/DD conditions	**1.4**	**21.7**	**15,592**	**1.3**	**12.0**	**9,485**
0–5	0.2	2.5	15,907	0.1	1.2	8,342
6–12	0.7	9.0	12,782	0.7	5.0	7,680
13–17	0.4	6.9	17,619	0.4	4.0	11,282
18–20	0.1	3.3	23,847	0.1	1.8	15,384

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. Behavioral health utilization and spending among children and youth with SUDs excludes children age 0 through 12. This table includes CY 2023 enrollment and spending for non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees younger than age 21. Spending includes federal and state funds. Total behavioral health spending on enrollees with a behavioral health diagnosis represents spending on services with a primary or secondary behavioral health diagnosis code and excludes spending on behavioral health drugs. The sum of enrollment or spending across age groups may not equal the totals due to rounding.

– Dash indicates zero.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

The share of behavioral health spending was highest for enrollees with mental health conditions and I/DD in most age groups (i.e., 0 through 5, 6 through 12, 18 through 20) (Table 2-9). Among enrollees age 13 through 17, those with co-occurring mental health and SUD conditions represented the largest share of spending on behavioral health services (76.7 percent).

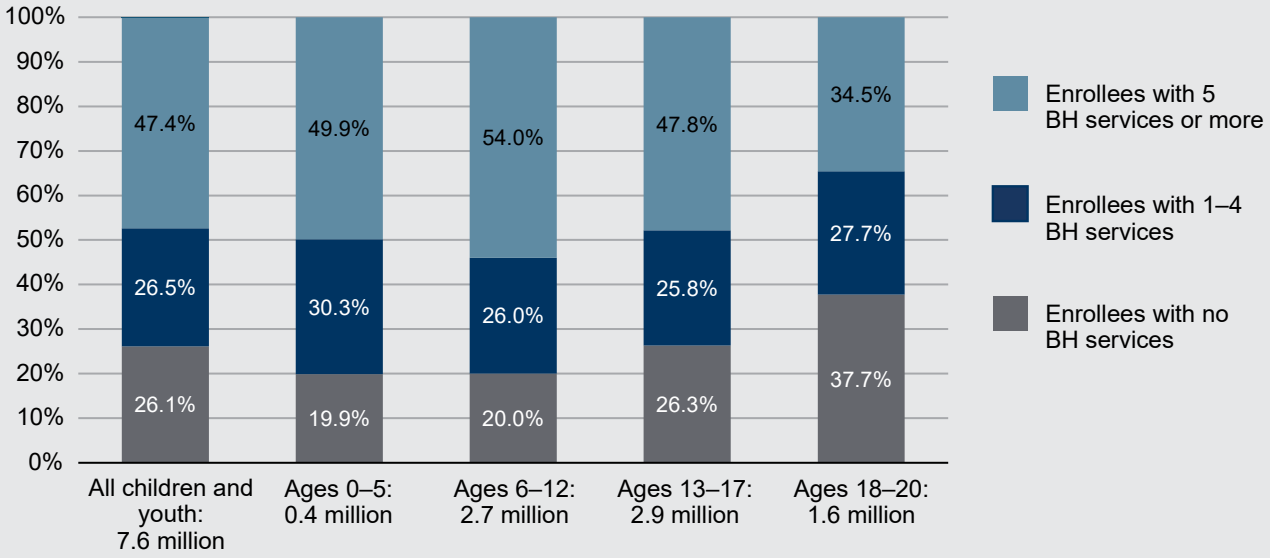
Behavioral health service use among children and youth

In 2023, almost three-quarters of children and youth age 0 through 20 in Medicaid and M-CHIP with behavioral health conditions (73.9 percent) used at least one behavioral health service (Figure 2-5). Just under half of children and youth with behavioral health conditions (47.4 percent) used five or more behavioral health services in 2023. Children age 6 through 12 used behavioral health services most frequently (54.0 percent).

Approximately 5.6 million children and youth enrolled in Medicaid and M-CHIP with behavioral health conditions used behavioral health services (excluding prescription drugs) in 2023, accounting for $26.5 billion in behavioral health spending (Table 2-9). Most users in this age group received behavioral health services in non-hospital outpatient settings (72.4 percent), which accounted for more than 40 percent of their total behavioral health spending (Figure 2-6). Just over 20 percent of users received inpatient care, representing 21.4 percent of spending. Additional commonly used care settings among this population include telehealth (24.3 percent), CMHCs (19.2 percent), and FQHCs (12.6 percent). Although less than 1 percent of enrollees used PRTF services, these services accounted for just under 3 percent of total behavioral health spending for this age group.

In 2023, 3.5 million children and youth with behavioral health conditions used behavioral health drugs and generated $3.2 billion in spending (Figure 2-7). Among enrollees age 0 through 20 with behavioral health conditions that used behavioral health drugs, more than half (59.0 percent) used attention deficit hyperactivity disorder drugs, which represented the largest share of behavioral drug spending (75.9 percent) for this age group. Almost half of enrollees in this age group used antidepressants (45.5 percent), but this drug group accounted for less than 4 percent of behavioral health drug spending. Approximately 17 percent of enrollees used antipsychotic drugs, accounting for about 12 percent of spending in this age group.

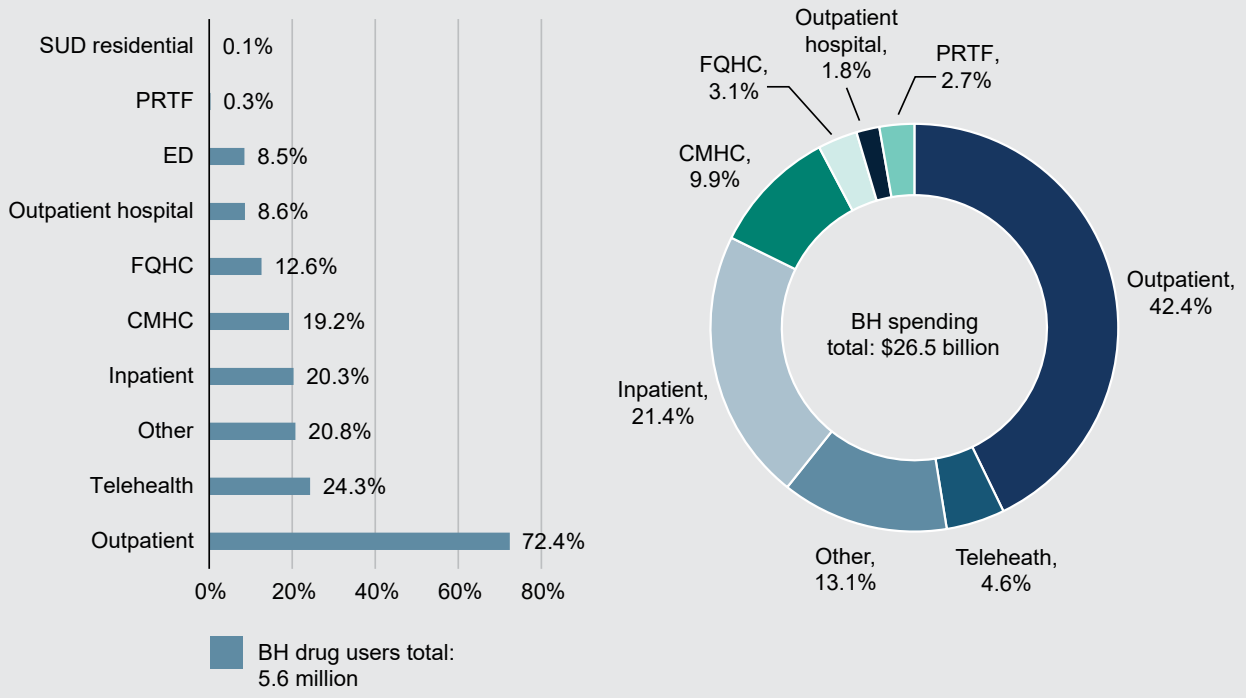
FIGURE 2-5. Behavioral Health Service Use among Children and Youth in Medicaid and Medicaid-Expansion State Children's Health Insurance Program with Behavioral Health Conditions by Age Group, CY 2023



Notes: CY is calendar year. BH is behavioral health. This figure includes non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees younger than age 21 with behavioral health conditions in CY 2023. The number under each bar represents the number of enrollees with behavioral health conditions in CY 2023. All children and youth include enrollees age 0 through 20. Prevalence of behavioral health conditions excludes children age 0 through 12 with a substance use disorder. Enrollees with no services include enrollees who met the criteria for a behavioral health condition based on service use information during the lookback period used for this analysis but did not have any behavioral health–related service use during CY 2023 (excluding prescription drugs).

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

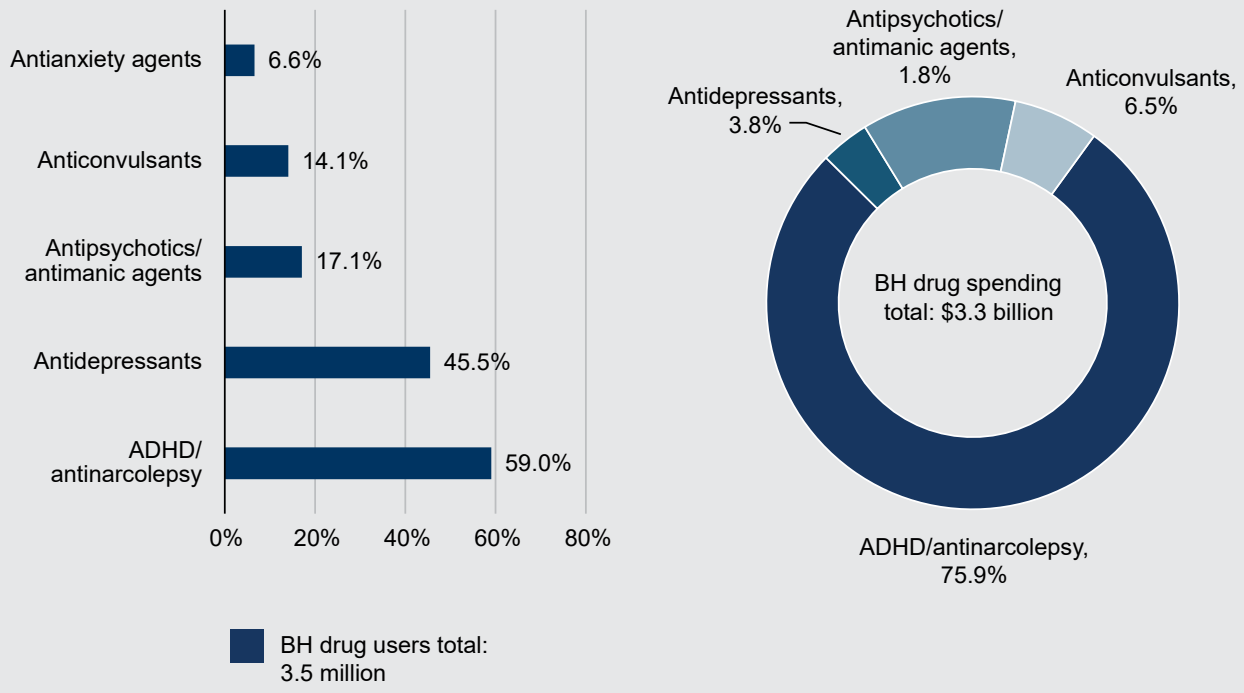
FIGURE 2-6. Total Behavioral Health Service Use and Spending among Children and Youth Users in Medicaid or Medicaid-Expansion State Children's Health Insurance Program with Behavioral Health Conditions by Care Setting, CY 2023



Notes: CY is calendar year. SUD is substance use disorder. PRTF is psychiatric residential treatment facility. ED is emergency department. FQHC is federally qualified health center. CMHC is community mental health clinic. BH is behavioral health. This figure includes CY 2023 behavioral health–related utilization and spending (excluding prescription drugs) for non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees younger than age 21 with behavioral health conditions. Spending includes federal and state funds. Outpatient includes services received in a clinic, office, or home setting. Because enrollees can receive services in multiple care settings, user percentages sum to more than 100. Behavioral health spending percentages across care settings will sum to 100. Spending for ED and SUD residential settings are not shown in the doughnut chart; they represent less than 1 percent of total spending on behavioral health services.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

FIGURE 2-7. Behavioral Health Drug Use and Spending among Children and Youth Users in Medicaid or Medicaid-Expansion State Children's Health Insurance Program with Behavioral Health Conditions by Drug Group, CY 2023



Notes: CY is calendar year. ADHD is attention deficit hyperactivity disorder. BH is behavioral health. This figure includes CY 2023 utilization and spending for non-dually eligible, full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees younger than age 21 with behavioral health conditions. Because enrollees can use multiple behavioral health drugs, user percentages sum to more than 100. Spending includes federal and state funds. The percentages for spending on behavioral health drugs across all drug groups will sum to 100. Spending for antianxiety agents and other drug groups are not shown on the doughnut chart; they represent 2 percent of total spending on behavioral health drugs.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

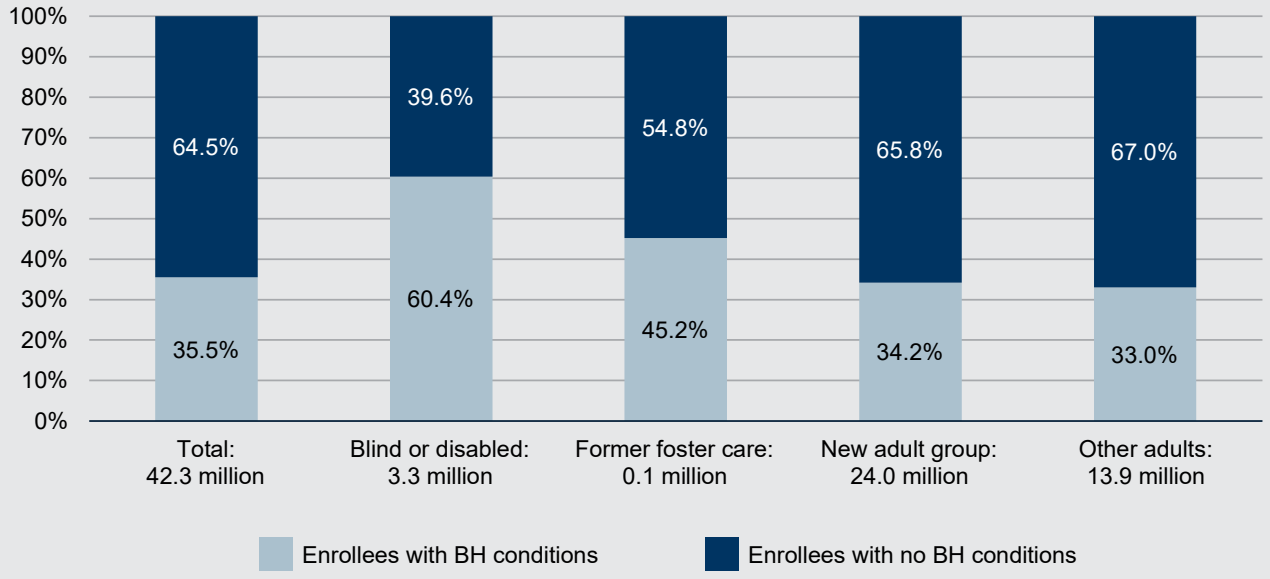
Adults Younger Than Age 65 in Medicaid with Behavioral Health Conditions

More than one-third of non-dually eligible adults age 21 through 64 enrolled Medicaid had a behavioral health condition in 2023 (Figure 2-8). Behavioral health conditions were most prevalent among adults in the blind or disabled eligibility group; those identifying as American Indian and Alaska Native, non-Hispanic; and adults residing in a rural area (Figures 2-8 through 2-10). Behavioral health spending represented more than one-fourth of total service-related spending for adults younger than age 65 in Medicaid with behavioral health conditions (Table 2-10). Adult enrollees in the blind or disabled eligibility group had the highest rates of behavioral health care utilization (Figure 2-11). More than half of adults with behavioral health conditions received behavioral health services in outpatient settings, which accounted for just under 29 percent of their total behavioral health spending (Figure 2-12).

Prevalence of behavioral health conditions among adults younger than age 65

Behavioral health conditions were most prevalent among adults in the blind or disabled eligibility group (60.4 percent), followed by the youth formerly in foster care eligibility group (45.2 percent) (Figure 2-8). About one-third of the new adults and other adults eligibility groups had a behavioral health condition, similar to the overall rate among all adults younger than age 65 (35.5 percent).

FIGURE 2-8. Behavioral Health Prevalence among Non-Dually Eligible Adults Younger Than Age 65 in Medicaid by Eligibility Group, CY 2023



Notes: CY is calendar year. BH is behavioral health. This figure includes non-dually eligible, full-benefit Medicaid enrollees age 21 through 64 and is limited to eligibility groups only with the largest number of adult enrollees in CY 2023; as a result, the sum across eligibility groups will not equal the total. Youth formerly in foster care are individuals younger than age 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care. The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

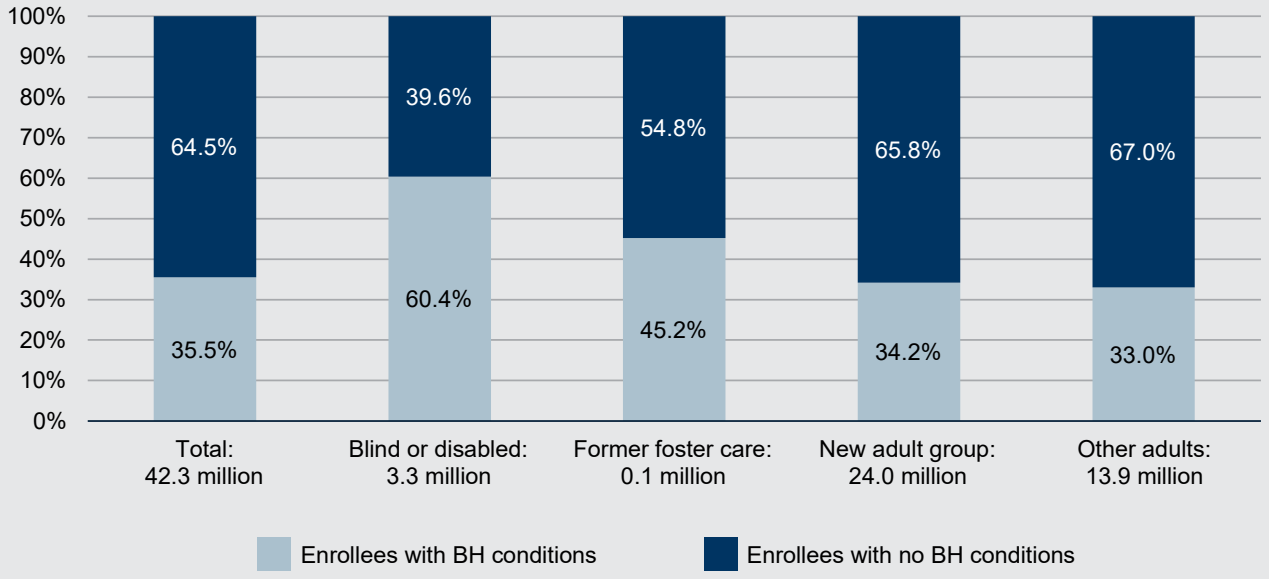
American Indian and Alaska Native, non-Hispanic, and white, non-Hispanic, enrollees had the highest prevalence of behavioral health conditions in 2023 (44.7 percent and 44.5 percent, respectively), while Asian and Pacific Islander, non-Hispanic, enrollees had the lowest prevalence (15.4 percent) (Figure 2-9). Hispanic and Black, non-Hispanic, enrollees had slightly lower rates of behavioral health conditions compared with the overall group of adult enrollees (28.1 percent and 33.7 percent, respectively, compared to 35.5 percent).

In 2023, a larger share of adult enrollees residing in rural areas had a behavioral health condition (44.4 percent), compared with enrollees residing in urban areas (33.8 percent) (Figure 2-10).

Spending patterns among adults younger than age 65

Behavioral health spending represented more than one-fourth of total service-related spending for adults age 21 through 64 with behavioral health conditions (Table 2-10). Percentages referenced in this section are derived from table data. Total behavioral health spending reflects services only and excludes spending on behavioral health drugs, while total service-related spending includes drug spending. Spending per enrollee on behavioral health services was highest for adults with co-occurring mental health and I/DD conditions ($41,104) and lowest for those with mental health conditions ($5,642).

FIGURE 2-9. Behavioral Health Prevalence among Non-Dually Eligible Adults Younger Than Age 65 in Medicaid by Race and Ethnicity, CY 2023



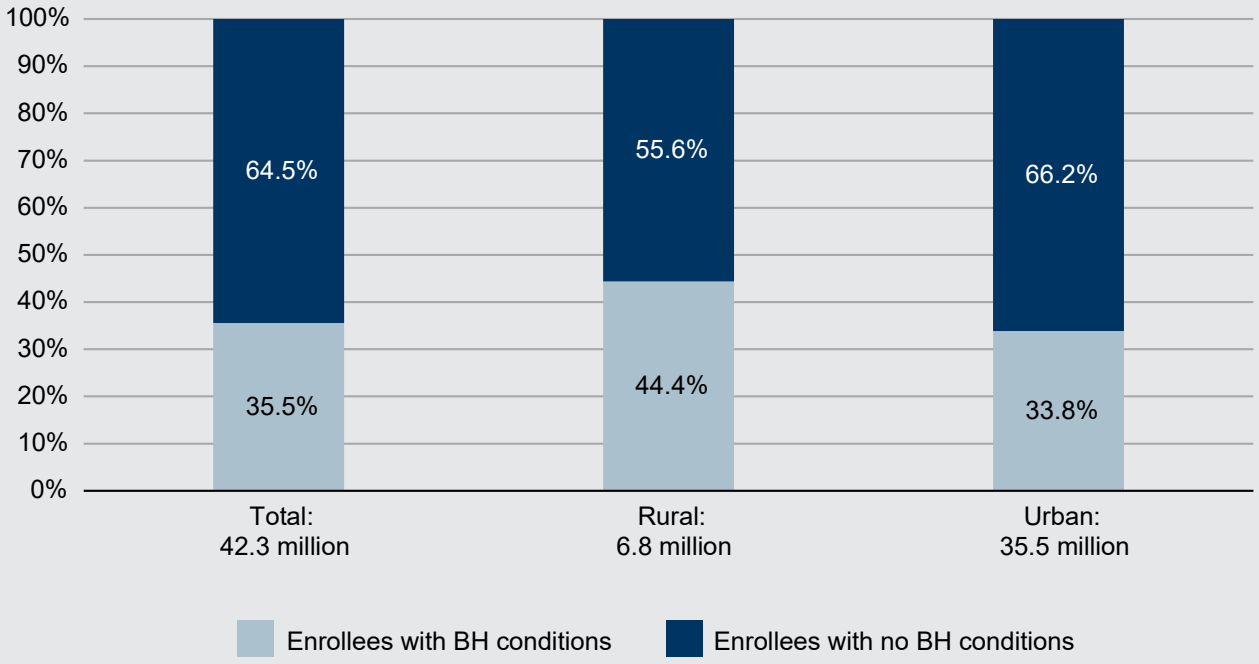
Notes: CY is calendar year. API is Asian and Pacific Islander. AIAN is American Indian and Alaska Native. BH is behavioral health. This figure includes non-dually eligible, full-benefit Medicaid enrollees age 21 through 64 in CY 2023 and excludes enrollees with missing or unknown race or ethnicity, who represent less than 3 percent of the population. The sum across racial and ethnic groups will not equal the total.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Among enrollees with mental health conditions, behavioral health spending on adults age 21 through 44 accounted for a larger share of total spending compared with adults age 45 through 64 (37.0 percent versus 20.1 percent, respectively) (Table 2-10). The same trend was observed for enrollees with an SUD (36.9 percent versus 19.1 percent) and enrollees with co-occurring mental health and SUD conditions (41.4 percent versus 23.3 percent). Behavioral health services accounted for the majority of spending on adults with I/DD conditions (61.3 percent) and co-occurring mental health and I/DD conditions (63.6 percent).

In general, per-enrollee spending for enrollees with behavioral health conditions was higher for adults age 45 through 64 ($7,108) compared to adults age 21 through 44 ($3,560), while per-enrollee spending on behavioral health services was generally more similar across the two age groups (Table 2-10). This pattern likely indicates that the difference in overall spending across the two age groups largely reflects differences in spending on non-behavioral health services.

FIGURE 2-10. Behavioral Health Prevalence among Non-Dually Eligible Adults Younger Than Age 65 in Medicaid by Geographic Location, CY 2023



Notes: CY is calendar year. BH is behavioral health. Urban or rural location is classified based on enrollee zip codes using the 2010 Rural-Urban Commuting Area code classification scheme from the U.S. Department of Agriculture. Refer to Appendix 2A for more information. This figure includes non-dually eligible, full-benefit Medicaid enrollees age 21 through 64 in CY 2023 and excludes enrollees with missing zip codes, who represent less than 0.5 percent of the population.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

TABLE 2-10. Overall and Behavioral Health–Related Spending among Non-Dually Eligible Adults Younger Than Age 65 in Medicaid with Behavioral Health or Intellectual or Developmental Disability Conditions by Age and Condition Category, CY 2023

Age groups	Total enrollees (millions)	Total spending (billions)	Total spending per enrollee	Total BH users (millions)	Total BH spending (billions)	Total BH spending per BH user
BH condition	**15.0**	**$197.0**	**$13,094**	**10.4**	**$53.2**	**$5,120**
21–44	10.2	104.2	10,170	7.0	36.4	5,191
45–64	4.8	92.7	19,343	3.4	16.7	4,972
MH condition	**11.6**	**164.4**	**14,226**	**8.6**	**48.4**	**5,642**
21–44	8.1	90.9	11,204	5.9	33.6	5,645
45–64	3.4	73.5	21,335	2.6	14.8	5,635
SUD condition	**8.0**	**120.0**	**14,995**	**5.5**	**33.4**	**6,024**
21–44	5.1	58.8	11,457	3.5	21.7	6,141
45–64	2.9	61.2	21,310	2.0	11.7	5,819
I/DD condition	**0.6**	**34.6**	**57,764**	**0.5**	**21.2**	**39,794**
21–44	0.5	28.9	55,354	0.5	17.7	38,161
45–64	0.1	5.7	74,123	0.1	3.5	50,804
MH and SUD conditions	**4.5**	**87.5**	**19,357**	**3.7**	**28.6**	**7,662**
21–44	3.0	45.4	15,181	2.5	18.8	7,659
45–64	1.5	42.0	27,545	1.3	9.8	7,667
MH and I/DD conditions	**0.4**	**21.4**	**60,086**	**0.3**	**13.6**	**41,104**
21–44	0.3	17.2	57,014	0.3	11.1	39,672
45–64	0.1	4.1	77,475	0.0	2.5	49,129

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. This table includes CY 2023 enrollment and spending for non-dually eligible, full-benefit Medicaid enrollees age 21 through 64. Spending includes federal and state funds. Total behavioral health spending on enrollees with a behavioral health diagnosis represents spending on services with a primary or secondary behavioral health diagnosis code and excludes spending on behavioral health drugs. The sum of enrollment or spending across age groups may not equal the totals due to rounding.

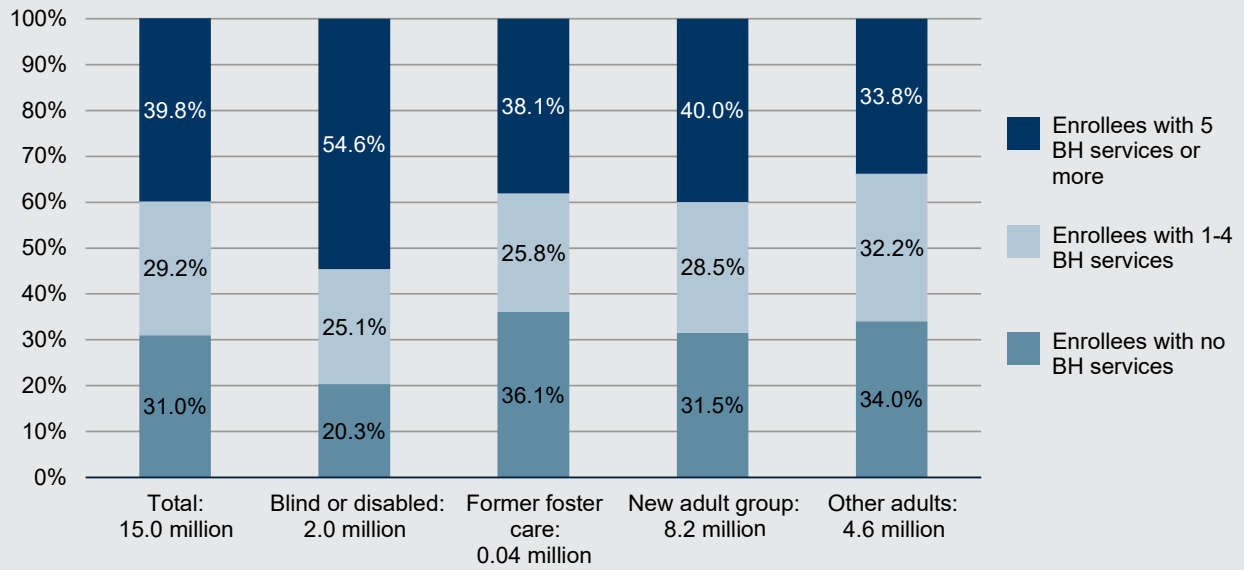
Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Behavioral health service use among adults younger than age 65

Among non-dually eligible adult enrollees younger than age 65 with behavioral health conditions in 2023, those in the blind or disabled eligibility group represented the highest share of enrollees who used at least one behavioral health service in the year (79.7 percent) (Figure 2-11). The remaining eligibility groups accounted for a similar share of enrollees who used at least one behavioral health service, ranging from 66.0 to 69.0 percent. Enrollees in the other adult eligibility group represented the lowest share of enrollees who used five or more services, with 33.8 percent, compared to enrollees in the blind or disabled eligibility group, who represented the highest share with 54.6 percent.

In 2023, 10.4 million non-dually eligible Medicaid enrollees age 21 through 64 with behavioral health conditions used behavioral health services (excluding prescription drugs), accounting for $53.2 billion in behavioral health spending (Table 2-10). More than half of users in this age group received behavioral health services in non-hospital outpatient settings (59.4 percent), which accounted for just under 29 percent of their total behavioral health spending (Figure 2-12). Additional commonly used care settings among this population include telehealth (24.2 percent), FQHCs (16.0 percent), and emergency departments (15.8 percent). Although just over 2 percent of users in this age group received services in an SUD residential facility, these services accounted for a slightly larger share of spending (3.7 percent).

FIGURE 2-11. Behavioral Health Service Use among Non-Dually Eligible Adults Younger Than Age 65 in Medicaid with Behavioral Health Conditions by Eligibility Group, CY 2023

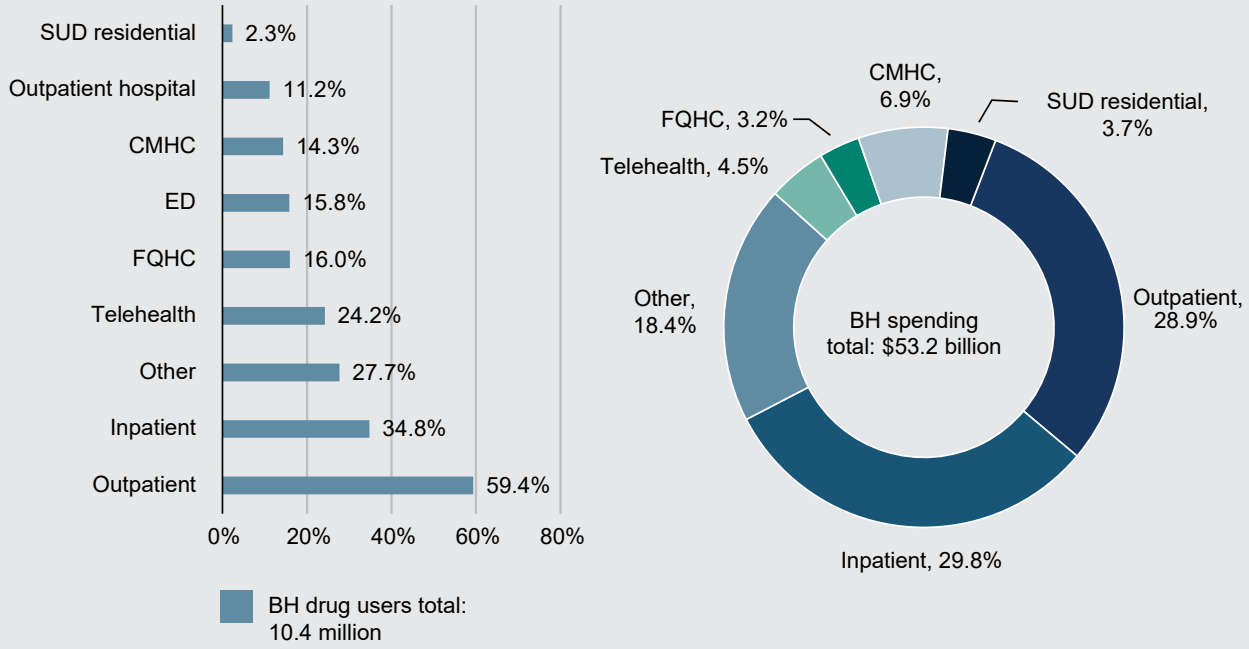


Notes: CY is calendar year. BH is behavioral health. This figure includes CY 2023 utilization for non-dually eligible, full-benefit Medicaid enrollees age 21 through 64 with behavioral health conditions. The number under each bar represents the number of enrollees with behavioral health conditions in CY 2023. Enrollees with no services include enrollees who met the criteria for a behavioral health condition based on service use information during the lookback period used for this analysis but did not have any behavioral health–related service use during CY 2023 (excluding prescription drugs).

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

In 2023, 10.6 million non-elderly adult enrollees with behavioral health conditions used behavioral health drugs and accounted for $12.2 billion in spending (Figure 2-13). Among enrollees age 21 through 64 with behavioral health conditions who used behavioral health drugs, most enrollees (69.2 percent) used antidepressants. However, this drug group represented only 9.1 percent of behavioral drug spending for this age group. Another commonly used drug group was anticonvulsants, which were used by 40.2 percent of enrollees. Similar to antidepressants, anticonvulsant drugs accounted for a much smaller share of behavioral health drug spending (7.2 percent) relative to the share of users. Conversely, less than one-quarter of enrollees in this age group used antipsychotic medications, though they accounted for almost half of spending (48.4 percent).

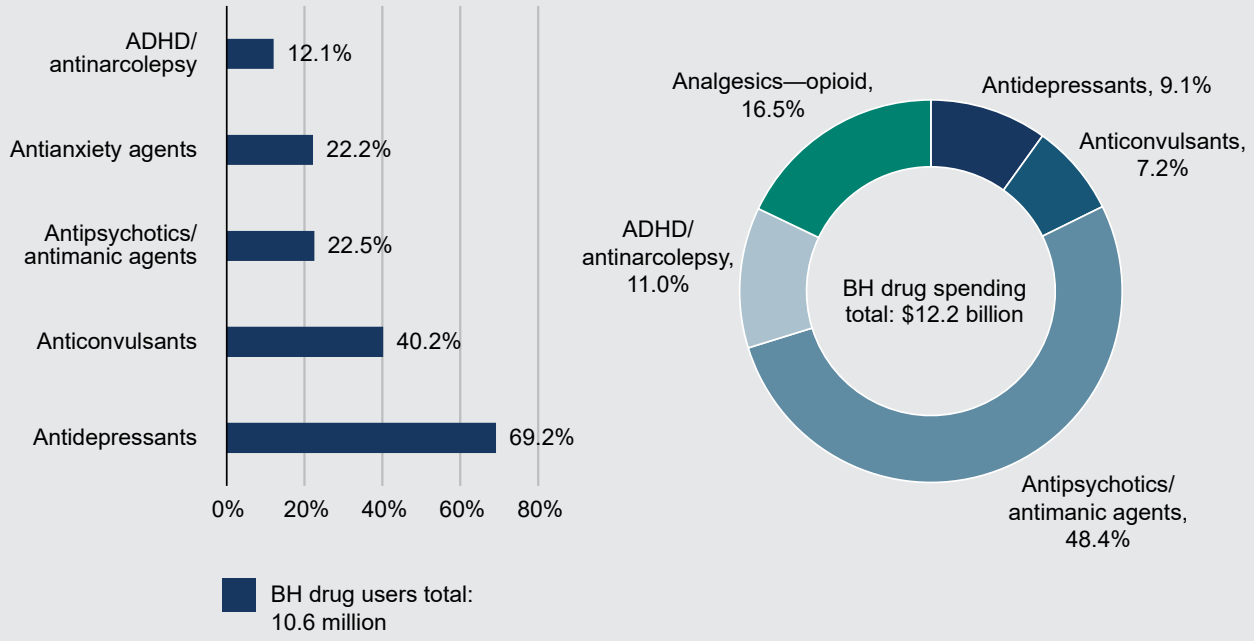
FIGURE 2-12. Total Behavioral Health Service Use and Spending among Non-Dually Eligible Adult Users Younger Than Age 65 in Medicaid with Behavioral Health Conditions by Care Setting, CY 2023



Notes: CY is calendar year. SUD is substance use disorder. CMHC is community mental health clinic. ED is emergency department. FQHC is federally qualified health center. BH is behavioral health. This figure includes CY 2023 behavioral health–related utilization and spending (excluding prescription drugs) for non-dually eligible, full-benefit Medicaid enrollees age 21 through 64 with behavioral health conditions. Spending includes federal and state funds. Outpatient includes services received in a clinic, office, or home setting. Because enrollees can receive services in multiple care settings, user percentages sum to more than 100. Behavioral health spending percentages across care settings will sum to 100. Spending for ED and outpatient hospital services are not shown in the doughnut chart; they represent less than 4 percent of total spending on behavioral health services.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

FIGURE 2-13. Behavioral Health Drug Use and Spending among Non-Dually Eligible Adult Users Younger Than Age 65 in Medicaid with Behavioral Health Conditions by Drug Group, CY 2023



Notes: CY is calendar year. ADHD is attention deficit hyperactivity disorder. BH is behavioral health. This figure includes CY 2023 utilization and spending for non-dually eligible, full-benefit Medicaid enrollees age 21 through 64 with behavioral health conditions. Because enrollees can use multiple behavioral health drugs, user percentages sum to more than 100. Spending includes federal and state funds. The percentages for spending on behavioral health drugs across all drug groups will sum to 100. Spending for antianxiety agents is not shown in the doughnut chart; they represented 2 percent of total spending on behavioral health drugs.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Looking Ahead

This analysis provides a foundation for future work on behavioral health use and spending in Medicaid and CHIP. Based on our analysis, in 2023 more than 25 percent of Medicaid and CHIP enrollees had a behavioral health condition, and spending for these enrollees accounted for more than half of total service-related Medicaid spending. Given Medicaid's role as a major source of coverage for behavioral health services and the large share of spending associated with enrollees with behavioral health conditions, the Commission will continue to examine this topic to better understand spending and access, particularly for vulnerable populations such as pregnant enrollees. Future work could include examining the relationship between payment and access to behavioral health services, a topic identified by MACPAC's access and payment roundtable (MACPAC 2025c). Building on the current focus on behavioral health care settings, future analyses could examine the relationship between payment and access by incorporating behavioral health provider types and payment rates. Analyzing these additional topics could provide insight into the extent to which payment rates and provider availability, including the emergence of unique provider types such as mobile crisis service providers, affect access to behavioral health services in the Medicaid program.

Endnotes

[1] In this instance, the inclusion of youth age 12 through 17 in the NSDUH analysis may have also contributed to the lower rate of MOUD use observed when compared to our analysis of T-MSIS data, which did not include youth.

[2] Data on the use of services and expenditures for Medicaid enrollees with diagnoses of behavioral health conditions came from the Medicaid Statistical Information System (MSIS) for calendar year 2011. Since then, states have transitioned from MSIS to T-MSIS, which led to the collection and availability of more administrative data, including managed care encounters.

[3] 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 (SAMHSA 2024). Although "SMI" is not a diagnostic term, it is indicative of individuals who have a mental illness that substantially interferes with or limits their ability to perform one or more major life activities (e.g., eating, bathing, or dressing) or instrumental activities of daily living (e.g., maintaining a household or taking prescribed medications).

[4] In 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act required behavioral health services in separate CHIP. That requirement was made permanent in the Consolidated Appropriations Act, 2024 (CAA 2024, P.L. 118-42) (Dwyer 2024).

[5] The CAA 2024 formally defined and added certified community behavioral health clinic services to the list of optional services coverable by Medicaid. Certified community behavioral health clinics provide rapid response, individual assessment, and crisis resolution by trained mental health and SUD treatment professionals and paraprofessionals, deployed to the location of the person in crisis.

[6] Though Medicaid coverage of prescription drugs is considered an optional benefit, all states and the District of Columbia have elected to provide this coverage.

[7] Anticonvulsant medications are considered effective in the treatment of certain behavioral health conditions, such as bipolar depressive disorder (Baldessarini et al. 2018).

[8] The SUPPORT Act required state Medicaid programs to cover FDA-approved MOUD and related counseling and behavioral therapies for five years beginning October 1, 2020 (MACPAC 2025a). The CAA 2024 extended and expanded some of the policies contained within the SUPPORT Act (Dwyer 2024). Specifically, the MOUD benefit mandate was extended permanently under the CAA 2024.

[9] As of January 2026, the Centers for Medicare & Medicaid Services has approved Section 1115 waiver demonstrations for IMD payment exclusion for SUD treatment for 38 states and IMD payment exclusion for mental health treatment for enrollees with SMI or serious emotional disturbance for 17 states (KFF 2026).

[10] In 2024, the eight states that offered behavioral health services through traditional FFS Medicaid were Alabama, Alaska, Connecticut, Maine, Montana, South Dakota, Vermont, and Wyoming (Kaye et al. 2025).

[11] Limited-benefit plans can include prepaid inpatient health plans and prepaid ambulatory health plans. Prepaid inpatient health plans or prepaid ambulatory health plans that solely offer behavioral health services are sometimes referred to as "behavioral health organizations."

[12] The mental health conditions identified for this analysis are attention deficit hyperactivity disorder, conduct disorders, suicide and self-harm, anxiety disorders, depressive and mood disorders, adjustment disorder, SMI, and other mental health disorders. The SUD conditions identified for this analysis are alcohol use disorders, tobacco use disorders, and drug use disorders (opioids, inhalants, stimulants, hallucinogens, cannabis, sedatives, hypnotics, anxiolytics, other, and unknown).

[13] The Centers for Medicare & Medicaid Services published the T-MSIS SUD Data Book annually for data years 2017 through 2021. In August 2025, the Centers for Medicare & Medicaid Services released the inaugural T-MSIS Behavioral Health Data Book, which builds on the T-MSIS SUD Data Book. MACPAC developed its methodology for identifying behavioral health conditions in T-MSIS before the publication of the T-MSIS Behavioral Health Data Book and therefore relied on the methodology from the T-MSIS SUD Data Book.

[14] Medicaid spending amounts reported in many MACPAC analyses and other federal budget documents frequently reflect the total amount of spending that has been matched by federal dollars. This amount represents payments states made directly to providers through FFS payments or to managed care plans through capitation payments (i.e., total Medicaid spending). However, state capitation payments to managed care plans are not necessarily indicative of the payments made by managed care plans to providers

for services received for a particular individual because the capitation payment reflects the average cost of an enrollee and also includes dollars to cover non-benefit costs (e.g., administrative costs).

[15] The capitation rate paid to a managed care plan on a per member, per month basis generally reflects the projected cost of the average enrollee for a particular rate cell.

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APPENDIX 2A: Methodology

MACPAC analyzed enrollment, claims, and managed care encounter data from Transformed Medicaid Statistical Information System (T-MSIS) for calendar year 2023. We also used data from calendar years 2021 through 2022 as a two-year lookback period for identifying enrollees with a behavioral health diagnosis. The study cohort includes full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program (M-CHIP) enrollees with at least one month of enrollment in calendar year 2023. The population excludes enrollees in separate CHIP and enrollees who receive a limited package of Medicaid benefits. This analysis includes data from all 50 states and the District of Columbia.

Identifying behavioral health and intellectual or developmental disability conditions

MACPAC's approach for identifying enrollees with behavioral health (i.e., mental health and substance use disorder (SUD) conditions) and intellectual or developmental disability conditions is an adapted methodology from the Centers for Medicare & Medicaid Services' Physical and Behavioral Health Integration algorithm, SUD Data Book, Chronic Conditions Data Warehouse, and the Milbank Memorial Fund's Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. The Centers for Medicare & Medicaid Services' Physical and Behavioral Health Integration algorithm is a claims-based methodology for identifying enrollees who would benefit from physical and behavioral health care (Hula et al. 2023). The Centers for Medicare & Medicaid Services' SUD Data Book is an annual publication that uses T-MSIS data to provide information on the number of Medicaid enrollees with an SUD and the services they received (CMS 2023). The Chronic Conditions Data Warehouse algorithm created 30 chronic condition categories, which include behavioral health and intellectual or developmental disability conditions, that can be identified using claims data based on diagnosis codes, qualifying claim criteria, and lookback periods (CMS 2024a, CMS 2024b). Milbank's methodology includes an extensive list of diagnosis codes for identifying behavioral health conditions, national drug codes for drugs used to treat behavioral health conditions, behavioral health service categories, and care settings (Sinha et al. 2024). For this analysis, MACPAC identified mental health, SUD, and intellectual or developmental disability conditions using all diagnosis codes available on the claim and, where applicable, procedure codes from each of the four methodologies and applied the qualifying claim criteria and lookback period from the Chronic Conditions Data Warehouse. Each condition category was further stratified to more specific subcategories, including but not limited to SMI, anxiety disorders, alcohol use disorders, and autism spectrum disorder.

Identifying enrollee characteristics

After identifying enrollees with behavioral health and intellectual or developmental disability conditions, we identified enrollee characteristics of interest. Enrollee characteristics were identified as follows:

- **Age.** We used enrollees' age as of December 31 of the calendar year or, if deceased, their date of death to classify them into seven age categories: 0 through 5 years old, 6 through 12 years old, 13 through 17 years old, 18 through 20 years old, 21 through 44 years old, 45 through 64 years old, and 65 years and older. We categorized enrollees with a missing date of birth into a "missing or unknown" group.
- **Medicaid eligibility group.** Using a combination of age, CHIP code, and Medicaid eligibility group code data elements, we classified enrollees into one of the following eligibility groups: aged, blind or disabled (0 through 20 years and 21 years and older), new adult group, other adults (non-VIII group), Medicaid children, Medicaid-expansion CHIP children, foster care youth, and missing or unknown. Enrollees in the foster care youth category were further stratified into current foster care and former foster care.
- **Dual eligibility status.** We determined whether an enrollee was dually eligible for both Medicare and Medicaid using the dual eligible code data element that shows the enrollee's most recent status. We classified enrollees as full-benefit dual eligibility status or Medicaid only.
- **Sex.** We identified enrollee sex using the same two categories that T-MSIS uses: female, male, or missing or unknown.

- **Race and ethnicity.** The data element for race and ethnicity is unusable or unreliable in many states. Therefore, we used the 2021 race and ethnicity imputation companion files for more complete enrollee race and ethnicity information for this analysis, which was the most recent version available at the time of our analysis. The race and ethnicity imputation file supplements state-reported data by estimating race and ethnicity based on enrollee information (first name, surname, self-reported race and ethnicity, and American Indian or Alaska Native certification); data from the T-MSIS analytic files geocoded address companion file for enrollees; and geographic, race and ethnicity, and surname data from the U.S. Census Bureau. Enrollee counts and expenditures stratified by race and ethnicity should be interpreted as approximations because the calculations use both self-reported and imputed probabilities of a person being classified as a given race and ethnicity. In addition, total counts and expenditures that are calculated by adding the values of the different race and ethnicity amounts may not be equivalent to the true totals because they are approximations.
- **Geographic location.** We used the 2010 Rural-Urban Commuting Area code classification scheme from the U.S. Department of Agriculture to assign enrollees to an urban or rural residence category based on the 2010 Rural-Urban Commuting Area code associated with their home or mailing address zip code in T-MSIS (ERS 2025).

Identifying behavioral health services

For this analysis, MACPAC defined a behavioral health service as any service-related claim or encounter (i.e., excluding capitation or supplemental payment) that includes a primary or secondary behavioral health–related diagnosis code. We identified behavioral health service use among enrollees with behavioral health conditions. MACPAC adapted Milbank's methodology to classify behavioral health claims by the various care settings in which these services were delivered. Using several variables on claims, such as type of bill, revenue codes, procedure codes, and provider taxonomy codes, we classified claims into the following care settings: inpatient, emergency department, federally qualified health center, community mental health center, outpatient (hospital, telehealth, and other), psychiatric residential treatment facility, SUD residential, other behavioral health residential, and other.

MACPAC identified behavioral health drug use and spending by defining behavioral health drug claims as any claim that included at least one national drug code from Milbank's list of national drug codes for behavioral health drugs. We then applied Wolters Kluwer's Medi-Span Generic Product Identifier to classify behavioral health drugs into broader categories.

Calculating spending

T-MSIS includes spending amounts on a claim at both the header and line levels. To calculate spending on drugs used to treat behavioral health conditions, we used the Medicaid paid amounts reported on the line; for all other spending, we used amounts reported on the header level. We included the following payment amounts in our analysis:

- **Fee-for-service payments.** The amount paid by the Medicaid agency directly to the provider.
- **Capitation payments.** The amount paid by the state Medicaid agency to its managed care organizations on a per member per month basis. Capitation payments are intended to cover the services the enrollees would need based on a risk-adjusted methodology for estimating their service use. These payments are also inclusive of administrative costs and any supplemental payments the state makes to the managed care organization, such as state-directed payments. As a result, capitation payments are often greater than the amount the managed care organization paid in encounters for covered services.
- **Managed care payments to providers.** The amount paid by the managed care organization directly to the provider for covered services rendered to their enrollees, captured in encounter data.

Because this analysis focuses on enrollees with a behavioral health diagnosis and their use and spending on services, particularly behavioral health–related services, this chapter reports on service-related spending.

APPENDIX 2B: State-Level Data

TABLE 2B-1. Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Behavioral Health Conditions by State, CY 2023

State	All enrollees (thousands)	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	I/DD	MH and I/DD
Total	**97,582.9**	**27.6%**	**23.1%**	**10.5%**	**6.1%**	**5.6%**	**2.1%**
Alabama	1,226.2	25.6	21.6	8.9	4.9	6.1	2.5
Alaska	289.5	26.1	19.2	13.7	6.8	4.4	1.8
Arizona	2,447.7	28.4	24.1	12.3	8.0	5.1	1.9
Arkansas	1,129.8	21.9	19.1	6.6	3.8	7.1	2.6
California	15,873.9	19.9	16.2	7.2	3.5	3.9	1.1
Colorado	1,802.9	29.4	24.1	12.3	7.0	4.8	1.9
Connecticut	1,156.6	33.5	28.8	13.3	8.6	4.5	1.9
Delaware	314.5	28.8	23.9	11.0	6.1	8.0	2.9
District of Columbia	311.8	26.0	23.0	8.4	5.4	3.7	1.1
Florida	5,361.2	19.8	17.1	5.7	3.0	6.4	2.3
Georgia	2,519.5	20.0	17.4	5.4	2.8	5.8	2.1
Hawaii	504.4	19.5	15.2	8.5	4.2	2.0	0.6
Idaho	465.8	31.9	27.3	12.1	7.4	7.9	3.5
Illinois	4,016.6	26.3	20.8	11.9	6.4	6.5	1.9
Indiana	2,175.6	30.2	25.7	10.6	6.1	4.9	1.8
Iowa	888.3	36.9	31.6	14.3	9.0	4.9	2.7
Kansas	511.3	35.3	32.1	9.7	6.4	5.0	2.7
Kentucky	1,773.8	39.5	32.4	17.6	10.6	6.1	2.7
Louisiana	2,023.6	35.3	28.3	15.4	8.4	5.3	1.9
Maine	413.9	43.9	37.5	18.6	12.1	7.6	4.3
Maryland	1,826.9	29.8	25.7	11.0	6.9	6.9	2.7
Massachusetts	2,097.7	37.1	32.0	15.0	9.9	5.9	2.6
Michigan	3,293.7	30.7	25.7	12.4	7.3	3.6	1.8
Minnesota	1,525.2	36.5	32.5	13.6	9.6	7.9	3.8
Mississippi	792.9	27.2	23.7	7.3	3.8	5.0	2.2
Missouri	1,636.6	31.0	26.1	12.6	7.6	5.9	2.6
Montana	330.2	39.2	32.5	17.4	10.7	5.4	2.5
Nebraska	446.7	31.7	27.5	11.7	7.5	3.6	1.9
Nevada	982.9	25.9	21.1	10.8	6.0	4.2	1.4
New Hampshire	278.6	37.5	32.2	14.1	8.8	7.9	3.6
New Jersey	2,309.2	26.3	21.0	11.5	6.2	5.3	2.1
New Mexico	931.5	29.8	24.4	12.5	7.2	6.4	2.0

TABLE 2B-1. (continued)

State	All enrollees (thousands)	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	I/DD	MH and I/DD
New York	8,540.8	23.0%	18.7%	9.4%	5.0%	5.2%	1.8%
North Carolina	2,557.0	29.2	24.8	10.3	5.9	8.0	3.1
North Dakota	151.9	36.1	30.7	15.0	9.6	7.9	3.8
Ohio	3,628.4	41.1	34.2	18.2	11.4	7.2	3.4
Oklahoma	1,480.7	29.5	24.9	10.6	5.9	4.7	1.9
Oregon	1,428.6	34.6	28.0	14.8	8.2	3.0	1.4
Pennsylvania	3,851.3	32.7	26.7	13.8	7.8	5.9	2.6
Rhode Island	407.6	32.9	29.4	10.0	6.6	6.2	2.6
South Carolina	1,403.6	25.3	21.9	7.1	3.7	7.5	2.4
South Dakota	170.5	29.3	25.5	9.7	5.9	6.6	3.2
Tennessee	1,899.3	27.2	23.1	10.2	6.1	5.3	2.1
Texas	6,122.9	16.8	15.3	3.8	2.2	7.5	2.4
Utah	561.5	30.3	26.3	11.1	7.1	6.6	2.4
Vermont	210.7	47.0	41.0	17.4	11.5	9.2	4.9
Virginia	2,124.2	27.4	23.4	10.1	6.0	5.2	2.1
Washington	2,334.5	29.6	24.1	12.2	6.7	3.3	1.3
West Virginia	671.3	39.1	31.9	16.6	9.4	3.4	1.8
Wisconsin	1,570.9	31.5	26.6	12.1	7.2	5.5	2.3
Wyoming	98.1	31.9	29.0	8.7	5.9	6.8	3.5

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. This table includes all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees in CY 2023. Because behavioral health categories are not mutually exclusive, some enrollees appear in more than one group. The national total represents an unduplicated count of Medicaid enrollees across states and therefore may be less than the state sum of Medicaid enrollees.

[1] Counts of enrollees with an SUD or with co-occurring mental health and SUD conditions exclude children age 0 through 12.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

TABLE 2B-2. Total Service-Related Spending on Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Behavioral Health Conditions by State, CY 2023

State	All enrollees (thousands)	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	I/DD	MH and I/DD
Total	**$642.3**	**57.5%**	**50.8%**	**25.0%**	**18.2%**	**21.4%**	**11.3%**
Alabama	6.1	58.2	52.1	23.7	17.5	20.1	11.6
Alaska	2.7	60.9	48.4	35.2	22.8	16.7	9.6
Arizona	15.1	64.2	57.8	36.1	0.8	19.6	10.5
Arkansas	5.1	55.5	51.3	17.2	12.9	32.7	14.8
California	95.2	51.2	43.9	22.6	15.2	18.6	7.7
Colorado	11.2	58.8	51.0	27.5	19.7	21.1	10.3
Connecticut	8.5	62.7	57.2	27.7	22.2	23.2	11.9
Delaware	2.7	56.0	48.4	24.0	16.4	26.6	13.3
District of Columbia	3.2	61.7	56.1	25.8	20.1	19.5	10.0
Florida	22.0	50.0	45.6	14.8	10.4	28.2	13.7
Georgia	11.4	48.0	41.5	18.2	11.7	19.9	9.2
Hawaii	2.1	45.7	36.4	23.7	14.5	13.3	4.8
Idaho	3.2	65.1	58.8	27.7	21.4	27.2	17.6
Illinois	22.7	59.3	50.5	29.5	20.7	17.5	8.5
Indiana	20.0	58.3	51.3	23.9	16.9	16.4	8.4
Iowa	6.1	66.4	60.5	26.8	20.9	24.5	16.3
Kansas	4.0	63.4	58.0	23.5	18.1	19.4	11.9
Kentucky	13.0	69.4	60.2	35.9	26.8	17.5	10.5
Louisiana	8.4	60.8	51.2	31.1	21.5	12.9	6.2
Maine	3.7	73.6	67.3	30.8	24.5	33.0	23.0
Maryland	15.7	62.1	56.2	27.2	21.3	24.7	13.7
Massachusetts	19.5	67.4	61.7	30.9	25.3	20.9	12.0
Michigan	16.9	63.9	56.6	29.4	22.1	17.5	11.1
Minnesota	16.9	69.0	64.5	29.9	25.4	28.9	18.3
Mississippi	4.4	55.1	48.6	18.2	11.7	17.7	8.3
Missouri	14.2	62.0	55.1	27.3	20.4	22.6	14.7
Montana	0.9	68.5	61.5	30.4	23.4	28.0	16.6
Nebraska	3.2	56.1	50.0	23.3	17.2	18.2	10.2
Nevada	4.1	62.7	54.5	33.1	24.9	15.3	8.3
New Hampshire	1.9	67.2	61.0	26.1	19.9	29.3	16.7
New Jersey	16.6	57.1	50.4	24.3	17.6	24.9	13.6
New Mexico	6.2	59.0	50.2	30.0	21.2	18.5	9.7

TABLE 2B-2. (continued)

State	All enrollees (thousands)	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	I/DD	MH and I/DD
New York	$74.0	52.6%	46.2%	21.3%	14.9%	20.5%	11.3%
North Carolina	19.3	59.7	52.9	24.6	17.8	25.9	14.0
North Dakota	1.5	65.4	58.8	26.8	20.2	29.4	19.8
Ohio	22.9	70.3	63.0	32.7	25.5	24.2	15.6
Oklahoma	7.4	62.7	54.5	27.8	19.6	17.1	9.8
Oregon	7.6	65.9	55.0	37.3	26.4	5.2	3.2
Pennsylvania	20.5	54.9	47.9	22.6	15.6	29.9	16.3
Rhode Island	2.8	59.2	55.1	19.7	15.6	22.7	12.3
South Carolina	6.5	48.2	41.3	18.8	11.9	24.2	9.6
South Dakota	1.2	61.8	55.2	23.6	17.0	25.7	16.9
Tennessee	10.0	59.2	53.5	23.0	17.3	23.5	13.2
Texas	33.9	40.1	36.6	12.8	9.3	26.5	10.2
Utah	2.1	65.4	58.8	31.6	24.9	22.4	12.5
Vermont	1.6	69.0	63.5	25.0	19.5	31.8	19.5
Virginia	15.8	59.1	52.3	25.0	18.1	22.7	11.8
Washington	14.3	58.1	49.9	28.4	20.2	13.8	7.9
West Virginia	4.6	68.3	58.8	31.7	22.2	14.6	9.6
Wisconsin	9.4	59.2	52.0	25.5	18.3	17.5	9.6
Wyoming	0.5	60.6	56.0	19.6	15.0	32.6	20.5

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. This table includes CY 2023 spending for all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees. Because behavioral health categories are not mutually exclusive, some enrollees appear in more than one group. Spending includes federal and state funds.

[1] Spending amounts on enrollees diagnosed with an SUD or co-occurring mental health and SUD conditions exclude children age 0 through 12.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

TABLE 2B-3. Per-Enrollee Spending on Medicaid and Medicaid-Expansion State Children's Health Insurance Program Enrollees with Behavioral Health Conditions by State, CY 2023

State	All enrollees	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	I/DD	MH and I/DD
Total	**$642.3**	**57.5%**	**50.8%**	**25.0%**	**18.2%**	**21.4%**	**11.3%**
Alabama	6.1	58.2	52.1	23.7	17.5	20.1	11.6
Alaska	2.7	60.9	48.4	35.2	22.8	16.7	9.6
Arizona	15.1	64.2	57.8	36.1	0.8	19.6	10.5
Arkansas	5.1	55.5	51.3	17.2	12.9	32.7	14.8
California	95.2	51.2	43.9	22.6	15.2	18.6	7.7
Colorado	11.2	58.8	51.0	27.5	19.7	21.1	10.3
Connecticut	8.5	62.7	57.2	27.7	22.2	23.2	11.9
Delaware	2.7	56.0	48.4	24.0	16.4	26.6	13.3
District of Columbia	3.2	61.7	56.1	25.8	20.1	19.5	10.0
Florida	22.0	50.0	45.6	14.8	10.4	28.2	13.7
Georgia	11.4	48.0	41.5	18.2	11.7	19.9	9.2
Hawaii	2.1	45.7	36.4	23.7	14.5	13.3	4.8
Idaho	3.2	65.1	58.8	27.7	21.4	27.2	17.6
Illinois	22.7	59.3	50.5	29.5	20.7	17.5	8.5
Indiana	20.0	58.3	51.3	23.9	16.9	16.4	8.4
Iowa	6.1	66.4	60.5	26.8	20.9	24.5	16.3
Kansas	4.0	63.4	58.0	23.5	18.1	19.4	11.9
Kentucky	13.0	69.4	60.2	35.9	26.8	17.5	10.5
Louisiana	8.4	60.8	51.2	31.1	21.5	12.9	6.2
Maine	3.7	73.6	67.3	30.8	24.5	33.0	23.0
Maryland	15.7	62.1	56.2	27.2	21.3	24.7	13.7
Massachusetts	19.5	67.4	61.7	30.9	25.3	20.9	12.0
Michigan	16.9	63.9	56.6	29.4	22.1	17.5	11.1
Minnesota	16.9	69.0	64.5	29.9	25.4	28.9	18.3
Mississippi	4.4	55.1	48.6	18.2	11.7	17.7	8.3
Missouri	14.2	62.0	55.1	27.3	20.4	22.6	14.7
Montana	0.9	68.5	61.5	30.4	23.4	28.0	16.6
Nebraska	3.2	56.1	50.0	23.3	17.2	18.2	10.2
Nevada	4.1	62.7	54.5	33.1	24.9	15.3	8.3
New Hampshire	1.9	67.2	61.0	26.1	19.9	29.3	16.7
New Jersey	16.6	57.1	50.4	24.3	17.6	24.9	13.6
New Mexico	6.2	59.0	50.2	30.0	21.2	18.5	9.7

TABLE 2B-3. (continued)

State	All enrollees	Any BH	Any MH	Any SUD[1]	MH and SUD[1]	I/DD	MH and I/DD
New York	$74.0	52.6%	46.2%	21.3%	14.9%	20.5%	11.3%
North Carolina	19.3	59.7	52.9	24.6	17.8	25.9	14.0
North Dakota	1.5	65.4	58.8	26.8	20.2	29.4	19.8
Ohio	22.9	70.3	63.0	32.7	25.5	24.2	15.6
Oklahoma	7.4	62.7	54.5	27.8	19.6	17.1	9.8
Oregon	7.6	65.9	55.0	37.3	26.4	5.2	3.2
Pennsylvania	20.5	54.9	47.9	22.6	15.6	29.9	16.3
Rhode Island	2.8	59.2	55.1	19.7	15.6	22.7	12.3
South Carolina	6.5	48.2	41.3	18.8	11.9	24.2	9.6
South Dakota	1.2	61.8	55.2	23.6	17.0	25.7	16.9
Tennessee	10.0	59.2	53.5	23.0	17.3	23.5	13.2
Texas	33.9	40.1	36.6	12.8	9.3	26.5	10.2
Utah	2.1	65.4	58.8	31.6	24.9	22.4	12.5
Vermont	1.6	69.0	63.5	25.0	19.5	31.8	19.5
Virginia	15.8	59.1	52.3	25.0	18.1	22.7	11.8
Washington	14.3	58.1	49.9	28.4	20.2	13.8	7.9
West Virginia	4.6	68.3	58.8	31.7	22.2	14.6	9.6
Wisconsin	9.4	59.2	52.0	25.5	18.3	17.5	9.6
Wyoming	0.5	60.6	56.0	19.6	15.0	32.6	20.5

Notes: CY is calendar year. BH is behavioral health. MH is mental health. SUD is substance use disorder. I/DD is intellectual or developmental disabilities. The national total represents an unduplicated count of Medicaid enrollees across states and therefore may be less than the state sum of Medicaid enrollees. This table includes CY 2023 spending for all full-benefit Medicaid and Medicaid-expansion State Children's Health Insurance Program enrollees. Because behavioral health categories are not mutually exclusive, some enrollees appear in more than one group. Spending includes federal and state funds.

[1] Spending amounts on enrollees diagnosed with an SUD or co-occurring mental health and SUD conditions exclude children age 0 to 12.

Source: MACPAC, 2025, analysis of 2021–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Chapter 3:

Medicaid for Justice-Involved Youth Transitions to the Community

Medicaid for Justice-Involved Youth Transitions to the Community

Key Points

- The Medicaid program has historically played a limited role in the care of justice-involved individuals during incarceration. However, recent changes in federal Medicaid policy have provided opportunities to improve health care transitions for adults and youth returning to the community.
- Young people involved in the juvenile justice system, also referred to as justice-involved youth (JIY), are predominantly age 15 years or older and male. Youth of color; lesbian, gay, bisexual, transgender, and queer youth; and youth with disabilities are overrepresented in the juvenile justice system. JIY have high rates of unmet physical and behavioral health needs and frequently have complex and comorbid health conditions. They also experience considerable trauma, adverse childhood experiences, and chronic stress, which correlate with poor health outcomes into adulthood.
- States may use Section 1115 demonstration authority to provide limited prerelease services to incarcerated youth. The Consolidated Appropriations Act, 2023 requires states to provide certain screenings and diagnostic services to eligible youth 30 days before release and targeted case management services 30 days before release and for at least 30 days thereafter, beginning January 1, 2025.
- Examples of state challenges to providing prerelease services include enrolling correctional providers as Medicaid providers and establishing needed billing processes. In response, some states are developing guidance for new correctional providers and have engaged a third-party administrator for billing and technical assistance.
- Coordination between Medicaid and correctional agencies and facilities is key to implementing the new requirements. Such coordination has not historically been the norm, and states are working to improve interagency connections. Ongoing coordination challenges include engaging some local correctional facilities and data sharing between Medicaid and corrections.
- Despite challenges to service implementation and the complexities of serving JIY, several stakeholders that we interviewed expressed optimism about the opportunities that evolving federal Medicaid policies provide to better serve these youth and support transitions to the community.

CHAPTER 3: Medicaid for Justice-Involved Youth Transitions to the Community

This chapter describes findings from MACPAC's examination of access to pre- and post-release services for Medicaid-eligible juveniles or "youth" involved in the juvenile justice system.[1] MACPAC completed this work as a follow-up to the analysis on Medicaid for justice-involved adults that appeared in MACPAC's June 2023 report to Congress. That chapter examined adults' ability to access Medicaid coverage upon release from incarceration and state efforts to provide timely coverage, care continuity, and access to services upon reentry into the community. In that chapter, we identified key considerations for implementing prerelease Medicaid services under Section 1115 demonstrations such as cross-agency collaboration, availability of prerelease services in jails, data sharing and infrastructure, provider continuity during the pre- and post-release period, and monitoring and evaluation of the 1115 demonstration. We noted that instituting prerelease Medicaid services requires substantial investment of time and resources to improve outcomes for individuals involved in the criminal justice system (MACPAC 2023). This finding, as well as the coverage and access challenges for adults that we highlighted, provides important context for understanding the issues and health care needs of similarly situated youth.

Justice-involved youth (JIY) share some characteristics with adults in correctional settings, but the circumstances of youth differ from adults in meaningful ways that have implications for their coverage and access to services. JIY also have distinct clinical needs and considerations when compared to justice-involved adults partly due to their ongoing physical, cognitive, and emotional development. Youth who are involved in the juvenile justice system have high rates of unmet physical and behavioral health needs—including mental health conditions and substance use disorder (SUD)—compared to their non-incarcerated peers and frequently have complex and comorbid health conditions. These poor health outcomes are compounded for youth of racial and ethnic minority groups; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth; youth with disabilities; and youth with child welfare system involvement, all of whom are overrepresented in the juvenile justice system (Barnert et al. 2016).

States and the federal government have taken measures to improve health care transitions for JIY as they leave correctional settings and return to the community, a critical period that can have implications for future justice system involvement. Research indicates that connecting youth with services upon release can reduce youth recidivism, thus highlighting the importance of a successful transition for both youth and the community (Aggarwal and Will 2023). Although Medicaid has historically played a limited role in the care of justice-involved individuals during incarceration, recent federal policy has allowed states more flexibility to provide Medicaid services to JIY. For example, Section 5121 of the Consolidated Appropriations Act, 2023 (CAA 2023, P.L. 117-328) requires states to provide certain Medicaid-eligible incarcerated youth with screening and diagnostic services before release and targeted case management services before and after release (CMS 2024).[2] These new requirements went into effect in 2025. In this evolving policy space, federal and state stakeholders have made considerable progress implementing new requirements while navigating numerous challenges related to changed processes, technical systems issues, and coordination across agencies that serve JIY. State implementation of these requirements is in the early stages, and resulting data and outcomes that address access to care and supports during the transition to community have yet to emerge.

To understand federal statutes, regulations, and guidance pertaining to the provision of health care for incarcerated youth, including those reentering the community, MACPAC contracted with RTI International to conduct a policy scan of the relevant provisions. RTI also assisted MACPAC by conducting a literature review to understand the physical and behavioral health care needs as well as access to and utilization of health services among JIY. To gather

stakeholder perspectives on Medicaid coverage and health care needs of JIY, RTI conducted interviews with Medicaid and juvenile justice officials from five selected states (Maryland, Nebraska, New Mexico, North Carolina, and Washington), federal officials, policy and research experts, advocates and service providers, and individuals with lived experience in the juvenile justice system.

This chapter provides background on juvenile justice settings, detention rates, and lengths of stay, then summarizes the demographic characteristics and health needs of youth who are incarcerated or transitioning from incarceration. Next, the chapter describes federal Medicaid policy for JIY, including recent changes to smooth health care transitions for youth leaving correctional settings. The chapter then explores how state Medicaid agencies are approaching transition periods and describes state-reported efforts to implement new federal Medicaid policy as well as whether any access barriers to health services are unique to JIY.

Youth in the Juvenile Justice System

Juvenile justice settings for JIY can be broadly categorized into facility-based and community-based settings, with some overlap between the types of settings. In both categories, a range of programs and interventions focus on rehabilitating JIY and reintegrating them into the community.[3] Common judicial interventions for JIY include secure confinement (placement in a long-term secure facility or residential program), secure detention (short-term confinement while awaiting adjudication or other court decisions), probation (a court-imposed intervention during which youth remain at home under system supervision), or diversion (programs to redirect youth away from formal criminal prosecution and toward rehabilitative programs) (OJJDP 2024; AECF 2022, 2021a, 2021b). Despite declines in arrests and incarceration over the last two decades, disparities among youth in the justice system persist (Rovner 2025a, 2025b).

Facility-based settings

Juvenile correctional facilities are common placement settings for JIY; however, alternatives to secure confinement have been a key area of focus in recent years (OJJDP 2024, NASEM 2022). Examples of alternatives include group homes or halfway houses that offer a structured environment for smaller groups of youth by focusing on building life skills and education in a less restrictive setting than correctional facilities. Other residential facility options include boot camps, wilderness programs, and juvenile halls, which vary widely in duration and intensity (OJJDP 2024, Barnert et al. 2016).

More restrictive settings include juvenile detention centers, residential treatment centers (RTCs), and long-term secure facilities. Juvenile detention centers most commonly serve as short-term holding facilities for youth while they await processing or disposition of charges. However, some states also use detention centers to hold youth who have been found delinquent as they await long-term placement. RTCs are facilities that focus on providing services to youth with substantial behavioral health needs. However, RTCs have considerable variability in staffing, treatment modalities offered, and security, and are more likely to be operated by a private entity (OJJDP 2011). Long-term facilities, which can be hardware secure or staff secure, are settings where youth are typically confined for several months or more after adjudication, which is the court process that determines if the juvenile committed the act for which he or she is charged (OJJDP 2025a).[4] Both detention centers and long-term facilities are typically operated by state or local juvenile justice agencies or private providers.

Community-based settings

Community-based programs include probation and diversion programs that aim to divert youth from the juvenile justice system before formal adjudication. Probation is court-ordered supervision of JIY in the community and is often used as an alternative to incarceration; it is the most common outcome for youth referred to juvenile and criminal courts. Youth

on probation must comply with certain court-mandated conditions, such as school attendance, counseling, or community service. Aftercare, or post-release supervision, involves the supervised release of youth from a detention facility, typically after they have served a portion of their sentence. Diversion programs, such as pretrial or restorative justice programs, often involve community service or therapy.

Other community-based programs include mentorship programs, peer support groups, counseling, and vocational training (Goldner and Ben-Eliyahu 2021). These programs are designed to help JIY address behavioral health needs. They also provide structured, educational, and vocational training to improve youth's academic skills and strengthen job readiness (Cramer et al. 2019). Family-based interventions such as multisystemic therapy and functional family therapy are evidence-based interventions that aim to improve family functioning and address mental, emotional, and behavioral needs through face-to-face therapy, typically in a home setting (Gottfredson et al. 2018, Robst 2015). Numerous community-based programs have been shown to reduce juvenile justice recidivism (OJJDP 2024).

Detention rates and lengths of stay

National rates of youth incarceration have decreased in the past two decades. Between 2000 and 2023, the number of youth in juvenile justice facilities dropped from 108,800 to 29,300, which represents a 73 percent decline (Rovner 2025b). Additionally, the number of youth in adult facilities declined from 10,420 in 2008 to 2,250 in 2021 (Zeng et al. 2023). These declines are attributed to a number of factors, such as reduced juvenile arrests and sentence lengths, reform legislation that set priorities for diversion and community-based rehabilitation options over detention, and reduced arrests and use of incarceration during the COVID-19 pandemic in an effort to reduce transmission of the disease in facilities (Rovner 2025b, Harvell et al. 2022, NASEM 2022, Puzzanchera et al. 2022). However, a limited monthly survey conducted of approximately 150 jurisdictions in 30 states suggests that the number of youth in detention is rising to pre-pandemic levels (AECF 2022).

Lengths of stay in correctional settings vary. In detention centers, which are used for transitional confinement, a 2022 analysis of youth held in 32 states showed that the average length of stay in a detention center was 40 days. Male youth stayed longer at 44 days than female youth at 25 days. According to this research, the length of stay in detention ranged from less than 24 hours to 21 months. This analysis also found that the average length of stay for youth in correctional facilities (after adjudication) was 259 days, or about 8.5 months (PbS 2022). Similar to detention lengths of stay, male youth were confined to correctional facilities about 1.5 months longer at 262 days compared to female youth who were confined for 219 days. Data from this analysis also showed that the length of stay in correctional facilities ranged from 1 day to 2,406 days, or more than 6.5 years (PbS 2022).

JIY population characteristics

JIY are predominantly male, which is reflected across different stages of the juvenile justice system. For example, of 29,314 youth in residential placement in 2023, male youth accounted for 85 percent of the placements, with female youth accounting for the remaining 15 percent (Puzzanchera et al. 2025, OJJDP 2023a). Compared to their male counterparts, female youth were also less likely to be petitioned, adjudicated, detained, or committed into out-of-home placement after arrest for most categories of delinquent offenses (Ehrmann et al. 2019). Despite representing half of the overall youth population, male youth were also involved in 72 percent of delinquency cases handled by juvenile courts in 2022 (Hockenberry and Puzzanchera 2024a). JIY also tended to be older, with those age 15 and older accounting for 85 percent of youth in residential placement in October 2023 (OJJDP 2023b).

Despite recent declines in rates of incarceration nationally, disparities among youth in the justice system persist. Black youth, in particular, continue to be overrepresented in correctional placements (Figure 3-1) as well as other stages of the juvenile justice system.

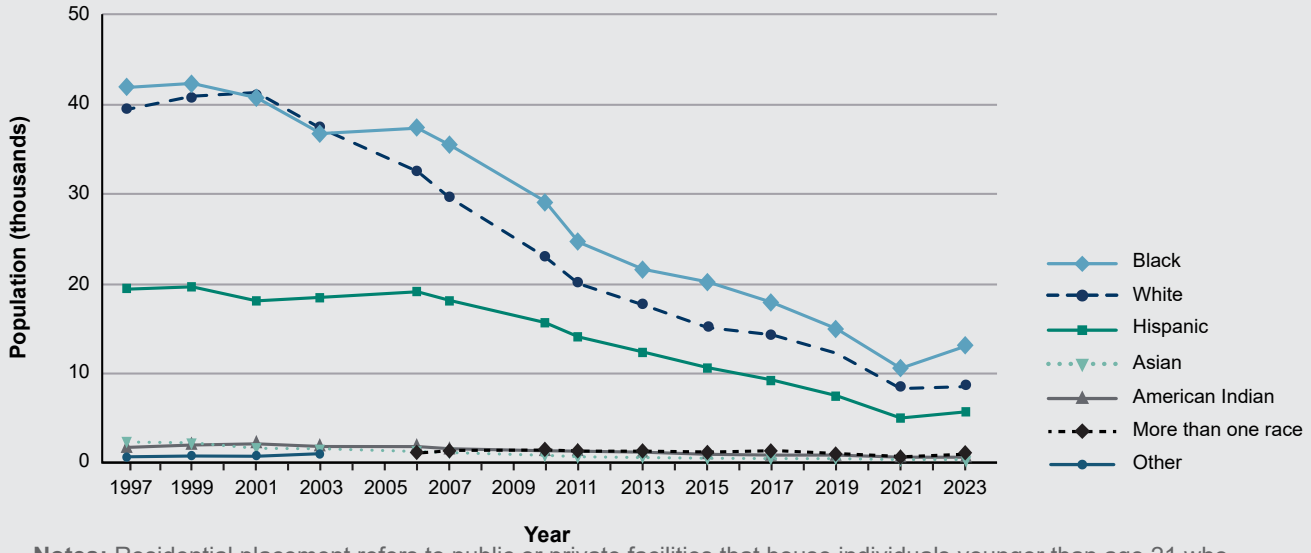
In 2023, Black youth were 5.6 times as likely to be placed in juvenile facilities as their white peers (Puzzanchera et al. 2025, Rovner 2025a). Additionally, based on 2023 data of placement in juvenile facilities, 46 percent of youth in these facilities were Black, despite Black youth comprising 15 percent of all youth across the United States. Black youth were also placed in juvenile facilities at a rate of 293 per 100,000 youth, compared to a white youth rate of 52 per 100,000 (Puzzanchera et al. 2025, Rovner 2025a).

Similar disparities played out in detention rates for Black youth as well as other groups, such as American Indian or Alaska Native youth. Although the detention rates for all racial and ethnic minority groups have declined since 2010, the detention rate for Black youth was almost eight times higher than the rate for white youth, and the rate for American Indian or Alaska Native youth was almost six times that of white youth in 2023 (Table 3-1) (OJJDP 2023c).

Additionally, research shows that youth of color are more likely to be formally prosecuted, referred to juvenile court, detained, petitioned, and charged as adults than white youth (Rovner 2025b, Ramos et al. 2022). This disparity also plays out in commitment rates for youth of color, which show that Black youth were 4.5 times as likely to be committed after adjudication than their white peers in 2023 (Table 3A-1) (OJJDP 2023d).

LGBTQ+ youth are also overrepresented in detention and other correctional settings (OJJDP 2014). Such youth are more likely to have contact with law enforcement than their heterosexual and cisgender peers and more likely to face arrest, including for minor offenses such as loitering (Ramos et al. 2022). Additionally, studies indicate that youth with disabilities are overrepresented in the juvenile justice system (OJJDP 2025b, 2017a). For example, one study estimates that 65 to 70 percent of JIY meet the criteria for a disability, which is more than three times higher than the general population (The Arc 2015). The disabilities among these youth include physical, learning, social-emotional, mental health, and intellectual and developmental disabilities (The Arc 2015).

FIGURE 3-1. Youth in Residential Placement by Race and Ethnicity, All Offenses, 1997–2023



Notes: Residential placement refers to public or private facilities that house individuals younger than age 21 who were charged with an offense or adjudicated for an offense. American Indian includes Alaska Native; Asian includes Pacific Islander.

Source: Puzzanchera et al. 2025.

Health Needs of Youth Involved with the Juvenile Justice System

Youth who are involved in the juvenile justice system have high rates of unmet physical and behavioral health needs compared to their non-incarcerated peers and frequently have complex and comorbid health conditions (Barnert et al. 2016). JIY also experience much more trauma, adverse childhood experiences, and chronic stress than other youth, which correlate with poor health outcomes, such as hypertension and cognitive difficulties, and future justice system involvement (NASEM 2022). Additionally, research finds that poor health outcomes among JIY persist into adulthood (Barnert, Abrams, and Dudovitz 2019; Barnert, Dudovitz, and Nelson 2017).

TABLE 3-1. Detention Rates by Race and Ethnicity, 1997–2023

Year	Detention rate (per 100,000 youth)						Ratio of detention rates relative to white youth				
	White	Black	Hispanic	AI/AN	API	More than one race	Black	Hispanic	AI/AN	API	More than one race
1997	54	264	122	125	48	–	4.9	2.3	2.3	0.9	–
1999	54	258	116	113	41	–	4.8	2.1	2.1	0.8	–
2001	52	223	109	112	37	–	4.3	2.1	2.2	0.7	–
2003	47	210	102	110	36	–	4.5	2.2	2.3	0.8	–
2006	43	221	97	116	26	–	5.1	2.3	2.7	0.6	–
2007	40	215	90	93	21	–	5.4	2.3	2.3	0.5	–
2010	34	192	78	103	17	22	5.6	2.3	3.0	0.5	0.6
2011	32	183	68	104	14	23	5.7	2.1	3.3	0.4	0.7
2013	30	179	60	87	11	27	6.0	2.0	2.9	0.4	0.9
2015	26	166	50	86	8	28	6.4	1.9	3.3	0.3	1.1
2017	27	165	44	96	9	24	6.1	1.6	3.6	0.3	0.9
2019	23	152	41	105	9	20	6.6	1.8	4.6	0.4	0.9
2021	18	116	24	87	5	15	6.4	1.3	4.8	0.3	0.8
2023	19	149	29	108	6	19	7.8	1.5	5.7	0.3	1.0

Notes: AI/AN is American Indian or Alaska Native. API is Asian or Pacific Islander. White, Black, and API racial groups exclude persons of Hispanic ethnicity. Until 2006, the Census of Juveniles in Residential Placement (CJRP) collected six detailed race and ethnicity categories (white, Black, Hispanic, American Indian or Alaska Native, Asian, and Native Hawaiian or Pacific Islander) and an "other" category. In 2006, the other category was replaced with "two or more races" (labeled here as "more than one race"). Rates for the more than one race category are displayed only for 2010 to the present.

Detained youth include youth being held as they wait for a court hearing, adjudication, disposition, or placement elsewhere. The detention rate is the number of youth in residential placement on the CJRP reference date per 100,000 youth age 10 through the upper age of original juvenile court jurisdiction.

The ratio of detention rates was created by dividing the rates for each racial or ethnic minority group by the white rate. A ratio of 1.0 indicates the rates for the comparison group are equal. For example, if white and Black youth were detained at the same rate, the ratio would be 1.0. A ratio greater than 1.0 means that the rate for the racial or ethnic minority group is greater than the rate for white youth. A ratio less than 1.0 means that the rate for the racial and ethnic minority group is less than the rate for white youth.

– Dash indicates omitted data.

Source: OJJDP 2023c.

Physical health conditions

Incarcerated youth have high rates of unmet physical health needs and higher mortality rates compared to the general youth population (Barnert et al. 2016). Youth with Medicaid coverage who enter the juvenile justice system often do so behind schedule on basic services such as well-child visits. As a result, many JIY are not up to date on recommended screenings (and subsequent assessments and treatment, as needed) for physical, developmental, social, behavioral, and mental health; hearing and vision; lead exposure; and speech and language. They are also more likely than other children to not have received needed routine childhood immunizations, preventive and restorative dental care, and eye care, including corrective lenses. JIY also need reproductive health services, which are not consistently provided in correctional settings (Barnert et al. 2016). Despite such needs, individuals with lived juvenile justice experience whom we interviewed cited difficulty obtaining medical care in the correctional facilities where they were held. For example, one individual noted that youth seeking health care were not believed that the service was needed, were punished for seeking care, or were not seen quickly unless it was an emergency.

In addition to an unmet need for routine care, some youth enter the juvenile justice system with chronic conditions such as asthma, diabetes, seizure disorders, and sickle cell disease as well as infectious diseases. These conditions are often undermanaged or undiagnosed in the JIY population, which can lead to serious consequences (Barnert et al. 2016). Researchers, state officials, and an individual with lived juvenile justice experience indicated that JIY also have emergency care needs, often arising from violence-related injuries. Beyond the need for health services, JIY need supports that address health-related social needs such as affordable and nutritious food, safe housing, employment assistance, and education to prepare them for reentry into the community.

Behavioral health conditions

Most youth in correctional settings have behavioral health needs. Studies estimate that 70 percent of JIY have a mental health condition, and more than 50 percent meet the criteria for an SUD (Cronin-Furman et al. 2023, Field et al. 2023). Other research notes that about two-thirds of youth in correctional settings have at least one diagnosable mental health issue, compared to an estimated 9 to 22 percent of the general population (OJJDP 2017b, Schubert 2014). Common diagnoses include depression, attention deficit hyperactivity disorder, posttraumatic stress disorder, anxiety disorder, conduct disorder, and SUD (Barnet et al. 2016, Shufelt and Cocozza 2006).

Despite the needs of this population, efforts to screen for appropriate services are mixed across correctional facilities.[5] For example, in a 2020 survey of residential placement facilities that held youth charged with or adjudicated for law violations, 76 percent of the facilities that reported information about substance use said that they evaluated all youth for SUD, 9 percent said they evaluated some youth, and 15 percent said they did not evaluate any youth. Seventy-four percent of facilities that responded to mental health evaluation questions reported that a mental health practitioner working in the facility evaluated all youth for mental health needs. However, detention centers reported much lower rates; only 55 percent of these responding facilities reported screening all youth for mental health needs. Nearly all facilities (96 percent of respondents who reported information on suicide screening) said that they evaluated all youth for suicide risk (Hockenberry and Sladky 2024b). Although federal data show high levels of behavioral health screening, a 2019 meta-analysis found that only 32.6 percent of detained or incarcerated youth obtained SUD or mental health services while incarcerated (White et al. 2019).

Other considerations for JIY

Although JIY share similarities with justice-involved adults in terms of unmet health needs, they have unique considerations that have implications for the nature of the care needed as well as access to services.

Child development needs. Youth have distinct clinical needs when compared to adults, partly because they are still physically, cognitively, and emotionally developing. These needs range from basic childhood care, such as routine child screenings and immunizations, to complex, trauma-informed mental health care. Trauma-informed care is particularly important to address adverse childhood experiences, such as growing up in a household with substance

use and mental health challenges, as well as the trauma that can be caused by justice system involvement. For example, an individual with lived juvenile justice involvement whom we interviewed noted that the experience of being incarcerated and the conditions in correctional settings create additional trauma at a formative time in the youth's life.

Educational needs. Youth have educational needs that must continue to be met while they are detained. If the JIY has been identified as needing special education and has an individualized education program (IEP), it must be sent to the correctional facility where the youth is held, and services under the IEP must be provided.[6] Although the educational services received in a correctional facility must be comparable to the services that the youth received in their school, an advocate we interviewed indicated that correctional facilities are not always equipped to carry out special education requirements (OSERS 2014).

Child welfare system involvement. Youth involved in the justice system may be simultaneously involved with the child welfare system. According to research, these dually involved youth make up as much as 55 percent of the juvenile justice system population, and an estimated 9 to 29 percent of youth involved in the child welfare system also become involved with the juvenile justice system (Puzzanchera et al. 2022, Herz 2010). The health needs of these youth may be exacerbated by stress or trauma related to family disruption.

Parental consent. Legal requirements for medical consent shape care for JIY. Youth depend on their parents or guardians for access to health care and require their consent to care in many circumstances. The laws for health care consent for JIY can differ across states and even within a state. For example, a state juvenile justice official whom we interviewed explained that the corrections system in their state may be able to provide consent for the youth to obtain basic health services, but parental consent is required for psychiatric medications if youth are younger than age 16.

Federal Medicaid Policy for Justice-Involved Youth

Most JIY are likely eligible for Medicaid; however, federal policies have historically limited Medicaid's role in providing coverage and paying for health services for youth in juvenile facilities (Barnert et al. 2016, Acoca et al. 2014). Section 1905(a)(32)(A) of the Social Security Act prohibits the use of federal Medicaid funds for health care services for Medicaid enrollees when they are inmates of public institutions, except in cases of inpatient care lasting 24 hours or more.[7] This payment prohibition is commonly referred to as the "inmate payment exclusion," and it applies to youth as well as adults. As such, Medicaid generally covers health care services for eligible and enrolled youth when they are on parole and probation, while correctional authorities (e.g., counties and state departments of corrections) typically pay for health care costs during confinement in juvenile detention facilities.[8] Even with Medicaid's limited role during incarceration, it is an important source of coverage for eligible youth released into the community. Additionally, there have been several federal policy changes in recent years in an effort to address the unmet need of this population and improve health care transitions for incarcerated youth.

Suspending Medicaid coverage

Section 1001 of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) prohibits states from terminating Medicaid eligibility for an eligible juvenile who becomes an inmate of a public institution and instead requires states to suspend the youth's Medicaid coverage for the duration of their incarceration (CMS 2023b, 2021).[9] Suspended coverage requires reactivation or reinstatement, while terminated coverage requires submission of a new application. In providing guidance to states on this provision, the Centers for Medicare & Medicaid Services (CMS) indicated that suspending Medicaid eligibility for eligible youth assists with timelier and streamlined reinstatement of coverage for them upon release from incarceration (CMS 2021).[10] Suspension

can reduce administrative burden for both states and eligible youth while also ensuring access to essential health services more quickly in the days after release. The SUPPORT Act also requires states to process Medicaid applications submitted by or on behalf of JIY while they are incarcerated and redetermine eligibility (without requiring a new application) of certain eligible juveniles before their release (CMS 2021).[11]

Section 1115 reentry demonstrations

Section 5032 of the SUPPORT Act directed the Secretary of the U.S. Department of Health and Human Services (HHS) to convene stakeholders to develop best practices for states to ease health care–related transitions for incarcerated individuals to the community and to develop a report to Congress. This report, which the HHS Office of the Assistant Secretary for Planning and Evaluation submitted in January 2023, identified a number of health coverage challenges for individuals reentering the community as well as best practices to assist with coverage and care upon reentry (ASPE 2023).[12] The SUPPORT Act also directed HHS, through CMS, to issue guidance on Section 1115 demonstration opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration and to base this guidance on the best practices identified in the report to Congress. In April 2023, CMS issued this guidance, which describes how states can receive federal financial participation (FFP) for certain prerelease services for up to 90 days before the incarcerated individual's expected date of release through a Section 1115 demonstration (CMS 2023a). Under such a demonstration, states must provide case management, medication-assisted treatment services, and a 30-day supply of prescription medications upon release, at a minimum. However, states can elect to cover additional prerelease services in their demonstrations. CMS's guidance further provides that states with approved demonstrations will be expected to conduct interim and summative evaluations. In designing the evaluation, states may include how they will test whether the demonstration improved care transitions for individuals released from incarceration, including whether and how the demonstration improved coverage and quality of care.[13] States are required to submit an interim evaluation report one year before expiration of the demonstration or when the state submits a request to extend the demonstration. The state is also required to submit the summative evaluation report within 18 months after the demonstration period ends (CMS 2023a).

As of January 2026, 19 states have approved reentry demonstrations; of these, 14 states include JIY in their demonstration covered populations.[14] An additional eight states and the District of Columbia—six of which include JIY—have pending reentry demonstrations.[15] Table 3-2 describes key characteristics of the approved and pending reentry demonstrations that include youth populations.

Mandatory pre- and post-release services for youth

Section 5121 of the CAA 2023 requires state Medicaid programs, beginning January 1, 2025, to provide certain screenings and diagnostic services to eligible youth (i.e., post-adjudicated youth younger than age 21 or youth formerly in foster care younger than age 26) in public institutions in the 30 days before release.[16] If the state is not able to provide these screenings before release, the statute specifies that the state must provide them not later than one week or as soon as practicable after release.[17] Section 5121 of the CAA 2023 also requires states to provide Medicaid-eligible youth targeted case management services in the 30 days before release and for at least 30 days thereafter. States must submit a state plan amendment to CMS for approval before implementing these required services. The requirements for pre- and post-release services also generally apply to JIY eligible for the State Children's Health Insurance Program (CHIP). Additionally, the CAA 2023 provisions align CHIP rules with existing Medicaid rules regarding suspension rather than termination of coverage while the youth is an inmate of a public institution.

TABLE 3-2. Characteristics of Approved and Pending State Section 1115 Reentry Demonstrations that Include Youth Populations as of January 2026

Characteristic	Approved states	Pending states
Eligibility		
All youth	AZ, CA, CO, HI, IL, KY, MA, MI, NC, NM, OR, UT, VT, WA	AR, CT, DC, ME, NV
Youth with certain medical diagnoses		NJ[1]
Duration of prerelease coverage		
60 days	KY	NJ
90 days	AZ, CA, CO, HI, IL, MA, MI, NC, NM, OR, UT, VT, WA	AR, CT, DC, ME, NV
Benefits		
Mandatory benefits only	CO, KY	NJ
Additional covered services	AZ[2], CA, HI[2], IL, MA, MI[2], NC[2], NM, OR, UT, VT[3], WA	AR[4], CT[5], DC[6], ME[7], NV[8]
Additional covered services offered		
Lab and radiology	CA, HI, IL, MA, MI, NC, NM, OR, UT, WA	CT, NV
Durable medical equipment	CA, HI, IL, MA, MI, NC, NM, UT, WA	CT
Community health worker services	CA, IL, NM, OR, UT, WA	CT, ME, NV
Family planning	NM, OR, UT	CT, ME
Treatment for hepatitis C	NM, UT, VT	CT, ME
Medications and medication administration	CA, IL, MA, MI, NC, NM, OR, UT, VT, WA	CT, NV
Tobacco cessation	NC	
Peer support services	AZ, HI, NM, OR, UT, VT	DC, ME, NV
Clinical consultation services	CA, MA, NM, OR, UT, WA	CT, ME, NV

Notes:

[1] New Jersey's Section 1115 demonstration proposal requests authority to provide limited Medicaid services for incarcerated individuals who meet the criteria of having a behavioral health diagnosis.

[2] The Section 1115 demonstrations in Arizona, Hawaii, Michigan, and North Carolina specify that the states also offer practitioner office visits (e.g., physical exam, wellness exam, evaluation and management visit, mental health or substance use disorder treatment, therapy, or counseling).

[3] Vermont's Section 1115 demonstration specifies that the state also offers screening for common health conditions.

[4] Arkansas's pending Section 1115 demonstration specifies that the state plans to provide all state plan services, including medication-assisted treatment and counseling, 30-day supply of prescription drugs upon release, and case management.

[5] Connecticut's pending Section 1115 demonstration waiver specifies that the state will also offer screening for common health conditions, such as high blood pressure, diabetes, hepatitis C, and HIV, within the incarcerated population.

[6] The District of Columbia's pending Section 1115 demonstration specifies that it will also offer comprehensive behavioral and physical health screenings; counseling and therapy; and intensive, family-based services for youth.

[7] Maine's pending Section 1115 demonstration specifies that the state will also offer HIV care.

[8] Nevada's pending Section 1115 demonstration waiver specifies that the state will also offer treatment for HIV.

Sources: MACPAC analysis of state Medicaid Section 1115 reentry demonstration documents as of January 2026; KFF and The Health and Reentry Project.

Optional pre-adjudication services for youth

Section 5122 of the CAA 2023 provides states the option, beginning January 1, 2025, to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth held in public institutions before adjudication. CMS's July 2024 guidance notes that a state electing this optional coverage would be required to provide Medicaid and CHIP services that an eligible juvenile would otherwise be entitled to if not for incarceration, for the duration of the prerelease period pending disposition of charges, regardless of the type of correctional facility in which they are confined. CMS encourages states covering the optional prerelease services to collaborate closely with the juvenile and adult justice systems to ensure that coverage of such services "does not effectuate a delay of an individual's release or lead to increased involvement in the justice systems" (CMS 2024).

State planning grants

Section 206 of the Consolidated Appropriations Act, 2024 (CAA 2024, P.L. 118-42) authorized CMS to make planning grants available to states for activities and expenses related to complying with the prerelease screening, diagnostic, and case management services requirements under the CAA 2023.[18] In particular, state Medicaid and CHIP agencies can use the planning grants to develop operational capabilities to promote continuity of care for eligible justice-involved individuals, including youth after incarceration in state-operated prisons; local, tribal, and county jails; and youth correctional or detention facilities. These grants can also be used to identify and address operational gaps to comply with the statutory requirements. CMS provided specific examples of uses for the funds, such as establishing standardized processes and automated systems for determining Medicaid and CHIP enrollment status of inmates and investing in information technology (IT) to enable bidirectional information sharing between relevant entities to support care transitions among other permissible uses (CMCS 2024, CMS 2025).[19] In two rounds in 2025, CMS awarded these grants, ranging from $1.2 million to $5 million, to 27 states, the District of Columbia, and Puerto Rico.[20]

State Implementation of Federal Medicaid Policy

In light of evolving federal Medicaid policy for JIY in recent years, the states that we spoke with reported efforts to implement the changes and navigate challenges to serve these youth. Such efforts include suspending Medicaid eligibility for incarcerated youth and implementing required pre- and post-release services for JIY per the CAA 2023. Such officials also noted challenges to these efforts, such as establishing Medicaid billing for correctional facilities, but are identifying approaches to support the facilities in this role.

Suspending Medicaid coverage

States' past experiences suspending Medicaid for incarcerated individuals informed their ability to implement suspensions for youth. States reported using automated or manual approaches to suspend Medicaid and experienced challenges with the complexity of implementing suspension processes and engaging local correctional facilities in suspension efforts.

Past state experience with suspension. In some states, past experience implementing Medicaid suspension for incarcerated populations is informing their current juvenile justice efforts. For example, Maryland Medicaid officials noted that the state has had a suspension process in place for adults for many years that they have refined and recently applied to the JIY population. New Mexico Medicaid officials reported that the state has been suspending Medicaid coverage for incarcerated individuals as part of a health program for inmates that the state developed in 2014.[21] Since then, New Mexico's systems suspend coverage for Medicaid-eligible individuals after 30 consecutive days of incarceration, while also ensuring that the state does not provide coverage or pay claims during those 30 days. Similarly, Washington state has been suspending Medicaid coverage for adults and youth who enter a correctional facility since 2017, per state legislation enacted in 2016.[22]

Automated versus manual suspension processing. The states we contacted also varied in the extent to which their suspension processes were automated or manual or involved both approaches. For example, officials from one state indicated that the Medicaid program receives an automated file from the state's juvenile services department to suspend coverage and another file from that department to indicate who is being released from state custody to have their coverage reinstated.

Some states indicated that they use both automated and manual processes for suspending youth Medicaid coverage. Medicaid officials in one state said that although processes for suspension and reinstatement of coverage for JIY are largely automated, the state continues to support processes for manual workarounds, in case they become necessary. For example, if the automated process misses that the youth is being transferred to a different type of facility, rather than returning to the community, the state uses manual processes to ensure that the coverage remains suspended.

In some states, manual suspension processing is necessary due to the lack of an automated file exchange between the state Medicaid agency and some juvenile justice agencies or facilities or adult correctional facilities that hold youth. For example, Medicaid officials in one state reported that using an automated or manual suspension process depends on whether the Medicaid agency has an electronic file exchange arranged with the correctional facility. These officials noted that this automated file exchange is in place with the state agency administering the juvenile justice system and some, but not all, facilities. Since the file exchange is not in place across all facilities, the juvenile justice agency provides the state Medicaid agency a weekly population report that identifies all juveniles who are incarcerated in the county detention centers as well as in the state's long-term correctional facilities. Medicaid staff must manually enter this information into the eligibility system, which processes the suspension automatically. In two of the states that we interviewed, Medicaid officials indicated that although they have automated suspension processes in place for adults, the process for suspending Medicaid coverage for youth remains manual. In one of these states, individual facilities notify the Medicaid agency to suspend coverage for youth entering their facilities. In the other state, the Medicaid agency tracks post-adjudicated youth to manually process suspensions as well as other activities associated with the youth, such as coverage renewals and reinstatements.

Complexity with suspending coverage. State officials described some of the complexities they face with implementing suspension processes. For example, one state indicated that because different authorities in the state administer adult and juvenile corrections, the Medicaid program must navigate different eligibility rules for adults and youth to enable new suspension processes. Several state officials also noted that reinstatement of Medicaid coverage for JIY is further complicated by unpredictable release dates, especially in settings such as jails, where stays are shorter and variable.

Engaging facilities in suspension efforts. Engaging local correctional facilities has had implications for implementing suspension processes. For example, Medicaid officials in one state explained that they receive little information about incarcerated youth from the local jails in the state because each jail is run at the county level, and there is not a central agency that collects their data. As such, the Medicaid program must reach out to each jail to collect information on youth incarcerations. Officials in this state added that it has been difficult to persuade jails to provide what is needed to serve these youth and implement suspension processes.[23] Another Medicaid official noted that there are no efforts to suspend Medicaid coverage for youth at the local and county levels in their state. In the local and county facilities, youth tend to have shorter stays of less than 30 days and are pre-adjudicated. Thus, this state's Medicaid program does not suspend the youth's coverage, but it opted to implement Section 5122 of the CAA 2023 to maintain the full Medicaid benefit for these pre-adjudicated youth.[24]

Implementing pre- and post-release services

Although it is still early in the implementation of Section 5121 of the CAA 2023, states are working with CMS to implement the required pre- and post-release services under different approaches, often using managed care, to serve JIY. States reported that they are implementing services incrementally (or among a subset of facilities), providing services but not billing Medicaid, or providing services as part of their Section 1115 reentry demonstration waiver. In their implementation efforts, states also reported challenges related to enrolling correctional providers as Medicaid providers and establishing processes for them to bill Medicaid in accordance with program requirements.

State approaches. States' implementation efforts to support JIY are as unique as the states in which they operate. For example, Washington state Medicaid officials reported that the state received approval from CMS to implement Section 5121 pre- and post-release services incrementally as part of the state's Section 1115 reentry demonstration.[25] Washington launched services in juvenile detention facilities in July and November 2025 and January 2026 and will add more facilities in March and July 2026, according to officials.[26] New Mexico Medicaid officials also reported their plans to cover Section 5121 services for youth through the state's Section 1115 reentry demonstration once all facilities are incorporated in the demonstration.[27]

Maryland's efforts to implement pre-release services reflect the state's practice of providing screening and diagnostic services for JIY when they first arrive at a juvenile facility, as opposed to 30 days before release as required by the CAA 2023. State officials noted that these services are not billed to Medicaid, and CMS guidance recognizes situations in which an eligible youth may be screened upon entry to the correctional facility and be considered in compliance with the CAA 2023.[28] Similarly, New Mexico Medicaid officials reported that the state's juvenile correctional facilities provided pre- and post-release services to JIY but were not permitted to bill Medicaid until the state received CMS approval in December 2025. Officials added that the state's juvenile justice agency and correctional facility staff were already providing many of these services to JIY. The only difference since CMS's approval is that the correctional facilities are now permitted to bill Medicaid.

Managed care. States leverage managed care to provide targeted case management, which the CAA 2023 requires as pre- and post-release services. For example, Washington opted to provide pre- and post-release services through their managed care organizations (MCOs) to help with continuity of care for JIY because many of them transition into the correctional system for short periods of time. New Mexico Medicaid officials reported that their MCOs include a position called a "justice liaison" that helps youth, as well as adults, make connections with care coordinators before release. The justice liaison helps both the youth and care coordinator prepare for discharge by entering the juvenile facility to start a transition of care assessment and plan before release. As a result, officials noted that when the JIY leaves the facility, they have their plan and any prescription medications so that they can continue to receive the services in the community.

Provider enrollment and billing challenges. State officials described challenges enrolling correctional providers as Medicaid providers and establishing billing processes in light of technical limitations. In some cases, these challenges arise due to unfamiliarity with how to bill for Medicaid with the required documentation. For example, although one state's Medicaid officials reported that they have been successful in creating a correctional provider type for providers who can bill Medicaid, it has been a challenge because the providers were unfamiliar with how to bill for services generally, and they tended to primarily use paper records for JIY. Washington Medicaid officials also cited their efforts to ensure newly enrolled correctional providers understand new processes and are supported as they bill Medicaid. These efforts include the state's development of in-depth billing guidelines for the CAA 2023 and Section 1115 demonstration benefits as well as retaining a third-party administrator to help the facilities and community providers serving JIY with billing and technical assistance. Officials consider this addition as a major operational component that essentially serves as a billing clearinghouse for the juvenile correctional facilities.

Federal officials noted that many juvenile justice facilities lack the technology and infrastructure needed to bill Medicaid for the pre-release services, thus challenging a state's ability to establish Medicaid billing processes for correctional providers. For example, New Mexico Medicaid officials noted that it has been difficult to ensure that the juvenile correctional facilities have the appropriate billing and electronic health records systems that they need to provide health care services and bill for Medicaid for them. According to these officials, the correctional facilities may not know that they need to upgrade their systems to enable the facility to receive and process information or that a system is needed for electronic medical records. New Mexico officials added that they are enrolling correctional providers in Medicaid as the state upgrades its Medicaid eligibility and provider payment systems, thus contributing to the complexity of adding new Medicaid providers and automating certain functionality until the new provider payment system is in place.

Cross-System Coordination for Serving JIY

Transitioning JIY from correctional settings to the community and ensuring access to Medicaid services requires coordination among state Medicaid, juvenile justice, child welfare, behavioral health, and other youth-serving systems. State officials face challenges to interagency coordination, including the complexity of arrangements, data sharing, and achievement of participation across correctional facilities.

Interagency relationships

Section 5121 of the CAA 2023 placed new requirements on state Medicaid agencies, but juvenile justice agencies, as well as adult correctional facilities that hold youth, play a critical role in implementing and operationalizing the necessary activities to fulfill the requirements. Several state officials whom we interviewed noted that partnerships and cross-system collaboration among these agencies, as well as child welfare, behavioral health, and other youth-serving systems, are key for implementation of the CAA 2023 provisions. State officials reported focusing on building the relationship between Medicaid and correctional agencies.

In some cases, state Medicaid agencies' existing relationships with the corrections agency helped with their ability to implement CAA 2023 requirements. For example, New Mexico's Medicaid and corrections agencies maintain a strong partnership since developing and implementing a targeted health program for incarcerated individuals in 2014. In addition, the agencies and long-term juvenile correctional facilities are in regular communication with each other as part of their work on an electronic file exchange. Washington Medicaid officials indicated that they rely on their existing relationship with the state's juvenile court administration association, which administers the juvenile correctional system, to build connections with other reentry stakeholders and achieve buy-in from the correctional facilities on the Medicaid agency's approach for implementing CAA 2023 requirements.

Ongoing coordination

State Medicaid and correctional agencies and facilities reported regular touchpoints to establish new processes needed to implement pre- and post- release services for JIY. For example, Maryland Medicaid officials noted that the Medicaid agency meets weekly with its correctional partners for both the Section 1115 demonstration and CAA 2023 work, including regular subgroup meetings on specific issues, such as legal requirements for data, that have helped protect sensitive juvenile information and increased data sharing across systems. Washington Medicaid officials also cited regular meetings between the Medicaid agency and the correctional facilities to discuss any operational questions and ensure compliance with the CAA 2023. In such meetings, the state Medicaid agency and third-party administrator answer questions and provide support as the facilities take on new tasks of screening for Medicaid eligibility, helping youth select managed care plans, and assisting with Medicaid applications. State Medicaid officials indicated that the team provides guidance and support to ensure that the facilities are comfortable with this new role.

Facility engagement

Although the CAA 2023 established requirements for state Medicaid agencies, it did not establish direct requirements for correctional facilities. As such, some officials noted the challenge of engaging some correctional facilities, even with the creation of new interagency connections. For example, officials in one state explained that correctional facilities are not mandated to attend meetings on CAA 2023 implementation and that different jurisdictions in the state have varying levels of interest in participating. Thus, the Medicaid agency has not been able to involve all correctional facilities at the local level. Another state similarly noted that there is no mandate to participate in the educational sessions that the state's Medicaid agency has developed for correctional facilities. As a result, officials noted that youth are "falling through the cracks" in some juvenile detention centers that have not engaged with the state and are not receiving prerelease services. Additionally, with correctional facilities facing a number of other state initiatives, they may not set priorities for Medicaid initiatives to transition released youth into the community.

Data sharing and systems

Barriers to data sharing between Medicaid and correctional agencies and facilities include technical complexity, use of paper (versus electronic) medical records in juvenile facilities, and limited funding for data infrastructure improvements. For example, one state official reported that the state has nearly 100 jails, each with its own data system for tracking inmates. The state is trying to build a centralized system but has faced difficulties consolidating the data from that number of facilities. Another state cited the challenge of sharing clinical information with community providers because most correctional facilities do not have electronic health records. An official from another state noted that the state has an outdated eligibility system that requires a substantial build but has not been able to set priorities for system upgrades. As a result, sharing data for Medicaid suspension and reactivation of coverage are cumbersome, manual processes in the state.

CMS officials whom we interviewed recognize that states may require additional support to improve their data infrastructure. These officials noted that potential resources for funding state data and infrastructure projects include Health Information Technology for Economic and Clinical Health Act funds, enhanced FFP for IT system expenditures with an Advance Planning Document, and implementation grants provided under the CAA 2024.

Complexities of Serving JIY

The suspension requirements established by the SUPPORT Act, the CAA 2023 requirements for pre- and post-release services for JIY, Section 1115 reentry demonstrations, and cross-agency coordination efforts provide opportunities to connect JIY with services and smooth their transition to the community. Even with these opportunities, officials whom we interviewed noted a number of complexities that can affect JIY's access to services, such as insufficient staffing, complex health conditions, and the availability of Medicaid providers. The frequent changes in placement that JIY experience and the involvement of their families can also present challenges to serving these youth.

Correctional staffing

Many youth detention facilities have an insufficient medical, therapeutic, and correctional workforce due to challenges with staff recruitment and retention. Federal and state officials as well as researchers and providers we spoke with noted that staffing shortfalls result in long wait times for necessary screenings and services in facilities and limited ability to transport youth to community-based appointments. Although officials described using telehealth to mitigate this issue, they noted that telehealth requires access to IT hardware and software, reliable broadband access, and a private space, which are not always available in juvenile correctional facilities. Interviewees also noted that recruitment for correctional health care providers can be challenging because these roles lack occupational prestige and are often located in rural, low-resource areas of the state. This scarcity is amplified when focusing on behavioral health providers. A federal

official mentioned the logistical and security rules that community-based providers must follow to enter justice facilities, including background checks, prescreening steps, dress code requirements, and security protocols. Workforce challenges extend beyond the facilities and affect probation and community-based services. Frequent turnover of probation officers can hinder youth's ability to access care after release, because youth may struggle building trust with new officers and may be less likely to express health needs. A shortage of probation officers also limits the resources available to support youth in accessing medical appointments.

Complex conditions

As noted above, JIY have complex and co-occurring health conditions and substantial behavioral health needs.[29] Such behavioral health conditions can be connected to trauma and adverse childhood experiences that are prevalent among JIY, prompting their need for trauma-informed care. A Medicaid official whom we spoke with indicated that the program must periodically consider whether its provider network is adept at addressing its population's needs when it encounters JIY who have considerable health concerns or who present with comorbidities. Additionally, such complex needs often translate to high health care and medication costs. Officials whom we interviewed, particularly those working in juvenile justice settings, explained that correctional facilities aim to provide comprehensive care while a youth is detained, since it is a unique period when youth are on the premises to attend appointments. However, providing comprehensive trauma-informed health care that addresses JIY's complex health needs increases the costs for the corrections system. One official whom we spoke with described correctional health care as "wildly underfunded" within state budgets, thus requiring facility leadership to make difficult decisions regarding the allocation of limited resources.

Provider availability

Once JIY return to the community, they face barriers accessing services due to a shortage of providers in the community or challenges finding Medicaid-enrolled providers. According to officials whom we spoke with, many communities—especially rural or underserved urban areas—face shortages of health care providers and long wait times to see the provider once they are able to locate one. As noted above, youth benefit from receiving care from child and adolescent specialists, such as adolescent psychiatrists; however, these providers are often not available in many communities. JIY also require tailored treatment options, especially related to substance use, as adolescents have different patterns of use and reasons for using compared to adults. However, adolescent behavioral health care remains an emerging field, with limited age-specific treatment options available in both the community and correctional settings.[30] Once youth return to the community, they may face barriers finding providers who participate in Medicaid. For example, one state official cited the few child and adolescent psychiatrists in the state and noted that reimbursement rates may not attract such developmentally appropriate providers for JIY.

Placement changes

Given JIY's complex medical needs, they benefit from having a consistent provider who is knowledgeable of their history and care requirements. However, many of these youth, especially those involved with the child welfare system, experience frequent changes in where they are placed in the community, which may result in reassignment of their MCO and subsequent changes in providers. As a result, care may be fragmented or discontinuous for these youth, and providers may lack complete medical records to provide consistent, high-quality services. Placement changes and a lack of an established health record can compound complex health needs by delaying timely access to initial or ongoing medical, therapeutic, or rehabilitative services. Additionally, because MCOs are often regionally based and are not always statewide, if a youth is placed within a different part of the state or in a different state altogether, they may have to navigate either a new MCO or Medicaid program. One state official whom we interviewed indicated that a statewide specialty health plan for all JIY could reduce these transitions and the resulting care fragmentation. However, another official noted that regionally based MCOs can benefit youth by offering specific knowledge about care in their service areas.

Family engagement

The involvement of a youth's family and caregivers, and their broader support system, are critical for reentry planning. Prerelease planning and treatment during incarceration and the reentry period are key touchpoints to promote shared decision making among youth, parents, and providers (Barnert et al. 2020). However, facilitating this engagement can be challenging and can have implications for a JIY's access to services. Officials whom we interviewed noted that parents may be unwilling or unable to engage in their child's care and planning for a variety of reasons, including distrust of state agencies and medical establishments or their own health challenges. In particular, mental illness and substance use can be multigenerational, and this may limit parents' abilities to support and engage with their children. According to an official whom we spoke with, challenges to family engagement are compounded by the lack of policies to support meaningful parental involvement in facilities while the youth is incarcerated. Additionally, given the substantial overlap between youth involved in the juvenile justice and child welfare systems, parental engagement may be limited by a court, thus challenging the ability to engage them in the youth's care.

Looking Ahead

In efforts to address access to care for youth leaving incarceration, CMS and states are relatively early in the implementation of CAA 2023 provisions as well as Section 1115 reentry demonstrations, where applicable. States are at different points in their efforts to connect youth with the required services and are working to address challenges to building their reentry programs according to their unique circumstances and priorities. Several stakeholders whom we interviewed expressed optimism about the opportunities that evolving federal Medicaid policies provide to better serve JIY and support transitions that could potentially change the course of further system involvement. With those efforts actively underway, much can be learned from federal and state experiences about the effects of the CAA 2023 on JIY and their communities in the coming years. Future data analysis may be needed to examine the extent to which the recent statutory changes are accomplishing the policy goals of supporting JIY transitions and reentry to the community.

Endnotes

[1] The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) Section 1001 defines "eligible juveniles" as individuals younger than age 21 and individuals enrolled in the mandatory eligibility group for former foster care children. For this chapter, the term "youth" is synonymous with this definition (CMS 2021).

[2] Under Section 5121 of the CAA 2023, states can receive federal financial participation (FFP) for pre- and post-release services for Medicaid-eligible youth younger than age 21 and youth formerly in foster care younger than age 26 who are being held after adjudication. The requirement for states to provide these services also generally applies to JIY eligible for the State Children's Health Insurance Program (CHIP).

[3] Youth enter the juvenile justice system in a number of ways, such as through arrest or referrals from parents, schools, or probation officers (Barnert et al. 2016).

[4] A hardware-secure facility primarily uses construction and hardware, such as locks, bars, or fences, to restrict freedom, while a staff-secured facility uses continuous staff or contractor presence to control entrances and exits and prevent unauthorized exits from the facility (NPRC 2014).

[5] Among juvenile correctional facilities that screen incoming youth, there is wide variation in the types of screening tools used for assessment. Although some facilities use evidence-based tools, others use tools that may not be supported by evidence (Pilnik et al. 2025).

[6] For children who receive special education services, an IEP is a written statement of an educational program designed to meet their individual needs. An IEP, which is developed by key school staff and the child's parents, establishes learning goals for the child and specifies services that the school will provide for the child (CPIR 2022).

[7] Under Section 1905(a)(31) of the Social Security Act, as amended by Sections 5121 and 5122 of the CAA 2023, states are prohibited from using federal Medicaid funds to pay for care or services for inmates of public institutions, with three exceptions: (1) when inmates are admitted as patients to medical institutions such as hospitals; (2) for services provided to eligible juveniles under Section 1902(a)(84)(D); and (3) effective January 1, 2025, for states

that elect to provide full Medicaid coverage for juveniles pending disposition of charges.

[8] Individuals on parole include people released through discretionary or mandatory supervised release from prison. In comparison, probation is a court-ordered period of correctional supervision in the community, typically viewed as an alternative to incarceration (MACPAC 2021). Medicaid and the state corrections authority, which runs state prisons and youth correctional facilities, are typically housed in different state agencies that report to the governor. Jails are generally operated at the local level by a sheriff, police chief, or other local official who may be appointed or independently elected (Carson and Kluckow 2023).

[9] Section 1001 of the SUPPORT Act defines an "eligible juvenile" as an individual who is younger than age 21 and an individual younger than age 26 who is eligible for Medicaid under the mandatory former foster care children group, so states must work with both juvenile and adult facilities to suspend coverage for youth depending on where the youth is held.

[10] States may adopt one of two approaches to effectuate the requirements in the SUPPORT Act: suspension of eligibility or suspension of benefits. Under an eligibility suspension, the juvenile's eligibility is not terminated, but it is effectively paused. The juvenile cannot receive Medicaid coverage for services, and FFP is not available. Under a benefits suspension, an eligible juvenile continues to be enrolled in Medicaid, but coverage is limited to inpatient services furnished to the juvenile while admitted to a medical institution for at least a 24-hour inpatient stay, in accordance with the inmate payment exclusion described above (Section 1905(a)(30) of the Social Security Act) (CMS 2021).

[11] The Consolidated Appropriations Act, 2024 (CAA 2024, P.L. 118-42) extended the youth suspension requirements from the SUPPORT Act to adults as well, thus requiring states to suspend Medicaid coverage for all incarcerated individuals as of January 1, 2026.

[12] The Office of the Assistant Secretary for Planning and Evaluation's Report to Congress identified challenges to obtaining health care coverage and transitioning health care for individuals reentering the community after incarceration, such as the inability to access and afford treatment and medications for opioid use disorder (MOUD) and other SUDs as well as health-related social needs, including obtaining housing, accessing food, and securing employment, among other challenges. It also identified practices to support reentry, such as expanded access to MOUD within correctional settings, discharge planning, and use of community navigators and peer support specialists, among other practices (ASPE 2023).

[13] CMS's April 2023 guidance also notes that state evaluations could include measurement of cross-system communication and collaboration, connections between correctional settings and community services, provision of preventative and routine physical and behavioral health care, avoidable emergency department visits and inpatient hospitalizations, and all-cause deaths, among other outcomes of interest (CMS 2023a).

[14] The 19 states with approved reentry demonstrations are Arizona, California, Colorado, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Washington, and West Virginia. See Table 3-2 for the states that include youth in their demonstrations.

[15] The nine states that have pending reentry demonstrations are Arkansas, Connecticut, District of Columbia, Louisiana, Maine, Minnesota, Nevada, New Jersey, and New York. See Table 3-2 for the states that include youth in their pending demonstrations.

[16] CMS guidance on the requirements of the CAA 2023 specifies that because youth formerly in foster care are eligible for Medicaid until age 26, the guidance could affect youth held in adult jails and prisons as well. As such, the guidance further provides that states should conduct pre-release outreach and make eligibility and enrollment support available to all incarcerated youth in both juvenile and adult facilities (CMS 2024).

[17] The CAA 2023 requires state Medicaid programs to have a plan in place for covering within 30 days of an eligible juvenile's release, any screenings and diagnostic services that meet reasonable standards of medical and dental practice, as determined by the state or as otherwise indicated as medically necessary, in accordance with the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, including behavioral health screenings or diagnostic services. Under this requirement, states have the flexibility to use EPSDT standards for screening and diagnostic services or to develop additional standards (CMS 2024).

[18] The CAA 2024 authorizes CMS to issue state planning grants to address operational barriers to complying with requirements described in sections 1902(a)(84)(A) and 2102(d) of the Social Security Act (42 USC 1396a(a)(84)(A)-(D), 1397bb(d)), which were amended by Section 205 of division G of the CAA 2024. These planning grants may also be used to support suspension requirements under the SUPPORT Act as well as state implementation of optional Medicaid coverage for pre-adjudicated youth under Section 5122 of the CAA 2023.

[19] Although CMS specified that states may propose other uses of the fund, the planning grants may not be used to pay for or directly administer health care services to an individual under Medicaid or CHIP or to build prisons, jails, or other correctional facilities or pay for their related improvements. However, any improvements that help directly meet the healthcare needs of individuals who are incarcerated and eligible for medical assistance under Medicaid or CHIP are an allowable exception to facility-related improvements (CMS 2025).

[20] CMS guidance provides that up to $106.5 million will be awarded under this funding opportunity in four budget period increments of 12 months each over a four-year period of performance (CMS 2025). In January 2025, CMS announced that the first round of grants was awarded to 12 states and territories: Alaska, District of Columbia, Kentucky, Maine, Massachusetts, Nevada, New Mexico, North Dakota, Puerto Rico, South Dakota, Utah, and Virginia. The awards for these recipients ranged from $1.5 million to $5 million per state or territory. In August 2025, CMS announced that the second and final round of grants were awarded to 17 states: Alabama, Arkansas, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, Oklahoma, Pennsylvania, Rhode Island, and West Virginia. The awards for these recipients ranged from $1.2 million to $4.6 million per state.

[21] New Mexico's Justice-Involved Utilization of State Transitioned Healthcare program, developed in 2014, established system processes to automatically suspend enrollment for incarcerated individuals, including some youth, who are eligible for Medicaid after 30 consecutive days of incarceration. When the Medicaid program receives release information through an electronic file exchange, the system will automatically reinstate the youth's enrollment in the managed care organization that they were previously enrolled in.

[22] State legislation directed the Washington State Health Care Authority to suspend, rather than terminate, medical assistance benefits for persons who are incarcerated starting July 1, 2017, as an effort to provide continuity of care for individuals upon reentry into the community (WSHCA 2016).

[23] In an effort to address this challenge, state Medicaid officials indicated that they are developing a toolkit to provide to jails who are willing to interact with the Medicaid program to do this work. The aim of this toolkit is to have local jails implement the process as quickly as possible once the Medicaid program achieves local buy-in.

[24] The CAA 2023 provides states the option, beginning January 1, 2025, to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth held in public institutions before being adjudicated in a delinquency hearing.

[25] According to Washington officials as well as state guidance, correctional facilities can satisfy the requirements of the CAA 2023 by participating in the state's Section 1115 reentry demonstration, or they can opt to provide only the pre- and post-release services as required by the CAA 2023 without participating in the demonstration.

[26] Washington's capacity-building process required correctional facilities to describe their existing capabilities, operational gaps, and technical assistance that may be needed to provide services under the state's demonstration. From this process the state developed a cohort selection and milestone approach in which a facility would receive demonstration funding every time a facility met a milestone.

[27] New Mexico officials noted that the state launched Section 1115 demonstration services for adults in three state prisons and is working to implement these services in a cohort of five county detention centers, including one juvenile detention center. The state projects that these services will be in place in June 2026. State officials noted that extending demonstration services to JIY ensures that they will have 90 days of pre-release services under the approved demonstration, as opposed to 30 days of pre-release services under the CAA 2023.

[28] According to CMS guidance, an eligible youth may have been screened or have received a diagnostic service upon entry to the correctional facility, among other specified time periods outside of 30 days before their scheduled release. In this situation, if the state determines that such services

align with the state's established standards for screening and diagnostic services, the screening and diagnostic requirements in the CAA 2023 may be considered satisfied (CMS 2024).

[29] Behavioral health is a substantial challenge among JIY, with 50 to 75 percent having a diagnosable mental health or SUD and suicidality being a serious concern (MACPAC 2021, Owen et al. 2020). Youth with histories of trauma or polyvictimization often experience stress responses that result in maladaptive behaviors such as impulsivity, hyperarousal, and decreased ability to self-regulate; these, in turn, may be associated with delinquency and contact with enforcement (Owen et al. 2020). They are also more likely to receive diagnoses of externalizing disorders (Owen et al. 2020).

[30] A researcher and provider and state officials whom we interviewed emphasized the importance of therapy and psychiatric services for treating depression, anxiety disorders, mood dysregulation, externalizing behaviors, traumatic stress, and other trauma-related needs. However, identifying a behavioral health condition does not necessarily translate to treatment of identified needs. One study found that although two-thirds of JIY had behavioral health disorders and likely needed treatment, only 33 percent received mental health treatment and 27.95 percent received SUD-related services at any point before incarceration (White et al. 2019). Additionally, several interviewees with lived experience in the juvenile justice system reported that therapy was not available to them while they were detained.

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APPENDIX 3A: Commitment Rates Among Youth of Color, 1997 to 2023

TABLE 3A-1. Commitment Rates by Race and Ethnicity, 1997–2023

Year	Commitment rate (per 100,000 youth)						Ratio of commitment rates relative to white youth				
	White	Black	Hispanic	AI/AN	API	More than one race	Black	Hispanic	AI/AN	API	More than one race
1997	143	696	338	346	144	–	4.9	2.4	2.4	1.0	–
1999	151	672	316	415	136	–	4.5	2.1	2.7	0.9	–
2001	154	631	250	438	82	–	4.1	1.6	2.8	0.5	–
2003	140	519	230	354	74	–	3.7	1.6	2.5	0.5	–
2006	124	502	207	353	54	–	4.0	1.7	2.8	0.4	–
2007	114	482	192	317	49	–	4.2	1.7	2.8	0.4	–
2010	94	435	147	313	33	105	4.6	1.6	3.3	0.4	1.1
2011	82	372	133	312	25	92	4.5	1.6	3.8	0.3	1.1
2013	71	317	111	295	20	81	4.5	1.6	4.2	0.3	1.1
2015	62	299	89	215	17	67	4.8	1.4	3.5	0.3	1.1
2017	57	246	71	173	12	75	4.3	1.2	3.0	0.2	1.3
2019	49	185	49	163	12	47	3.8	1.0	3.3	0.2	1.0
2021	29	107	31	94	8	24	3.7	1.1	3.2	0.3	0.8
2023	31	139	35	86	8	28	4.5	1.1	2.8	0.3	0.9

Notes: AI/AN is American Indian or Alaska Native. API is Asian or Pacific Islander. White, Black, and API racial groups exclude persons of Hispanic ethnicity. Until 2006, the Census of Juveniles in Residential Placement (CJRP) collected six detailed race and ethnicity categories (white, Black, Hispanic, American Indian or Alaska Native, Asian, and Native Hawaiian or Pacific Islander) and an "other" category. In 2006, the "other" category was replaced with "two or more races" (labeled here as "more than one race"). Rates for the more than one race category are displayed for only 2010 to the present.

Committed youth include youth placement in the facility as part of a court-ordered disposition. Committed youth may have been adjudicated and disposed in juvenile court or convicted and sentenced in criminal court. The commitment rate is the number of youth in residential placement on the CJRP reference date per 100,000 youth age 10 through the upper age of original juvenile court jurisdiction.

The ratio of commitment rates was created by dividing the rates for each racial or ethnic minority group by the white rate. A ratio of 1.0 indicates the rates for the comparison group are equal. For example, if white and Black youth were detained at the same rate, the ratio would be 1.0. A ratio greater than 1.0 means that the rate for the racial or ethnic minority group is greater than the rate for white youth. A ratio less than 1.0 means that the rate for the racial and ethnic minority group is less than the rate for white youth.

– Dash indicates omitted data.

Source: OJJDP 2023d.

Chapter 4:

Access to Care for Medicaid-Enrolled Youth in Foster Care

Access to Care for Medicaid-Enrolled Youth in Foster Care

Key Points

- Children and youth in foster care represent less than 2 percent of all children enrolled in Medicaid, and are an especially vulnerable population. Youth in foster care have experienced neglect and abuse and other trauma, such as being removed from their home, which can contribute to poor physical, oral, and behavioral health outcomes, as well as fragmented use of health care services.
- Nearly all children in the child welfare system are eligible for Medicaid through several federal statutory pathways. Children in foster care, like all Medicaid-eligible children under the age of 21, are entitled to services under the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, but studies show that children in foster care are less likely to receive mandatory EPSDT screenings. Children and youth in foster care also have substantial behavioral health needs and are at risk of being overprescribed psychotropic medications.
- Federal law requires state Medicaid agencies provide health insurance coverage to youth in foster care, and state child welfare agencies are responsible for ensuring that the health needs of children in foster care are met.
- Collaboration among agencies serving this population at the federal and state levels is important, but there are challenges to doing so, including unaligned priorities and resource constraints. At a state level, child welfare agencies must coordinate with Medicaid on aspects of foster care program design and develop health care oversight and coordination plans, which must include information about the state's approach to health screenings, treatments, and ensuring continuity of care. There is no requirement for state Medicaid agencies to consult with child welfare agencies on Medicaid program design. In addition, federal rules on interagency information sharing are limited.
- Several factors affect the ability of state agencies to meet the needs of youth in foster care, such as frequent placement transitions, availability of providers who can provide trauma-informed care particularly related to behavioral health needs, and behavioral health and oral health workforce shortages.
- Many states serve children in foster care through managed care, with most enrolling these youth in managed care organizations (MCOs) that serve the general child beneficiary population, and others using specialized MCOs that serve primarily just youth in foster care.
- States continue to address challenges by improving cross-agency collaboration and information sharing, supporting access to trauma-informed care, and by leveraging relationships with MCOs. Collaboration among Medicaid and child welfare and other agencies should be a state priority.

CHAPTER 4: Access to Care for Medicaid-Enrolled Youth in Foster Care

Children and youth in the child welfare system represent a small but highly vulnerable segment of the Medicaid-enrolled population.[1] The child welfare system serves children and families whom the state determines to need additional assistance and services to keep the children safe in their own homes or in temporary out-of-home care, also known as foster care.[2] In 2024, 328,947 children were in foster care in the United States (ACF 2025). A 2014 study found that 70 percent of children and youth were placed in foster care by court order because of abuse and neglect that occurs in the context of parental substance abuse and addiction, extreme poverty, parental mental illness, transient living situations or homelessness, extreme family violence, and parental criminal activity (Szilagyi et al. 2015). Once removed from their homes, children and youth face a heightened risk of experiencing additional trauma related to separation from familiar environments and placement instability.[3]

Congress has made resources available to the federal government and states to provide services and health care to children and youth in the child welfare system. Title IV-E of the Social Security Act (the Act) provides federal funding for child welfare assistance to low-income children who have been removed from their homes. Children receiving assistance under Title IV-E are automatically eligible for Medicaid. The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services provides matching federal funds to states to operate their child welfare programs via a single state agency (ACF and CMS 2022).

State child welfare agencies are the legal custodians of children in foster care and are responsible for the health, safety, and well-being of these children; the agencies connect the children to a permanent and safe home if they cannot be reunited with their biological parents (§ 421 of the Act).[4] If a child is removed from their home, child welfare agencies provide maintenance payments to foster families or other caregivers, including those providing foster care in group homes or institutional settings, to help cover the cost of room and board. The agency also provides case management and permanency planning for the child (Stoltzfus 2018). The child welfare system interacts closely with the justice system (often family or juvenile court), the education system, and the health care system. Collaboration at the agency level is important to ensure children and youth in foster care are receiving appropriate and necessary care.

Children involved in the child welfare system, specifically those in foster care, have disproportionately high rates of acute and chronic physical conditions, behavioral health issues, developmental delays, and oral health concerns (Lamminen et al. 2020, Turney and Wildeman 2016, Deutsch and Fortin 2015, Szilagyi et al. 2015). In addition to the health impacts of neglect and abuse that necessitate the involvement of the child welfare system, the removal of a child from their home is a traumatic event that contributes to poor physical and behavioral health (AAP 2021a, Côté et al. 2018). Family instability, poverty, placement changes or placement instability, fragmented service delivery, and poor information sharing across systems also exacerbate these health challenges.

A range of Medicaid-covered services may be necessary and appropriate for meeting the significant health, behavioral, and other needs of children in foster care. Given the complex health needs of children in foster care, which are often a result of the trauma and maltreatment they have experienced, average Medicaid spending is much higher than that of most other children enrolled in Medicaid (MACPAC 2015a). One study estimated that children who were maltreated or at risk of being maltreated incurred Medicaid expenditures that were on average more than $2,600 higher per child per year than the expenditures for children not maltreated or at risk of being maltreated. The authors estimated that these higher costs (i.e., the additional spending above what would otherwise be expected) reflected 9 percent of Medicaid spending for non-disabled children (Florence et al. 2013).

The Commission has previously stated that access to and use of Medicaid services could be improved for the child welfare population—for example, by

ensuring regular health screenings and reducing unmet needs for mental health care as well as addressing inappropriate psychotropic medication use. Additionally, improved collaboration among Medicaid, child welfare, and other agencies is critically important, given that the majority of these children are eligible for Medicaid-financed services and care coordination (MACPAC 2015a). However, challenges in serving children in foster care persist due to fragmentation across financing streams and delivery systems, differences in program goals for the child welfare system and Medicaid, poor interagency coordination, and limited data sharing. Furthermore, a lack of knowledge among staff about other programs' benefits can hamper collaboration.

This chapter examines how Medicaid meets the unique needs of children and youth in the child welfare system, with a focus on those currently in foster care.[5] First, it provides background information about children and youth in foster care as well as their health status and utilization of health care. Next, it highlights key federal requirements for child welfare and Medicaid state agencies. Then, this chapter describes selected considerations for states in providing health care access to children in foster care based on our review of seven states.

Children and Youth in Foster Care

Although children and youth in foster care represent less than two percent of all children enrolled in Medicaid, they are an especially vulnerable population whose safety and well-being are the legal responsibility of the state. The number of children entering foster care has continuously declined over the last five years (ACF 2025). In 2024, the largest share, 28 percent, of children entering foster care were age 1 to 5; 20 percent, the largest share, of children exiting foster care reported that their duration in foster care was 12 to 18 months (ACF 2025). One study found that, in 2023, 39 percent of children in foster care experienced more than two placements, meaning their living arrangements changed at least three times a year (AECF 2025a).

Research shows that children from racial minority groups and children with lower socioeconomic status are more likely to be represented in the child welfare system. Three-quarters of reports to child protective services involve neglect allegations, and families in poverty are more likely to be reported for child neglect compared to families with higher incomes (Children's Bureau 2021). Children of color are more likely to be placed into foster care than white children (Minoff and Citrin 2022). In 2024, Black children comprised 25 percent of children in foster care but only 14 percent of the total child population in the United States. (ACF 2025, CDF 2023). American Indian and Alaska Native children made up three percent of those in foster care but only one percent of the total child population (ACF 2025, CDF 2023).

Health status

The physical, behavioral, and oral health needs of children and youth in foster care are complex and greater than children in the general population. These children experience social risk factors (e.g., child abuse or neglect) that adversely affect their health. Child abuse is defined as intentional harm or mistreatment (physical, sexual, or emotional). Child neglect is defined as the failure to meet a child's needs (food, shelter, supervision, medical care), and 76 percent of all confirmed maltreatment cases is from child neglect (Children's Bureau 2023). Traumatic life experiences are common among individuals in foster care, which has consequences for an individual's long-term physical and behavioral health.

Adverse childhood experiences (ACEs) are potentially traumatic events that occur before a child turns age 18 that have lasting negative physical and behavioral health consequences. Examples of ACEs include abuse, neglect, witnessing violence in the home, removal from home, and placement instability (CDC 2025). These experiences can exacerbate mental health challenges. The longer a child spends in the foster care system, the more likely they are to have three or more placements. These placement changes lead to fragmented health care and challenges with continuity of care (Casey Family Programs 2023). Studies show that children with a high ACE score, such as those in foster care, are at an increased risk

for long-term medical issues, including heart disease, stroke, cancer, respiratory diseases, diabetes, and depression (Radel et al. 2023, Merrick et al. 2019).

Physical health and developmental conditions. Children in foster care are more likely to be in poor health and have chronic conditions, such as asthma or obesity, activity limitations, learning disabilities and speech delays, developmental delays, and vision problems, compared with children in the general population (Turney and Wildeman 2016). The complex trauma histories of children who enter foster care and their limited access to appropriate health care services compound their substantial unmet health needs. Childhood trauma and adversity underlie health issues, and the ongoing loss and uncertainty in foster care may exacerbate health conditions (AAP 2021a, Szilagyi et al. 2015). Overall, 33 percent of children and youth enter into foster care with a chronic health condition; 46 to 60 percent of children younger than six years have a developmental disability (Szilagyi et al. 2015).

Other research has shown that children and youth with special health care needs are more likely to enter the foster care system, as their family is unable to meet their health care needs (Hess 2020). Because children with diagnosed disabilities need higher levels of care, they are more likely to be placed in residential treatment facilities, which may be better equipped to provide such care. They are also more likely to spend more time in foster care, experience multiple placements, and achieve permanency at lower rates than other foster care children (Sepulveda et al. 2020). In 2021, states reported they were more likely to find permanent homes for the general foster care population exiting foster care (89.6 percent) than for children with diagnosed disabilities who exited foster care (81.5 percent) (Children's Bureau 2021).

Behavioral health conditions. Children in foster care are more likely to be diagnosed with behavioral health conditions as compared to children in the general population (MACPAC 2021). Behavioral health diagnoses vary for children in foster care depending on their age, whether they are subjected to multiple child welfare investigations during their childhood, the length of time they spend in out-of-home care, and the stability of their foster care experience. Compared to children in the general population with similar socioeconomic status, children in foster care are three to four times more likely to have a diagnosis of a mental health disorder (Engler et al. 2020). In one study, children who experienced out-of-home placement in early childhood (age two to six) were twice as likely to have psychiatric diagnoses in young adulthood than peers who did not experience foster care (Côté et al. 2018). A prior review of Medicaid claims data indicates that prevalent mental health and developmental disorders among youth in foster care include attention-deficit/hyperactivity disorder (ADHD) (11.0 percent), bipolar disorders (5.6 percent), and depressive disorders (5.4 percent) (Keefe et al. 2022). Children in foster care tend to have a higher rate of suicidality than children without a history of child welfare involvement; one study found that preadolescents in foster care experience suicidality at five times the rate of suicidality in the general population (Engler et al. 2020, Taussig et al. 2014).

Oral health conditions. Children involved in the child welfare system are at a higher risk for inconsistent oral health care, leading to poor oral health outcomes (AAPD 2025, Sarvas et al. 2021, Morón et al. 2019). Children in foster care are more likely to experience dental caries and gingivitis than other children enrolled in Medicaid (Morón et al. 2019). Youth with a history of placement in foster care are 1.5 times more likely than children in the general population to have an oral health problem, with 15.6 percent of children in foster care reporting decayed teeth or cavities. They are also less likely to receive routine or acute dental care (Sarvas et al. 2021). Caregivers of children in foster care cited challenges finding dentists who accept Medicaid and, in some states, the lack of authority to consent for dental care and the lengthy process for obtaining consent from legal authorities as reasons for the delays in dental care (AAPD 2025).[6]

Health care utilization

Children and youth in foster care have lower rates of health care utilization, such as for primary care, behavioral health care, and oral care, compared to children and youth who are not (AECF 2025b). Children in foster care can experience fragmented health care when removed from their home and from placement changes while in out-of-home care. Research from

the American Academy of Pediatrics shows that interruptions in care and lower health care utilization negatively affect children's health and increase the risk of poor health outcomes (AAP 2021b).

Use of psychotropic medications. The Commission has had long-standing concerns about the use of psychotropic medication to manage the behavioral and mental health problems of children in foster care (MACPAC 2015b).[7] Limited safety and efficacy data exist on those younger than 18 using these medications, and some child welfare and behavioral health experts have concerns about inappropriate use (Keefe et al. 2023, Radel et al. 2023). Other concerns are that psychotropic medications may not address the underlying trauma or the issues at the root of challenging behaviors in some children (Zito et al. 2008). Children in foster care are three times more likely to be prescribed psychotropic medications than other Medicaid-enrolled children and are more likely to be kept on them for a longer period of time (Szilagyi et al. 2015). Nine percent of youth age 12 to 17 in the child welfare population who did not have a behavioral health diagnosis received at least one psychotropic medication, which is double the rate of beneficiaries in other Medicaid eligibility groups who do not have behavioral health diagnoses (Radel et al. 2023). Some researchers have posited that reasons for this potentially inappropriate prescribing include caregiver demand to manage disruptive behavior, provider and caregiver lack of understanding about the effects of childhood trauma on mental health, a lack of pediatric mental health professionals to provide alternative treatments (e.g., psychotherapy), and the misdiagnosis of trauma symptoms as other mental health conditions (e.g., ADHD) (Szilagyi et al. 2015).

Federal Requirements for the Child Welfare System and Medicaid

Below we describe federal child welfare and Medicaid requirements for the provision of health care for children and youth in the foster care system. As previously mentioned, child welfare agencies are responsible for ensuring that the health needs of children in foster care are met. State Medicaid agencies provide health insurance coverage for services, including under the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, to address the health needs of this population.

Child welfare system

The child welfare system encompasses programs intended to preserve families; protect and promote the welfare of all children; and achieve permanency, including child abuse and neglect prevention, foster care, and subsidized adoption (§ 421 of the Act). Child welfare agencies investigate allegations of abuse and neglect and, when necessary for a child's safety, remove the child from the home and place them in foster care. ACF is responsible for developing and issuing federal regulations for state child welfare agencies to implement Titles IV-B and IV-E of the Act. Title IV-B provides capped grants to states for a range of child welfare services. There are no federal eligibility criteria because the programs are designed to protect and promote the safety of all children, and states may use the funding for services to meet the broad goals of the agency. Under Title IV-E, which is an open-ended entitlement program, states are entitled to reimbursement for some of the costs of providing foster care, adoption assistance, or kinship guardianship assistance for eligible children. Child welfare agencies may not use federal funds under Title IV-E to provide health care for children. Thus, these agencies rely on Medicaid funding to cover the cost of care (Stoltzfus 2018). Federal and state agencies operate these programs in partnership, with state child welfare agencies required to meet federal statutory and regulatory requirements to receive federal funds.

Coordination with state Medicaid agencies. Federal rules require state child welfare agencies to coordinate with state Medicaid programs. First, state child welfare agencies must have comprehensive operating plans that describe how they coordinate with other state agencies when developing their child welfare program. Second, state child welfare agencies must maintain information systems with accurate and current data about the program overall as well as individual children. Third, child welfare agencies must establish mechanisms for health care oversight and coordination of child welfare populations with Medicaid and clinical providers in their state (45 CFR 1357.15).

These mechanisms include child welfare agencies partnering with state Medicaid agencies to enroll foster care children in Medicaid, sharing the child's health care information with necessary parties, and in some instances, giving permission to health care providers for treatment (ACF and CMS 2022). Medicaid agencies do not have a parallel federal requirement to coordinate with their state child welfare agency when developing their Medicaid policies (e.g., through state plans and waivers).

Child and family service plans. Each state child welfare agency must develop and submit child and family service plans (CFSPs) to ACF for review and approval to receive Title IV-B grants and Title IV-E federal financial participation (§ 422-423 of the Act, 45 CFR 1357.15). Three of the 15 required CFSP elements are relevant to Medicaid and the access of these benefits: coordination of services, health care oversight and coordination plans, and case plans and case reviews. State child welfare agencies outline how services within the CFSP will be integrated and coordinated with services (e.g., social, health, education, or economic support) offered by other federal programs that serve similar populations, aiming to achieve comprehensive support for children and families while avoiding duplication and maximizing resource efficiency (45 CFR 1357.15). Additionally, each state's CFSP must include a health care oversight and coordination plan developed by the state child welfare agency in collaboration with the state Medicaid agency and in consultation with pediatricians, health care experts, and child welfare experts (§ 422(b)(15)(A) of the Act). Last, for each child they serve, state child welfare agencies must maintain individual case plans with the child's health history and current information and give the case plan to the child when they age out of foster care. Child welfare agencies must have a process in place to review, update, and provide a copy of the child's case plan to each foster parent or provider with whom the child is placed (§ 475(1)(D) of the Act).

Psychotropic medication. Federal rules require child welfare agencies to monitor and manage psychotropic medication use by children in foster care and report their findings to ACF. Federal law requires state child welfare agencies to submit health care oversight and coordination plans to ACF (as part of CFSPs) that include protocols for appropriate use and monitoring of psychotropic medications (§ 422(b)(15) of the Act). Additionally, the Family First Prevention Services Act, part of the Bipartisan Budget Act of 2018 (P.L. 115-123), amended child welfare funding streams in Titles IV-B and IV-E of the Act and requires that state child welfare agencies develop procedures that ensure children are not inappropriately diagnosed with mental illness, emotional disorders, or behavioral disorders, which can lead to inappropriate psychotropic medication prescribing.[8] State child welfare agencies must document these procedures in their health care oversight and coordination plans.

Medicaid

States rely on myriad federal authorities to design and fund Medicaid programs aimed at addressing the unique health care needs of children in foster care.

Eligibility pathways. Nearly all children in the child welfare system are eligible for Medicaid through several federal statutory pathways. Children who receive Title IV-E foster care maintenance payments are automatically eligible for Medicaid (42 CFR 435.145).[9] Children who do not qualify for state-funded foster care under Title IV-E because, for example, they receive in-home services or have family income above their state's 1996 Aid to Families with Dependent Children (AFDC) eligibility standard, are not automatically eligible for Medicaid but may be eligible through other Medicaid pathways, such as a disability-based eligibility pathway (MACPAC 2015a).[10] States may also use the Ribicoff option for Medicaid coverage, which allows states to cover what is called a "reasonable category" of children, such as those who are in foster care but are not eligible for Title IV-E funding, if they meet the income limits established under AFDC (§1902(a)(10)(A)(ii)(I) of the Act and 42 CFR 435.222). In addition, section 1902(e)(12) of the Act requires 12 months of continuous Medicaid eligibility to all eligible children younger than age 19, allowing children, including those who move in and out of foster care, to maintain access to and continuity of health care.

All states are required to provide Medicaid coverage to youth formerly in foster care until age 26, regardless of income or assets.[11] Initially, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required states to provide such coverage to in-state former foster youth. States could also

choose to cover former foster youth who aged out of foster care in another state (CMS 2013). Later, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) made coverage of out-of-state former foster youth mandatory, which phased in beginning with youth who turned age 18 on or after January 1, 2023. SUPPORT Act requirements will apply to all former foster care youth beginning in 2031. In the interim, states can use the Section 1115 demonstration authority to extend Medicaid coverage to out-of-state former foster youth (CMS 2022). States also have the option to cover former foster care children up to age 21 through the independent foster care adolescents eligibility group, also known as the Chafee option (§1902(a)(10)(A)(ii)(XVII) of the Act and 42 CFR 435.226). In contrast to the mandatory ACA pathway, the Chafee option is less restrictive with regard to prior coverage and residence; there is no requirement for prior Medicaid enrollment or to have been in foster care in the same state in which the youth is currently residing. States may establish income criteria, may restrict eligibility to those who received assistance funded under Title IV-E, and may not cover individuals age 21 or older (MACPAC 2015a).

EPSDT. Under Section 1905(a) of the Act, all Medicaid-eligible children younger than age 21, including children in foster care, are entitled to services under the EPSDT requirement. Federal law requires Medicaid coverage of any allowable service that is determined medically necessary to ameliorate a physical or behavioral health condition, even if the services are not included in the Medicaid state plan. Services under EPSDT include comprehensive health screenings, vision and hearing services, dental services, lead screenings, immunizations, diagnostic services, and treatments for conditions discovered by any screening and diagnostic procedures. States are required to develop or adopt a schedule of recommended screenings to determine the existence of physical or mental illnesses for EPSDT-eligible children, and states must ensure children have access to these screenings (CMS 2024).[12] However, one study found that nearly 33 percent of Medicaid children in foster care did not receive at least one EPSDT screening, and slightly more than 25 percent received at least one required screening late (OIG 2015).

Most states provide enhanced services for children in foster care in both fee-for-service and managed care delivery models. Examples of such services include:

- case management;
- targeted engagement of child welfare and behavioral health partners;
- specific assessments and screenings;
- psychotropic medication monitoring;
- foster care transition services; and
- non-medical services and supports (CMS 2024).

States and the federal government share responsibility for overseeing children's access to necessary services based on the EPSDT requirement, including when provided through managed care. State Medicaid agencies must also ensure their managed care contracts clearly define plans' responsibility for covering and providing services under EPSDT, and states must monitor managed care organization (MCO) compliance with the requirement.

Psychotropic medication monitoring. State Medicaid agencies must design and implement programs to monitor and manage appropriate use of antipsychotic medications by all Medicaid-enrolled children, including children in foster care, and report to the Secretary on these efforts (§ 1902(oo)(1)(B) of the Act). Specifically, state Medicaid agencies must annually submit to the Centers for Medicare & Medicaid Services (CMS) information regarding activities completed under their monitoring and management program as part of the state's Medicaid Drug Utilization Review report (§ 1927(g)(3)(D) of the Act). States can also help reduce unmet needs for mental health care and inappropriate psychotropic medication use among child welfare–involved youth by improving timely access to community-based behavioral health treatments. Several states also require written consent by the legal guardian, court, or authorized person at the child welfare agency before psychotropic medications can be prescribed for a child in foster care; adolescents in foster care have the same rights as other teenagers to consent to mental health services without a guardian (Szilagyi et al. 2015).

Managed care. States' approaches to providing Medicaid coverage for children in the child welfare system vary, but states are now increasingly using managed care delivery systems. Although there is a statutory prohibition on mandatory enrollment of individuals in the child welfare system in managed care, states may seek approval from CMS to waive this provision (§ 1932(2)(A)(iv-v) of the Act). In 2007, 29 states used some form of managed care to deliver Medicaid to some or all children in foster care; by 2021, this number had grown to 42 states and the District of Columbia (Thompson 2022). States may use different models of managed care, such as general managed care plans, administrative service organizations (ASOs), and specialized managed care plans. States may choose to enroll children in foster care in the same general managed care plans that serve non–foster care populations and implement specific programs and policies designed to meet the needs of children in foster care. Some states may enroll children in foster care in specialized managed care plans that serve child welfare populations and other children and youth with special health care needs. Although less common, states can use ASOs instead of managed care plans (Thompson 2022).

State Medicaid agencies using managed care delivery models for children in foster care must comply with federal oversight and monitoring requirements, including CMS approval of contracts, implementation readiness review, external quality review activities, and Managed Care Program Annual Reports (42 CFR 438).[13] States must also comply with the specific approval, monitoring, and renewal requirements of the federal authority.

State Medicaid agencies and MCOs often provide children and youth in foster care enhanced benefits, which are Medicaid coverable services, such as care coordination, that have been augmented to meet their complex needs. Approaches to care coordination vary across the states and include targeted case management; integrated care coordination that connects medical, behavioral, and social services in a patient-centered approach; and intensive care coordination for children and youth with complex health care needs. A couple of states require MCOs to have a liaison between the managed care plan, behavioral health providers, and trauma-informed case managers; several states promote system-level coordination, such as routine meetings with local child welfare agencies (Thompson 2022).

Data sharing

Federal Medicaid rules allow, but do not require, state Medicaid agencies to share beneficiary information with other agencies, if it is for a purpose directly related to administration of the state Medicaid plan (§ 1902(a)(7) of the Act). These purposes include establishing eligibility, determining the amount of medical assistance, and providing services for beneficiaries (42 CFR 431.302). State Medicaid agencies wishing to exchange information with other state agencies must execute a data exchange agreement to safeguard the information to be released (42 CFR 431.306(g)). Although federal rules require managed care plans to develop and maintain systems to exchange health information with state Medicaid agencies in prescribed formats, there is no requirement that these plans configure their health information system to exchange data with the state child welfare agency (42 CFR 438.242).

Alternatively, child welfare rules require state child welfare agencies to share medical information of children in foster care with Medicaid. Through CFSPs, state child welfare agencies must coordinate with the state Medicaid agency on a methodology for updating and sharing the medical information of children in foster care (§ 422(b)(15)(A) of the Act). States may elect to develop a Comprehensive Child Welfare Information System (CCWIS). ACF regulations require that information sharing that occurs via the state's CCWIS must have 11 bidirectional data exchanges capable of information and data sharing with other state health and human service systems. State child welfare and Medicaid agencies must be able to share data with one another to effectuate Medicaid eligibility and enrollment as well as Medicaid claims and encounter processing (45 CFR 1355.52(e)). Like state Medicaid agencies, state child welfare agencies must implement safeguards regarding the data exchanged.

Challenges and Considerations for Serving Youth in Foster Care

States face several challenges in serving children in the foster care system and are pursuing a range of approaches to meet the health care needs of these children and youth. A number of factors affect the care needs of youth in foster care, which should inform the efforts of states, health plans, and providers.

Collaboration between Medicaid and child welfare agencies

Individuals interviewed for our analysis agreed that cross-agency collaboration on policy, data sharing, and health care delivery methods is ideal for serving children in foster care. They also noted that limited staff resources amid other programmatic goals and responsibilities can pose barriers to robust and consistent collaboration.

Federal collaboration. Collaboration among federal agencies serving children in foster care is important to ensure consistent agency policies that result in clear guidance to states. However, federal officials and national experts described two challenges to federal collaboration: (1) federal agencies do not coalesce around a shared set of policy priorities in the administration of the foster care program, leading to confusion among state agencies, and (2) federal officials often face constrained bandwidth to focus on collaborative efforts. However, even when federal agencies collaborate, some efforts may not have the intended effect. CMS, ACF, and the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation collaborate on issue areas that affect children in foster care, such as behavioral health, Medicaid eligibility for young adults transitioning out of foster care, and data sharing. In 2022, CMS and ACF partnered on a months-long collaboration to develop a data-sharing toolkit for child welfare and Medicaid agencies, but some states noted they were not aware of the toolkit.

Federal requirements for state agency collaboration. Federal statute requires state child welfare agencies to coordinate with Medicaid agencies and providers on specified aspects of foster care program design. However, state Medicaid agencies are not required to consult with child welfare agencies on Medicaid program design. For example, state child welfare agencies must coordinate with the state Medicaid agency to develop health care oversight and coordination plans, which are required to include information about the state's overall approach to screening schedules, treatment and monitoring, sharing of health care information, continuity of care, oversight of psychotropic medications, and avoidance of inappropriate diagnoses. These plans may include periodicity schedules that are more intensive than the general Medicaid schedule required under EPSDT.

Some state Medicaid agencies in our study indicated that they are proactively coordinating with child welfare agencies even if it is not federally required. For example, officials from Kentucky indicated that the child welfare and Medicaid agencies routinely coordinate with each other to develop initiatives focused on the child welfare population, such as increasing access to behavioral health services for children in foster care. Both agencies are under the umbrella of the state's Cabinet for Health and Family Services, which state officials noted helps their collaboration. Some of the states in our study indicated that they have taken steps to promote collaboration, including co-locating agency staff, encouraging joint participation in federal initiatives, and involving the behavioral health authority in the efforts to serve children and youth in the child welfare system. In one state in our study, state legislators attempted to mandate cross-agency collaboration for the child welfare population, but the effort failed.

State Medicaid officials reported more engagement with child welfare agencies in states that use a Medicaid specialized managed care model to provide services to children in foster care. The three states we studied that use a single, specialized MCO (Illinois, Kentucky, and West Virginia) to serve children in the child welfare system commented that coordination between the Medicaid and state child welfare agencies made it easier to implement the specialized managed care program.

Intra-state collaboration. State officials explained that cross-agency collaboration occurs most often when implementing new programs. For example, officials from New York's Medicaid and child welfare agencies collaborated before transitioning children in foster care into managed care, including convening weekly design meetings to discuss implementation plans and address potential challenges. After implementation, engagement tapered to monthly cross-agency meetings and office hours with Medicaid and child welfare staff participating to address questions from providers. New York officials also worked together to address gaps in their Medicaid provider network by implementing a special health facility license for their Voluntary Foster Care Agencies, which allowed agency clinical staff to deliver not only child welfare services for children in foster care, but also Medicaid health services, including EPSDT services (New York OCFS 2024).[14] Illinois Medicaid leaders coordinate with the state's behavioral health agency to design requirements for and implement a single, specialized MCO for children in foster care, YouthCare (YouthCare 2025a). Officials told us the state's behavioral health chief continues to participate in ongoing operational meetings.

Several state officials described a crisis orientation to collaboration, in which state agency officials work together when needed to address the extensive, and often frequent, needs of individual children in foster care. For example, state Medicaid and child welfare officials, as well as MCO personnel and providers, frequently engage with one another to identify treatment options for children in foster care with behavioral health diagnoses requiring residential or inpatient levels of care. Residential treatment services for children are behavioral health interventions intended to provide intensive clinical treatment to children with serious emotional disturbance. Qualified residential treatment programs, for example, provide time-limited trauma-informed treatment for children in foster care with behavioral health disorders (MACPAC 2025).[15] However, despite collaboration among state Medicaid and child welfare officials, the lack of available residential treatment beds may delay the receipt of needed care by children in the child welfare system. These children are often forced to wait in emergency departments or hospitals for prolonged periods of time until needed treatment becomes available.

National experts we spoke to stressed the importance of effective collaboration among state Medicaid, child welfare agencies, and MCOs. For example, child welfare agency leaders in one state provided input on the types of specialty providers included in the selected MCO's network based on their familiarity with the health care needs of children in foster care. In another state, Medicaid agency officials included child welfare agency officials in developing the contract between the state Medicaid agency and the specialized MCO; leaders from both of this state's agencies also described working together to request an expansion of the populations served under the state's waiver from CMS. Child welfare directors we spoke to in three states with specialized MCOs described asking for and receiving customized dashboards from either the state Medicaid agency or the specialized MCO for use in reporting on children in foster care.

Information sharing between Medicaid and child welfare agencies

Information sharing between Medicaid and child welfare agencies is needed to ensure access to care for children in the welfare system. The lack of federal rules related to interagency data sharing contributes to the inconsistent interpretation about which data can be shared and leads to limited data sharing between the state Medicaid and child welfare agencies. Additionally, little federal guidance exists on what data on children in foster care must be maintained in state Medicaid agency or MCO health information systems, unlike federal requirements for state child welfare agencies. Federal agency officials indicated that states have made relatively little progress with data sharing between Medicaid and child welfare agencies.

State Medicaid and child welfare agencies maintain separate health care data collection systems for children in foster care, putting them at risk of overlooked health needs, delayed routine care, interrupted treatments, and misuse of psychotropics (ACF and CMS 2022). Information technology systems maintained by state child welfare and Medicaid agencies vary in their capabilities to exchange information, leading staff to share information verbally or on paper or by entering it into a system that other

child-serving personnel are unable to access (Mark et al. 2022). State laws also vary regarding who has the authority to release medical information for children in foster care and who has the authority to consent to their treatment.

Stakeholders noted that perceived legal barriers to sharing information, technical and financial limitations (e.g., incompatible data formats and systems), and the cost of updating state information technology systems are barriers to interagency information sharing. For example, state officials indicated that confusion about and compliance concerns with the Health Insurance Portability and Accountability Act (HIPAA) and other confidentiality laws can lead to reluctance with data sharing across agencies. States use varying approaches to share data among state Medicaid and child welfare agencies, MCOs, and other agencies that may furnish services to children in foster care, such as departments of public health or behavioral health. For example, in Illinois, data are shared directly between the systems of child welfare, Medicaid, and the state's single, specialized Medicaid MCO serving children in foster care. Data are pushed daily between Medicaid and child welfare to link child information (e.g., address, phone number, caseworker) and Medicaid claims data, which are then stored in the state's Statewide Automated Child Welfare Information Systems (Illinois DCFS 2025).[16] The plan's information system includes a portal that child welfare staff can access, which includes information on screenings, assessments, care plans, referrals, and health records (e.g., medications, immunizations, lab work, and allergies).[17]

Medicaid eligibility and claims data reported to the Transformed Medicaid Statistical Information System (T-MSIS) do not differentiate children in foster care from other enrolled children who receive Title IV-E assistance (e.g., children receiving adoption assistance or in guardianship care). Consequently, some Medicaid fee-for-service and general MCO staff are unable to configure systems to efficiently produce foster care-specific reporting to share with child welfare agency staff. Officials in several states noted that they must rely on manual and time-consuming approaches to share data about children in foster care. In one state where data for children in foster care exist across several different state systems, child welfare staff pull down and send Medicaid staff a monthly flat file roster of children in foster care. This information is then matched against Medicaid claims data and sent back for staff to enter into the state's child welfare system. Interviewed state officials reported needing clearer federal expectations around data sharing, model data use agreements, and technical assistance.

Some states established data exchanges between state agencies and MCOs by using data sharing agreements. Officials in Connecticut described state statutory requirements that require Medicaid, child welfare, and behavioral health agencies to develop memorandums of understanding (MOUs), data sharing agreements, and business associate agreements to assist in coordination and sharing of data among agencies (CT § 19a-45a). In California, MCOs are required to enter into MOUs with child welfare county departments to support coordination and data sharing. The MCOs provide each county welfare agency with a dashboard with health utilization information, such as well-child visits or emergency department visits. To support implementation of these new requirements, the state Medicaid and child welfare agencies developed MOU templates for use by county agencies to ensure standardized and complete data exchange (California DHCS 2023).

The Commission has previously shared and maintains its view that collaboration between Medicaid and child welfare and other agencies should be a state priority, given that the vast majority of child welfare-involved youth are eligible for Medicaid-financed services and care coordination.

Factors that affect children in foster care

Several factors affect the health care needs of children and youth in the foster care system and the ability of state agencies to meet them. Some of the factors are unique to this population, while others affect access for all children but may have greater implications for children in foster care. These include the traumatic effects of foster care placement and placement instability, the subsequent need for trauma-informed care in particular to address behavioral health challenges, and workforce shortages.

Effects of foster care placement and placement instability. Our research and previously published research indicate that placement in foster care itself, and subsequent disruptions in placement, negatively

affect children's behavioral health and their access to consistent care. The Adoption Assistance and Child Welfare Act (P.L. 96-272) mandates that placements be in the least restrictive environment to meet the child's needs, so most children reside in foster care (28 percent) or kinship care (38 percent) rather than group homes or residential treatment facilities (9 percent) (ACF 2025, Szilagyi et al. 2015). Frequent placement transitions and changes in caregivers, who may lack information on the child's health needs and prior service use, affect continuity of care (Allen and Hendricks 2013). Beneficiary advocates stressed that continuing to reduce the number of children entering foster care is important to preserve community-based placements for children who do need to be removed from their families and to prevent placement disruptions.[18]

Some states are using evidence-based approaches that support children remaining in the home and prevent placement instability, such as mobile crisis response or intensive home-based treatment (IHBT). States are increasingly using mobile crisis response approaches to provide timely interventions in emergency situations, which may prevent a foster child from being removed from a foster family and placed in a congregate or inpatient setting. For example, New Jersey's mobile response program has significantly decreased disrupted placements; from 2014 to 2018, 95 to 97 percent of children serviced by the mobile response program were able to remain in their current living situation (Casey Family Programs 2018, New Jersey DCF 2017). Illinois state officials also described that mobile crisis response teams help streamline and improve the timeliness of behavioral health supports provided to children in foster care. Some state Medicaid programs cover IHBT, which is a community-based comprehensive service that includes crisis response, stabilization, and safety planning; psychoeducational skill building with youth; parenting and behavior management; cognitive and emotional coping with a focus on trauma-informed care; family systems therapy; and resilience and support-building interventions (Bruns et al. 2021).

In several states, Medicaid and child welfare agencies collaborate to implement therapeutic foster care programs as a strategy to create greater placement stability for certain children with complex needs. These programs can provide a higher level of support than traditional foster care, including specialized training for foster parents, to increase the likelihood that children stay in one place rather than moving several times. States consider therapeutic foster care as a means of preserving community-based placements instead of placing children in institutional settings. For example, Iowa's Medicaid and child welfare agencies started the Therapeutic Foster Home Program, which began as a pilot program and is now part of the state plan. The state enrolls children with serious emotional disturbance who live with family or a foster family in a 1915(c) waiver that provides in-home intensive behavioral health services (Iowa DHS 2024). Other state officials expressed a desire to implement similar therapeutic foster care programs in their states.

Need for trauma-informed care. The complex trauma histories of children before, during, and after placement in foster care, poor access to appropriate health care services, and the high prevalence of mental health conditions in this population necessitate having health care providers who are trained in trauma-informed care.[19] Pediatricians may need assistance from professionals trained in trauma-informed care to evaluate and diagnose children. For example, the American Academy of Pediatrics developed a practice standard it recommends for children in foster care that considers the complexity and intensity of their needs. It recommends that every child entering foster care receive a health screening within 72 hours of placement and a comprehensive health admission visit within 30 days of placement (Forkey et al. 2021). Foster care health experts recommend that children should receive trauma-informed mental health services consistent with their diagnoses. Trauma-informed, evidence-based therapies, such as parent-child interaction therapy, parent-child psychotherapy, and trauma-focused cognitive behavioral therapy, are treatments that pediatricians and therapists recommend to manage childhood trauma symptoms (Forkey et al. 2021, Szilagyi et al. 2015).

State officials highlighted that some children in foster care may have additional access issues related to their need for and lack of pediatric behavioral specialists trained in trauma-informed care. To improve access to trauma-informed care, several states have established partnerships with specific Medicaid providers to complete screenings and in some cases, provide follow-up care. For example, one state Medicaid

and child welfare agency partnered with local health care systems to develop urgent crisis centers, to serve children, including those in foster care, who are experiencing a behavioral health crisis but do not require emergency department level of care.

Workforce shortages. State Medicaid and child welfare agency officials described difficulty ensuring timely access to behavioral and oral health care for children in foster care due to provider shortages, especially in rural areas. State officials identified the lack of behavioral health providers accepting Medicaid as a challenge regardless of the Medicaid delivery system and managed care vehicle (e.g., general or specialized MCOs). State officials also noted that workforce shortages affect the states' ability to offer specialty residential care for some children in foster care. One state shared that they have attempted to ameliorate their Medicaid dental provider shortage with mobile dental vans in some regions. However, state officials noted anecdotal reports that despite these efforts for all children, children in foster care continue to not receive their oral care assessment within 30 days of entering placement, as required by the state's child welfare agency.

Specialized MCOs

Although most states using managed care for children in foster care enroll them in the same MCOs available to the general child beneficiary population, almost one-third of states (14 states and the District of Columbia) procure specialized MCOs (Thompson 2022). These specialized MCOs often cover additional benefits and exclusively serve either children and youth in the child welfare system (including children in foster care and children in subsidized adoption) or children in foster care plus other Medicaid populations with similar needs due to chronic and complex conditions. Some state officials indicated that specialized MCOs can help with care coordination and measure and track outcomes for children in foster care because these MCOs are designed to serve primarily just that population. Stakeholders shared that specialized MCOs may face the same core challenges present across all delivery systems (e.g., provider availability and network adequacy).[20]

Care coordination. Specialized MCOs hire care coordination staff with experience serving children in foster care given their membership. For example, Illinois requires an assigned care coordinator for every beneficiary enrolled in their specialized MCO who has training in serving children in the child welfare system, such as providing trauma-informed care (YouthCare 2025b). West Virginia requires that specialized MCO care managers have knowledge of children in foster care, coordinate health and social services, and ensure all members of the beneficiary's care team are informed (West Virginia DHHR 2023a). As previously mentioned, some states require MCOs to have liaisons to work with child welfare case managers to address these case managers' challenges with navigating the complex Medicaid system.

Population-specific initiatives and reporting. State and federal officials highlighted the ability of specialized MCOs to implement initiatives designed to address the needs of children in foster care and report data and outcomes for children in foster care. Quality improvement activities such as the performance improvement projects (PIPs) of specialized MCOs are focused on the youth in foster care by design.[21] Because specialized MCOs cover a narrowly defined population, PIP resources can be focused. West Virginia's specialized MCO implements PIPs designed to address specific needs of youth in foster care, youth who receive adoption assistance, and youth with serious emotional disorders. The MCO's PIPs have addressed lead screening, annual dental visits, care for adolescents, and reduction of out-of-state placements for children in foster care (West Virginia DHHR 2025, 2023b). We note that states could also require general MCOs to implement PIPs and quality improvement activities for children in foster care.

Officials from states using specialized MCOs to serve children in foster care reported that they can easily identify and address gaps with physical health and prevention services when all children in foster care are enrolled in one MCO. For example, Illinois's specialized MCO maintains a data dashboard tracking timeliness of well-child visits and immunizations and shares the dashboard with child welfare case workers, which can help them identify whether children are receiving this care (YouthCare

2025a). The specialized MCOs in Kentucky and West Virginia leverage care coordination staff to track EPSDT services. Both states require the plans' primary care providers to track EPSDT screenings for their assigned enrollees and participate in outreach to enrollees' caregivers when screenings are due (West Virginia DHHR 2023a, Kentucky CHFS 2021).

States with specialized managed care programs for children and youth in foster care collect and analyze data differently from states that have children in foster care enrolled in general managed care or fee for service (Thompson 2022). State officials indicated that their contracts sometimes require reporting from their specialized MCOs that is not required of general MCOs to capture data on specialized MCO members. Officials in another state indicated that having their entire population of children in foster care statewide enrolled in one MCO enables easier tracking of their health information, particularly if they change placements multiple times. Medicaid and child welfare officials in states using general MCOs indicated that they have limited visibility on health outcomes for enrollees who are children in foster care due to challenges in stratifying quality measures accordingly.

State administrative burden. Officials in states that enroll children in foster care in single, specialized MCOs described working with a single MCO as less administratively burdensome and simpler than having to work with multiple MCOs. One state Medicaid official indicated that having to keep track of processes and policies for just one MCO instead of multiple MCOs made it easier to work with MCO staff to resolve any issues and advocate for this population. Officials in states enrolling children in foster care into multiple general MCOs are required to navigate multiple policies and processes, which can add to administrative burden and confusion.

Next Steps

Children and youth in foster care have unique and complex health care challenges that require partnership between the state child welfare and Medicaid agencies to address. These myriad challenges include substantial behavioral health needs and risk of being overprescribed psychotropic medications, trauma associated with being removed from the home and placement instability, and fragmented care. States continue working to address these concerns—for example, by improving cross-agency collaboration and information sharing, supporting access to trauma-informed care, and leveraging relationships with the expertise of MCOs. However, cross-agency collaboration and information sharing has been limited thus far. Some states enroll youth in foster care in specialized managed care that serves a narrower population than general MCOs, which may ease certain functions (e.g., reporting). Further analysis is needed to better understand how states are leveraging specialty and general MCOs to meet the needs of children in foster care.

Endnotes

[1] States must cover infants (under age 1) and children age 1 to 18 up to 133 percent of the federal poverty limit (§§ 1902(a)(10)(A)(i)(I), (III), (VI), (VII); 1902(l)(1)(C) and (D); 1905(n); and 42 CFR 435.118). For children above the 1997 Medicaid eligibility levels, states may choose to provide Medicaid to targeted low-income children (under age 19) using funding from the State Children's Health Insurance Program (CHIP) (§ 1902(a)(10)(A)(ii)(XIV), 42 CFR 435.229). States may cover all children or a state-defined reasonable classification of children under age 21 up to the state's 1996 Aid to Families with Dependent Children (AFDC) levels (§§ 1902(a)(10)(A)(ii)(I) and (IV), 1905(a)(i), and 42 CFR 435.222).

[2] Federal regulations define the term "foster care" as 24-hour substitute care for children placed away from their parents or guardians and for whom the Title IV-E agency has placement and care responsibility. This includes but is not limited to placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes (45 CFR 1355.20(a)).

[3] Placement instability is when a child or youth has several placement changes outside of their home. A placement change, also known as a "placement disruption," occurs when a child in foster care is moved from one foster home or setting to another. This can involve moving to a different foster family home, a group home, or a residential facility or returning to the birth family (AECF 2025b, Casey Family Programs 2023).

[4] In the child welfare context, the goal of permanency is to reunite children with their biological parents or place them with another permanent family through an adoptive or guardianship arrangement (Stoltzfus 2018).

[5] MACPAC engaged Mathematica and its subcontractor, the Innovations Institute at the UConn School of Social Work, to conduct a systematic examination of federal requirements and state delivery methods of Medicaid benefits to children in the child welfare system. Children in the child welfare system may move between foster care, residential care, kinship care, reunification with their biological family, or adoption. This research focused on children currently in foster care. This study consisted of a federal policy review, literature review, in-depth profiles of seven states' child welfare and Medicaid systems, and more than 30 interviews with federal and state stakeholders as well as subject matter experts. The seven states are California, Connecticut, Illinois, Iowa, Kentucky, New York, and West Virginia.

[6] State laws vary regarding who has the authority to release medical and dental information for children in foster care and who has the authority to consent to their treatment.

[7] Psychotropic medications are generally used to treat conditions such as depression, anxiety, schizophrenia, bipolar disorder, and attention-deficit/hyperactivity disorder (ADHD), and are an important component in the treatment of behavioral health conditions (MACPAC 2015b).

[8] The Family First Prevention Services Act also gave states the option to use child welfare funds to access specific mental health and substance use treatment and in-home parenting skills training services to prevent children from being placed in foster care.

[9] Historically, children's eligibility for the Medicaid program was closely linked to cash payments under the former federal-state Aid to Families with Dependent Children (AFDC) program, also known as "welfare," and for those with disabilities, the federal Supplemental Security Income (SSI) program. Eligibility for Title IV-E is still tied to the former AFDC program (which ended in 1996) or the SSI rules. Although Congress has made a number of changes to expand Medicaid for all children based on their low-income states, children enrolled in Title IV-E programs are automatically connected to Medicaid coverage without having to complete a Medicaid application.

[10] For example, children younger than age 19 in foster care, but not receiving Title IV-E payments, are also Medicaid eligible since only the child's income is considered when the child is living in a home that does not include a biological parent, adoptive parent, or step parent. (MACPAC 2015a).

[11] States, such as Illinois, Massachusetts, New Jersey, and Ohio, provide transition supports and family-based therapy services for kids aging out of foster care (Landers 2019).

[12] Most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics (CMS 2024).

[13] MCOs must maintain eligibility, enrollment, claims and encounter, utilization management, and grievance and appeals data in formats prescribed by the state Medicaid agency and in compliance with the CMS reporting requirements (42 CFR 438.242).

[14] Voluntary Foster Care Agencies are authorized agencies approved by New York's Office of Child and Family Services to "care for or board out children and to provide limited health-related services as defined in regulations of the department either directly or indirectly through a contract arrangement" (New York OCFS 2024). New York state licensing law, Article 29-I, authorized Voluntary Foster Care Agencies to provide core health-related services, including nursing, skill building, Medicaid treatment planning and discharge planning, clinical consultation and supervision, and managed care liaison and administration. Other limited health-related services include screening, diagnosis, and treatment services related to physical, developmental, and behavioral health.

[15] For a qualified residential treatment program 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).

[16] Statewide Automated Child Welfare Information Systems (SACWIS) were a federally funded, comprehensive, computerized case management tool used by state child welfare agencies to track and manage information about children and families involved in the child welfare system (Illinois DCFS 2025). On June 2, 2016, the ACF issued a new regulation that replaced the SACWIS requirements with a Comprehensive Child Welfare Information System (CCWIS). The CCWIS final rule provides state and tribal Title IV-E agencies with flexibility to determine the size, scope and functionality of its information system and does not require

states to build a CCWIS. However, for states that elect to build and operate a CCWIS, the CCWIS final rule specifies the core requirements that must be met (ACF 2016).

[17] Approved health plan staff also have access to the state child welfare agency's system and the Illinois Department of Children and Family Service's Statewide Automated Child Welfare Information System (SACWIS), which contains information regarding child intake, investigations, case management, service planning, unusual incident reporting, and child health and education information (Illinois DCFS 2025).

[18] The number of children in foster care for fiscal year (FY) 2022 decreased by nearly six percent compared to FY 2021, which is a greater decrease than the nearly four percent decrease in FY 2021 relative to FY 2020 (ACF 2025).

[19] Trauma-informed care recognizes the signs and symptoms of trauma in patients, responds by fully integrating knowledge about trauma into procedures and services, and actively seeks to prevent re-traumatization (SAMHSA 2024).

[20] One review of Medicaid MCOs across 14 states found that, on average, 12 percent of primary care physicians left the network annually, and 34 percent exited over a period of five years, with specialized networks seeing the highest turnover rate (Ndumele et al. 2018).

[21] States must require all MCOs to implement performance improvement projects (PIPs). The purpose of PIPs is to achieve substantial improvement in measurement of quality performance with objective indicators as well as to generally sustain this improvement over time (42 CFR 438.330). States must require MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans to conduct clinical and non-clinical PIPs to examine access to and quality of care.

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Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI (in this section referred to as "CHIP") affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ''MedPAC'') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Verlon Johnson, MPA, (Chair), is executive vice president and chief strategy officer at Acentra Health, a Virginia-based health information technology firm that works with state and federal agencies to design technology-driven products and solutions that improve health outcomes and reduce health care costs. Ms. Johnson previously served as an associate partner and vice president at IBM Watson Health. Before entering private industry, she was a public servant for more than 20 years, holding numerous leadership positions, including associate consortium administrator for Medicaid and CHIP at the Centers for Medicare & Medicaid Services (CMS), acting regional director for the U.S. Department of Health and Human Services, acting CMS deputy director for the Center for Medicaid and CHIP Services (CMCS), interim CMCS Intergovernmental and External Affairs group director, and associate regional administrator for both Medicaid and Medicare. Ms. Johnson earned a master of public administration with an emphasis on health care policy and administration from Texas Tech University.

Robert Duncan, MBA, (Vice Chair), is chief operating officer of Connecticut Children's – Hartford. Before this, he served as executive vice president of Children's Wisconsin, where he oversaw the strategic contracting for systems of care, population health, and the development of value-based contracts. He was also the president of Children's Community Health Plan, which insures individuals with BadgerCare Plus coverage and those on the individual marketplace, and Children's Service Society of Wisconsin. He has served as both the director of the Tennessee Governor's Office of Children's Care Coordination and the director of the Tennessee Children's Health Insurance Program, overseeing the state's efforts to improve the health and welfare of children across Tennessee. Earlier, he held various positions with Methodist Le Bonheur Healthcare. Mr. Duncan received his master of business administration from the University of Tennessee at Martin.

Heidi L. Allen, PhD, MSW, is an associate professor at Columbia University School of Social Work, where she studies the impact of social policies on health and financial well-being. She is a former emergency department social worker and spent several years in state health policy, examining health system redesign and public health insurance expansions. In 2014 and 2015, she was an American Political Science Association Congressional Fellow in Health and Aging Policy. Dr. Allen is also a standing member of the National Institutes of Health's Health and Healthcare Disparities study section. Dr. Allen received her doctor of philosophy in social work and social research and a master of social work in community-based practice from Portland State University.

Sonja L. Bjork, JD, is the chief executive officer of Partnership HealthPlan of California (PHC), a non-profit community-based Medicaid managed care plan. Before joining PHC, Ms. Bjork worked as a dependency attorney representing youth in the child welfare system. During her tenure at PHC, she has overseen multiple benefit implementations and expansion of the plan's service area. Ms. Bjork served on the executive team directing the plan's $280 million strategic investment of health plan reserves to address social determinants of health. These included medical respite, affordable housing, and substance use disorder treatment options. Ms. Bjork received her juris doctor from the UC Berkeley School of Law.

Doug Brown, RPh, MBA, is senior vice president of value and access at Red Nucleus, with more than 30 years of pharmacy management experience. Mr. Brown provides executive-level health care consulting and market access support services to life science companies and health care organizations, including the development of value- and outcomes-based contracting strategies with state Medicaid programs, pharmacy benefit administrators, manufacturers, and the Centers for Medicare & Medicaid Services. Before joining COEUS in 2020, he served in several roles for Magellan Rx Government, including as the chief strategy officer. While at Magellan, he led preferred drug list management for more than half the state Medicaid programs in the country, provided subject matter expertise on federal and state government legislation that impacted state Medicaid programs, and offered policymakers a national view of evolving events in Medicaid. Mr. Brown is a registered pharmacist and holds a bachelor of science in pharmacy from the University of Rhode Island and a master of business administration from Virginia Commonwealth University.

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Angelo P. Giardino, MD, PhD, MPH, is the Wilma T. Gibson Presidential Professor and chair of the Department of Pediatrics at the University of Utah's Spencer Fox Eccles School of Medicine and chief medical officer at Intermountain Primary Children's Hospital in Salt Lake City, Utah. Before this, Dr. Giardino worked at Texas Children's Health Plan and Texas Children's Hospital from 2005 to 2018. He received his medical degree and doctorate in education from the University of Pennsylvania, completed his residency and fellowship training at the Children's Hospital of Philadelphia, and earned a master of public health from the University of Massachusetts. He also holds a master in theology from Catholic Distance University and a master in public administration from the University of Texas Rio Grande Valley.

April Hartman, MD, FAAP, is a board-certified general pediatrician with over 25 years of clinical experience in both rural and urban settings. She serves as professor and division chief of general pediatric and adolescent medicine at the Medical College of Georgia at Augusta University. She currently chairs the Medicaid Task Force for the Georgia Chapter of the American Academy of Pediatrics; serves as president of the Board of Directors for Child Enrichment, Inc.; and is the medical liaison for Resilient Communities of East Georgia. Dr. Hartman earned her medical degree from Meharry Medical College in Nashville, Tennessee.

Dennis Heaphy, MPH, MEd, MDiv, is a health justice advocate and researcher at the Massachusetts Disability Policy Consortium, a Massachusetts-based disability rights advocacy organization. He is also a dually eligible Medicaid and Medicare beneficiary enrolled in One Care, a plan operating in Massachusetts under the CMS Financial Alignment Initiative. Mr. Heaphy is engaged in activities that advance equitable whole person–centered care for beneficiaries in Massachusetts and nationally. He is cofounder of Disability Advocates Advancing Our Healthcare Rights (DAAHR), a statewide coalition in Massachusetts. DAAHR was instrumental in advancing measurable innovations that give consumers voice in One Care. Examples include creating a consumer-led implementation council that guides the ongoing development and implementation of One Care, an independent living long-term services and supports coordinator role on care teams, and an independent One Care ombudsman. Previously, he worked as project coordinator for the Americans with Disabilities Act for the Massachusetts Department of Public Health (MDPH) and remains active on various MDPH committees that advance health equity. In addition to policy work in Massachusetts, Mr. Heaphy is on the advisory committee of the National Center for Complex Health & Social Needs and the Founders Council of the United States of Care. He is a board member of Health Law Advocates, a Massachusetts-based nonprofit legal group representing low-income individuals. He received his master of public health and master of divinity from Boston University and master of education from Harvard University.

Timothy Hill, MPA, is an experienced health policy executive. Mr. Hill held several executive positions within the Centers for Medicare & Medicaid Services, including as a deputy director of the Center for Medicaid and CHIP Services, the Center for Consumer Information and Insurance Oversight, and Center for Medicare. Mr. Hill earned his bachelor's degree from Northeastern University and his master's degree from the University of Connecticut.

Carolyn Ingram, MBA, is plan president and senior vice president of Molina Healthcare, Inc., which provides managed health care services under the Medicaid and Medicare programs as well as through state insurance marketplaces. Previously, Ms. Ingram served as the director of the New Mexico Medicaid program, where she launched the state's first managed long-term services and supports program. She also held prior leadership roles, including vice chair of the National Association of Medicaid Directors and chair of the New Mexico Medical Insurance Pool.

Ms. Ingram earned her bachelor's degree from the University of Puget Sound and her master of business administration from New Mexico State University.

Anne Karl, JD, is a partner at Manatt Health with 15 years of experience in health care. She advises states and providers across the country on a wide range of Medicaid and CHIP issues. Ms. Karl has expertise with complex Medicaid payment and financing issues. She also leads teams that support states as they develop, negotiate, and implement Medicaid 1115 waivers. Ms. Karl received her law degree from Yale Law School.

Patti Killingsworth is a senior consultant for government strategy at Imagine Pediatrics. She is a former Medicaid beneficiary and lifelong family caregiver with 25 years of Medicaid public service experience. Previously, she was the assistant commissioner and chief of LTSS for TennCare, the Medicaid agency in Tennessee. Ms. Killingsworth received her bachelor's degree from Missouri State University.

John B. McCarthy, MPA, is a founding partner at Speire Healthcare Strategies, which helps public and private sector entities navigate the health care landscape through the development of state and federal health policy. Previously, he served as the Medicaid director for both the District of Columbia and Ohio, where he implemented a series of innovative policy initiatives that modernized both programs. He has also played a significant role nationally, serving as vice president of the National Association of Medicaid Directors. Mr. McCarthy holds a master's degree in public affairs from Indiana University's Paul H. O'Neill School of Public and Environmental Affairs.

Adrienne McFadden, MD, JD, is vice president and chief medical officer of Medicaid at Elevance Health, where she serves as the strategic clinical thought leader for the Medicaid line of business. After beginning her career in emergency medicine, Dr. McFadden has held multiple executive and senior leadership roles in health care, digital health, and public health. Dr. McFadden received her medical and law degrees from Duke University.

Michael Nardone, MPA, currently leads an independent consulting practice providing strategic advice on Medicaid health policy and long-term services and supports. He has extensive experience in leading health and human services programs at the state, local, and national levels, most recently as director of the Disabled and Elderly Health Programs Group at the Center for Medicaid and CHIP Services. Mr. Nardone previously led the Pennsylvania Department of Human Services as acting secretary and was the state's Medicaid director, serving on the executive committee of the National Association of Medicaid Directors. After leaving Pennsylvania state government, he joined Health Management Associates (HMA) as a managing principal and led the establishment of the HMA Harrisburg office. He also served as the city of Philadelphia's deputy managing director for special needs housing and has held government relations positions for the Commonwealth of Massachusetts and the University of Pennsylvania Health System. Mr. Nardone received a master's degree in public affairs from the Princeton School of Public and International Affairs.

Jami Snyder, MA, is the president and chief executive officer of JSN Strategies, LLC, where she provides health care–related consulting services to a range of public and private sector clients. Previously, she was the Arizona cabinet member charged with overseeing the state's Medicaid program. During her tenure, Ms. Snyder spearheaded efforts to stabilize the state's health care delivery system during the public health emergency and advance the agency's Whole Person Care Initiative. Ms. Snyder also served as the Medicaid director in Texas and as the president of the National Association of Medicaid Directors. Ms. Snyder holds a master's degree in political science from Arizona State University.

Biographies of Staff

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Ranjani Anirudhan, MPH, is a research assistant. Before joining MACPAC, Anirudhan worked as a Title V Maternal and Child Health intern for the Nevada State Health Department and was a Teach for America corps member, working in low-income schools at the intersection of health and education. Anirudhan received a master of public health from The George Washington University and a bachelor of science in neuroscience from the University of Texas at Austin.

Gabby Ballweg is an analyst. Before joining MACPAC, Ballweg worked as the project coordinator for the Wisconsin Community Health Empowerment Fund and interned at Action on Smoking and Health. Ballweg graduated from the University of Wisconsin, Madison, with a bachelor of science in biology and political science.

Kirstin Blom, MIPA, is a policy director. Before joining MACPAC, Blom was an analyst in health care financing at the Congressional Research Service. Before that, Blom worked as a principal analyst at the Congressional Budget Office, estimating the federal budgetary effects of proposed legislation affecting the Medicaid program. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office. Blom holds a master of international public affairs from the University of Wisconsin, Madison, and a bachelor of arts in international studies and Spanish from the University of Wisconsin, Oshkosh.

Caroline Broder is the director of communications. Before joining MACPAC, Broder led strategic communications for a variety of health policy organizations and foundations, developing and implementing communications strategies to reach both the public and policymakers. Broder has extensive experience working with researchers across multiple disciplines to translate and communicate information for the public. Earlier positions include working as a reporter covering health and technology policy issues. Broder holds a bachelor of science in journalism from Ohio University.

Michelle Conway, MPA, is a senior analyst. Most recently, Conway worked for the Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare & Medicaid Services" working as a state lead for states participating in the Financial Alignment Initiative. Conway provided technical assistance to states, including on the transition from the Medicare-Medicaid plans to Medicare Advantage dually eligible special needs plans. Before joining MMCO, Conway was a program analyst at the Center for Health Care Strategies, working on payment and delivery system reform, including evaluating value-based payment policies and regulations in Medicaid. Conway received a master of public affairs in domestic policy from Princeton University, with a certificate in health and health policy, and a bachelor's degree in urban studies from Columbia University.

Tamara Huson, MSPH, is the contracting officer and a senior analyst. Before joining MACPAC, Huson worked as a research assistant in the Department of Health Policy and Management at The University of North Carolina. Huson also worked for the American Cancer Society and completed internships with the North Carolina General Assembly and the Foundation for Health Leadership and Innovation. Huson holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of arts in biology and global studies from Lehigh University.

Joanne Jee, MPH, is a policy director. Before joining MACPAC, Jee was a program director at the National Academy for State Health Policy, focused on children's coverage issues. Jee also has been a senior analyst at the U.S. Government Accountability Office, a program manager at The Lewin Group, and a legislative analyst in the U.S. Department of Health and Human Services Office of Legislation. Jee has a master of public health from the University of California, Los Angeles, and a bachelor of science in human development from the University of California, Davis.

Linn Jennings, MS, is a senior analyst. Before joining MACPAC, Jennings worked as a senior data and reporting analyst at Texas Health and Human Services in the Women, Infants, and Children program and as a budget and policy analyst at the Wisconsin Department of Health in the Division of Medicaid. Jennings holds a master of science in population health sciences with a concentration in health services research from the University of Wisconsin, Madison, and a bachelor of arts in environmental studies from Mount Holyoke College.

Patrick Jones, MPP, is an analyst. Before joining MACPAC, Jones served as a consultant at Koné Consulting, LLC, supporting multiple projects related to human services and the Medicaid program. Jones received a master of public policy from Georgetown University's McCourt School of Public Policy and a bachelor of arts from Bard College.

Carolyn Kaneko is the graphic designer. Before joining MACPAC, Kaneko was design lead at the Artist Group, handling a wide variety of marketing projects. Kaneko's experience includes managing publication projects at all stages of design production and collaborating in the development of marketing strategies. Kaneko holds a bachelor of arts in art from Salisbury University with a concentration in graphic design.

Junhua (Lucy) Liu, MSCS, is the information technology (IT) service director, bringing more than 20 years of experience in information technology leadership, cybersecurity, and digital transformation. Before joining MACPAC, Liu was the vice president of IT at American Occupational Therapy Association for more than five years. Liu holds a master of science in computer science from Ball State University and is a certified Project Management Professional.

Kate Massey, MPA, is the executive director. Before joining MACPAC, Massey was senior deputy director for the Behavioral and Physical Health and Aging Services Administration with the Michigan Department of Health and Human Services. Massey has nearly 20 years of operational and policy expertise in Medicaid, Medicare, CHIP, and private market health insurance. Massey previously served as chief executive officer for Magellan Complete Care of Virginia. Before that, Massey served as vice president for Medicaid and Medicare and government relations for Kaiser Permanente of the Mid-Atlantic States, overseeing the launch of two Medicaid managed care organizations in Virginia and Maryland. Massey also has worked for Amerigroup, establishing its Public Policy Institute and serving as executive director. Earlier positions include working for the Office of Management and Budget, where Massey led a team focused on Medicaid, the State Children's Health Insurance Program (CHIP), and private health insurance market programs. Massey also served as unit chief of the Low-Income Health Programs and Prescription Drugs Unit in the Congressional Budget Office. Massey has a master of public affairs from the Lyndon B. Johnson College of Public Policy at the University of Texas at Austin and a bachelor of arts from Bard College.

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Brian O'Gara is an analyst. Before joining MACPAC, O'Gara was a health policy analyst at the Bipartisan Policy Center, with a focus on improving and expanding access to high-quality long-term services and supports. O'Gara graduated from American University with a bachelor of arts in political science and public health.

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Katherine Rogers, MPH, PhD, is the deputy director. Before joining MACPAC, Dr. Rogers served as long-term care director for the Medicaid program in Washington, DC, overseeing day-to-day operations in the Medicaid long-term care system as well as the launch of two new integrated Medicare-Medicaid programs. Before that, Dr. Rogers worked on programs serving people who are eligible for Medicare and Medicaid, long-term care users, and other complex populations in both nonprofit and government roles. Dr. Rogers holds degrees from The George Washington University, the University of Pennsylvania, and Cornell University.

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Chris Thompson is a principal analyst. Before joining MACPAC, Thompson was the division director for the Division of Reimbursement Policy within the Financial Management Group at the Centers for Medicare & Medicaid Services (CMS), overseeing the analysis of state payment methodologies, financing structures, and the claiming of state program administrative expenditures. With a 21-year career at CMS, Thompson brings knowledge and experience in Medicaid financial policy, collaborative problem-solving, and guidance of teams through complex regulatory and fiscal challenges. Chris contributed to major policy initiatives, strengthened state-federal relations, and helped advance CMS's mission to support high-quality, sustainable health programs. Chris holds a bachelor of science in business administration from Bowie State University.

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