May 7, 2026

Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

Review of recommendations and draft chapter for June report

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Medicaid and CHIP Payment and Access Commission

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Overview

- Review of draft June 2026 chapter
- Draft recommendations
- Next steps

Review of Draft June 2026 Chapter

Background

- Federal law requires services (e.g. behavioral health) be provided to youth with disabilities
  - In the most integrated setting appropriate (ADA, P.L 101-336); and
  - In community-based settings if they are appropriate, and can be reasonably accommodated (Olmstead v. L.C.)
- Some youth with intense treatment needs or who pose a safety risk to themselves or their families and cannot be served in the community require access to residential treatment
- Residential treatment services for youth may be provided in a psychiatric residential treatment facility (PRTF), qualified residential treatment program (QRTP) for children in foster care, or in other settings that do not meet the requirements of a PRTF or QRTP

Overview of Federal Rules

- The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement mandates that states provide beneficiaries age 21 and younger access to medically necessary Medicaid services
- The institution for mental diseases (IMD) exclusion prohibits Medicaid payments for services provided in IMDs unless the state covers PRTF services provided (i.e., psych under 21 benefit)
- Federal rules set requirements for PRTFs and QRTPs (e.g., accreditation, certification or assessment of need, and plan of care)

Information on Facility and Bed Availability

- Difficulty finding real-time information on facility and bed availability and specialized care can hinder access to residential services
- Some state and federal sources provide information but there are gaps in information (e.g., state registries, FindTreatment.gov)
- Existing federal bed registry efforts and databases can be instructive regarding development and implementation
  - Centers for Disease Control and Prevention's (CDC) Hospital Bed Capacity Project: 12 to 18 month phase-in in three pilot states, state-run, voluntary participation, updates every 15 to 60 minutes, not accessible to the public
  - The Substance Abuse and Mental Health Services Administration's (SAMHSA) FindTreatment.gov: phased-in approach, federally-run, voluntary participation in facility survey, updated annually and as needed, searchable database but does not provide bed availability

Data Collection, Sharing, and Analysis

- There is no single federal data source on the use of residential treatment, including in out-of-state facilities
- PRTF annual attestation statements to states must include the number of beneficiaries receiving the psych under 21 services in the facility, the number of out-of-state patients, and a list of states from which it has received payment for psych under 21 services
- Transformed Medicaid Statistical Information System (T-MSIS) behavioral health data book provided information on use of services by state, but does not differentiate between children and adults, in- or out-of-state users

Out-of-state Placements

- Out-of-state placements occur if in-state facilities are unable to meet a child's needs or denies admission, but there is no national data source on these placements
- Out-of-state placements can make it difficult to maintain connections with family and transition back to the community in the sending state
- Federal rules for discharge planning are brief and do not address out-of-state considerations

Returning to the Community

- Discharge planning can help facilitate transitions from inpatient settings to other health care settings, including community-based providers
- CMS has highlighted the importance of discharge planning and beneficiaries returning to their communities upon discharge (e.g., Section 1945A Health Homes, Medicare hospital discharge)
- Some states have publicly posted PRTF discharge policies that describe required elements for the discharge plans
- Some beneficiaries may also experience delayed discharge as a barrier to beneficiaries returning to their respective communities

Draft Policy Recommendations

Draft Recommendation 1: Recommend Congress to require HHS to develop and maintain a directory of youth residential treatment facilities

To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require that the Secretary of the U.S. Department of Health and Human Services (HHS) develop, maintain, and make publicly available a federally-administered, up-to-date, real-time registry of youth residential treatment facilities serving Medicaid beneficiaries. The Secretary should work with HHS agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. At a minimum, this registry should include information on the behavioral health conditions facilities specialize in treating, ages served, regularly updated bed availability as soon as possible after a bed becomes available for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities. The Secretary should leverage information already being collected by federal agencies and states, while also integrating other information needed to determine whether the facility can meet beneficiary need

Draft Recommendation 1: Rationale

- There is no single source of information to help states, families, and providers identify Medicaid-serving residential treatment facilities, the conditions they treat, and bed availability, which can lead to delays in services for youth needing care
- There is no federal mandate that states or CMS produce such information about residential treatment facilities
- Information currently collected by federal and state agencies can be limited and is not always designed to provide bed availability

Draft Recommendation 1: Implications

- **Federal:** CBO estimates that this recommendation would not affect federal direct spending
- **States:** States may experience greater ease in identifying facilities with available. States may be asked to take on responsibilities such as educating providers and users of the registry and monitoring use of the registry
- **Enrollees:** Enrollees may experience greater ease in identifying facilities with available beds
- **Plans:** Plans may experience greater ease in identifying facilities with available beds
  Providers: Providers may experience greater ease in identifying facilities with available beds. Facilities will have to update the bed registry according to specifications

Draft Recommendation 2: Recommend CMS to report on the use of residential treatment services, including non-PRTFs and out-of-state providers

To ensure that reliable and consistently collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities (PRTF), non-PRTFs, and out-of-state residential treatment providers. This report should provide available data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; average length of stay; and discharge outcomes. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid. If data are unavailable to report on key measures, CMS should develop a plan for collecting and publicly reporting on the data elements. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts

Draft Recommendation 2: Rationale

- Data are not readily available to understand use and outcomes of residential treatment facility services, which could be used to develop interventions to address access concerns
- Federal regulations do not require that CMS or states report information on the use of residential treatment in non-PRTF settings or out-of-state providers
- Congress has previously called for data on the use of out-of-state providers serving children with medical complexity in Section 1945A health homes

Draft Recommendation 2: Implications

- **Federal:** CBO estimates this recommendation would increase federal direct spending by less than $10M over the 2026-2036 period
- **States:** States may have to take on additional data collection and reporting. They may also experience some costs associated with systems changes. States will have new information on use of residential treatment services
- **Enrollees:** We do not anticipate any direct effects on enrollees
- **Plans:** We do not anticipate any direct effects on plans
- **Providers:** Providers may incur resource expenditures (e.g., related to systems changes, staff time)

Draft Recommendation 3: Recommend CMS to revise federal rules to establish minimum requirements for discharge planning

To ensure that youth discharged from out-of-state residential treatment facilities return to their home states and communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 441.155 to establish minimum requirements for discharge planning processes that mandate that the process involves all relevant actors including providers, plans, families and caretakers; and identifies an appropriate community provider or alternative residential placement prior to discharge and that this alternate placement has availability to accept the beneficiary. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning for an out-of-state beneficiary, and establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers

Draft Recommendation 3: Rationale

- Research shows that discharge planning can help facilitate transitions from inpatient to other health care settings, including in the community
- Federal PRTF rules require a plan of care that includes a discharge plan, but does not elaborate on requirements for discharge planning, including for youth in out-of-state facilities
- CMS has expectations for discharge planning and beneficiaries returning to the community for other CMS programs (e.g., Section 1945A health homes, Medicare hospital discharge planning)

Draft Recommendation 3: Implications

- **Federal:** CBO estimates this recommendation would increase federal direct spending by less than $10M over the 2026-2036 period
- **States:** States may need to develop and disseminate guidance to plans and providers regarding discharge planning. States may need to engage in oversight and monitoring
- **Enrollees:** Enrollees in out-of-state placement and their families and caregivers will have a clearer understanding of how discharge plans should be developed. They may also experience improved transitions back to their communities
- **Plans:** Plans would establish guidance for network and non-network providers regarding discharge planning and coordinating the return to community of youth. Plans would gain information about the ongoing treatment needs of youth in out-of-state facilities
- **Providers:** Providers may need to spend more time on discharge planning than they currently do. Post-discharge providers will have information about the health care needs of youth coming into their care from out-of-state facilities

Next Steps

Next steps

- This draft recommendation will be subject to a vote
- The chapter will be included in the June 2026 Report to Congress
- Feedback on clarity and tone of the chapter are welcome

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