

Chapter 4:

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

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## Recommendations

- 4.1** 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 and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability 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.
- 4.2** 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 contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. 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.
- 4.3** 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, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process 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.

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## Key Points

- Medicaid supports a wide range of services for children and youth with complex behavioral health needs. These include residential treatment services, which are considered when medically appropriate.
- Federal law prohibits Medicaid payments for services provided to beneficiaries residing in an institution for mental diseases. However, there are several exceptions, including the “psych under 21” benefit. The benefit allows states to cover medically necessary services delivered in psychiatric residential treatment facilities, a psychiatric hospital, or a psychiatric unit of a general hospital to beneficiaries younger than age 21.
- The lack of easily attainable and specific information about the facilities serving Medicaid beneficiaries (e.g., bed availability and specialty area) makes it difficult for providers, beneficiaries, and caregivers to find residential treatment. States may seek out-of-state placement if an in-state placement cannot be identified.
- There is no single federal data source on the use of residential treatment by children enrolled in Medicaid, making it difficult to conduct a comprehensive analysis of their utilization of residential treatment services.
- Beneficiaries who are treated in residential treatment facilities, particularly out-of-state facilities, can experience challenges returning to their communities. Discharge planning can help with transitions from inpatient settings to community-based settings; however, current federal rules for discharge planning lack specificity.
- The Commission’s recommendations address challenges that providers, families, and states face when identifying facilities with the capability and capacity to treat beneficiaries; the lack of publicly available, easily obtainable information on the use and users of residential treatment services; and the challenges that beneficiaries in a residential placement face in returning to their communities.
- MACPAC will continue to explore work that focuses on addressing the behavioral health needs of children enrolled in Medicaid with complex behavioral health needs across the continuum of care, including access to intensive community-based behavioral health services.

# CHAPTER 4: Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

The ongoing youth behavioral health crisis has been well documented, and research shows that children, including those with Medicaid, can face barriers to care in both community-based and residential treatment settings. For children whose needs cannot be met in the community, it is important that residential treatment options be available when they are needed. Medicaid supports a wide range of behavioral health services for children, including residential treatment programs when determined medically appropriate (MACPAC 2021).

Residential treatment services for children are clinical behavioral health interventions to treat individuals, including youth, with serious emotional disturbance (SED), serious mental illness (SMI), and substance use disorder (SUD).<sup>1</sup> Medicaid-enrolled children and youth typically access this intensive level of care in psychiatric residential treatment facilities (PRTFs), qualified residential treatment programs (QRTPs), or other settings. Prior analyses of Medicaid claims data have demonstrated that approximately 4.2 percent of Medicaid-enrolled children use residential treatment (Pires et al. 2018).<sup>2</sup> Studies in selected states have found that teens, males, and Black children are more likely to have disproportionately high uses of residential treatment (Rose and Lanier 2017, Wulczyn et al. 2015, Connor et al. 2004). In addition, youth involved in the child welfare system represent a small share of the Medicaid population but a disproportionate share of admissions to residential behavioral health treatment settings, including through custody relinquishment and the use of voluntary placement agreements (Hill 2017).

Children with behavioral health needs may be referred to residential treatment settings from several sources,

ranging from providers to various child welfare agencies. Children may also be referred for residential treatment from emergency departments (EDs), mobile crisis response providers, urgent care, and home- and community-based service providers after a crisis or exacerbation in symptoms. In addition, in certain circumstances, courts may refer children who are involved in the child welfare system for placement in PRTFs or QRTPs if they have behavioral health needs that cannot be met in the community.<sup>3</sup>

As part of MACPAC's ongoing examination of children's access to behavioral health care, the Commission studied the factors affecting access to residential treatment for youth who need such services. The June 2025 report to Congress described Medicaid coverage of residential treatment services and the federal policies informing that coverage; the ways in which children may be referred for residential treatment, including in out-of-state facilities; and barriers to appropriate residential treatment. The Commission described both upstream and downstream effects on access to residential care when there is a lack of availability of home- and community-based behavioral health services; the challenges state Medicaid agencies, beneficiaries, and their families and providers experience in identifying treatment facilities with the capability and capacity to serve children in need of care; the lack of a nationwide data source to understand the use and users of residential behavioral health treatment; and the factors informing the use of out-of-state facilities.

Based on these findings, the Commission recommends:

- 4.1 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 and the Substance Abuse and Mental Health Services Administration, state Medicaid

agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability 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.

- 4.2 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 contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. 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.
- 4.3 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, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential

placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process 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.

Building on the chapter in the June 2025 report to Congress, this chapter begins with a brief overview of access to residential treatment for Medicaid-enrolled youth, including the types of facilities available and the federal policies describing facility standards. The chapter then reviews the key findings from our work, highlighting the challenges families and providers face in locating appropriate placements for Medicaid-covered youth needing residential treatment, the limited publicly available data on the use and users of residential treatment facilities in Medicaid, and challenges youth in out-of-state placement face in returning to their communities. The chapter describes the Commission's policy recommendations for addressing these key challenges, their rationale, and the implications.

## Background

Federal laws protect individuals, including children, from inappropriate use of institutional care, such as residential treatment facilities, and require state Medicaid agencies to ensure access to residential care for covered children who need it. The Americans with Disabilities Act of 1990 (ADA, P.L. 101-336) prohibits discrimination against individuals with disabilities, including Medicaid beneficiaries with SED and SMI, and requires that services such as necessary mental health treatment be provided in the most integrated setting appropriate. Under the U.S. Supreme Court's ruling in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), states must provide treatment for individuals with disabilities, including SMI and SED, in community-based settings if the individuals do not oppose such services and if such placement is appropriate and can be reasonably accommodated by the state. Congress and the Centers for Medicare & Medicaid Services (CMS) have established key federal rules for Medicaid coverage of residential treatment services.

## Early and Periodic Screening, Diagnostic, and Treatment

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement, consistent with Section 1905(r)(5) of the Social Security Act (the Act), entitles eligible Medicaid beneficiaries age 21 and younger to any treatment, including residential treatment, that is necessary to correct or ameliorate physical or mental conditions. Thus, children and youth with behavioral health needs have a statutory right to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment is medically necessary. States have flexibility in how they meet their obligation to assess the availability of Section 1905(a) services for EPSDT-eligible youth.

## Institutions for mental diseases

Federal Medicaid statute generally prohibits payments for services provided to beneficiaries residing in institutions for mental diseases (IMDs) (§ 1905(a)(30) (B) of the Act). 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 persons with mental diseases, including medical attention, nursing care, and related services” (§ 1905(i) of the Act). The IMD exclusion applies to facilities with more than 16 beds, including inpatient SUD and mental health treatment facilities as well as residential SUD and mental health programs (MACPAC 2019, CMS 2012). The definition encompasses several different types of facilities. The exclusion was designed to ensure that states and local governments retained their historical responsibility for funding inpatient psychiatric care (MACPAC 2019).

The “psych under 21” benefit is a federal statutory exemption to the IMD exclusion for children younger than age 21 (§§ 1905(a)(14), (16), (29)(B) of the Act).<sup>4</sup> States that have adopted this optional benefit can cover services delivered in a PRTF, a psychiatric hospital, or a psychiatric unit of a general hospital. Under the EPSDT requirement, all states must cover this optional benefit if an assessment determines that the level of service is medically necessary. If a state is unable to provide the psych under 21 benefit within its own borders, the state Medicaid program must cover the needed services in an out-of-state facility (CMS 2012).

Section 1115 demonstration authority also permits states to receive federal financial participation (FFP) for services provided to Medicaid beneficiaries with SMI or SED during short-term stays in psychiatric hospitals or residential treatment settings that are IMDs. States may also use the Section 1115 demonstration authority to receive FFP for services delivered to Title IV-E beneficiaries (i.e., children in foster care) in a QRTP that is an IMD (CMS 2019).<sup>5</sup> States must commit to improving connections to community-based care after stays in acute care settings, ensure a continuum of care is available to address the needs of beneficiaries with SMI or SED, provide a full array of crisis stabilization services, and promptly engage beneficiaries in treatment (CMS 2018).

Medicaid-enrolled children and youth typically access this intensive level of care in PRTFs, QRTPs, or other settings.

## Facilities

Children with Medicaid in need of residential treatment services generally access residential treatment services in PRTFs and QRTPs.

**PRTFs.** PRTFs are non-hospital-based facilities that have an agreement with a state Medicaid agency to provide the psych under 21 benefit. Before admission to a PRTF, a youth’s health care team certifies that community resources do not meet the treatment needs of the youth, treatment of the youth’s psychiatric condition requires an inpatient level of care under the direction of a physician, and services can be reasonably expected to improve the youth’s condition or prevent regression. Emergency admissions must be certified within 14 days of admission (42 CFR 441.152). The team must include a physician with competence in the diagnosis and treatment of mental illness (42 CFR 441.153). During their admission, a youth must receive active treatment specified in an individualized plan of care that must be reviewed at least every 30 days. The individualized plan of care must be based on a diagnostic evaluation, be developed by an interdisciplinary team of licensed mental health providers, include state treatment objectives, prescribe specific therapies and activities, and include post-discharge plans to ensure continuity of care with the youth’s family, school, and community (42 CFR 141.154-156).

**QRTPs.** The Family First Prevention Services Act, enacted as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), made substantial reforms to the child welfare system, including restricting the availability of Title IV-E foster care maintenance payments to 14 days unless the child is placed in a newly defined category of group homes called QRTPs.<sup>6</sup> QRTPs provide time-limited, trauma-informed treatment for children, including those in foster care with behavioral health disorders whose needs cannot be met in a family setting. Medicaid may reimburse for clinical, therapeutic, and rehabilitation services, depending on the state's Medicaid plan, if the QRTP is not an IMD (BBI 2019). Title IV-E may not reimburse the cost of any treatment services received by any child regardless of the child's Title IV-E eligibility. Title IV-E funds may reimburse QRTPs for maintenance costs, which include room and board, supervision, case management, and allocated indirect costs for children who are eligible. If a QRTP claims FFP for services under a 1915(i) state plan amendment, it must meet the home- and community-based service setting requirements (42 CFR 441.710(a)(1) and (2)).

QRTPs with more than 16 beds are likely to be subject to the IMD exclusion. FFP is available only if the facility complies with PRTF standards or the state uses a Section 1115 demonstration to deliver services to Title IV-E beneficiaries (i.e., children in foster care) in a QRTP that is an IMD (CMS 2019). An expert we spoke with noted that including QRTPs in Section 1115 demonstrations is administratively burdensome for states due to requirements for monitoring, reporting, and budget neutrality and that the length of stay limits previously approved by CMS are likely insufficient to treat youth who are eligible for QRTP placement. Federal QRTP rules allow 30 days to conduct an assessment to develop behavioral health treatment goals.

**Number of facilities.** In fiscal year (FY) 2026, there were 376 PRTFs in 36 states (CMS 2026). CMS reported that nationwide, the number of PRTFs declined from 372 in 34 states in FY 2021 to 344 in 34 states in FY 2023 before increasing in 2024 (360), 2025 (365), and 2026 (376) (CMS 2026).<sup>7</sup> Each state maintains a list of licensed QRTPs, but no publicly available database or repository includes, for example, the number of beds in each facility, the demographic and clinical profile of the children served by each

facility, the total number of beds by state, or the number of children placed in out-of-state QRTPs under the Interstate Compact on the Placement of Children.<sup>8</sup>

## Identifying Residential Treatment Facilities and Bed Availability

Families, providers, and state Medicaid agencies experience difficulty identifying residential treatment facilities with the expertise and capacity to treat children covered by Medicaid due to a lack of readily available, real-time, and comprehensive information. Missing information includes facility bed availability, specialty treatment areas, and populations served.

### Facility treatment expertise and bed availability

Our research found that the difficulty in finding real-time information to identify facilities that can serve children and facility bed availability can hinder access to needed residential services (General Assembly 2022, Morrissette 2021, Virginia DBHDS 2021). Finding appropriate residential treatment options can be challenging for children with more complex needs, such as those with co-occurring intellectual and developmental disabilities (I/DD) or physical disabilities, SUD, sexualized behaviors, eating disorders, aggression, and more than one behavioral health diagnosis. Although the literature is limited, some research also finds that individuals with physical disabilities experience barriers to treatment, such as inaccessible treatment facilities and communication difficulties (Clemans-Cope and Lynch 2025). Other demographic characteristics of populations struggling to access appropriate residential care include age, location, language, sexual orientation, and race. In some cases, the lack of accessible residential treatment beds can lead to an out-of-state placement. Such placements can occur if in-state facilities lack the staff or expertise to address certain behavioral health conditions or if facilities decline an in-state placement in favor of an out-of-state placement because the latter provides higher payment than the former.

In our interviews, states expressed concern about their ability to readily discern the types of residential treatment facilities and their respective treatment modalities and expertise in out-of-state facilities when such care is needed. The process of finding a residential placement for a child who needs it can require families or providers to make multiple phone calls and can take from several hours to several days (Mark et al. 2019a). For example, the family of a child experiencing a behavioral health crisis or exacerbation of symptoms may seek treatment in an ED. If the child does not meet the medical necessity criteria for an acute hospital admission but requires intensive treatment, the ED may refer the youth for treatment in a residential facility. The ED staff must search, often by telephone, for an open bed at a facility that is capable of serving the child. This can be a laborious and lengthy process, and it can take days before staff can locate an appropriate placement and arrange safe, supervised transportation.

These longer-than-necessary stays in the ED, referred to as “ED boarding,” increase stress for patients and delay needed behavioral health treatment that can mitigate the need for inpatient treatment. In addition, boarding consumes ED resources, worsens ED crowding, delays ED treatment for other patients who also have urgent needs, and includes financial repercussions for the ED (Morrisette 2021). ED boarding may cause patients to experience increased stress and delay mental health treatment that could mitigate the need for an inpatient stay (The Joint Commission 2021). Though longer-than-necessary stays in the ED can worsen patient stress and out-of-state placements may help with access to treatment, it can be difficult for states to monitor the care of beneficiaries placed out of state and for beneficiaries to maintain connections to their community in their home state.

There are some efforts to improve the availability of information on behavioral health providers, including residential treatment facilities. These efforts include federal and state databases or directories of facilities as well as state-operated registries of inpatient and residential treatment facilities.

## Federal efforts

CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) operate databases that identify facilities providing behavioral health services; however, the databases are not designed to provide real-time information on bed availability. Bed registries are intended to provide such information, but a federal PRTF bed registry does not exist. Bed registries such as the hospital bed registry operated by the Centers for Disease Control and Prevention (CDC), though not a psychiatric bed registry, can provide insight into considerations for operating a real-time registry.

**Databases of facilities providing behavioral health care.** CMS and SAMHSA currently publish some limited information about facilities. CMS’s Quality, Certification, and Oversight Reports website lists PRTFs and the findings from the required state-conducted health and safety surveys (Howard 2024).<sup>9</sup> States must provide CMS with information collected from PRTFs’ annual attestation of compliance on the number of out-of-state youth served in the PRTF and a list of all states from which the PRTF has received payment for the psych under 21 benefit (CMS 2024). The website also provides information such as PRTF address, phone number, accreditation type, and ownership type but does not provide information about areas of expertise or treatment modalities. CMS does not independently verify the accuracy of the information from states (Howard 2024).

Congress directed SAMHSA to establish a searchable database of behavioral health providers, requiring that it include providers’ names, locations, contact information, and services provided.<sup>10</sup> SAMHSA’s FindTreatment.gov website allows users to search for behavioral health treatment facilities based on criteria such as location and acceptance of Medicaid, but it does not provide bed availability or identify whether facilities are PRTFs, QRTPs, or IMDs (SAMHSA 2025). FindTreatment.gov is updated annually from facility responses to SAMHSA’s National Substance Use and Mental Health Services Survey (N-SUMHSS). SAMHSA adds new facilities meeting minimum requirements monthly while updating facility

names, addresses, telephone numbers, and services weekly for facilities informing the agency of changes (SAMHSA 2026).

SAMHSA implemented FindTreatment.gov in phases, which included planning and discovery (including an extensive gap analysis of information in existing substance abuse and behavioral health treatment locators), technical design requirements and considerations, database design and staging, and database launch. SAMHSA completed the design and implementation of the website in approximately 10 months. The agency regularly assesses the website and makes changes to improve its usability (e.g., with the user interface), addresses shortcomings, and keeps systems aligned with technological advances. A contractor implements the N-SUMHSS and is responsible for the quality of provider information before it is included on the website.

Key challenges in maintaining this database include ensuring that the provider information is accurate and clear and ensuring provider participation in the N-SUMHSS, which is used to populate the database. SAMHSA's user support team is responsible for addressing inaccuracies.<sup>11</sup> Securing provider participation in the survey is a challenge. SAMHSA's contractor conducts extensive state and provider engagement to improve the survey response rate and to reduce provider burden. For example, the contractor sends a prepopulated survey to providers who previously responded so that the providers have to update only the necessary information. SAMHSA does not have a dedicated team for maintaining the website and, given its complexity, draws on the expertise of officials across several components of the agency.

**Non-behavioral health facility registries.** CDC operates the Hospital Bed Capacity Project, which provides an example of a federally-administered bed registry. The Hospital Bed Capacity Project supports the automated, near-real-time collection of hospital bed capacity information to inform responses to public health emergencies and ensures the use of a standard definition of bed capacity by jurisdictions and hospitals (CDC 2026a).<sup>12</sup> Although the Hospital Bed Capacity Project is not specifically focused on behavioral health facilities, it offers insights into considerations for developing a national bed registry, including limitations and challenges.

Participation in the Hospital Bed Capacity Project is voluntary for states, the District of Columbia, and territories. Hospital participation is also voluntary, with acute-care and critical access hospitals, including federal hospitals and inpatient psychiatric facilities, eligible to participate (CDC 2026a).<sup>13</sup> Participating hospitals provide information, which is updated between every 15 minutes to an hour, on the number of occupied and unoccupied beds by bed type for each hospital (CDC 2026a).<sup>14</sup>

The CDC started the Hospital Bed Capacity Project in 2022 with a three-state pilot over 12 to 18 months, leveraging an existing platform for reporting hospital respiratory bed information, to test the feasibility of state collection and reporting of a standard set of bed availability data.<sup>15</sup> After the pilot, in December 2023, the CDC expanded the project and began recruiting additional states and territories to participate.<sup>16</sup> The CDC provided participating states and territories grant funding available for spending from January 2024 to July 2027 to support these efforts as well as ongoing technical assistance (CDC 2026c, Binder et al. 2025, Golshir and Sacht n.d.).<sup>17</sup> These jurisdictions lead the bed database reporting and are required to set up a governance committee to guide this work. For example, the governance committee determines how to approach the data collection, which vendors to engage, and who has access to the data and the level of that access. Due to the voluntary nature of reporting, participation levels vary, and some jurisdictions have experienced challenges with hospital engagement due to staffing constraints, technical requirements, and reporting burden.

## State efforts

Some state agencies have developed and maintain online resources such as bed registries and searchable facility databases to help identify residential treatment options. State psychiatric bed registries vary in the type and completeness of information they make available, such as bed availability and treatment specialties of facilities. The Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) reported that in 2018, 17 states had bed tracking systems, and of those states, 5 made the information publicly available (Mark et al. 2019a).

To establish registries, some states have engaged stakeholders to guide the development, operation, and oversight of the registries (Michigan DHHS 2025, JLARC 2022).

In general, providers are responsible for entering bed availability information into a web-based platform, which authorized users can access to obtain bed availability. The frequency of updates varied among states from one to three times a day. Some states update registries in the morning and afternoon, while other states instruct hospitals to update registries once there is bed availability. The specificity of information reported also varies, with one state requiring hospitals to report on available staffed beds by sex for child, adult, and elderly patients.<sup>18</sup> ASPE also reported that facilities delegate responsibility for updating bed availability to a staff member such as an administrative professional, charge nurse, utilization manager, case manager, or social worker (Mark et al. 2019a).<sup>19</sup>

In 2023, North Carolina launched the Behavioral Health Statewide Central Availability Navigator that monitors daily bed availability in inpatient, residential, and other settings. The registry is available to clinical providers and staff at facilities, including EDs, inpatient psychiatric hospitals, and mobile crisis providers, that regularly interact with behavioral health beneficiaries who may be experiencing a crisis. The registry also allows providers and staff to search for an available bed based on demographics, acuity, commitment status, and location (North Carolina DHHS 2026). However, even with the bed registry, information on specialized care for sexualized behavior, autism spectrum disorder, co-occurring I/DD, and SUD is often unavailable (General Assembly 2022). Nonetheless, users of the state's registry describe it as helpful in identifying facilities that may be able to serve youth with residential treatment needs. Mississippi's Department of Mental Health maintains a psychiatric hospital bed registry that includes information on facility vacancies, scheduled admissions, whether individuals in different settings (e.g., jails, home) are awaiting a psychiatric bed, and the dates and times of the latest registry update (Mississippi DMH n.d.).

Several states have created publicly available dashboards to track bed availability. For example, Maryland's Department of Health Behavioral Health

Administration created and maintains a crisis bed facilities dashboard that includes information about facility bed count and acceptance of referrals and walk-ins (Behavioral Health Administration 2026). Nebraska's Department of Health and Human Services develops and releases weekly regional bed capacity and wait time reports for two psychiatric facilities (Nebraska DHHS 2026a, 2026b). Virginia's Office of Children's Services hosts a web-based directory of providers that is intended to include contact information, real-time bed availability, and the type of patients being admitted in all public and private inpatient psychiatric facilities in the state (Virginia DBHDS 2021, 2020). However, in practice, the directory does not always include updated information on bed availability, types of residential settings, or residential facilities with particular specialties (JLARC 2022; Virginia DBHDS 2021, 2020). Kansas partnered with a community-based organization to develop and maintain the HealthSource Community Bed Board (HealthSource 2026).<sup>20</sup> This bed board provides the facility name and phone number, city and county, the category of services provided (e.g., inpatient psychiatric, sobering), and the ages served. The bed board also lists the number of available beds and color-codes facilities based on bed availability. Facilities that are color-coded green have available beds, while facilities that are color-coded red do not.

No nationwide studies have been published on the effect of psychiatric hospital bed registries on access to care; however, reports from users indicate that registries have improved access to residential treatment services and reduced wait times (JLARC 2022, Mark et al. 2019b, NRI 2017). Some states indicate that they can refer to information on a registry when engaging with hospitals, particularly when admission has been denied (Mark et al. 2019a). Users of a registry in one state reported that the registry improved access and helped to reduce ED wait times, although they did not have data to quantify the effects. These individuals also noted that psychiatric bed registries are helpful in identifying gaps in capacity (Mark et al. 2019a).

## Bed registry design considerations and limitations

Establishing bed registries and facility databases is complex, and there are numerous design considerations. To implement bed registries, states have engaged stakeholders on these issues and conducted feasibility analyses to assess registry needs, objectives, and capability; examined implementation options (e.g., whether to use a phased approach); and identified funding (BerryDunn 2024, Maryland HSCRC 2022, Etherington 2021). In addition to providing complete, accurate, and real-time information, bed registries should be easy for care providers and seekers to use, provide information that can be filtered based on user-selected criteria, be interoperable with electronic health records, and provide data analysis and reporting capabilities (Virginia DBHDS 2020, Morrisette and Pinals 2018). Some stakeholders suggested that registries should also allow providers to reserve beds (Mark et al. 2019b).

States identified several limitations and challenges with bed registries, and some review their psychiatric bed registries to identify opportunities for improvements (Virginia DBHDS 2020, NRI 2018). Bed registries can help identify providers but do not necessarily eliminate the need for reaching out to facilities to confirm bed availability or treatment capabilities since the identification of an open bed in a facility does not guarantee placement (Massachusetts BHA 2026, Mark et al. 2019a, NRI 2018, HealthSource 2026). Some states that have implemented psychiatric bed registries have experienced difficulty securing hospital participation in the registry, which limits the registry's completeness and usefulness (Mark et al. 2019a; NRI 2018, 2017). Some providers and other clinical staff have expressed concern that the time spent on updating the registry impinges on time for patient care (Mark et al. 2019a).

Bed registries can be difficult to update in real time and are more likely to be periodically updated (JLARC 2022, APSE 2019, NRI 2018). Even so, the information can be used to connect individuals, including those already in facilities that are unable to provide the level of care needed, to facilities that can serve their needs (NRI 2017). Registry information can quickly become out

of date as beds can be filled between the time one provider updates the registry and another provider checks it for bed availability (Mark et al. 2019a). Staff may have limited opportunities to update registries throughout the day (Mark et al. 2019b). Some states have taken steps to address the timeliness of registry updates by offering incentives such as expediting prior authorization processes for hospitals entering bed information, establishing performance metrics for timely updates, and monitoring the frequency of updates (Mark et al. 2019b). Challenges with outdated information are more likely to occur with registries that require manual data entry and may be mitigated with automated systems, which are less reliant on staff for updating bed information (Mark et al. 2019a). Finally, providers, many of whom are accustomed to identifying facilities and seeking bed availability by making telephone inquiries, may need training on using registries (Mark et al. 2019b).

## Use of Residential Treatment

There are little publicly reported data on beneficiary use of residential treatment. Published research to assess utilization of residential treatment services by children enrolled in Medicaid, including those involved in the child welfare system, relies on disparate data sources and methodologies. For example, a 2018 analysis examining children's behavioral health services and expenditures from 2005 to 2011 found that roughly 4 percent of children age 0 to 18 had a claim for residential services (Pires et al. 2018). Another study of claims data found that in 2019, less than 0.1 percent of children age 3 to 17 who were enrolled in Medicaid with behavioral health conditions used residential treatment services (Radel et al. 2023).<sup>21</sup> A third study, using data from the National Survey on Drug Use and Health, found that in 2023, about 5 percent of non-institutionalized youth age 12 to 17 with Medicaid and Children's Health Insurance Program (CHIP) coverage received either residential services, had been hospitalized, or received other inpatient treatment for a mental health condition (SAMHSA 2024b).

## Current data and reporting

No single federal data source systematically collects and analyzes the use of residential treatment by Medicaid-enrolled children age 0 to 21, which makes understanding their use of these services challenging (Lanier et al. 2024).<sup>22</sup> In addition, federal regulations do not require that states collect and report information on the use of residential treatment in settings other than PRTFs.

The CMS Transformed Medicaid Statistical Information System (T-MSIS) Behavioral Health Data Book provides numerous tables on Medicaid beneficiaries' use of behavioral health services, including mental health and SUD services across the continuum of care by state. In some cases, the data are reported separately for children and adults.<sup>23</sup> Specifically, the data book provides separate counts of child and adult beneficiaries receiving treatment for behavioral health and for co-occurring mental health and SUD. However, much of the reported data, including the use of residential treatment care services, readmissions, and the use of the ED after discharge, are not disaggregated by age. The data book reports service use by setting, including residential setting; however, the definition of residential setting includes a number of settings such as long-term care hospitals and assisted living facilities (CMS 2025). In addition, the data book does not differentiate between different types of residential facilities, including IMDs, or whether services are provided to in- or out-of-state children. Disaggregating data by beneficiary type (adult or child) and residential facility type (PRTF, QRTP, or other congregate care facility) would help states and policymakers understand who uses the services, the utilization, and the types of facilities treating children. The data book does not provide information on child beneficiary use of out-of-state services or the number of out-of-state youth that states serve.

Data limitations make conducting a comprehensive claims analysis of residential treatment services by youth difficult. PRTFs are assigned a specific place of service code, making it easier to identify claims associated with this provider type. Identifying QRTPs and other residential provider types is challenging, as those provider types may or may not have a specific

place of service code assigned by their respective state Medicaid agency. Without specific place of service codes, it is difficult to differentiate claims submitted for clinical, therapeutic, or rehabilitative services delivered in an institution that is not an IMD from those delivered in office-based settings. An analysis of PRTF-only claims would likely be of limited generalizability as youth also receive residential treatment in non-PRTF settings (Brown et al. 2010).

Most states in our study collect some information about denials of admission, such as the reason for denial. Among the states in our study, the most common reasons for denied admission in residential treatment facilities included the beneficiary's older age; having current or previous child welfare or juvenile justice involvement; having a history of aggressive or sexualized behaviors or elopement; and having co-occurring conditions, including SUD, I/DD, or autism. In some cases, these characteristics may be a factor in a beneficiary's need for a residential level of care. Some PRTFs may also deny admission due to co-occurring medical conditions. Denials of admission could lead to delays in getting the care that is needed, prolonged ED boarding, and the need for placement in an out-of-state facility.

Existing CMS data collection may also be helpful in describing youth utilization of residential treatment services and may provide a foundation for more robust reporting. CMS collects limited information from states through the PRTF certification process, but CMS does not validate or publish it. Specifically, states must provide CMS with information collected from PRTFs' annual attestation of compliance on the number of out-of-state youth served in the PRTF and a list of all states from which the PRTF has received payment for the psych under 21 benefit (CMS 2024). In addition, CMS will collect data from hospitals on ED boarding of children and adults beginning with voluntary reporting for the calendar year 2027 reporting period and mandatory reporting beginning with the calendar year 2028 reporting period. CMS plans to make the data public.<sup>24</sup>

## Out-of-State Placements

Out-of-state placements may be necessary if in-state facilities lack the capacity or expertise to address the behavioral health needs of youth referred for treatment or if they otherwise deny admission. Out-of-state placements can help ensure access to needed residential treatment; however, youth in these facilities can experience challenges maintaining ties to their families and communities.

### Use of out-of-state placements

When families, providers, and states are unable to find treatment and services in a child's community, they broaden their search for options, which can include out-of-state treatment facilities.<sup>25</sup> For example, in-state PRTFs may deny admission due to a child's diagnosis or functional or behavioral health characteristics or to reserve beds for out-of-state patients to secure higher payment rates. Securing appropriate residential treatment options can be challenging for some children and youth, such as those with more complex needs or certain demographic characteristics (e.g., age, language needs) (MACPAC 2025a). In addition, states with large rural or frontier areas reported difficulty in maintaining access for all youth in their state and may seek out-of-state placement for beneficiaries.<sup>26</sup>

National-level data on the use of out-of-state placement in residential treatment facilities are not publicly reported. However, certain state-level data indicate that in some states, out-of-state placements have increased in recent years. For example, the number of Montana children placed in out-of-state PRTFs increased from 174 in state fiscal year (SFY) 2023 to 198 in SFY 2024 (Montana DPHHS 2024). Similarly, Montana's out-of-state placement report for SFY 2024 showed the overall number of children who received residential treatment in PRTFs and other facilities outside the state increased from 239 in SFY 2023 to 254 in SFY 2024.<sup>27</sup> In addition, the most common diagnoses for Montanan youth with a Medicaid-funded out-of-state placement were disruptive and impulse control behaviors (32.1 percent), depressive disorders (29.1 percent), trauma and stress disorders (19.4 percent), and autism spectrum disorders (8.9 percent) (Montana DPHHS 2024).<sup>28</sup> In North Carolina, of the children placed in

PRTFs, the percentage placed out of state increased from 27 percent in 2016 to 44 percent in 2022 (Lanier et al. 2024, General Assembly 2022). Another state included in our study indicated that it makes few out-of-state placements but that there has been an increase in children coming from out of the state for residential treatment services.

States typically make multiple attempts to find an appropriate in-state residential setting before making an out-of-state PRTF placement to provide the psych under 21 benefit. For example, a Medicaid official in one state reported having to make between 40 and 60 referrals to facilities before being able to find a placement, and some facilities do not provide timely responses about denials or acceptances. Some states are working to minimize out-of-state placements and focus resources on keeping children in state. Montana tries to place children in the lowest level of care in state and requires denials from two in-state PRTFs before it places children out of state (Montana DPHHS 2024). North Carolina officials reported working with facilities to create specialized placements to keep children in state, but the parents and guardians may still decide to send children out of state.

## Returning to the Community

Stays in residential treatment facilities are intended to be short term, with the goal of returning the patient to community-based care as quickly as is medically appropriate. Our research found that beneficiaries being served in residential treatment facilities, whether in or out of state, can face barriers to returning to their communities and community-based care.

### Delayed discharge

Some beneficiaries may experience delayed discharge, in which they remain in a facility even after a clinical team deems that the level of care is no longer necessary because the family, provider, or state is unable to find appropriate community-based care (Eldeib 2020). Delayed discharge from inpatient psychiatric hospitals, EDs, and hospitals is well documented, but there is little literature about this phenomenon when patients leave PRTFs, which are

non-hospital facilities (Teale et al. 2024, Illinois DCFS 2023, Eldeib 2020, PCG 2018).<sup>29</sup> However, hospitals, EDs, and PRTFs are likely to face similar challenges securing community-based behavioral health services for patients who can be transitioned out of the facilities. Examples of factors contributing to delayed discharge include limited or no available providers in the community, family concerns about the transition, lack of support with the transition, and insufficient discharge planning (Minnesota DOH 2024, Teale et al. 2024, Micallef et al. 2020, LAC 2019, MHA 2019, PCG 2018).

Delayed discharge can lead to deterioration of the youth's condition, unnecessary costs for the Medicaid program, and additional challenges when reintegrating back into their home communities (MACPAC 2025b, Abdelhalim et al. 2024, AHA 2022). In addition, delayed discharge can limit the ability of facilities to admit and treat other youth awaiting residential placement (Teale et al. 2024, Micallef et al. 2020, PCG 2018). Youth who are discharged to temporary or inappropriate placements and experience discontinuity of care are at risk of readmission, which may strain limited residential bed capacity (PCG 2018). Examples of interventions to help with timely discharge from hospital inpatient behavioral health settings or EDs include the use of discharge coordinators (e.g., a single clinician or a team) and the use of electronic health record integrated tracking tools, which can help improve the discharge process and reduce the length of stay (Bechir and Bechir 2025, Ibrahim et al. 2022, Houghton et al. 1996).

## Discharge from out-of-state placement

Some state Medicaid officials reported that out-of-state placements can make it difficult for children and youth to maintain connections with family and transition back to their respective states of residence. Federal rules are in place to ensure that the needs of youth can be met and to mitigate gaps in care while the youth are in residential treatment facilities and on discharge. However, these rules do not specifically address circumstances in which a beneficiary is placed in an out-of-state facility. Discharge planning is further complicated when a youth has been placed out of state. The distance between the youth and their family may make it difficult for caregivers to engage in

treatment, treatment planning, and care coordination to reintegrate the youth into their home, community, and school (MACPAC 2025b). Caregiver engagement is associated with positive treatment outcomes during and after treatment (Haine-Schlagel and Walsh 2015).

The lack of an adequate discharge plan that identifies where youth will be treated on discharge from the facility, including out-of-state locations, contributes to the transition challenges families and providers of youth in residential treatment facilities face (MACPAC 2025b). Some youth in out-of-state facilities may experience particular challenges with returning to their communities if, for example, the receiving PRTF is unable to adequately treat them due to the complexity of their needs or because their condition decompensates to the point of needing a higher level of care that the facility cannot provide. Some of these youth may present in hospital EDs in the receiving state that do not have a provider agreement with the sending state, and the responsibility for the care of the youth may be unclear. In some cases, youth may return home, although the lack of services in the community persists (CRD 2022). In Maine, in the past, some children in foster care with behavioral health needs were discharged from hospitals and residential treatment to hotels and homeless shelters because the state's Office of Child and Family Services could not secure homes for their long-term care, placing them at risk of reinstitutionalization (PCG 2018).<sup>30</sup>

## Discharge planning

Discharge planning can help with transitions from inpatient settings to other health care settings, including community-based providers (Tyler et al. 2021, Xiao et al. 2019, Smith et al. 2017). Discharge planning can help ensure continuity of care, connect discharged individuals to appointments after discharge, and reduce readmissions (Smith et al. 2022). Several elements comprise discharge planning, such as the identification of post-discharge treatment needs and providers, communication among inpatient and outpatient providers and patients or their caregivers to establish post-discharge treatment plans and preferences, scheduling of appointments, and transmittal of necessary medical records (Smith et al. 2022, Xiao et al. 2019, Smith et al. 2017). The American Academy of Child and Adolescent

Psychiatry (AACAP) principles for the treatment of children and adolescents with mental illnesses in residential treatment centers identifies the return of admitted youth to the community as a central goal of residential treatment and describes discharge planning as a key component of treatment plans. AACAP calls for discharge planning that begins on admission to a residential treatment facility, ensures that children have a provider to go to for care on discharge, and coordinates with community-based providers (AACAP 2010). Although discharge planning is generally considered a standard of care for patients leaving inpatient settings, researchers have noted the need for additional research to understand how it is implemented and its effects on transitions between care settings (Smith et al. 2017).

Federal regulations for the plan of care developed for beneficiaries admitted to PRTFs describe requirements for discharge planning, but the requirements lack specificity. Federal regulations require that a physician develop a written plan of care for each beneficiary before admission and that it is entered into the beneficiary's record and reviewed every 30 days (42 CFR 441.155(a), 42 CFR 441.155(c)). The plan of care must include plans for discharge when appropriate and post-discharge plans that include coordination with other inpatient services and community-based services on release (42 CFR 456.180, 42 CFR 441.155(b)(5)). Federal rules do not further address PRTF discharge planning or the contents of discharge plans.

CMS has highlighted the importance of beneficiaries returning to their communities on discharge from a facility in the context of other CMS programs and discharge planning. For example, CMS's guidance to states for coordinating care provided by out-of-state providers for children in Section 1945A health homes emphasized the importance of maintaining connections to the community and facilitating seamless returns after a stint in out-of-state care (CMS 2021).<sup>31</sup> In addition, Medicare rules include detailed conditions of participation related to hospital discharge planning (42 CFR 482.43). The rules describe requirements for the hospital discharge planning process (e.g., timeliness, assistance for families in selecting post-discharge providers), the transfer of the patient's medical information to

post-discharge providers, and a discharge planning evaluation for individuals who are likely to suffer adverse health consequences on discharge if no such plan is established (CMS 2023). CMS requires timely discharge planning evaluations to do the following:

- ensure that care arrangements are made before discharge to prevent unnecessary delays in discharge;
- evaluate the need for appropriate post-discharge services, including non-health services and community-based care providers, and the availability of the services;
- be included in the patient's medical record and be discussed with the patient or the patient's representative;
- ensure that hospitals arrange for the development and implementation of discharge plans upon a physician's request;
- be developed by or under the supervision of a registered nurse, social worker, or other appropriately qualified personnel; and
- regularly reevaluate the individual's condition to determine if changes to discharge plans are needed.

The rules also require that hospitals reassess their discharge planning processes regularly, including reviewing a sample of discharge plans, and that hospitals assist patients in selecting a post-acute care provider and share data on quality measures relevant to the patient's goals of care and treatment preferences (42 CFR 482.43).<sup>32</sup>

Some state Medicaid programs have publicly posted PRTF discharge policies and state discharge plan requirements, which vary state to state. For example, West Virginia's guidance for PRTF discharge planning dictates that the discharge plan identifies the planned and actual discharge date, the name of the person or entity expected to take responsibility for care and custody, and the address of where the beneficiary is expected to live on discharge. The state also requires the PRTF to provide a written copy of an aftercare plan, a supply of current prescription medication, and documentation of communication

between the facility and community psychiatrist (West Virginia DHHR 2013).<sup>33</sup> Montana's discharge planning guidance specifies that PRTFs must identify prescribing providers in the community and schedule an outpatient visit (Montana DPHHS 2023). One study of state regulations and policies for state residential treatment of behavioral health conditions for adults found that treatment planning and discharge planning requirements are more likely to be a function of licensure standards than they are state Medicaid regulations (O'Brien et al. 2021).

## Commission Recommendations

The Commission makes three recommendations to Congress to improve appropriate access to residential behavioral health treatment for children and youth enrolled in Medicaid.

### Recommendation 4.1

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 and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability 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.

### Rationale

This recommendation addresses the challenges that states, providers, and families face in identifying residential treatment facility options with the capability and capacity to serve youth with Medicaid by having HHS lead and coordinate efforts to develop and maintain a registry of facilities.

This registry is needed because 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 such care. The process of finding a residential placement for a child who requires it can take several hours to several days, which, in the case of children in crisis in an ED, can lead to ED overstays. It can be especially difficult to find appropriate treatment options for certain children with complex needs or co-occurring conditions. Some states said that finding placement for youth with certain characteristics, such as being a younger age or having a rural residence, can be harder than it is for other children.

There is no federal requirement that states or CMS maintain a real-time registry of psychiatric residential treatment providers. Despite the lack of a federal mandate, the federal government and states already collect and make available some facility information. State efforts include databases and registries, which vary in their scope and requirements. No current source provides the full complement of real-time information needed to identify residential treatment options when such care is needed. For example, one state's system provides information on inpatient and residential bed availability, while another's identifies facilities but does not include bed availability. In general, users of the state registries describe them as helpful in identifying facilities that may be able to serve youth with residential treatment needs. Given the role of out-of-state providers in serving Medicaid youth, a centralized registry would help to ensure that information is consistently reported and mitigate users having to find and navigate multiple directories or registries.

Although CMS's QCOR website has basic information about PRTFs, and SAMHSA's FindTreatment.gov website identifies providers of behavioral health services nationwide, the agencies' facility databases are not intended to provide real-time bed availability and do not provide key aspects of information needed to determine whether facilities can meet beneficiary need. CMS's QCOR website is primarily intended to provide information about facilities' recent certification and quality survey results. It does not provide information such as treatment expertise or bed availability. SAMHSA's database is searchable and includes the names, locations, contact information, services provided, and accepted insurance of the providers who choose to respond to the survey, which collects facility information. It does not identify whether facilities are PRTFs or QRTPs.

The Commission weighed the complexity of developing and operating a national registry with the needs of children who have intense behavioral health conditions that cannot be met in the community and the challenges faced by families, providers, and states in finding appropriate residential treatment options. Our research shows that there is a lack of readily available and complete information needed to help families find residential treatment options for youth when they most need it. Delays in accessing medically necessary residential treatment can harm youth and burden caregivers, providers, and states. Operationalizing a national registry will be challenging and will require careful examination of numerous policy and operational considerations and thoughtful and deliberate planning.

In developing the registry, the Secretary should leverage information that is already collected and the experience of agencies operating facility databases and registries. It will be important that the process to develop and maintain the facility registry minimizes duplication and burden on providers, states, and federal agencies. HHS should also engage stakeholders to ensure that the registry will meet user needs while minimizing facility reporting burden. Stakeholders include federal partners with responsibility for behavioral health and experience with facility registries such as SAMHSA and the CDC, state Medicaid agencies, beneficiaries and

their representatives, hospitals, managed care plans, crisis services experts, community-based providers, information technology systems experts, and law enforcement officials. HHS should seek input on all aspects of registry development, including, for example, technical specifications for the registry, applicability of the registry (e.g., which facilities should report), reporting parameters (e.g., frequency of reporting, whether providing reporting is mandatory or voluntary), developing documentation and guidance for submitting and using information from the registry, and establishing monitoring and oversight of the development and use of the registry. Stakeholders may also be a helpful resource for identifying and developing approaches to address challenges that may arise in the development and maintenance of the registry (e.g., provider participation).

### Implications

**Federal spending.** The Congressional Budget Office (CBO) estimates this recommendation would not affect federal direct spending. HHS will need to commit time and personnel for the development, implementation, and maintenance of the registry; create guidance for the use of the registry; and monitor registry use and facility participation.

**States.** State Medicaid agencies and providers may experience costs associated with investing in technology and infrastructure to support a real-time registry. Depending on how the registry is structured, states could be responsible for certain functions, such as ones to encourage the use of the registry and timely provider updates. States will experience greater ease in identifying facilities with available beds that may be able to serve Medicaid beneficiaries compared to current practices.

**Enrollees.** Beneficiaries and their families and caregivers may experience greater ease in identifying facilities with available beds that may be able to serve them or their loved ones compared to current practices.

**Plans.** Plans may experience greater ease in identifying facilities with available beds that may be able to serve Medicaid beneficiaries compared to current practices.

**Providers.** Providers may experience greater ease in identifying facilities with available beds that may be able to serve Medicaid beneficiaries compared to current practices. Facilities may be required to update the bed registry according to specifications for bed availability updates, which will add to their administrative burden.

## Recommendation 4.2

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 contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. 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.

### Rationale

The lack of consistently collected and reported data impedes a systematic analysis of the use of residential treatment services. Such an analysis would be helpful for understanding trends in service use, such as which services are most frequently used and by whom, geographic differences in residential treatment use, trends in out-of-state facility use, differences in service use by beneficiary demographic characteristics, overstay in the ED, and characteristics of beneficiaries experiencing overstay. Understanding trends on these and other measures would be helpful in detecting whether there are access challenges to certain services, in certain states, or for particular subgroups of beneficiaries. Greater reporting of data on the use of residential treatment services may also

be helpful for improving our understanding of which Medicaid beneficiaries are referred to, admitted to, denied admission to, and discharged from residential treatment facilities. A data reporting and collection approach will help fill current knowledge gaps and strengthen the ability of CMS, states, and stakeholders to make data-informed decisions about policy and programmatic changes to address access concerns.

Federal regulations do not require that CMS or states collect and report information on the use of residential treatment in settings other than PRTFs for children covered by Medicaid and CHIP. Because beneficiaries may be served in settings other than PRTFs, an analysis of PRTF claims only would underestimate the use of residential treatment services. Similarly, there are no federal requirements for state reporting on the use of out-of-state residential treatment providers by Medicaid beneficiaries.

Congress has previously contemplated the need for data on the use of out-of-state providers to serve children with medically complex conditions. Specifically, in creating the 1945A health home state plan option for children with medical complexity, Congress required states to describe in their state plans their methodology for tracking access to medically necessary care from out-of-state providers (§ 1945A(f)) and to report to the Secretary on the number of characteristics of providers, including out-of-state providers, serving children under the health home option (§ 1945A(g)(2)(A)).

CMS already collects data that may be helpful in shedding some light on youth utilization of residential treatment services. For example, CMS collects some information from states through the PRTF certification process, but that information is limited, and CMS does not validate or publish it. In addition, CMS's behavioral health T-MSIS data book lacks detail for understanding the experience of youth in Medicaid, does not differentiate among different types of residential facilities, and does not describe use of out-of-state facilities. States collect some data for their own programmatic purposes, which can be helpful for identifying in-state trends, but those data lack comparability across states. Disaggregating data by age (i.e., for adults and children) and residential facility type (e.g., PRTF, QRTP, or other congregate care facility) would help states and policymakers that want to understand the frequency of children receiving

residential treatment services and the types of facilities children are commonly sent to for treatment. The data collection and reporting effort for CMS's new hospital Emergency Care Access and Timeliness electronic clinical quality measure may also be an important source of information on ED boarding for youth awaiting residential treatment.

To the greatest extent possible and to minimize burden, CMS should leverage data that are already collected and existing reporting mechanisms. Some residential treatment services data are not currently readily available and may require CMS to develop a plan for working with states and other stakeholders to collect them. For example, certain facilities, such as QRTPs, do not have a specific place of service code for claims and may be difficult to identify in the administrative data. Additionally, some measures that are not regularly reported may require an assessment of data availability and quality and feasibility of reporting (e.g., average length of stay). CMS should develop and publicly share a plan for assessing additional data needs, collecting those data, and publishing findings. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts. To establish this data reporting effort, CMS should engage states and other stakeholders on data elements that should be collected and reported and opportunities to leverage existing data collection mechanisms.

### Implications

**Federal spending.** The CBO estimates this recommendation would increase federal direct spending by less than \$10 million over the 2026 to 2036 period.

**States.** Some states may have to take on additional data collection and reporting, if they do not already collect data that would be newly required as a result of implementing this recommendation. They may also experience some costs associated with systems changes needed for transmitting data to CMS. States may benefit from having newly available information on the use of residential treatment services.

**Enrollees.** Beneficiaries, families, and caregivers may have an improved understanding of trends in residential treatment service use.

**Plans.** Plans may have an improved understanding of trends in residential treatment service use.

**Providers.** Providers of residential treatment services may experience some burden and resource expenditures (e.g., related to systems changes, staff time) to fulfill new reporting requirements. Providers may have an improved understanding of trends in residential treatment service use.

## Recommendation 4.3

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, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process 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.

### Rationale

Treatment in psychiatric residential facilities for beneficiaries who require that level of care is intended to be short term with the goal of transitioning beneficiaries back into their communities or states, in the case of those in out-of-state facilities. However, beneficiaries, in particular those in out-of-state placement, experience challenges related to discharge and returning to their communities. For example, children sent out of state may face challenges maintaining connections with their families and caregivers who are integral to their post-discharge care. In some instances, children are ready to be discharged, but providers and families experience challenges with identifying an adequate provider in the youth's community, which can lead to delayed discharge.

Discharge planning processes are important for documenting a plan for transitioning individuals from inpatient care to community-based care and can help ensure discharged individuals are connected to providers and services once they leave the facility. For example, discharge plans can describe requirements and processes for identifying post-discharge treatment needs and providers, communicating between inpatient and outpatient providers and patients or their caregivers to establish post-discharge treatment plans and preferences, scheduling appointments, and transmitting necessary medical records. Discharge planning is generally considered the standard of care. AACAP calls for discharge planning that ensures that children have a provider on discharge who coordinates with community-based providers (AACAP 2010).

There are few federal Medicaid requirements for discharge planning from PRTFs. In contrast, Medicare hospital discharge rules are detailed and include several specific discharge planning requirements to ensure beneficiaries return to their communities. Similarly, some states have implemented PRTF discharge planning requirements.

To ensure that expectations are clear for facilities, providers, beneficiaries, families, and caregivers, this recommendation would ensure that discharge plans thoroughly and clearly identify which entities are responsible for PRTF discharge planning processes and actions and require that a specific community-based provider be identified before discharge. This recommendation would also require the involvement of those who would be involved in the beneficiary's post-discharge care, including families and caregivers. In implementing this recommendation, CMS should engage stakeholders, including families, providers, and states, to identify other required elements for PRTF discharge planning, which may include, for example, which clinicians and professionals should be involved in discharge planning, updates to discharge plans, and monitoring and oversight of discharge plan implementation.

### Implications

**Federal spending.** The CBO estimates this recommendation would increase federal direct spending by less than \$10 million over the 2026 to 2036 period.

**States.** States may need to update discharge policies based on new federal requirements and may need to develop and disseminate guidance to plans and providers. States may need to engage in oversight and monitoring to ensure discharge plans satisfy requirements and to ensure the fidelity of implementation.

**Enrollees.** Beneficiaries in out-of-state placement and their families and caregivers will have a clearer understanding of how discharge plans should be developed. Beneficiaries may also experience improved transitions back to their communities, including being connected with local providers capable of meeting their needs.

**Plans.** Plans would need to establish guidance for providers regarding expectations for discharge planning and coordinating a return to the community for youth placed in out-of-state facilities. Plans would also gain information about the ongoing treatment needs of covered youth in out-of-state facilities, which should help with care management efforts.

**Providers.** Providers may need to implement new discharge planning processes and activities, which may take longer to conduct than current approaches. Post-discharge providers will have information about the health care needs of youth coming into their care from out-of-state facilities.

## Looking Ahead

These recommendations are intended to help with appropriate access to residential behavioral health treatments for youth with Medicaid coverage who require that level of care. Residential treatment, while a last resort, is an important part of the continuum of behavioral health care. To fully meet the behavioral health needs of children and youth with Medicaid coverage, the continuum must also include myriad community-based services. In future work, MACPAC will examine access to intensive community-based behavioral health services as well as quality of care and safety within residential treatment facilities.

## Endnotes

<sup>1</sup> SED describes a child who has a diagnosable mental, behavioral, or emotional disorder (e.g., bipolar disorder and schizophrenia) that substantially interferes with their life and ability to function (SAMHSA 2024a). 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 2024a).

<sup>2</sup> The authors defined residential treatment as “mental health and/or substance use treatment in a licensed, highly structured, usually secure out-of-home program providing continuous 24-hour observation and supervision with typically a full complement of in-house programs including education.” The authors described therapeutic group homes as providing “24-hour out-of-home mental health and/or substance use services in a licensed, non-secure facility, with children typically involved in community-based activities, such as school, work, or recreation” (Pires et al. 2018).

<sup>3</sup> Such placements may occur if the child welfare agency files a petition with the court for an out-of-home placement order after substantiating abuse or neglect and a finding of imminent harm or after prevention services and supports have been deemed unsuccessful. The court may place the child with kin or in foster care or therapeutic foster care as well as in a QRTP, PRTF, or other congregate care setting, depending on the child’s needs. Section 473(b)(1) of the Social Security Act (the Act) requires that Title IV-E eligible youth be considered to be receiving cash assistance. Section 1902(a)(10)(A)(i)(I) of the Act makes those cash assistance recipients eligible for Medicaid (42 CFR 435.145).

<sup>4</sup> Section 1012 of the SUPPORT Act (the SUPPORT Act, P.L. 115-271) also created a limited exception to the IMD exclusion for certain women who are eligible for Medicaid on the basis of pregnancy. Specifically, it prohibits states from denying FFP for non-IMD services delivered to pregnant women (and up to 60 days postpartum) that are patients of an IMD for the treatment of an SUD. Typically, FFP is not available for services delivered outside of an IMD if an individual is a patient of an IMD (MACPAC 2019).

<sup>5</sup> Title IV-E of 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.

<sup>6</sup> The term “foster care maintenance payments” means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child’s personal incidentals, liability insurance with respect to a child, reasonable travel to the child’s home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence (P.L. 115-123).

<sup>7</sup> The count of PRTFs refers to the number of such providers for which CMS has survey records in the agency’s online survey and certification reporting system.

<sup>8</sup> The Interstate Compact on the Placement of Children is a statutory agreement between all 50 states, the District of Columbia, and the U.S. Virgin Islands. The agreement governs the placement of children in the custody of a state who are being placed for private or independent adoption or, under certain circumstances, being placed by a parent or guardian in a residential treatment facility from one state into another state (APHSA n.d.).

<sup>9</sup> The website pulls data from the Automated Survey Process Environment and certification reporting system used by state survey agencies to document their required health and safety surveys of PRTFs.

<sup>10</sup> The 21st Century Cures Act (P.L. 114-255) required that SAMHSA develop and maintain an online, searchable behavioral health treatment services locator (OIG 2025). SAMHSA also makes available a written directory of the facilities that are included on the SAMHSA’s FindTreatment.gov website. The providers listed on the website and in the directory are public and private providers of behavioral health services that responded to the National Substance Use and Mental Health Services Survey (SAMHSA 2024b).

<sup>11</sup> In a March 2025 report, the U.S. Department of Health and Human Services Office of the Inspector General described finding inaccurate or incomplete information (e.g., addresses, facility treatment approaches) for several facilities, but SAMHSA has since addressed these concerns (OIG 2025).

<sup>12</sup> The Hospital Bed Capacity Project is implemented through the CDC’s National Healthcare Safety Network (NHSN). The data collected under the initiative are intended to help with the coordination and response to emergencies.

The NHSN is a tracking and response system to identify threats across health care, including healthcare-associated infections, antibiotic-resistant infections, and antibiotic use (CDC 2026a).

<sup>13</sup> Inpatient psychiatric facilities include freestanding facilities and CMS-certified inpatient psychiatric facility units within a hospital.

<sup>14</sup> There are two options for transmitting bed data: hospitals can send data directly to CDC's NHSN, and states can send data to the NHSN on behalf of hospitals. In either scenario, health IT vendors can send data to the NHSN on behalf of facilities and jurisdictions (CDC 2026a). Facilities may report on occupied and unoccupied adult and pediatric psychiatric beds (CDC 2024). This bed measure provides the census across all CMS-certified pediatric psychiatric beds, which are used to treat serious mental disorders. Care includes monitoring and providing appropriate interventions for behavioral or psychosocial issues (CMS 2024).

<sup>15</sup> During the pilot phase, states recruited facilities to participate, built the automated systems and processes necessary to submit real-time data according to specifications, and began submitting data to the CDC.

<sup>16</sup> To date, 34 states, the District of Columbia, the Commonwealth of the Northern Mariana Islands, and Puerto Rico participate (CDC 2026b).

<sup>17</sup> Through its Epidemiology and Laboratory Capacity funding, the CDC provides funds to states and territories to support health departments' epidemiology, laboratory, and health information systems and to help strengthen their responses to infectious disease threats and public health emergencies (CDC 2026c).

<sup>18</sup> The Health Resources and Services Administration (HRSA) defines a staffed bed as a "licensed and physically available [bed] with staff on hand to attend to patients, including both occupied and available beds" (HRSA 2021).

<sup>19</sup> Interoperability of bed registries and electronic health records is cited as a goal to support implementation and use of bed registries but is difficult to achieve (GAO 2025, BerryDunn 2024, Virginia DBHDS 2020). The status of state efforts to establish bed registries that are interoperable with electronic health records was unavailable.

<sup>20</sup> HealthSource is a non-profit organization serving communities, particularly those with behavioral health needs, throughout the state.

<sup>21</sup> The data include children with Medicaid or CHIP coverage for full or comprehensive benefits who were enrolled for at least six consecutive months.

<sup>22</sup> Other federal data systems collect data on children's mental health, including the National Survey of Children's Health and the National Survey of Drug Use and Health, which asks respondents (i.e., non-institutionalized youth) about past stays in residential settings. HHS also collects case-level information from state and tribal Title IV-E agencies on all children in foster care, including those who live in an institution. Institutions are defined as "a child care facility operated by a public or private agency and providing 24-hour care and/or treatment for children who require separation from their own homes and group living experience" (ACF 2015). These facilities may include: child care institutions, residential treatment facilities, maternity homes, nursing homes, hospitals, etc.

<sup>23</sup> The Consolidated Appropriations Act, 2024 (P.L. 118-42) directed CMS to report annually on several metrics such as the number and distribution of Medicaid beneficiaries and CHIP enrollees using behavioral health services, diagnoses, the types of services used and settings, and delivery systems.

<sup>24</sup> Similarly, there is no federal requirement for the reporting of ED boarding of youth with Medicaid while they await appropriate behavioral health treatment, including residential treatment services. The literature indicates that ED boarding continues to occur for youth with behavioral health issues, including for those with Medicaid coverage (McConnell et al. 2025, Overhage et al. 2024). One analysis of Medicaid claims for youth age 5 to 17 years in 44 states found that 1 in 10 visits resulted in 3 to 7 days of ED boarding in 2022 (McConnell et al. 2025). Rates of ED boarding among youth with Medicaid vary by state and may be affected by the type of mental health conditions the youth experience, state coverage decisions, and bed capacity (McConnell et al. 2025). CMS's calendar year 2026 Hospital Outpatient Prospective Payment System final rule (CMS-1834-FC) established the new Emergency Care Access and Timeliness electronic clinical quality measure as part of CMS's Hospital Outpatient Quality Reporting program. The measure will be calculated using four outcome metrics that quantify access to and timeliness of care in an ED setting, including: (1) patient wait time, (2) whether the patient left the ED without being evaluated, (3) patient boarding time in the ED, and (4) patient ED length of stay. The measure will be stratified by two age groups—younger than 18 years and 18 years and older—and two diagnosis groups—with mental

health diagnosis and without mental health diagnosis. Data collected will also include payer information (eCQI n.d.).

<sup>25</sup> If a state sends a beneficiary out of state, the state must ensure that the receiving PRTF is certified (CMS 2013).

<sup>26</sup> A 2018 survey of Medicare-enrolled hospitals found that 30 percent of rural and 57 percent of urban hospitals had a psychiatrist on staff or available for consultation (Ellison et al. 2022).

<sup>27</sup> The state placed these children in PRTFs or therapeutic group homes. Medicaid covers the cost of care for the majority of the children placed out of state, but care for some children is covered by another state agency such as the state's Department of Corrections or the Child and Family Services Division (Montana DPHHS 2024).

<sup>28</sup> The reporting period is July 1, 2023 to June 30, 2024.

<sup>29</sup> Receiving agencies or placement sites can also contribute to delayed discharge for beneficiaries. The Maryland Hospital Association found that upward of 42 percent of behavioral health patients in EDs faced discharge or transfer delays, most often because beneficiaries are waiting for bed space to become available at their next placement. The same study found that children and youth were likelier to experience a longer delayed discharge compared to an adult (MHA 2019). A Minnesota study of 33 EDs and 13 inpatient units found that approximately 18 percent of behavioral health patients faced delays when being discharged. The most common reasons for delayed discharge from the ED or inpatient settings included a lack of available beds and a waitlist for the receiving facility. Notably, most of the patients who experienced discharge delays in both settings were enrolled in Medicaid or the state's Basic Health Plan, MinnesotaCare (Minnesota DOH 2024).

<sup>30</sup> The Maine Office of Child and Family Services 2018 assessment of children's behavioral health services found that longer lengths of stay in private non-medical institutions could limit the number of children who can be served by them (PCG 2018). Private non-medical institutions provide intensive mental health treatment and rehabilitative services for individuals with mental illness (Office of Behavioral Health 2026). Residential services are intended to be short term (up to six months); however, longer services are often caused by lack of an appropriate service for discharge (PCG 2018).

<sup>31</sup> Section 1945A of the Act provides a state plan option for states to cover health home services, such as care coordination and management, and patient and family

support for children with medically complex conditions, including through out-of-state providers. Thus far, states have not implemented this state plan option.

<sup>32</sup> Although the Medicare hospital discharge rules are an example of more detailed discharge requirements, they do not explicitly address unique considerations for discharge from an out-of-state hospital.

<sup>33</sup> West Virginia defines aftercare planning as “[occurring] following placement in an out of home setting...[involving] a clearly delineated process that...always includes the family's involvement...[and] should address every aspect of an individual's life so that when issues arise, they will have the support and guidance to handle the stressors [appropriately and productively]” (WV DHHR 2017).

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## Commission Vote on Recommendations

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 recommendations 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 recommendations. 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 these recommendations on May 7, 2026.

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

**4.1** 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 and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability 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.

4.1 voting result	#	Commissioner
<b>Yes</b>	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
<b>No</b>	0	

**4.2** 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 contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. 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.

4.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

- 4.3** 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, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process 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.

4.3 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	