October 29, 2026

Intensive Community-Based Behavioral Health Services

Findings from a claims analysis of the Transformed Medicaid Statistical Information System (T-MSIS) and stakeholder interviews

Linn Jennings and Holly Saltrelli

MACPAC

Medicaid and CHIP Payment and Access Commission

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Overview

- Project background
- Summary of federal and state scan findings
- T-MSIS findings on behavioral health (BH) service use
- Stakeholder interview findings
- Next steps

Project Background

Project Overview

- **Purpose:** Examining access to intensive community-based BH services for Medicaid-covered children and youth with a diagnosis of serious mental illness (SMI) or serious emotional disturbance (SED)
- **Service focus:** MACPAC's prior work demonstrates that access to these services can improve clinical and functional outcomes for children and youth with significant mental health conditions and help them remain in their communities and avoid unnecessary residential treatment
- **Methods:** Reviewed existing federal Medicaid authorities and state approaches for supporting children and youth with complex BH needs to remain in the community, and conducted a T-MSIS analysis and stakeholder interviews to assess whether there are access or coverage gaps that can be addressed with federal policy

Project Services

Service	Definition
Intensive care coordination (ICC) and targeted case management (TCM)	Care coordination approaches for youth with serious emotional or behavioral challenges. ICC coordinates services across systems (e.g., mental health, education, child welfare, juvenile justice) to support the whole family; TCM provides individualized support to help youth and families access and managed BH and related services
High-fidelity wraparound (HFW)	Evidence-based, youth- and family-driven care planning process that assembles a team of professionals and natural supports to develop a highly individualized care plan for youth with complex BH needs
Mobile crisis response	Rapid-response services delivered by a mobile team to the beneficiary's location (e.g., home, school, community) to de-escalate BH crises, prevent unnecessary out-of-home placements, and connect families to ongoing care, including through 24/7 regional or statewide call centers
Crisis stabilization	Short-term intensive support for beneficiaries experiencing a BH crisis, delivered in a structured, non-hospital setting to stabilize the situation and avoid hospitalization or institutionalization
Respite	Temporary supportive care or relief services that are provided to families and caregivers to reduce stress and prevent crises or out-of-home placements

Source: MACPAC analysis of CMS guidance 2024, 2018, 2013.

Summary of Federal and State Scan

State Approaches to Covering BH Services

- States can cover intensive community-based BH services through optional benefit categories and use different optional state plan authorities and waivers depending on policy goals, population needs, and program structures
  - Each waiver authority has different requirements for geography (e.g., statewideness), diagnostic eligibility criteria, and enrollment caps
- There are many state approaches to covering these services
  - Some cover all five services through a combination of state plan amendments (SPA) and waivers, whereas some only cover one service
  - Some are very prescriptive in defining services and the level of training or certification required to provide them
  - Some cover one or more of these services for a broad population of children and youth with behavioral health needs, while some cover these services for a targeted population only (e.g., SED diagnosis, state-defined level of care, etc.)

Access to Intensive Community-based BH Services

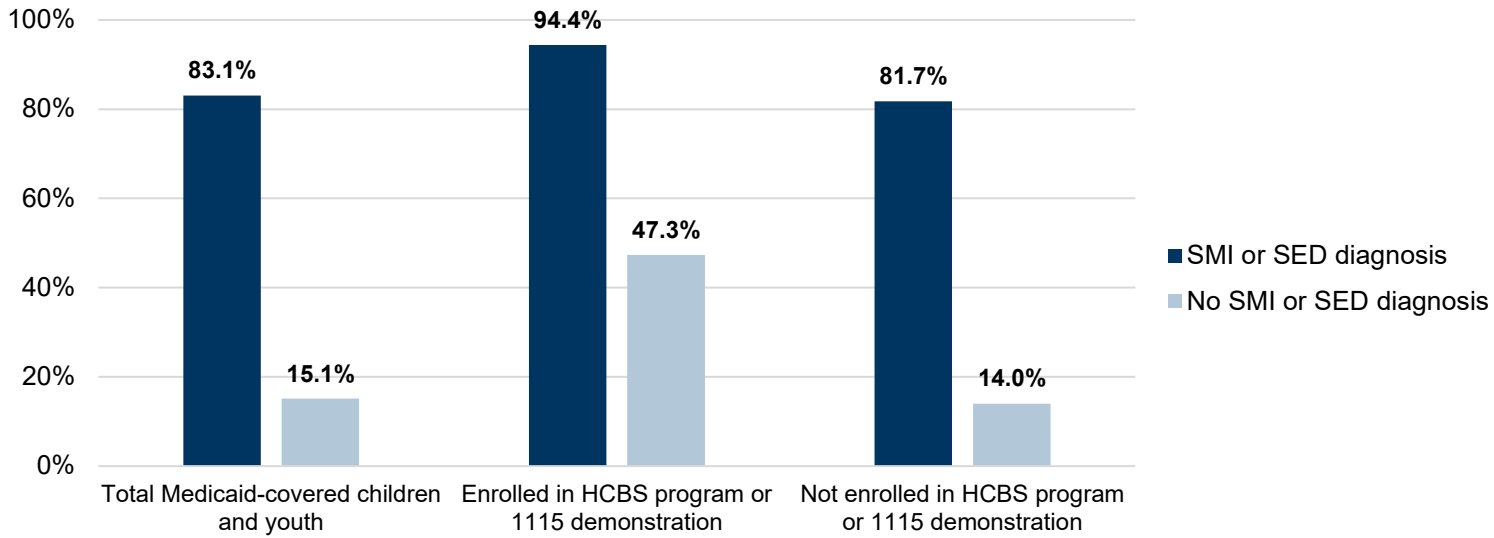
- Findings from prior MACPAC work indicate that Medicaid-covered children and youth experience challenges accessing BH services
  - Challenges include understaffing and workforce constraints, coordination among multiple agencies
- Findings from the literature demonstrate that insufficient access to intensive community-based BH services can lead to foregone care, higher acuity needs, increased BH-related emergency department (ED) use, and unnecessary residential treatment
  - Research indicates an increasing rate of children and youth are being referred to the ED for BH-related care for conditions and care that could be provided in outpatient settings

T-MSIS analysis on BH service use

Methods

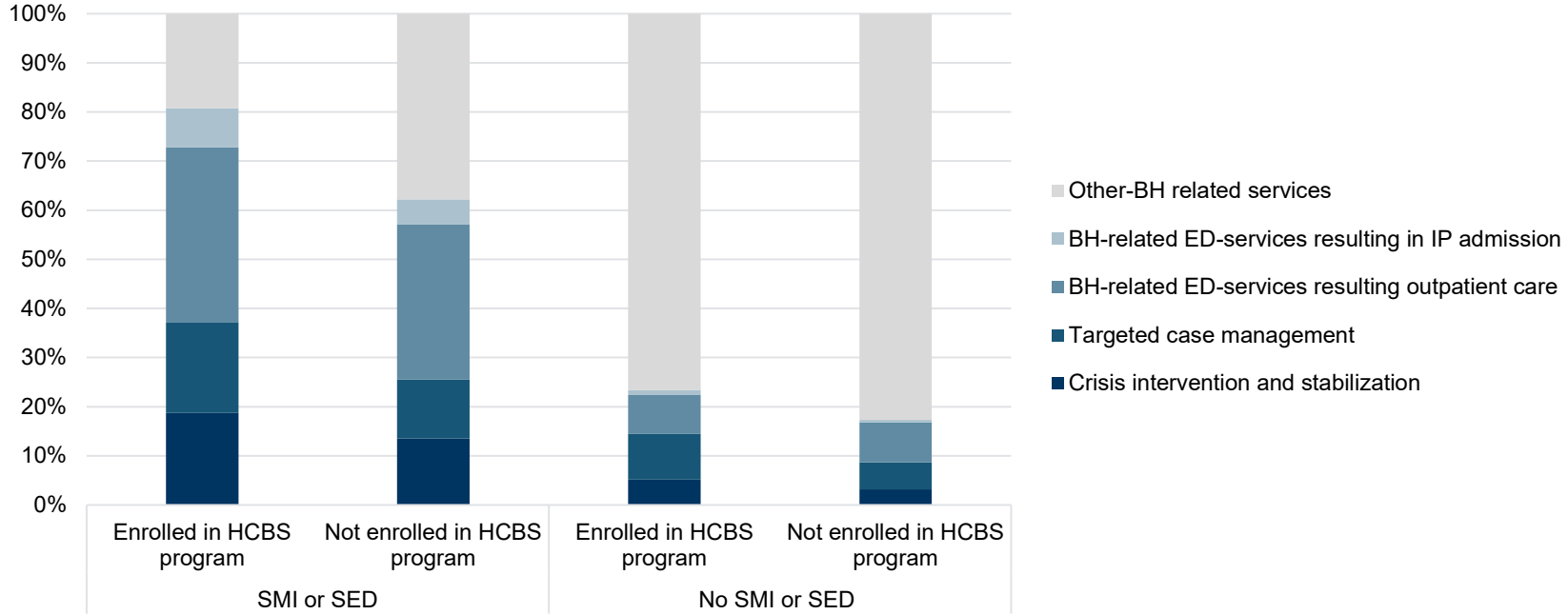
- **Purpose:** Examined how Medicaid-covered children and youth use intensive community-based BH services using calendar year (CY) 2024 enrollment, claims, and encounter data from T-MSIS
- **Population of focus:** Children and youth 1-20 years with and without and SMI or SED diagnosis
- **Key measures**
  - Use of any BH-related service
  - Use of BH-specific services: TCM, crisis intervention and stabilization services, BH-related ED service use resulting in outpatient care, and BH-related ED services use resulting in inpatient (IP) admission
- **Scope:** Data analysis did not include mobile crisis, HFW, or respite

Figure 1. Percentage of Medicaid-Covered Children and Youth Ages 1-20 with at Least One BH-Related Service Claim, CY 2024



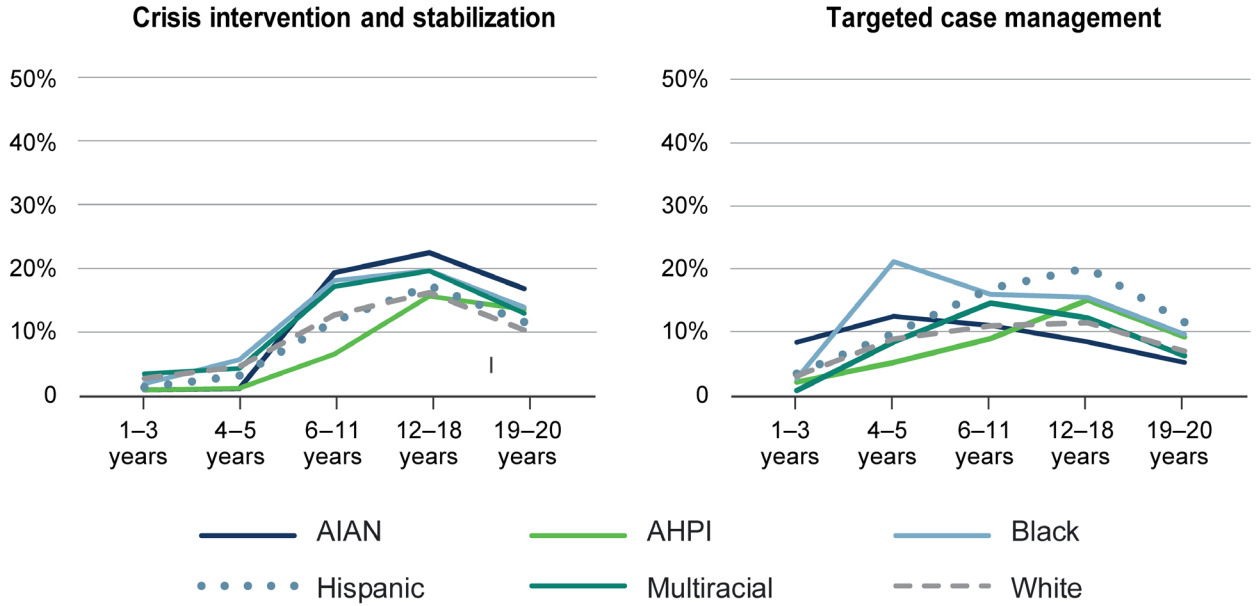
Notes: SMI is serious mental illness. SED is serious emotional disturbance. HCBS is home- and community-based services. Those enrolled in an HCBS program include those enrolled in a waiver under Section 1915(c) HCBS, 1915(i), 1915(j), and 1915(k) authority.
Source: MACPAC, 2026, analysis of T-MSIS, CY 2024.

Figure 2. Percentage of Medicaid-Covered Children and Youth with at Least One BH-Related Service Claim who Received Specific BH-Related Services, CY 2024



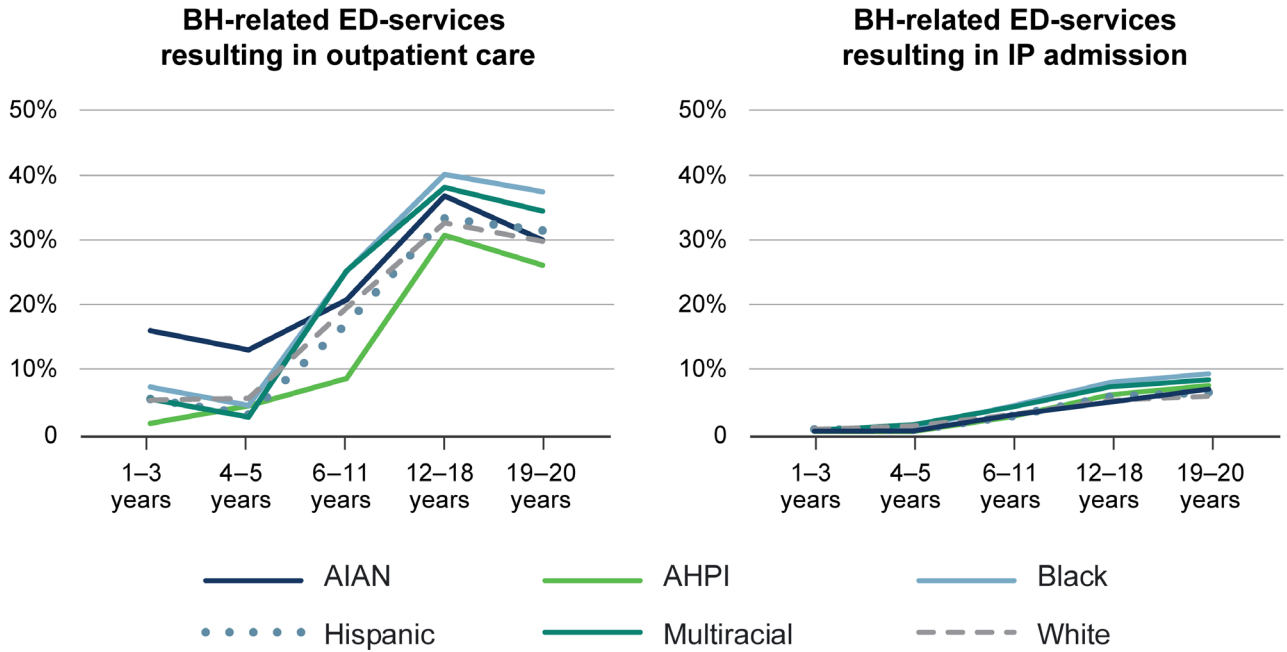
Notes: SMI is serious mental illness. SED is serious emotional disturbance. SMI or SED is having an SMI or SED diagnosis. BH is behavioral health. HCBS is home- and community-based services. ED is emergency department. IP is inpatient. Enrolled in an HCBS program includes those enrolled in an HCBS program under Section 1915(c) HCBS, 1915(i), 1915(j), and 1915(k) authority and those enrolled in a Section 1115 demonstration.
Source: MACPAC, 2026, analysis of T-MSIS, CY 2024.

FIGURE 3. Percentage of Medicaid-Covered Children and Youth with an SMI or SED Diagnosis Receiving a BH-Related Service by Age Group and Race and Ethnicity, CY 2024



Notes: The Y-axis percentages represent the percentage of all Medicaid-covered children and youth who received a specific BH-related out of all Medicaid-covered children and youth who received at least one BH-related service in CY 2024. All race categories exclude those who reported their ethnicity as Hispanic. AIAN is American Indian and Alaska Native. AHPI is Asian, Hawaiian, and Pacific Islander. Multiracial includes anyone who reported multiple races and excludes those who reported their ethnicity as Hispanic. Race and ethnicity estimates are calculated using the T-MSIS Analytical Files race/ethnicity imputed compiled files.
Source: MACPAC, 2026, analysis of T-MSIS, CY 2024.

FIGURE 4. Percentage of Medicaid-Covered Children and Youth with an SMI or SED Diagnosis Receiving a BH-Related Service by Age Group and Race and Ethnicity, CY 2024



Notes: The Y-axis percentages represent the percentage of all Medicaid-covered children and youth who received a specific BH-related service out of all Medicaid-covered children and youth who received at least one BH-related service in CY 2024. All race categories exclude those who reported their ethnicity as Hispanic. AIAN is American Indian and Alaska Native. AHPI is Asian, Hawaiian, and Pacific Islander. Multiracial includes anyone who reported multiple races and excludes those who reported their ethnicity as Hispanic. Race and ethnicity estimates are calculated using the T-MSIS Analytical Files race/ethnicity imputed compiled files.
Source: MACPAC, 2026, analysis of T-MSIS, CY 2024.

Key Takeaways

- Use of BH-related services was greater among children and youth under age 21 who had an SMI or SED diagnosis compared to those without a diagnosis
  - Among those with a diagnosis, the majority of children and youth under 21 used BH services regardless of enrollment in an HCBS program or 1115 demonstration
- Among those who received BH-related services, there were differences in specific BH-related service utilization
  - Over one-third of those with an SMI or SED diagnosis and enrolled in an HCBS program or demonstration received TCM or crisis intervention and stabilization services
  - About one-third of BH-related service utilization for those with an SMI or SED diagnosis (regardless of enrollment in a waiver) was for BH-related ED services resulting in outpatient care
  - Utilization of BH-related ED services resulting in outpatient care was greatest for 12-18 year old Black, non-Hispanic youth compared to all other age groups and races and ethnicities

Stakeholder Interview Findings

Existing Authorities Allow States to Cover These Services in Line with State Priorities

- Federal officials and national experts reported that most services can be covered under existing authorities
- States select and layer authorities that advance their programmatic goals within available resources
  - Administrative effort and approval timelines influence which authorities states use
- CMS helps states design BH programs and coverage; states and experts reported a need for clearer implementation guidance
- Although flexibility allows states to target coverage to enrollees with the most complex needs, stakeholders raised that this can inadvertently make it harder for children with mid-acuity needs to obtain services

States Experience Challenges Covering and Providing Respite Services

- Respite is important for keeping youth in the community but is not a 1905(a) benefit
  - It is not subject to the early and periodic screening, diagnostic, and treatment (EPSDT) requirement
- States often cover respite using the 1915(c) authority, which permits enrollment caps and requires an institutional level of care
- 1915(i) allows coverage to be targeted to subgroups but does not permit enrollment caps, which can deter states concerned about cost
  - Waives the comparability requirement that applies to 1905(a) services, which lets states target by subgroup (e.g., by age or diagnosis) within an eligibility category
- Conflict-free case management rules require states covering respite under HCBS waivers to ensure that decisions about a beneficiary's services are made independently of the organizations that deliver them
  - Section 1915(i) extends these standards and requires an independent eligibility determination and needs assessment before services begin
  - Stakeholders reported this delays access; in one state, approval can take up to 30 days

Access to Services Depends on Care Coordination

- Access depends on coordination across the entities responsible for screening, referral, authorization, and service delivery
- Access to services can improve when there are multiple entry points, but experts noted that no state has a true “no wrong door” approach as described by SAMHSA
- Breakdowns in referral and handoff processes can shift responsibility to families to find BH providers
- Coordination between state Medicaid agencies and child-serving systems can be inconsistent

Availability of Covered Services Depends on Provider Capacity and Payment

- Reimbursement rates and training costs may limit provider participation and retention
  - However, although one state reported “substantially” increasing reimbursement rates for these services, it was not sufficient to increase capacity
- Workforce shortages and limited provider capacity present barriers to accessing these services
  - Access to crisis and respite services in rural and frontier areas
  - Limited availability of child-focused mobile crisis services
- States face uncertain financing circumstances, such as time-limited American Rescue Plan Act (ARPA) funding and upcoming changes to state directed payments

Limited Community-based Capacity and Reliance on Residential Treatment

- Gaps in community-based services, such as respite, mobile crisis, and ICC and HFW, can lead to residential treatment or ED use when less restrictive care would be appropriate
- Limited step-down services may reinforce reliance on residential treatment
- Data to assess access and diversion from avoidable residential care are limited
  - No interviewed state evaluates use of these services or their effect on use of residential treatment
  - Inconsistent service definitions and billing codes limit evaluation and cross-state comparison

Summary of Interview Findings

- Existing authorities give states flexibility to cover these services, and determine who can access them
- Respite is particularly constrained because of limitations prescribed by coverage authorities
- Coverage alone does not ensure access, which also depends on care coordination, provider capacity, and stable financing
  - Our T-MSIS analysis shows that there may be unmet BH-related need
- Limited community-based capacity contributes to reliance on residential care
- Limited data makes diversion difficult to assess

Next Steps

- We welcome Commissioner feedback and questions on our findings
- There are several areas identified that may yield potential policy options, but additional research and analysis are needed:
  - For respite, the 1915(i) requirement for two independent assessments before services begin
  - Limited service-specific data to assess access
  - Lack of federal standards for child-focused mobile crisis services

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OCTOBER MEETING

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