

REDUCING PEDIATRIC MENTAL HEALTH BOARDING AND INAPPROPRIATE EXTENDED HOSPITAL STAYS

A State Policy Framework to
Improve Access, Safety, and System Efficiency

Children across the United States are experiencing mental and behavioral health challenges, which increasingly result in emergency department visits. When the next appropriate level of mental health care is unavailable or inaccessible during these visits, patients may be boarded. This boarding often takes place in emergency departments or medical inpatient units, keeping patients there when they do not require hospital-level medical care.¹

In 2021, a national state of emergency in children's mental health was jointly declared by the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA).² While the issue of boarding was a challenge prior to the COVID-19 pandemic, it remains common, with a sustained increase in volume since the onset of the pandemic.³

There are real and significant consequences that continue to plague patients, families, and hospitals as a result of boarding challenges going largely unaddressed at the system level. Boarding stays have negative physical and psychological impacts on children, while straining emergency department and medical inpatient units to the point some facilities have had to divert trauma care to other trauma centers. Additionally, children with medical and psychiatric complexities may experience prolonged boarding while awaiting placement at a treatment facility.³ Research points to negative outcomes of boarding, such as care delays, clinical deterioration, and rising costs.⁴

Although hospital-based quality improvements can mitigate harm, they cannot resolve boarding without state-level policy action. **States play a decisive role in:**

- **Medicaid payment and benefit design.**
- **Behavioral health capacity development.**
- **Data transparency and accountability.**
- **Cross-system coordination** (health, child welfare, education, juvenile justice).

This paper outlines evidence-informed strategies and sets out specific actions that state legislatures, Medicaid agencies, behavioral health authorities, and managed care programs should adopt to reduce unnecessary boarding, protect children and families, and improve system efficiency. Throughout, the recommendations are framed as operational requirements — not optional considerations — and include examples of policy language states can adapt in statutes, regulations, budget provisos, Medicaid state plan amendments, managed care contracts, and interagency protocols.

¹ Hoffmann, Jennifer A., et al., "Pediatric Mental Health Boarding in US Emergency Departments, 2018-2022," *Journal of the American College of Emergency Physicians Open*: Vol. 6, No. 100180, 2025.

² "AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health," American Academy of Pediatrics, October 2021.

³ Snow, Kathleen, D., et al., "Pediatric Mental Health Boarding: 2017 to 2023," *Pediatrics*, Vol. 155, No. 3, March 2025.

⁴ McConnell, K. J., et al., "Variations in Psychiatric Emergency Department Boarding for Medicaid-Enrolled Youths," *JAMA Health Forum*, Vol. 6, No. 8, August 2025.

What States Should Do in the Next 12 Months

State leaders do not need to wait for perfect data or a full system redesign to begin reducing pediatric mental health boarding. Within the next 12 months, lawmakers and Medicaid agencies can take a defined set of actions that improve accountability, reduce avoidable delays, and lay the groundwork for longer-term capacity expansion.

IMMEDIATE LEGISLATIVE ACTIONS (NEXT SESSION)



- Require the state to designate or procure a pediatric behavioral health coordination entity with authority to identify boarding cases, manage referrals, escalate barriers, and report performance.
- Establish a statutory boarding threshold and mandatory escalation process once a child exceeds that threshold after being determined no longer to require hospital-level care.
- Appropriate start-up and operating funds for coordination infrastructure, assessment and stabilization alternatives, and targeted community capacity in regions with the longest delays.
- Direct Medicaid, behavioral health, child welfare, and juvenile justice agencies to adopt a common referral and dispute-resolution protocol for children experiencing prolonged boarding.
- Require routine public reporting on boarding duration, denials, transfer delays, out-of-state placements, and unmet service needs by region and population.
- Close behavioral health coverage gaps by creating a state program that funds intensive mental health treatment and care coordination for children with complex needs when private insurance falls short.

IMMEDIATE MEDICAID AND ADMINISTRATIVE ACTIONS (0-6 MONTHS)



- Issue agency guidance defining when the boarding clock starts, which cases must be referred, and which entities must participate in escalation at 24, 48, or 72 hours.
- Amend managed care contracts to require expedited authorization for pediatric behavioral health transfers, provider participation in coordination infrastructure, and annual pediatric network adequacy analysis.
- Conduct a rapid pediatric behavioral health access review to identify service lines, populations, and regions where rates, benefit design, or contracting practices are suppressing capacity.
- Define the pediatric crisis and step-down services that must be available to Medicaid-enrolled children under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and specify how those services are accessed.
- Begin monthly cross-agency review of high-duration boarding cases to identify immediate policy and operational barriers.

NEAR-TERM IMPLEMENTATION MILESTONES (6-12 MONTHS)



- Launch regional or statewide referral and escalation infrastructure with defined data requirements, denial tracking, and dashboard reporting.
- Implement rate or payment adjustments for priority pediatric crisis, subacute, and step-down services where access gaps are clearly documented.
- Stand up or expand assessment, stabilization, or transition alternatives for youth who do not require ongoing hospitalization but cannot yet return home safely.
- Adopt a small set of statewide performance measures and publish a baseline report to guide appropriations and purchasing decisions for the following year.

I. The Problem:

Why Pediatric Mental Health Boarding Is a State Issue

Between 2016 and 2021, mental health emergency department (ED) cases (ages 3-18) increased 58.6% at children's hospitals and maintained that higher level through 2024. During this same timeframe (2016-2021), children's hospitals' suicide self-injury ED cases (ages 5-18) increased 168.6% and maintained that higher level through 2024.⁵ Nationwide, approximately 55% of children (ages 3-17) face difficulties obtaining needed mental health care.⁶ A research study determined that boarding stays remain elevated above pre-pandemic levels and suggested that efforts are needed at the hospital and state levels to enhance access and engagement of outpatient community-based mental health services to prevent acute crisis hospitalization. Additionally, the study found some factors associated with prolonged boarding included government (Medicaid/CHIP) insurance type, increasing medical complexity, and discharge disposition to the patient's home.¹

Boarding presents a considerable emotional toll for patients, families, and patient care staff. Additionally, it may lead to challenges related to not only patient safety, but also staff safety and restraint use. Ultimately, boarding suggests an inability to find timely and appropriate care for children and youth in crisis. Evidence shows negative outcomes of boarding, such as care delays, clinical deterioration, and rising costs, may disproportionately impact low-income children who face systemic barriers to timely and coordinated care.¹

Another study found that child-welfare-involved youth represent a small share of the Medicaid population, but account for a disproportionate share of residential behavioral health admissions. Reasons for this include circumstances due to custody relinquishment and voluntary placement agreements. Lastly, some state reports share evidence that children in foster care disproportionately utilize residential services.

Research demonstrates that the practice of boarding patients for pediatric mental health conditions while they await outside psychiatric care is common at children's hospitals in the United States.¹ In a behavioral health learning collaborative, children's hospitals reported that even when hospitals improved internal stabilization and discharge workflows, boarding persists when states lack adequate downstream capacity, real-time visibility into placements, and enforceable accountability for timely transitions.⁷

For lawmakers and Medicaid leaders, the implication is straightforward: Boarding should be treated as a measurable system failure that requires statutory, contractual, operational, and budgetary correction — not as an unavoidable hospital operations issue.

WHY HOSPITALS CANNOT FIX THIS ALONE

Although the boarding crisis plays out in hospitals, hospitals do not control many of the core policy and financing levers necessary to end it. The availability of community mental health placements is largely shaped by state policy, licensing, and funding decisions. In many states, the number of residential, step-down, and other community-based placements has not kept pace with need because of budget constraints, workforce shortages, and operational challenges associated with maintaining quality and safety standards. The result is an inadequate supply of clinically appropriate options for children who are ready to leave hospital care.

There are several barriers impacting access to appropriate residential treatment for children covered by Medicaid who need this care. These barriers include the availability of home- and community-based services, federal policy restrictions, limited facility and/or bed information available, assessment variations, data collection, and workforce challenges.

⁵ Data Source: Pediatric Health Information System (PHIS), Data Years 2016-2024. Participating hospitals in PHIS are the largest and most advanced children's hospitals in America, and constitute the most demanding standards of pediatric care in America.

⁶ Child and Adolescent Health Measurement Initiative. "Interactive Data Query: National Survey of Children's Health (2023-2024)", Data Resource Center for Child and Adolescent Health, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Maternal and Child Health Bureau (MCHB).

⁷ Information based on discussions with members of the Children's Hospital Association's Behavioral Health Learning Collaborative from 2022- current.

Medicaid payment policy is another major driver. States set payment rates for residential facilities, which includes the rates for out-of-state facilities. The need for residential treatment for children unable to receive care in their home states, in conjunction with higher out-of-state payment incentives, can heighten the need for out-of-state placement. Under EPSDT, states are required to find a residential treatment facility for a child in need of that level of care, even if there is an existing insufficient capacity level issue based on their in-state psychiatric residential treatment facilities (PRTFs). Additionally, facilities may be more willing to accept out-of-state pediatric patients due to their potentially higher Medicaid payments. This can subsequently cause a lack of available in-state residential beds or ultimately denials by in-state facilities.

When payment levels do not reflect the true cost of delivering care, providers may reduce capacity or close programs altogether, further narrowing the continuum of care needed to move children safely out of hospitals.⁷

Finally, cross-county and cross-provider coordination remains outside hospital control but significantly affects discharge timeliness. Many children who board are involved with multiple public systems, including child welfare, behavioral health, developmental disability, and juvenile justice agencies. These agencies, like hospitals, often lack real-time visibility into available capacity and may not have formal mechanisms for coordinated decision-making across jurisdictions. As a result, children's hospitals become default holding environments even when hospital care is no longer clinically appropriate.

To address the behavioral health needs of children covered by Medicaid, an approach will need to be curated that addresses barriers along the continuum of care. This means that to elevate access to appropriate residential treatment, residential care-specific concerns must be tackled, as well as access challenges for home- and community-based behavioral health services.

WHAT WORKS: EVIDENCE-INFORMED PRACTICES

Hospital-Based Best Practices

In the absence of sufficient system-level reform, children's hospitals have developed practices to reduce harm during boarding. These efforts include standardized psychiatric stabilization protocols, more active treatment while children await placement, and operational strategies to improve patient and family experience during unavoidable delays.

Monroe Carell Jr. Children's Hospital at Vanderbilt implemented a model that included hiring and training a dedicated pediatric crisis assessment team for the emergency department, instituting regular behavioral health huddles, and strengthening discharge planning and community resource connection. These improvements helped reduce both the average length of stay for children experiencing prolonged boarding and the number of children who became boarded in the first place.⁸

These examples underscore an important policy point: Hospital-led redesign can reduce harm and improve throughput, but does not remove the need for state action regarding payment, placement capacity, and cross-system escalation. States should therefore reward hospital participation in crisis and stabilization models while avoiding policies that shift uncompensated system failures onto children's hospitals.

Nationwide Children's developed a full crisis continuum of care that includes: tele-crisis services, stabilization and crisis planning; a mobile response and stabilization service; critical assessment and treatment clinic; a psychiatric crisis department; and youth crisis stabilization unit. These services provide rapid assessments, family-centered care in the community, touch points between inpatient and outpatient services, and acceptance of walk-ins and referrals from EMS, law enforcement, and hospitals. This comprehensive approach dropped total boarding days from a record 4,238 days to 694 over the course of four years but still didn't eliminate the patient boarding crisis.⁹

⁸ "Standardizing Behavioral Health Care to Improve Safety and Outcomes," The Children's Hospital Association, February 2026.

⁹ Chapman, Meredith, R., et al., "Continuum of Crisis of Care," Child and Adolescent Psychiatric Clinics of North America, Vol. 35, No. 3, July 2026.

Boston Children's Hospital implemented interventions in efforts to reduce pediatric mental health boarding and increase acute care access. The main intervention areas included staffing additional care team members to enhance boarding crisis stabilization and expanding inpatient psychiatry beds. One year after the intervention onset, there was a 53% reduction in the average length of boarding for all patients transferred to high and intermediate levels of care. Additionally, there was a 27% decrease in the average length of stay across all the hospital's inpatient psychiatry and community-based acute treatment (CBAT) units with significantly improved throughput. Despite these interventions, the average wait for inpatient or CBAT programs was still five days at the end of 2022. **The study notes that this ongoing delay highlights the need for greater bed availability and adequate staffing for treatment programs.**¹⁰

Cincinnati Children's Hospital developed a comprehensive change package that has effectively reduced boarding in inpatient psychiatric units by transforming approaches to access management and discharge planning. Internally, Cincinnati initiated a system redesign effort using a Rapid Cycle Improvement Collaborative to standardize workflows, define escalation, and develop an early disposition risk stratification protocol.¹¹ Next, Cincinnati ensured a standing coordination process with residential treatment networks and community providers. They also partnered with OhioRISE, a care management entity, to fund a role dedicated to care planning, services access, and system navigation for children and youth boarding in their inpatient unit.¹²

These strategies are important and should be incentivized for broad adoption, but even models like the one at Nationwide Children's Hospital do not eliminate boarding without downstream capacity and policy alignment. In addition, many of these interventions impose unreimbursed costs on hospitals that already shoulder a disproportionate share of care for children who are system-involved and children insured by Medicaid.⁷ As Cincinnati discovered in their work, discharge delays are influenced by factors out of hospital control, including placement availability, payer authorization processes, and custody-related constraints. While hospital-based process improvement efforts can decrease rates of boarding, persistent structural barriers will continue, leaving the boarding crisis unresolved.¹³

¹⁰ Ibeziako, Patricia, et al., "Reducing Pediatric Mental Health Boarding and Increasing Acute Care Access," *Journal of the Academy of Consultation-Liaison Psychiatry*, Vol. 65, No. 5, October 2024.

¹¹ Whitesell, K., Fread, T., Collins, S., Hale, S., & Hill, A. (2026, April). Reducing pediatric inpatient psychiatry discharge delays: Access and disposition barriers at Cincinnati Children's. Cincinnati Children's Hospital Medical Center, Cincinnati, OH.

¹² *Id.* at pg 8.

¹³ *Id.* at pg. 19

II. The Critical Policy Gaps

1. LACK OF SYSTEM-LEVEL CAPACITY MANAGEMENT

The core challenge is that many states lack a coordinated, real-time mechanism to identify children who are clinically ready for transfer, match them to appropriate available placements, and actively manage transfers. Many states also lack a clear accountability structure for situations in which a child remains in a hospital because no responsible entity is acting to secure the next placement.

Without real-time system visibility and coordinated transfer management, children remain in inappropriate settings, hospitals independently search for placements, and state leaders lack reliable data about where the true bottlenecks exist. This weakens accountability and makes it harder for lawmakers to target investments effectively.

III. Policy Solutions

1. STATE-SUPPORTED CAPACITY MANAGEMENT: TRANSFER CENTERS

Borrowing from trauma and medical transfer systems, a patient transfer center involves:

- **Central identification** of children boarding beyond clinical thresholds.
- **Real-time visibility** into inpatient, subacute, residential, and crisis capacity.
- **Designated authority** to coordinate placements and transfers.
- **One accountable entity**, reducing duplication and delay.

For state leaders, the implication is that every state with persistent pediatric boarding should designate a statewide or regional pediatric behavioral health coordination entity with authority to identify boarding cases, monitor real-time capacity, support transfers, escalate barriers, and report performance. At a minimum, that entity should receive standardized data from hospitals, crisis programs, residential treatment providers, managed care organizations, and relevant public agencies; maintain a common referral and denial-tracking process; and operate under clear escalation timelines once a child exceeds a defined boarding threshold.

States will need to build a system-wide transfer center capable of extending beyond hospitals to other critical providers and services. However, there are functioning and affordable models that are beginning to gain real traction and generate meaningful outcomes in a limited set of states.

Illinois: BEACON (Behavioral Health Care and Ongoing Navigation)

Illinois offers an example of a statewide family navigation and cross-agency access tool rather than a full transfer-center model. The state's BEACON portal, launched through the Illinois Children's Behavioral Health Transformation Initiative, provides a single entry point to identify behavioral health services, connect with state-funded programs, and navigate resources across multiple agencies. This is valuable infrastructure for family access and cross-agency coordination, but states should not confuse a public-facing navigation portal with active case-level capacity management for children already boarding in hospitals.

Georgia: Bed Registry

Georgia illustrates a narrower but useful building block: near-real-time bed visibility. Proposed and existing work in Georgia has centered on electronic psychiatric bed registries and integration with the Georgia Crisis and Access Line. This helps providers identify available beds more quickly and improves statewide visibility into capacity. Bed registries can materially reduce search burden and should be required where they do not already exist, but registries alone do not resolve denials, custody barriers, prior authorization delays, or cross-agency stalemates. States should therefore pair bed registries with escalation authority, standardized referral processes, and accountability for timely acceptance or documented denial.

Minnesota: Mental Health Collaboration Hub

Minnesota's Mental Health Collaboration Hub is a stronger example of active coordination infrastructure. The Hub was created to help connect youth boarding in hospitals and emergency departments with mental health treatment and safe living environments. These connections happen through a secure statewide platform that accepts de-identified referrals, notifies participating providers that match the child's needs, and supports ongoing case-level coordination.¹⁴ Public materials describe the Hub as involving hundreds of youth and a large, multi-organization network of hospitals, treatment providers, and social service agencies. The key lesson is that effective models combine real-time case identification, broad provider participation, common referral processes, and data to inform policy and purchasing decisions.

Based on the Hub's most recent impact report, 309 organizations currently participate and 601 children have been helped. Additionally, this impact report provides insights regarding case numbers, diagnoses, boarding settings, recommended services, and the average number of days boarded by year.¹⁵

For lawmakers, the value of this model extends well beyond resolving individual placement delays. A statewide or regional coordination entity should be required to routinely report where children are boarding, how long they remain, service needs driving denials, which regions lack capacity, and how often children are placed out of state. States should use these reports to guide appropriations, managed care procurement, rate setting, and provider network requirements. Without this infrastructure, policy decisions are often made using incomplete administrative data or anecdotal reports.

In short, hospitals can and should take steps to reduce harm associated with psychiatric boarding, but they cannot solve the problem alone. Durable progress requires state action to improve coordination, expand clinically appropriate alternatives, and align financing with the needs of children and families.

2. EXPAND ALTERNATIVES TO HOSPITALIZATION

A key issue the Medicaid program faces is the insufficient access to home- and community-based behavioral health providers for Medicaid beneficiaries. This insufficiency can have upstream and downstream impacts on access to residential treatment. The lack of alternative treatments in communities for youth with serious mental illness, serious emotional disturbance, and other behavioral/mental health challenges may lead to unnecessary residential treatment placement. This in turn has the potential to decrease the number of available beds for children deemed in need of this level of care. Home- and community-based services (HCBS) can help reduce the requirement for and utilization of residential treatment, while potentially enabling earlier intervention and decreasing residential lengths of stay. Additionally, if the availability of HCBS for behavioral health is increased, facilities may be more equipped to transition patients out of the facility to less restrictive care settings, such as partial hospitalization programs or intensive outpatient programs. This has the potential to vacate residential beds to allow other beneficiaries to access care more readily.

Stakeholders have expressed concerns regarding the processes for pediatric patients to be assessed and admitted to residential treatment, citing fragmentation and variability among agencies, facilities, and providers. This lack of uniformity ultimately means that this setting could be used inappropriately and/or inconsistently among different populations, such as children in foster care compared to children who are not in the foster care system. Additional concerns regard many EDs' lack of psychiatric staff to evaluate children's behavioral health needs. This shortage may lead to residential treatment referrals due to the lack of awareness of specific behavioral health HCBS available or possibly the processes to refer pediatric patients to local services. In terms of opportunities for improvement, stakeholders noted the lack of follow-up assessments after residential treatment referrals, a standard for PRTF certification of need, and inconsistent requirements for validated assessment tools.

¹⁴ "Mental Health Collaboration Hub – Getting to Yes!," Mental Health Collaboration Hub, 2026.

¹⁵ "Getting to Yes Impact Update – June 2026," Mental Health Collaboration Hub, June 2026.

The process of finding a residential placement can range in processing time from days to months, which can potentially cause unnecessary extended lengths of stay in an ED for a child in crisis. Some states and agencies have made efforts to facilitate locating facilities and, in some situations, available beds. However, inconsistencies remain regarding the comprehensiveness of sources that provide facility and bed availability information.

Ultimately, the lack of residential treatment beds can prompt an out-of-state placement. Out-of-state placements may be indicated if home state facilities do not have the staffing or expertise needed to care for specific behavioral health conditions or if an out-of-state placement is prioritized due to financial motivation. Additional considerations regarding out-of-state placements include potential challenges not only for states as they oversee provision of care to their beneficiaries, but also for beneficiaries to sustain personal connections within their communities.

As the American Academy of Child & Adolescent Psychiatry has stated, boarding in the ED may offer a safe space, but it lacks access to continuous, evidence-based mental health evaluation and treatment required to meet the clinical needs for this acute patient population. This indicates a potentially missed chance for stabilization or discharge to a lower level of care. Prolonged boarding can negatively impact patient and family wellbeing, elevate the risk of continued behavioral escalation, and substantially affect ED workflow and resource utilization.¹⁶

For states, this reflects both a system design failure and a clear policy opportunity.

3. ASSESSMENT CENTERS & SECONDARY CUSTODY FRAMEWORKS

Community-Based Assessment Centers

States can reduce hospital overutilization by investing in community-based assessment centers that provide short- to mid-term placement for youth requiring multidisciplinary evaluation. These centers are specifically designed to:

- Conduct comprehensive behavioral health and risk/needs assessments in a more naturalistic environment.
- Provide immediate access to clinical care, stabilization, and family engagement.
- Determine appropriate placement and level of care based on real-world functioning.

Ohio: Community-Based Juvenile Assessment Centers

The Early Intervention and Diversion Center screens youth and families, conducts behavioral health assessments, and connects them to community-based services—diverting thousands of youth annually away from more restrictive settings.¹⁷

Secondary Custody Frameworks for Assessment Periods

In parallel, states can address a critical legal and operational gap by establishing temporary, secondary custody mechanisms for youth who cannot safely return home during assessment.

A well-structured secondary custody policy should:

- Be time-limited and explicitly tied to the assessment period.
- Preserve parental rights and avoid unnecessary system penetration.
- Assign temporary decision-making authority to a state-designated child advocate entity (e.g., an Office of the Child Representative or equivalent).

¹⁶ "Policy Statement on the Care of Pediatric Patients Awaiting Psychiatric Care in Emergency Departments," The American Academy of Child & Adolescent Psychiatry, July 2025.

¹⁷ "Cuyahoga County, Ohio Juvenile Court Early Intervention and Diversion Center (EIDC)," National Assessment Center Association, 2021.

This approach enables placement in assessment centers or stabilization programs without defaulting to hospital boarding or premature child welfare intervention. States that pursue this option should define in law who may authorize the temporary placement; how long the arrangement may last before judicial or administrative review; what due-process protections apply; who consents to routine treatment; how education and family visitation will be maintained; and which agency is financially responsible during the assessment period.

There are real incentives, especially during periods of budget constraints, for states to implement these alternatives. The hospital-based models outlined previously have shown they can assist with the efforts to reduce hospital boarding and associated costs and improve the accuracy of placement and treatment decisions. The inherent value of improved placement outcomes is the direct correlation to a decrease in costly repeat crisis episodes and readmissions.

Solutions to Address Access Challenges for Children and Youth With Mental Health Complexity Covered By Commercial Insurance

Commercial insurance coverage limitations commonly impact children and youth with mental health complexities when accessing appropriate higher levels of care.

A 2026 national survey found that privately insured children and youth with special health care needs continue to experience significant unmet service needs despite having coverage. The survey reported that insurance and financial barriers were common, frequent inadequate availability for specialty care and respite services, information and navigation barriers for families seeking home health services.¹⁸

It is not uncommon for kids to remain in hospital settings because their insurance coverage does not allow them to access other important services, ranging from residential treatment to home and community-based services.¹⁹

Creating Stop Gap Measures and Alternative Solutions for the Commercially Insured

Children with complex behavioral health needs can remain unable to access intensive services even when they have private insurance. States can address this by creating programs that provide access to services beyond what commercial insurance alone can deliver, such as Colorado's Children and Youth Mental Health Treatment Act (CYMHTA).

CYMHTA allows children with significant mental health needs who are ineligible for Medicaid, including many with commercial insurance, to access intensive behavioral health services and care coordination when they are at risk of out-of-home placement. The program serves as an alternative to child welfare involvement and provides access to a full continuum of mental health treatment, including residential services when necessary.

The most innovative aspect of CYMHTA is that Colorado effectively created a publicly financed behavioral health benefit for children who would otherwise fall into a coverage gap. The program can provide funding when there is no other appropriate source of payment, including when private insurance is insufficient to cover needed services.

This allows youth with commercial insurance to access intensive supports that frequently exceed what private plans are willing to cover. Services are arranged through designated behavioral health agencies and include care coordination, assessment, treatment planning, and access to intensive behavioral health services.

¹⁸ NORC at the University of Chicago, Unmet Need for Services Among Publicly and Privately Insured Children, Data Brief, January 2026.

¹⁹ Medicaid and CHIP Payment and Access Commission (MACPAC), Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid (June 2025)

Services Available

While services are individualized, Colorado describes CYMHTA as providing access to a **full range of mental health treatment services, including residential care**, for eligible children and youth who are not Medicaid eligible.²⁰

A Colorado family highlighted by the state reported receiving:

- Intensive in-home behavioral health services.
- Psychiatry services.
- Respite care.
- Dedicated care coordination/case management.
- Additional family supports designed to keep the youth safely at home and prevent hospitalization or other system involvement.²¹

Legislative Opportunities

State lawmakers should treat this as a near-term modernization agenda rather than a long-range aspiration. At a minimum, legislation and budget language should:

- Fund regional or statewide assessment, stabilization, and transition capacity that can safely serve youth who do not need continued hospitalization.
- Establish clear authority for time-limited assessment placements or temporary custodial arrangements when needed to protect the child without unnecessary hospital use or deeper system involvement.
- Direct Medicaid, behavioral health, child welfare, and juvenile justice agencies to adopt coordinated referral, authorization, and transition protocols so that youth move promptly to the least restrictive clinically appropriate setting.
- Appropriate start-up and ongoing operating funds for regional assessment, stabilization, and transition programs that can serve as alternatives to hospital stays for youth who need multidisciplinary evaluation or short-term crisis care.
- Create clear statutory authority for time-limited assessment placements or temporary custodial arrangements when needed to keep youth safe without defaulting to unnecessary hospitalization or deeper child welfare involvement.
- Direct Medicaid, behavioral health, child welfare, and juvenile justice agencies to align regulations, referral pathways, and contracting requirements so assessments and transitions occur in clinically appropriate, non-hospital settings whenever hospital-level care is no longer medically necessary.
- Create a state-funded children and youth mental health treatment program that guarantees access to intensive behavioral health services for children whose needs exceed the limits of commercial insurance coverage.

These changes represent a **high-impact, bipartisan policy solution** to reduce system strain while improving outcomes for vulnerable youth and families.

²⁰ Colorado Children and Youth Mental Health Treatment Act, C.R.S. §27-67-102

²¹ Colorado Department of Human Services. (2022, January 31). CYMHTA brings behavioral health care directly to Colorado families. Colorado Department of Human Services. <https://cdhs.colorado.gov/blog-post/cymhta-brings-behavioral-health-care-directly-to-colorado-families>

IV. Essential Policy Actions for States

1. PROPERLY INCENTIVIZE CHILDREN'S HOSPITALS AND OTHER PEDIATRIC-SPECIFIC PROVIDERS TO BUILD AND OPERATE COMPREHENSIVE APPROACHES TO CRISIS CARE

States should explicitly direct Medicaid programs to cover, contract for, and adequately pay for a pediatric crisis service array consistent with EPSDT. Services may include screening and assessment, urgent and crisis response, mobile crisis, crisis stabilization, intensive outpatient or step-down supports, and medically necessary inpatient care when clinically indicated. CMS's September 2024 EPSDT guidance emphasized that states are responsible for ensuring access to medically necessary behavioral health services for children and youth in the most appropriate setting and that the covered service array should include crisis services and community-based services at varying levels of intensity.

Operationally, this means states should review pediatric behavioral health rates at least annually; identify services where rates are insufficient to sustain access; require managed care organizations to contract with pediatric-capable crisis, subacute, and step-down providers; and adopt payment approaches that support clinically appropriate transitions rather than paying only for the highest-acuity setting. States may use directed payments, enhanced case rates, per-member care coordination payments, or other value-based arrangements so long as those arrangements include pediatric quality and access safeguards.

Illustrative contract language states can adapt includes: "The Contractor shall maintain a pediatric behavioral health network sufficient to provide timely access to crisis receiving, crisis stabilization, intensive community-based services, and clinically appropriate step-down services for members under age 21. The Contractor shall reimburse participating providers at rates sufficient to sustain access and shall submit an annual pediatric network adequacy and payment analysis to the State."

2. ESTABLISH STATEWIDE PEDIATRIC BEHAVIORAL HEALTH CAPACITY MANAGEMENT AND ACCOUNTABILITY INFRASTRUCTURE

States should establish a statewide or regional pediatric behavioral health coordination entity with explicit authority to identify children who are boarding, match them to available placements, escalate barriers, and report performance to state leaders monthly. The entity may be housed in a state agency, contracted nonprofit or health care association, or a designated administrative services organization. Its authority, required participants, and reporting obligations should be defined in law, regulation, contract, or formal interagency agreement.

At a minimum, states should require Medicaid-contracted hospitals, crisis providers, residential treatment providers, managed care organizations, and relevant child-serving agencies to participate in the coordination process and submit standardized data on bed availability, referral status, denials, and barriers to discharge. Participation requirements should specify frequency of updates, required data fields, permissible uses of de-identified and identified data, and response-time expectations when a referral is sent or an escalation is triggered.

States should also define a pediatric boarding threshold that triggers mandatory escalation. A practical example: "If a child remains in an emergency department, medical inpatient unit, or other hospital setting for more than 24 hours after clinical determination that hospital-level care is no longer medically necessary, the case shall be referred to the state-designated pediatric behavioral health coordination entity. If the child remains boarded for more than 72 hours, the Medicaid agency, managed care plan, and any other responsible public agency shall participate in a case escalation review within one business day."

States should then require public reporting on boarding duration, placement denials, transfer delays, out-of-state placements, and unmet service needs.

Budget language should identify the staff and functions required to operate the model effectively, including clinical review, care coordination, utilization management, family navigation, analytics, and interagency escalation support. States should avoid creating an unfunded mandate on hospitals. If hospitals are expected to submit data, participate in huddles, or host treatment and transition functions during boarding, payment policy should recognize those responsibilities.

Technology specifications should include real-time or near-real-time capacity updates, referral routing, denial reason capture, cross-agency notes, audit trails, and dashboard reporting by age, payer, acuity, geography, and special population. States should also define who has access to what information and how privacy protections will be maintained. Without this capability, states cannot distinguish between a true shortage of services and a failure of coordination, authorization, or network participation.

States may need to begin with regional implementation funding where statewide infrastructure is not immediately feasible, with a plan for phased expansion. In some instances, counties have built up the requisite services to meet their local needs and these can be expanded quickly.

3. ALIGN MEDICAID PAYMENT, UTILIZATION MANAGEMENT, AND EPSDT COMPLIANCE WITH CHILDREN'S LEVEL-OF-CARE NEEDS

States should use Medicaid policy to ensure medically necessary services are available across the full pediatric behavioral health continuum and payment and authorization rules do not create avoidable barriers to discharge or access.

As a first step, Medicaid agencies should conduct a pediatric behavioral health access review and identify where reimbursement levels, benefit design, or managed care contracting practices are suppressing capacity. States should then increase rates or adopt alternative payment approaches where current reimbursement is insufficient to maintain access. This may include crisis stabilization, subacute treatment, intensive home- and community-based services, and specialized pediatric placements.

States should define, in state plan language or managed care contracts, the pediatric crisis and step-down services that must be available to children after emergency department or inpatient evaluation. This should include crisis receiving, crisis stabilization, observation, bridge therapy, intensive care coordination, and short-term in-home or community-based transition supports where medically necessary. Those services should be visible to and reachable through any state capacity-management system.

States should separately analyze and purchase capacity for children who are most likely to experience prolonged boarding, including youth with developmental disabilities, autism, aggression, eating disorders, co-occurring conditions, child welfare involvement, or juvenile justice involvement. General pediatric psychiatric capacity alone will not resolve boarding if the highest-need children continue to be declined by existing providers.

States should also eliminate administrative barriers that cause children to miss available placements. Medicaid agencies and managed care plans should require expedited prior authorization and concurrent review for pediatric behavioral health transfers with defined turnaround times. Illustrative language includes: "The Contractor shall not deny, delay, or condition authorization for a clinically appropriate pediatric behavioral health transfer in a manner that causes the loss of an available placement. For urgent transfer requests, the Contractor shall issue an authorization decision on the same calendar day."

4. ESTABLISH TIMELY PLACEMENT ACCOUNTABILITY AND CROSS-SYSTEM DECISION-MAKING REQUIREMENTS

States should clarify the responsible entity when a child is ready for discharge but remains in the hospital because of delays in placement, authorization, custody, or interagency coordination.

Lawmakers and Medicaid leaders should define maximum pediatric boarding thresholds and mandatory response obligations in statute, regulation, Medicaid contracts, or agency guidance. The policy should identify: the event that starts the clock; which entity must be notified at each threshold; which agency is responsible for convening case review; what information must be reviewed; and what authority exists to resolve disputes involving managed care, child welfare, juvenile justice, developmental disability services, or county-administered systems.

Policies should also address the subset of cases in which no parent, guardian, agency, or other responsible actor is available or willing to authorize the next placement. States should specify who has temporary decision-making authority, how legal review is triggered, and what timelines apply. Interagency governance should include formal dispute-resolution pathways so that hospitals are not left to manage cross-system stalemates. States may also tie participation to licensure, certification, or contracting requirements. For example, a state may require licensed pediatric behavioral health providers and Medicaid-contracted plans to participate in the coordination process, respond to referrals within a defined timeframe, and document a clinically specific reason for any denial.

5. FUND ACTIVE TREATMENT AND FAMILY SUPPORT DURING UNAVOIDABLE BOARDING

Even when states move aggressively to reduce boarding, some delays will still occur. States should therefore require that children receive active treatment, family support, and transition planning during any unavoidable boarding period rather than custodial supervision alone. This is particularly important when a child remains in a medical inpatient unit or emergency department for multiple days after acute medical or psychiatric stabilization.

States should permit Medicaid reimbursement, through state plan authority, managed care contract requirements, or other available mechanisms, for medically necessary therapeutic and care coordination services delivered during boarding. This may include psychiatry, psychology, nursing, social work, child life, peer or family support, and intensive care coordination when those services are not otherwise separately reimbursed.

Illustrative Medicaid or contract language includes: “For members under age 21 who remain in a hospital setting after determination that hospital-level care is no longer medically necessary, the State or Contractor shall reimburse medically necessary behavioral health treatment, family support, and discharge planning services furnished during the boarding period when those services are expected to reduce harm or expedite transition to a lower level of care.”

6. BUILD AND SUSTAIN THE FULL CONTINUUM OF COMMUNITY-BASED SERVICES

Lasting progress will require states to build and sustain a full continuum of community-based services that prevents crisis, shortens hospital stays, and reduces repeat emergencies. Capacity investments should be guided by data from hospitals, Medicaid, managed care plans, families, community providers, and the state’s capacity-management infrastructure—not by anecdote alone.

Lawmakers should prioritize appropriations and Medicaid coverage for mobile crisis, crisis receiving and stabilization, intensive in-home treatment, family peer support, wraparound, respite, and other home- and community-based services that can prevent hospitalization or support earlier discharge. Appropriations language should specify target populations, regions to be served, reporting requirements, and expected implementation timelines.

States should also make targeted investments in specialized treatment and support options for children with the most complex needs, including intellectual or developmental disabilities, autism, co-occurring conditions, aggression, eating disorders, or child welfare involvement. These service lines should be separately tracked in rate reviews, network adequacy analyses, and capacity reports because they are often the primary drivers of prolonged boarding.

States should use licensing, procurement, workforce, and purchasing strategies to stabilize high-need provider capacity, particularly in underserved regions. Sample approaches include start-up grants tied to performance milestones, enhanced rates for pediatric specialty providers, workforce incentive programs for hard-to-staff settings, and contract requirements that providers participate in the state’s referral and escalation infrastructure.

Summary Table: Actions States Can Codify, Contract For, and Measure

POLICY GOAL	LEGISLATIVE ACTION	MEDICAID/ADMINISTRATIVE ACTION	ILLUSTRATIVE POLICY LANGUAGE	ACCOUNTABILITY METRIC
Build pediatric crisis capacity	Appropriate funding for pediatric crisis receiving, stabilization, and step-down services; require annual review of pediatric access gaps.	Review rates annually; require managed care contracting with pediatric-capable providers; define covered crisis and step-down services under EPSDT.	"The Contractor shall maintain a pediatric behavioral health network sufficient to provide timely access to crisis receiving, crisis stabilization, intensive community-based services, and clinically appropriate step-down services for members under age 21."	Network adequacy by region; median wait time for crisis and step-down services; provider participation trends.
Establish real-time capacity management	Designate or procure a statewide or regional coordination entity and require participation by key providers and agencies.	Specify required data submission, referral standards, denial tracking, and monthly reporting obligations in contracts or guidance.	"If a child remains in a hospital setting for more than 24 hours after determination that hospital-level care is no longer medically necessary, the case shall be referred to the state-designated pediatric behavioral health coordination entity."	Median and 90th percentile boarding duration; number of cases escalated; denial reasons; out-of-state placements.
Reduce administrative delays	Require expedited transfer and placement decision timelines for children exceeding boarding thresholds.	Amend managed care contracts to require same-day urgent authorization and one-business-day review for all other pediatric behavioral health transfers.	"The Contractor shall not deny, delay, or condition authorization for a clinically appropriate pediatric behavioral health transfer in a manner that causes the loss of an available placement."	Authorization turnaround time; percentage of transfers delayed by utilization management; lost-placement incidents.
Create alternatives to hospitalization	Fund assessment, stabilization, and transition programs and establish authority for time-limited assessment placements where appropriate.	Define referral criteria, payment responsibilities, and interagency protocols for non-hospital assessment and transition settings.	"The State shall support regional assessment and stabilization capacity for youth who do not require continued hospitalization but need multidisciplinary evaluation or short-term transition support."	Number of youth diverted from prolonged hospital stays; average time from referral to placement; readmissions after diversion.
Support active treatment during unavoidable boarding	Recognize boarding-period treatment and family support as necessary services to reduce harm and improve discharge readiness.	Permit reimbursement for medically necessary therapeutic, care coordination, and family support services delivered during boarding.	"For members under age 21 who remain in a hospital setting after determination that hospital-level care is no longer medically necessary, the State or Contractor shall reimburse medically necessary behavioral health treatment, family support, and discharge planning services furnished during the boarding period."	Treatment contact during boarding; family support utilization; discharge readiness indicators; repeat crisis episodes.
Strengthen accountability and oversight	Require public reporting and annual legislative review of pediatric boarding trends, gaps, and corrective actions.	Publish dashboards and use findings to guide rate setting, procurement, and network requirements.	"The State shall publish quarterly reports on pediatric behavioral health boarding duration, placement denials, transfer delays, and unmet service needs, stratified by region and key population."	Quarterly trendlines for boarding, denials, transfer delays, and unmet needs; corrective action completion rate.

Conclusion

Pediatric psychiatric boarding harms children, strains families, and undermines the efficient use of hospital resources. It is not a therapeutic intervention, and it does not align with evidence-based standards for high-quality behavioral health care. Boarding also ties up scarce emergency and inpatient beds, while the use of hospital-level services for children who no longer require that level of care is substantially more expensive than clinically appropriate step-down services.

States have both the authority and the responsibility to ensure that children with behavioral health needs receive services in the least restrictive, medically appropriate setting. That responsibility extends beyond general oversight. It requires enforceable policy choices: funding the right service array, defining accountability when a child cannot be discharged, directing Medicaid and managed care plans to remove administrative barriers, and requiring cross-system coordination supported by real-time data.

Pediatric mental health boarding is a visible symptom of deeper system misalignment, but it is also a fixable policy problem. States can reduce boarding most effectively by establishing real-time capacity management, aligning Medicaid payment and EPSDT implementation with children's level-of-care needs, imposing timely placement accountability, and investing in a full continuum of pediatric behavioral health services. Children's hospitals are essential partners, but durable progress depends on state leaders making these expectations explicit in law, contracts, budgets, and agency operations.

