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Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care

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REPORT HIGHLIGHTS

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Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care

Why OIG Did This Review

- Suicide is the second leading cause of death for children in the United States. In 2023, nearly 225,000 children aged 10–17 who were enrolled in Medicaid were hospitalized or visited the emergency department (ED) for suicidal thoughts or behaviors.
- Providing timely followup care after children experience suicidal thoughts or behaviors is critical to decreasing the likelihood of re-hospitalization and preventing suicide. OIG interviewed experts who told us that a followup visit should occur anywhere from 24 hours to 1 week after a child's discharge from the hospital or ED.

What OIG Found

In half of cases (i.e., hospitalizations or ED visits for suicidal thoughts or behaviors), children did not receive a followup visit in the week after their discharge—a critical time for intervention.

When children did receive followup visits, most visits occurred with behavioral health providers such as counselors, social workers, and psychiatrists.

Subject matter experts whom OIG interviewed attributed the lack of timely followup visits to provider shortages and difficulties connecting children to care. The experts also shared that brief interventions from any type of provider could support children while they await more comprehensive care from a behavioral health professional (e.g., telephone contacts and safety planning).

What OIG Recommends

In past work, OIG recommended that CMS take steps to expand access to behavioral health providers for Medicare and Medicaid enrollees. This evaluation provides further evidence of the need for CMS to make necessary efforts to increase enrollees' access to behavioral health care providers. In addition to prior recommendations, OIG recommends that CMS assist low-performing States to better ensure that children at risk of suicide receive timely followup care.

CMS concurred with this recommendation.

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BACKGROUND

OBJECTIVES

1. To examine the type and timeliness of followup care, if any, provided to children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) who received treatment for suicidal thoughts or behaviors.
2. To determine whether rates of timely followup care varied by State for children enrolled in Medicaid or CHIP who received treatment for suicidal thoughts or behaviors.
3. To identify access issues and best practices regarding timely followup care for children enrolled in Medicaid or CHIP who received treatment for suicidal thoughts or behaviors.

Suicidal ideation,[1] intentional self-harm,[2] and suicide attempts (referred to collectively as suicidal thoughts and/or behaviors) are devastating public health issues, and important predictors of death by suicide.[3, 4] Suicide is the second leading cause of death for children in the United States; between 2018 and 2023, over 10,000 children aged 10–17 lost their lives to suicide.[5, 6]

Rates of suicidal thoughts and behaviors among children have been on the rise for over a decade.[7, 8] The Children's Hospital Association found that between 2016 and 2022, children's hospitals saw a 166-percent increase in emergency department (ED) visits for suicidal thoughts and behaviors.[9] To address these rising rates and prevent suicide, the Centers for Disease Control and Prevention (CDC) has identified several strategies, including ensuring timely access to care and providing followup care after a child experiences suicidal thoughts or behaviors.[10]

Medicaid/CHIP and Mental Health Care

The Centers for Medicare & Medicaid Services (CMS) provides health coverage to more than 160 million enrollees through Medicare, Medicaid, CHIP, and the Health Insurance Marketplace.[11] The Medicaid program is the single largest payer of behavioral health services in the United States, providing coverage to 27 million children under age 18 in the United States.[12] Many of these behavioral health services are provided through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which requires the provision of services to prevent, screen, assess, and treat mental health and substance use disorders.[13] These services may be provided in a variety of settings such as physicians' offices and clinics; federally

qualified health centers; rural health clinics; inpatient and outpatient hospitals; and schools.[14] Similarly, all CHIPs are required to provide mental health services.[15]

Mental Health Followup Care

Providing timely followup care after a child experiences suicidal thoughts or behaviors is critical to decreasing the likelihood of re-hospitalization and preventing suicide. Research has shown that the first week after discharge from inpatient care is a period of extraordinarily high suicide risk.[16] For patients with identified suicide risk history, the suicide rate for the first week after discharge is 300 times higher than the general population's suicide rate, and is greatest in the first few days after discharge.[17, 18] Timely followup care can reduce this heightened risk of suicide; one study found that the risk of suicide during the 6 months after psychiatric hospitalization was decreased among youth who had an outpatient mental health visit within 7 days after discharge.[19]

Followup care is also cost-effective, lowering the overall cost of care by reducing utilization of emergency and inpatient services. For example, studies have found that interventions intended to address suicidal thoughts and behaviors can all improve outcomes for patients while reducing costs for payers such as Medicaid.[20, 21, 22, 23]

Elements of Effective Followup Care

Followup care aims to reduce the frequency and intensity of suicidal ideation and prevent recurrence of self-harm and premature death for children who experience suicidal thoughts or behaviors.[24] According to guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA), most effective followup care is evidence-based; is conducted by a licensed mental health professional (e.g., a psychologist, psychiatrist; clinical social worker; or marriage and family therapist); and takes place over multiple sessions.[25] Followup care can occur in a variety of settings, such as outpatient visits or partial hospital programs, and can be delivered in person or virtually.[26] Followup care should address suicidal thoughts and behaviors directly as well as any underlying disorders that commonly co-occur with suicidal thoughts and behaviors (e.g., depression and borderline personality disorder).[27]

SAMHSA identifies several effective followup care interventions. Although SAMHSA highlights interventions such as Dialectical Behavior Therapy (i.e., a cognitive-behavioral treatment that includes concurrent individual and family therapy; multifamily skills training; and telephone coaching), it emphasizes that there is no one-size-fits-all treatment for suicidal thoughts and behaviors in children.[28] Providers should select the intervention that best fits the characteristics and needs of each child who will be served.[29] Regardless of the specific intervention selected, the following elements should be strongly considered within treatment programs:

- comprehensive assessment;
- safety planning;
- family involvement;
- coping skills training; and
- promotion of continuity of care.[30]

Guidelines for Mental Health Followup Care

CMS has adopted a set of children's health care quality measures referred to as the Child Core Set, which includes two followup measures for children who were hospitalized or treated in the emergency department for any of over 1,700 behavioral health diagnoses.[31] Each measure includes the percentage of discharges for which the child had a mental health followup visit within 7 days and within 30 days after discharge.[32]

Similarly, several professional and public health organizations have issued guidance on when followup care should be initiated or be provided for individuals who experience suicidal thoughts or behaviors:

- The American Academy of Pediatrics recommends that providers schedule a followup visit with children who are at risk for suicide within 72 hours.[33]
- SAMHSA's 988 Suicide and Crisis Lifeline requires that network centers provide followup services for individuals experiencing suicidal thoughts within 24–72 hours of their initial contact with the Lifeline.[34]
- The National Action Alliance for Suicide Prevention recommends that providers assist children in scheduling an outpatient behavioral health appointment following a suicide attempt no later than 7 days after discharge.[35]

Methodology

Data Analysis

We analyzed Transformed Medicaid Statistical Information System (T-MSIS) data from 54 States and territories for children aged 10–17 who (1) were hospitalized or visited an ED for suicidal thoughts or behaviors in FY 2023 and (2) were continuously enrolled in Medicaid or CHIP for at least 60 days following the date of discharge. We also limited claims to children who were entitled to full-scope or comprehensive Medicaid or CHIP benefits during the 60 days following their discharge from the ED or hospital.[36] We determined whether children received followup care after their hospitalization or an ED visit department for suicidal thoughts or behaviors; the time (in days) it took for children to receive followup care; and what type of care (i.e., provider type) children received.

To better understand barriers to timely followup care, we conducted structured interviews with 10 subject matter experts who represent a variety of public health and professional organizations, including:

- SAMHSA;
- the National Alliance on Mental Illness;
- the American Foundation for Suicide Prevention; and
- the Suicide Prevention Resource Center.

See the Detailed Methodology for more information.

Limitations

Our quantitative analysis is limited to the Medicaid claims data included in T-MSIS. Although T-MSIS is the most comprehensive national Medicaid and CHIP data set, it has known data quality concerns.[37] Additionally, Medicaid claims may not capture all followup care for children with multiple insurers or private pay, or some school-based care. It is possible that some suicidal thoughts and behaviors may be miscoded, as assessment of intent may vary depending on provider experience and discernment and ICD-10-CM codes do not distinguish between suicidal and non-suicidal self-harm.[38] See the Detailed Methodology section for more information.

Standards

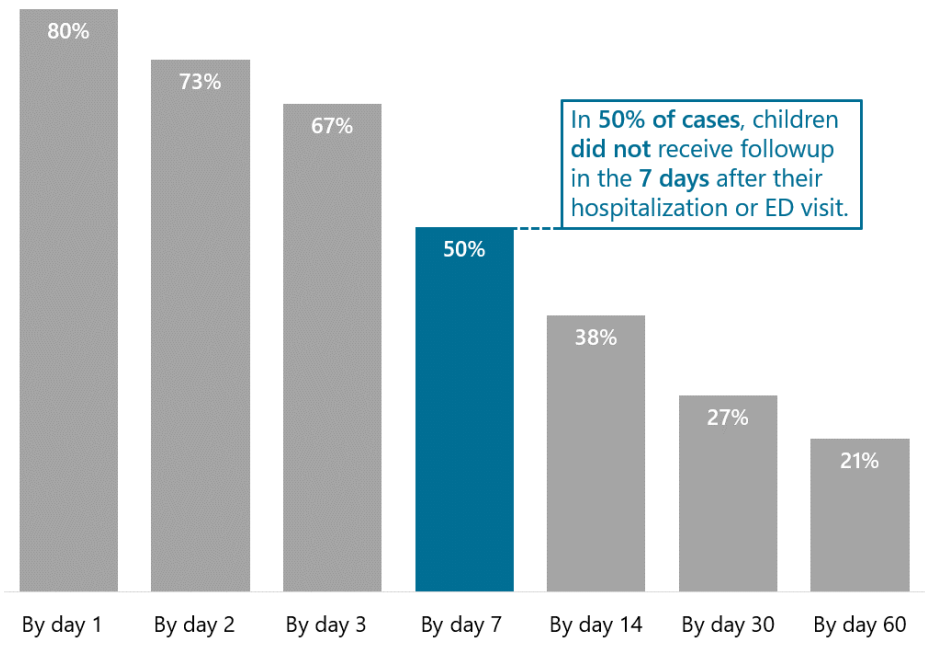
We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

In 2023, 224,759 children aged 10–17 who were enrolled in Medicaid and CHIP (hereinafter collectively referred to as "Medicaid") were hospitalized or visited the ED for suicidal thoughts or behaviors. Some of these children had multiple hospitalizations/ED visits during FY 2023.[39] Our analysis included 258,458 unique hospitalizations or ED visits for suicidal thoughts or behaviors for these children (referred to throughout this report as cases).

In half of reviewed cases, children did not receive a followup visit in the week after their hospitalization or emergency department visit for suicidal thoughts or behaviors

Exhibit 1: Percentage of cases in which children did not receive followup after their hospitalization or ED visit for suicidal thoughts or behaviors

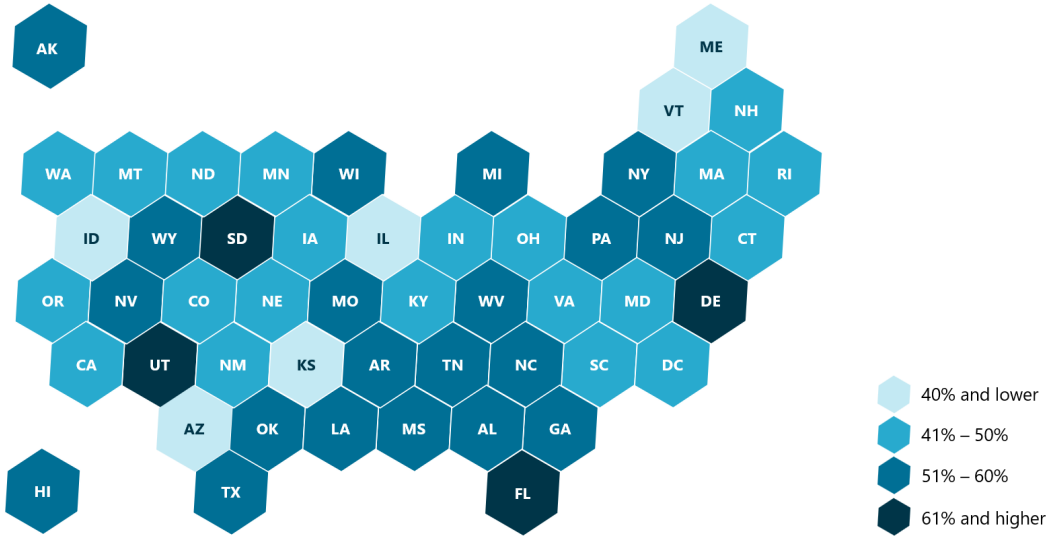


Source: OIG analysis of FY 2023 T-MSIS data, 2025.

In 50 percent of cases, children did not receive a followup visit within a week of their hospitalization or ED visit for suicidal thoughts or behaviors. The percentage of cases in which children did not receive followup care in the week after a hospitalization or ED visit for suicidal thoughts or behaviors varied greatly across States (see Exhibit 2, next page). We also analyzed followup rates by children's Medicaid plan types (i.e.,

Comprehensive Managed Care Organization, Prepaid Ambulatory Health Plan, Prepaid Inpatient Health Plan, Primary Care Case Management, or other); initial diagnoses (i.e., suicide attempt, intentional self-harm, or suicidal ideation); and other characteristics. See Appendix A for followup rates by State and Appendix B for followup rates by child and plan characteristics.

Exhibit 2: The percentage of cases in which children did not receive followup care in the week after a hospitalization or ED visit for suicidal thoughts or behaviors varied greatly across States*



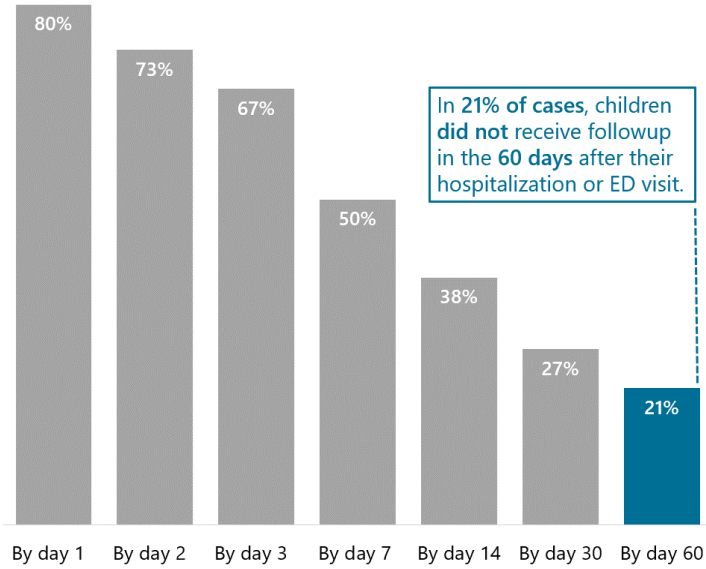
** Due to small population sizes and differences in program operation, we do not provide the rates for no followup care in the Virgin Islands (VI) and Puerto Rico (PR).*
Source: OIG analysis of FY 2023 T-MSIS data, 2025.

Consistent with guidance from professional organizations, nearly all experts in youth mental health and suicide prevention whom we interviewed indicated that a followup visit should occur anywhere from 24 hours to 1 week after a child's hospitalization or ED visit for suicidal thoughts or behaviors. According to these experts, this timeline is important because children are at a heightened risk of repeat suicide attempts within a week of their initial event and a followup visit can help reduce this risk.[40] See the Detailed Methodology section for more information about the experts whom we interviewed.

In 21 percent of cases, children did not receive any followup visits in the 60 days after their hospitalization or emergency department visit for suicidal thoughts or behaviors

Although most professional guidance and subject matter experts whom we interviewed indicated that followup should occur within a week, we analyzed claims for 60 days after children's hospitalizations or ED visits to capture all potential followup visits. In 21 percent of cases, no followup visits occurred during the 2 months after children were hospitalized or visited an ED for suicidal thoughts or behaviors (see Exhibit 3). This is concerning, as research shows that children's risk of suicide remains elevated for months after a psychiatric hospitalization.[41]

Exhibit 3: Percentage of cases in which children did not receive followup after their hospitalization or ED visit for suicidal thoughts or behaviors

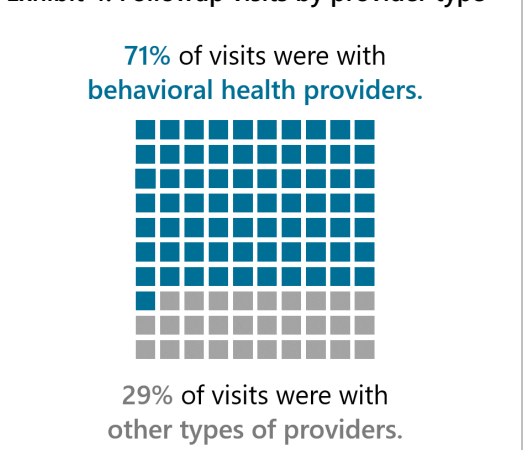


Source: OIG analysis of FY 2023 T-MSIS data, 2025.

When children did receive followup visits, most visits occurred with behavioral health providers

When children received followup visits, 71 percent occurred with behavioral health providers (see Exhibit 4). Of these providers, children most commonly visited counselors, who provided 28 percent of all visits. Children also visited social workers (22 percent of visits); psychiatrists and neurologists (19 percent of visits); psychologists (17 percent of visits); and psychiatric nurse practitioners (5 percent of visits).

Exhibit 4: Followup visits by provider type



Source: OIG analysis of FY 2023 T-MSIS data, 2025.

The remaining 29 percent of followup visits occurred with other types of providers who do not specialize in behavioral health. Among these providers, the most common type was case managers, who provided 7 percent of all visits. Children also visited pediatricians (4 percent of visits); non-psychiatric nurse practitioners (2 percent of visits); family medicine physicians (2 percent of visits); and physician assistants (2 percent of visits).

Consistent with guidance from professional organizations, nearly all subject matter experts we interviewed emphasized that no one type of provider is ideal for treating every child. In addition to behavioral health providers, other types of providers can play an important role in treating children who experience suicidal thoughts and behaviors.

Subject matter experts attributed the lack of timely followup visits to behavioral health provider shortages and difficulties connecting children to care

We interviewed 10 subject matter experts in youth mental health and suicide prevention who attributed the lack of timely followup visits to provider shortages and difficulties connecting children to care. These experts included leaders from the SAMHSA Center for Mental Health Services; the National Alliance on Mental Illness; the American Foundation for Suicide Prevention; the Suicide Prevention Resource Center; and other organizations.

Behavioral health provider shortages may have contributed to a lack of timely followup visits

Subject matter experts whom we interviewed emphasized that the national shortage of behavioral health providers impedes children from receiving timely followup visits. The United States does not have enough behavioral health providers to meet the current demand for mental health services. More than 120 million Americans live in Federally designated mental health professional shortage areas, and previous OIG work identified a lack of behavioral health providers in Medicare and Medicaid specifically.[42, 43] Subject matter experts reported that many children must wait weeks or months for an appointment with a behavioral health provider, and others may not even be able to find a provider who is accepting new patients to their waitlist. In such cases, children and their families are unable to access timely followup care during a period of extraordinarily high suicide risk.

Subject matter experts stated that providers who do not specialize in behavioral health can help meet the demand for followup care

"Increasing the capacity, comfort and competence of primary care providers in addressing suicidality within their setting—because we have to, because we're sometimes the only option—is an important piece of this puzzle."

- *Medical Director and Pediatrician interviewed by OIG*

To meet the high demand for followup care, subject matter experts whom we interviewed whom we interviewed described the need to train providers who do not specialize in behavioral health to better support children who experience suicidal thoughts and behaviors. Although providers with a behavioral health specialization may be the best equipped to care for children who experience suicidal thoughts and behaviors, current shortages in the behavioral health workforce limit their ability to meet children's needs for care. Training for these providers can help ensure they are able to provide suicide-specific interventions and help children safely transition from the hospital or ED to ongoing followup care.[44]

Difficulties connecting children to care may have contributed to a lack of timely followup visits

Subject matter experts whom we interviewed reported that children are often unable to connect with followup care after they are discharged from the hospital or ED due to the difficult nature of navigating the healthcare system. Because children often leave the hospital or ED without a followup visit scheduled, their families are tasked with identifying and scheduling a followup visit. Access to followup care may be further impeded when children lack transportation to appointments or experience stigma surrounding mental health care from their families and communities.

*"Oftentimes **when children and families leave an inpatient unit or an emergency room**, unless they have an appointment or another point of connection, there is a fair likelihood that **they will be lost to followup**."*

- Child and Adolescent Psychiatrist and Chief Medical Officer interviewed by OIG

Brief interventions can help children safely transition to ongoing followup care

Subject matter experts whom we interviewed shared that brief interventions, which are intended to bridge the gap between children's discharge and their first followup visit, can help children safely transition to ongoing followup care. While brief interventions alone may not be sufficient to treat suicidal thoughts and behaviors and are not intended to replace ongoing followup care, they have been shown to increase the likelihood that children receive a followup visit.[45, 46] Brief interventions help children and their families connect with providers and develop strategies to manage their mental health while they wait for a followup appointment, and include:

- warm handoffs (i.e., children's current providers introducing them to their new providers before the care transition occurs);[47]
- caring contacts (i.e., brief communications expressing care from providers that can be delivered by phone, letter, postcard, email, or text);[48, 49] and
- safety planning (i.e., efforts to develop strategies for children to use in the event of future suicidal ideation).[50]

In December 2024, CMS published a final rule for Medicare to allow for new separate coding and payment for safety planning interventions and post-discharge follow up contacts (i.e., caring contacts) performed in conjunction with a discharge from the ED for a behavioral health or other crisis encounter.[51] These new codes represent an important opportunity for States to evaluate the potential benefits of covering brief interventions in their Medicaid programs.

CONCLUSION AND RECOMMENDATIONS

Suicide is the second leading cause of death for children in the United States, and in 2023, nearly 225,000 children aged 10–17 who were enrolled in Medicaid and CHIP were hospitalized or visited the ED for suicidal thoughts or behaviors. We found that in half of cases, children did not receive a followup visit within a week of their hospitalization or ED visit for suicidal thoughts or behaviors. In 21 percent of cases, children did not receive *any* followup visits in the 60 days after their hospitalization or ED visit. Many of the subject matter experts with whom OIG spoke attributed the lack of timely followup visits to behavioral health provider shortages and difficulties connecting children to care.

To reduce suicide rates among children, States must implement accessible and effective prevention efforts, including timely followup care for children who exhibit suicidal thoughts or behaviors. In past work, OIG recommended that CMS take steps to expand access to behavioral health providers.[52] In addition to these efforts, we urge CMS to work with State Medicaid agencies to better ensure that children who are at risk of suicide receive timely followup care. We recommend that CMS:

Assist low-performing States to better ensure that children at risk of suicide receive timely followup care

To better ensure that children who are treated for suicidal thoughts or behaviors receive timely followup care, CMS should provide additional assistance to low-performing States. To support children who are most at risk of suicide, CMS should consider focusing its efforts on the 24 States identified in this report in which more than half of children do not receive followup care within 7 days of a hospitalization or an ED visit for suicidal thoughts or behaviors.

CMS could accomplish this by providing technical assistance to State Medicaid directors through CMS's webinar series or during periodic calls with State Medicaid directors, which represent a valuable forum for facilitating information exchange among States. Through these venues, CMS could work with States to facilitate information sharing on promising practices to improve followup rates, such as:

1. brief interventions such as caring contacts and safety planning, which have been shown to help children safely transition to ongoing followup care,[53, 54, 55] and
2. training opportunities or other resources that States identify as useful for engaging non-behavioral health providers in efforts to care for children at risk of suicide.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with our recommendation.

In response to our recommendation—that CMS assist low-performing States to better ensure that children at risk of suicide receive timely followup care—CMS committed to providing additional technical assistance to States, with a particular focus on the States identified in OIG's report. CMS noted its efforts to assess the quality of health care for children enrolled in Medicaid through State reporting on the Core Set of Children's Health Care Quality Measures, which became mandatory in 2024. CMS also described steps it has taken to support States in improving behavioral health care for Medicaid enrollees. Specifically, CMS stated that it has provided technical assistance to States through its Quality Improvement Program and facilitated a learning collaborative that included a webinar on behavioral health care access and coordination. CMS also provided more intensive support to three States—Arizona, Minnesota, and Mississippi—that participated in an affinity group on behavioral health. We appreciate CMS's efforts to improve behavioral health care and urge CMS to take additional steps to better ensure that children at risk of suicide receive timely followup care.

For the full text of CMS's comments, see the Agency Comments appendix at the end of the report.

DETAILED METHODOLOGY

Claims analyses

States submit Medicaid and CHIP (hereinafter collectively referred to as "Medicaid") data to CMS through the Transformed Medicaid Statistical Information System (T-MSIS). We collected both fee-for-service and managed care encounter data from all 54 States and territories that submitted data to T-MSIS in FY 2023: 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. Data included enrollment information, institutional claims, and outpatient physician services.

Identifying the population

We used T-MSIS claims data to identify children who were hospitalized or visited an ED for suicidal thoughts or behaviors (i.e., a suicide attempt, intentional self-harm, or suicidal ideation) in FY 2023.[56, 57] We limited these claims to children who (1) were aged 10–17 years at the time of their qualifying event and throughout their 60-day followup period and (2) were continuously enrolled in Medicaid or CHIP during the 60 days following their discharge from the ED or hospital. We also limited claims to children who were entitled to full-scope or comprehensive Medicaid or CHIP benefits during the 60 days following their discharge from the ED or hospital, with one exception: We included all children who received care in Oregon, as benefit type was missing from nearly all of these children's enrollment information.[58, 59, 60]

We excluded 1,650 children with claims that indicated participation in hospice and 284 children with a date of death populated during the 60 days following the initial hospitalization/ED visit. We also excluded 88,947 initial hospitalizations/ED visits that occurred within 60 days of a subsequent qualifying hospitalization/ED visit, as these children did not have the full 60 days to receive followup care before the subsequent event occurred. Finally, we excluded 862 initial hospitalizations that lasted 60 days or more, as these children received ongoing care during their hospitalization.

Identifying followup care claims

We analyzed T-MSIS claims data to determine whether children received followup care after a hospitalization or an ED visit for suicidal thoughts or behaviors. To identify visits that qualified as followup care, we began by identifying all claims for care that the children in our population received during the 60 days after their qualifying hospitalization or ED visit.

To limit these claims to just those that constituted followup care, we identified and included all claims with at least one of the following:

1. a behavioral health procedure code;
2. a behavioral health type of service code; or
3. a behavioral health diagnosis code and *either*
    a. an evaluation and management procedure code *or*
    b. evidence that the billing or servicing provider is a behavioral health provider.

Identifying provider type

To identify behavioral health providers, we required at least one of the following:

1. the billing or servicing provider taxonomy listed in T-MSIS was for a behavioral health provider;
2. the billing or servicing provider taxonomy obtained by matching the National Provider Identifier (NPI) to the National Plan and Provider Enumeration System (NPPES) was for a behavioral health provider;
3. the billing or servicing provider specialty is for a behavioral health provider; or
4. the billing or servicing provider type code is for a behavioral health provider.

Some claims had missing or incomplete provider information that made it difficult to determine a provider's specialty or classification. For example, many claims only listed organizations where provider details should have been listed. We excluded such claims from our analysis of followup by provider type.

Calculating followup rates

We analyzed the number of days it took for children to receive followup care up to 60 days after their discharge from the hospital or ED.

Calculating followup rates by the State in which children received care

We conducted subgroup comparisons to determine the extent to which each State where children received care was associated with timely followup care. We analyzed T-MSIS data from 54 States and territories, but we did not provide the rates for no followup care in (1) the Virgin Islands and Guam, due to the low number of children who were hospitalized or visited the emergency department for suicidal thoughts or behaviors there, and (2) Puerto Rico, due to differences in how its program is operated.[61]

CMS's DQ Atlas notes issues with the completeness of "other service" claims data in several States and territories for FY 2023: Alabama, Delaware, Georgia, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Nevada, New Jersey, North Carolina, Puerto Rico, Rhode Island, South Dakota, Utah, Vermont, the Virgin Islands, and Wisconsin.[62, 63] We found that removing these States from our analysis did not meaningfully impact followup rates and thus included all States in our analysis of followup claims.

Interview analyses

We conducted structured interviews with 10 subject matter experts who were purposively selected due to their expertise in the field of youth mental health and suicide prevention. These experts included leaders and other representatives from:

- the SAMHSA Center for Mental Health Services;
- the National Alliance on Mental Illness;
- the American Foundation for Suicide Prevention;
- the Suicide Prevention Resource Center;
- the Indian Health Service;
- the Meadows Mental Health Policy Institute;
- the Ann & Robert H. Lurie Children's Hospital of Chicago;
- the Indian Country Child Trauma Center at University of Oklahoma; and
- Stellar Pediatrics.

All 10 experts were practicing or former providers, including psychiatrists, psychologists, pediatricians, and social workers. We asked interviewees (1) how soon followup care should occur after a child is hospitalized or visits the ED for suicidal thoughts or behaviors; (2) whether a particular type of followup care leads to better outcomes for children at risk of suicide; and (3) what challenges and best practices experts have encountered regarding access to followup care.

APPENDICES

Appendix A: Followup Rates by State

In 2023, 224,759 Medicaid-enrolled children aged 10–17 were hospitalized or visited the ED for suicidal thoughts or behaviors. Some of these children had multiple hospitalizations/ED visits during FY 2023.[64] Our analysis included 258,458 unique hospitalizations or ED visits for suicidal thoughts or behaviors for these children (referred to as cases).

State/Territory	FY 2023 Medicaid Population (age 10–17)*	Number of Cases	No Followup Within 7 Days	No Followup Within 60 Days
Alabama	362,170	3,993	57%	23%
Alaska	50,632	837	58%	33%
Arizona	464,989	5,872	28%	12%
Arkansas	231,034	4,369	60%	25%
California	2,706,612	19,515	45%	20%
Colorado	323,528	4,884	44%	19%
Connecticut	190,699	2,680	46%	16%
Delaware	59,270	791	64%	30%
District of Columbia	43,912	403	46%	25%
Florida	1,330,088	12,781	61%	31%
Georgia	796,217	9,403	57%	26%
Guam	10,769	14**	--	--
Hawaii	79,446	512	53%	28%
Idaho	102,290	2,011	38%	16%
Illinois	735,388	10,191	31%	13%
Indiana	414,719	7,871	49%	21%
Iowa	182,459	3,829	42%	15%
Kansas	154,126	3,255	33%	12%
Kentucky	303,114	5,551	43%	13%
Louisiana	371,351	7,105	57%	26%
Maine	66,627	931	39%	12%
Maryland	341,939	3,802	48%	18%
Massachusetts	372,950	4,997	46%	18%
Michigan	534,520	7,369	56%	22%
Minnesota	282,267	4,580	45%	15%
Mississippi	223,475	2,256	56%	29%

State/Territory	FY 2023 Medicaid Population (age 10–17)*	Number of Cases	No Followup Within 7 Days	No Followup Within 60 Days
Missouri	336,324	8,338	54%	25%
Montana	64,651	1,657	46%	18%
Nebraska	93,436	1,746	49%	18%
Nevada	183,049	2,510	56%	30%
New Hampshire	51,129	1,039	50%	13%
New Jersey	385,804	3,033	51%	22%
New Mexico	177,153	2,803	48%	20%
New York	1,290,437	9,679	54%	20%
North Carolina	654,483	8,840	54%	22%
North Dakota	26,412	727	50%	17%
Ohio	635,780	11,904	46%	17%
Oklahoma	309,645	4,082	59%	23%
Oregon	259,961	2,746	43%	18%
Pennsylvania	717,519	10,230	58%	23%
Puerto Rico	189,848	1,296**	--	--
Rhode Island	62,117	961	50%	16%
South Carolina	360,945	4,366	48%	20%
South Dakota	43,897	1,265	66%	32%
Tennessee	440,199	6,443	60%	22%
Texas	1,867,072	23,012	54%	25%
Utah	113,057	1,858	63%	28%
Vermont	34,638	631	24%	7%
Virginia	407,758	6,279	48%	15%
Virgin Islands	6,716	17**	--	--
Washington	439,910	5,643	44%	20%
West Virginia	116,810	1,973	54%	20%
Wisconsin	292,270	4,895	51%	19%
Wyoming	25,308	683	56%	27%
Total		258,458	50%**	21%**

** This column displays the number of children who were (1) aged 10–17 and (2) enrolled in Medicaid or CHIP for at least 60 consecutive days at any point during FY 2023. For more details, see the Detailed Methodology section.*

*** We did not provide the rates for no followup care in Guam (GU), Puerto Rico (PR), and the Virgin Islands (VI). GU and VI had low numbers of children who were hospitalized or visited the emergency department for suicidal thoughts or behaviors, and we did not provide the rates for PR due to differences in how its program is operated.*

Source: OIG analysis of FY 2023 T-MSIS data, 2025.

Appendix B: Followup Rates by Child and Plan Characteristics

In 2023, 224,759 Medicaid-enrolled children aged 10–17 were hospitalized or visited the ED for suicidal thoughts or behaviors. Some of these children had multiple hospitalizations/ED visits during FY 2023.[65] Our analysis included 258,458 unique hospitalizations or ED visits for suicidal thoughts or behaviors for these children (referred to as cases).

Child's Initial Diagnosis	Number of Cases	No Followup Within 7 Days	No Followup Within 60 Days
Suicide attempt	20,562	48%	19%
Intentional self-harm*	34,532	51%	23%
Suicidal ideation**	203,364	50%	21%
Total	**258,458**	**50%**	**21%**

** This count displays cases that include a diagnosis of intentional self-harm but not a diagnosis of suicide attempt.*
*** This count displays cases that include a diagnosis of suicidal ideation but not a diagnosis of intentional self-harm or suicide attempt.*
Source: OIG analysis of FY 2023 T-MSIS data, 2025.

Child's Medicaid Plan Type	Number of Cases	No Followup Within 7 Days	No Followup Within 60 Days
Comprehensive Managed Care Organization (MCO)	206,259	50%	21%
Other*	19,043	52%	24%
Prepaid Ambulatory Health Plan (PAHP)	17,675	50%	22%
Primary Care Case Management (PCCM)	8,698	55%	22%
Prepaid Inpatient Health Plan (PIHP)	6,783	48%	17%
Total	**258,458**	**50%**	**21%**

** For a complete list of Medicaid Managed Care Plans, see the T-MSIS Data Guide.*[66]
Source: OIG analysis of FY 2023 T-MSIS data, 2025.

Child's Age (at time of followup)	Number of Cases	No Followup Within 7 Days	No Followup Within 60 Days
10	6,804	50%	21%
11	14,001	50%	21%
12	25,044	49%	20%
13	36,531	49%	20%
14	44,729	50%	20%
15	48,903	50%	21%
16	45,496	51%	22%
17	36,950	53%	24%
Total	**258,458**	**50%**	**21%**

Source: OIG analysis of FY 2023 T-MSIS data, 2025.

Child's Sex	Number of Cases	No Followup Within 7 Days	No Followup Within 60 Days
Female	178,001	49%	20%
Male	80,456	52%	23%
Unspecified	1*	--	--
Total	258,458	50%	21%

** Due to small population size, we do not provide the rates for no followup care.*
Source: OIG analysis of FY 2023 T-MSIS data, 2025.

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Appendix C: Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 13, 2025

TO: Ann Maxwell
Deputy Inspector General
for Evaluation and Inspections

FROM: Dr. Mehmet Oz DR
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care (OEI-07-23-00510)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS remains committed to optimizing the health outcomes and well-being of those who are living with, or at risk of developing, behavioral health conditions. To accomplish these goals, CMS continues to implement the CMS Behavioral Health Strategy and is embarking on a multi-faceted approach to increase access to high-quality behavioral health services and improve outcomes for people covered by Medicaid.[1]

Within the Medicaid program, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) requirements help ensure that individual eligible children get the health care they need, when they need it, in the most appropriate setting. The EPSDT requirements, as laid out in sections 1905(a)(4)(B) and 1905(r) of the Social Security Act (the Act), entitle eligible children to coverage of a wide array of diagnostic and treatment services, as well as other measures described in section 1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are covered under the state plan. While "behavioral health" is not an identified, stand-alone service defined within the Act, the EPSDT requirements generally ensure that eligible children have access to a variety of behavioral and mental health treatment options.

One of the ways in which CMS and states assess the quality of health care being provided to Medicaid eligible children is through reporting on the Core Set of Children's Health Care Quality Measures (Child Core Set). While historically voluntary, reporting of the Child Core Set became mandatory in 2024 for all states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S Virgin Islands, and Guam. States submit state-level data to CMS annually, and CMS publicly publishes data on measures that are reported by at least 25 states that meet data quality standards. Through annual guidance, CMS provides updates to the measures included in the Child Core Set, along with the specific annual

[1] CMS, Addressing & Improving Behavioral Health, 2025. Accessed at https://www.cms.gov/about-cms/what-we-do/addressing-improving-behavioral-health

reporting requirements with which states must comply.[2] CMS works closely with states to improve the quality of the data reported, ensure consistency in quality measure reporting, and support state efforts to drive improvements in health care quality and health outcomes using Core Set measures. One of the measures (FUM-CH) that has been included in the Child Core Set for several years assesses the percentage of emergency department (ED) visits for children ages 6 to 17 with a principal diagnosis of mental illness or intentional self-harm that had a follow-up visit for mental illness within (1) 7 days of the ED and (2) 30 days of the ED visit. In calendar year 2022, the most recent year of data available, state reported data showed that 52 percent of ED visits for children and adolescents ages 6 to 17 with mental illness or intentional self-harm diagnoses had a follow-up visit within 7 days, and 70 percent had a follow-up visit within 30 days.[3] The OIG's analysis was generated using T-MSIS data, which may result in differences from how states calculate the FUM-CH measure for Core Set reporting.

CMS regularly partners with states to improve the quality of care provided to Medicaid beneficiaries. For example, the Quality Improvement (QI) Program provides states with the information, tools, and expert support they need to improve care and health outcomes.[4] Technical assistance is available to help states build QI knowledge and skills, develop QI projects, and implement, spread and scale-up QI initiatives. In 2021, CMS facilitated the "Improving Behavioral Health Follow-Up Care" learning collaborative to support state efforts to improve access to and coordination of follow-up care for beneficiaries who were hospitalized or who visited an emergency department for a mental health or substance use condition.[5] A series of webinars presented as part of the learning collaborative described strategies states could use to improve behavioral health care access and care coordination. States interested in acting on the concepts were then invited to participate in an action-oriented affinity group, and from September 2021 to June 2023, three states participated: Arizona, Minnesota, and Mississippi.[6] For the duration of the affinity group, CMS supported states in using data-driven approaches to identify, test, implement, and evaluate strategies to improve follow-up care for beneficiaries with behavioral health care needs. CMS also regularly communicates about quality improvement topics and best practices with states through a Quality Technical Advisory Group, and with state Medicaid medical directors through the Medicaid and CHIP Quality Exchange.

The OIG's recommendation and CMS's response is below.

OIG Recommendation

Assist low-performing States to better ensure that children at risk of suicide receive timely follow-up care.

[2] CMS, 2026 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance, 2024. Accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/sho24007.pdf
[3] CMS, Quality of Care for Children in Medicaid and CHIP: Findings from the 2023 Child Core Set, 2024. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-child-chartpack.pdf
[4] CMS, Quality Improvement Initiatives. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives
[5] CMS, Improving Behavioral Health Follow-up Care. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative
[6] CMS, Highlights from the Improving Behavioral Health Follow-Up Care Affinity Group, 2023. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/downloads/bhfua-high-light-reprt.pdf

CMS Response

CMS concurs with this recommendation. Timely follow-up care after an ED visit for mental illness or intentional self-harm may reduce repeat ED visits, prevent hospital admissions, and improve health outcomes. The period immediately after the ED visit is important for engaging individuals in mental health treatment and establishing continuity of care. To encourage states to ensure that children at risk of suicide receive timely follow-up care, CMS will provide additional technical assistance to states, with a particular focus on the states identified in the OIG's report.

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ENDNOTES

[1] Suicidal ideation refers to thinking about or planning suicide. Although suicidal ideation does not include physically harmful behaviors, over one-third of adolescents who experience suicidal ideation will attempt suicide within their lifetimes. SAMHSA, "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth," December 10, 2020. Accessed on April 22, 2025.

[2] Although self-harm can encompass both suicidal and non-suicidal behaviors, *intentional* self-harm occurs when a person hurts their own body on purpose. A person who intentionally self-harms is at higher risk of attempting suicide and dying by suicide if they do not get help. SAMHSA, "Self-Harm." Accessed on April 22, 2025.

[3] Mars et al., "Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population-based birth cohort study." *Lancet Psychiatry*. Accessed on April 22, 2025.

[4] Ghanbari et al., "Suicide Prevention and Follow-Up Services: A Narrative Review." *Global Journal of Health Science*. Accessed on April 22, 2025.

[5] Hua et al., "Suicide and Suicide Risk in Adolescents." *Pediatrics*. Accessed on April 22, 2025.

[6] CDC, "Multiple Cause of Death database." Accessed on April 22, 2025.

[7] CDC, "WISQARS Fatal and Nonfatal Injury Reports." Accessed on June 17, 2025.

[8] APA, "Kids' mental health is in crisis." Accessed on April 22, 2025.

[9] Children's Hospital Association, "Addressing Pediatric Suicide." Accessed on April 22, 2025.

[10] CDC, "Preventing Suicide." Accessed on April 22, 2025.

[11] CMS, "About CMS." Accessed on May 28, 2025.

[12] CMS, "Behavioral Health Services"; "Children and Youth." Accessed on May 28, 2025.

[13] CMS, "Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth." Accessed on May 28, 2025.

[14] Ibid.

[15] Section 2103(c)(5) of the Social Security Act.

[16] Chung et al., "Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation." *BMJ*. Accessed on April 22, 2025.

[17] Ibid.

[18] Riblet et al., "Death by Suicide Within 1 Week of Hospital Discharge: A Retrospective Study of Root Cause Analysis Reports." *The Journal of Nervous and Mental Disease*. Accessed on April 22, 2025.

[19] Fontanella et al., "Association of Timely Outpatient Mental Health Services for Youths After Psychiatric Hospitalization With Risk of Death by Suicide." *JAMA Network*. Accessed on April 22, 2025.

[20] Utah Department of Human Services, "Safe Care Transitions for Suicide Prevention." Accessed on April 22, 2025.

[21] Denchev et al., "Modeling the Cost-Effectiveness of Interventions to Reduce Suicide Risk Among Hospital Emergency Department Patients." *Psychiatric Services*. Accessed on April 22, 2025.

[22] Richardson et al., "The Return on Investment of Postdischarge Follow-Up Calls for Suicidal Ideation or Deliberate Self-Harm." *Psychiatric Services*. Accessed on April 22, 2025.

[23] Le et al., "Modelling the cost-effectiveness of brief aftercare interventions following hospital-treated self-harm." *BJPsych*. Accessed on April 22, 2025.

[24] SAMHSA, "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth." Accessed on April 22, 2025.

[25] Ibid.

[26] Ibid.

[27] Ibid.

[28] Ibid.

[29] Ibid.

[30] Ibid.

[31] CMS reports two rates for followup at 7 and 30 days that combine over 1,700 behavioral health diagnoses, such as bipolar disorder, obsessive-compulsive disorder, and autism spectrum disorder. Because CMS only reports aggregate rates, this data cannot be used to explore followup care for a subset of children who are at heightened risk of suicide: children who were treated for suicidal thoughts or behaviors. CMS, "Technical Specifications and Resource Manual for 2025 Core Set Reporting." Accessed on May 28, 2025.

[32] Ibid.

[33] American Academy of Pediatrics, "Caring for Patients Who Need Further Mental Health Evaluation." Accessed on April 22, 2025.

[34] 988 Suicide and Crisis Lifeline, "Crisis Center Guidance," February 16, 2023. Accessed on April 22, 2025.

[35] National Action Alliance for Suicide Prevention, "Best Practices in Care Transitions for Individuals with Suicide Risk." Accessed on April 22, 2025.

[36] We also limited claims to children who were entitled to full-scope or comprehensive Medicaid or CHIP benefits during the 60 days following their discharge from the ED or hospital, with one exception: we included all children who received care in Oregon, as we were unable to determine these children's benefit type. CMS, "Identifying Beneficiaries with Full-Scope, Comprehensive, and Limited Benefits in the TAF." Accessed on June 9, 2025.

[37] CMS, "T-MSIS Data Quality: Number of Open Priority Items." Accessed on April 22, 2025.

[38] Gabella et al., "Multi-site medical record review for validation of intentional self-harm coding in emergency departments." *Injury Epidemiology*. Accessed on Oct. 18, 2023.

[39] Of the 224,759 children aged 10–17 who were hospitalized or visited the ED for suicidal thoughts or behaviors in FY 2023, 29,637 children had more than 1 hospitalization/ED visit (referred to throughout this report as a case): 25,831 children had 2 cases, 3,553 children had 3 cases, 250 children had 4 cases, and 3 children had 5 cases.

[40] Fontanella et al., "Association of Timely Outpatient Mental Health Services for Youths After Psychiatric Hospitalization With Risk of Death by Suicide." *JAMA Network*. Accessed on April 22, 2025.

[41] Chung et al., "Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-analysis." *JAMA Psychiatry*. Accessed on April 22, 2025.

[42] Health Resources & Services Administration (HRSA) determines shortage area designations based on mental health need and ratios of population to one of three different mental health provider categories. Of note, plans were announced in March 2025 to combine multiple agencies—including HRSA—into a new, unified entity called the Administration for a Healthy America (AHA). HRSA, "Health Workforce Shortage Areas"; HHS, "HHS Announces Transformation to Make America Healthy Again." Accessed on April 22, 2025.

[43] OIG, *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (OEI-02-22-00050), March 2024.

[44] Zero Suicide, "Zero Suicide Toolkit." Accessed on April 22, 2025.

[45] Doupnik et al., "Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: a Systematic Review and Meta-analysis." *JAMA Psychiatry*. Accessed on April 22, 2025.

[46] Pitts et al., "Brief Interventions for Suicidal Youths in Medical Settings: A Meta-Analysis." *Pediatrics*. Accessed on June 24, 2025.

[47] Utah Department of Human Services Substance Abuse and Mental Health, "Safe Care Transitions for Suicide Prevention." Accessed on April 22, 2025.

[48] Ibid.

[49] Burkhardt et al., "Identifying opportunities for informatics-supported suicide prevention: the case of Caring Contacts." *AMIA Symposium*. Accessed on April 22, 2025.

[50] Doupnik et al., "Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis." *JAMA Psychiatry*. Accessed on April 22, 2025.

[51] CMS published a final rule in December 2024 that details plans to create separate coding and payment for (1) safety planning interventions and (2) post-discharge telephonic followup contacts performed in conjunction with a discharge from the ED for behavioral health or other crisis encounter. See 89 Fed. Reg. 97710, 97919-97923 (Dec. 9, 2024), and CMS, "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule." Accessed on April 22, 2025.

[52] OIG, *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (OEI-02-22-00050), March 2024.

[53] CMS published a final rule in December 2024 that details plans to create separate coding and payment for (1) safety planning interventions and (2) post-discharge telephonic followup contacts performed in conjunction with a discharge from the ED for behavioral health or other crisis encounter. See 89 Fed. Reg. 97710, 97919- 97923 (Dec. 9, 2024), and CMS, "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule." Accessed on April 22, 2025.

[54] Doupnik et al., "Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis." *JAMA Psychiatry*. Accessed on April 22, 2025.

[55] Pitts et al., "Brief Interventions for Suicidal Youths in Medical Settings: A Meta-Analysis." *Pediatrics*. Accessed on June 24, 2025.

[56] Our population of qualifying events was limited to hospitalizations and ED visits. Hospitalizations were identified using inpatient services claim type codes, and ED visits were identified by searching the admission type, place of service, type of service, revenue center, accommodation rate, and procedure code fields for any values that indicated treatment occurred in the ED.

[57] OIG developed a list of diagnosis codes, in consultation with the OIG Medical Director, that indicate suicidal thoughts or behaviors (i.e., a diagnosis of either a suicide attempt, intentional self-harm, or suicidal ideation). This list included over 1,000 codes that represent suicide attempts, intentional self-harm, and suicidal ideation. We considered a child to have been hospitalized or seen in the ED for suicidal thoughts or behaviors if their T-MSIS claim contained at least one of these diagnoses, anywhere on the claim.

[58] CMS, "Identifying Beneficiaries with Full-Scope, Comprehensive, and Limited Benefits in the TAF." Accessed on June 9, 2025.

[59] CMS's Data Quality (DQ) Atlas notes that benefit type data was often missing for enrollees in New Hampshire in FY 2023; however, our population did not include any children in New Hampshire who were missing this variable. CMS, "DQ Atlas: Restricted Benefits Code." Accessed on June 9, 2025.

[60] CMS's DQ Atlas assesses benefit type on the basis of the percentage of Medicaid and CHIP beneficiaries with a known benefit type in the restricted benefits code field in the T-MSIS Analytic Files. CMS, "DQ Atlas: Background and Methods Resource." Accessed on June 9, 2025.

[61] The Puerto Rico Medicaid program differs in many aspects from those in the 50 states and District of Columbia. For example, the Puerto Rico Medicaid program generally receives Federal funding up to an annual ceiling and must use territory funds once it meets that ceiling to cover any additional Medicaid expenses. MACPAC, "Medicaid and CHIP in Puerto Rico." Accessed on June 10, 2025.

[62] CMS, "DQ Atlas: Claims Volume - OT." Accessed on June 9, 2025.

[63] CMS's DQ Atlas assesses other service claims volume on the basis of (1) total other service header volume as a percentage of the national median, (2) total other service line volume as a percentage of the national median, and (3) average number of other service line records per header as a percentage of the national median in the T-MSIS Analytic Files. CMS, "DQ Atlas: Background and Methods Resource." Accessed on June 9, 2025.

[64] Of the 224,759 children aged 10–17 who were hospitalized or visited the ED for suicidal thoughts or behaviors in FY 2023, 29,637 children had more than 1 case: 25,831 children had 2 cases; 3,553 children had 3 cases; 250 children had 4 cases; and 3 children had 5 cases.

[65] Of the 224,759 children aged 10–17 who were hospitalized or visited the ED for suicidal thoughts or behaviors in FY 2023, 29,637 children had more than 1 case: 25,831 children had 2 cases; 3,553 children had 3 cases; 250 children had 4 cases; and 3 children had 5 cases.

[66] CMS, "T-MSIS Data Guide: MCR.002.024." Accessed on June 24, 2025.

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