Background
Mental health (MH) and substance use disorders (SUDs) account for about one in eight emergency department visits for U.S. adults.¹ Due to a lack of inpatient psychiatric beds, individuals experiencing a mental health or substance use disorder crisis often leave emergency departments without appropriate follow up care. For many vulnerable individuals, this can lead to a cycle of poor outcomes for themselves and their communities.²

Medicaid is the largest payer for mental health services and continues to play a large role in payment for SUD services.³ One in five individuals out of Medicaid’s over 70 million enrollees have a MH/SUD diagnosis and nearly 12 percent over the age of 18 have a SUD.⁴ People with MH and SUD needs may require a range of treatment options, from counseling or prescription drugs to inpatient treatment.⁵

Institution for mental diseases (IMDs), is defined as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”⁶ Since Medicaid was enacted in 1965, IMDs have been excluded from Medicaid coverage, known as the “IMD exclusion” ⁷ and does not apply to adults aged 21-64. The IMD exclusion is antiquated, it creates barriers for people to access a full array of evidence-based treatment, and prohibits a service that may be necessary for some people’s treatment. This policy discriminates against individuals with MH and SUD illnesses and creates barriers for patients to access care. The IMD exclusion unnecessarily limits Medicaid
beneficiaries’ access to inpatient care at a time when demand for such services is increasing. In addition, the exclusion goes against the intent of the Mental Health Parity and Addiction Equity Act (MHPAEA) which is to have a general equivalence between medical/surgical benefits and MH/SUD benefits, as there are not similar restrictions placed on reimbursement for physical health inpatient visits.

**Federal and State Action**

States have some ability to cover services in IMDs; for example, current statute includes exemptions for adults 65 and older and individuals under 21. However, additional flexibility is needed to cover adults 21-64. Federal legislative activity and regulatory guidance in the past few years also paved the way for additional opportunities, including short IMD stays under Medicaid managed care coverage. Large legislative packages like the 21st Century Cures Act and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act expanded guidance on 1115 waivers for MH and SUD services in IMDs including a new state plan option. This option would cover “no more than a period of 30 days (whether consecutive or not) during a 12-month period,” and sunsets September 30, 2023. Some states also use disproportionate share hospital payments (DSH) to pay for IMDs. While these policies have provided progress, there remains a need to permanently remove the IMD exclusion in order to increase access to inpatient care when it is medically necessary.

**Recommendation**

- **ABHW supports permanently eliminating the IMD exclusion to allow people who rely on Medicaid to have access to MH and SUD treatment delivered in IMDs.** People with mental illness and SUDs should have access to a full range of treatment options and inpatient psychiatric care may be an essential component of their treatment.

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1 https://www.nami.org/mhstats
2 https://www.treatmentadvocacycenter.org/component/content/article/220-learn-more-about/3952-the-medicaid-imd-exclusion-and-mental-illness-discrimination-
3 https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html
https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
https://fas.org/sgp/crs/misc/IF10222.pdf