NAMD
National Association of Medicaid Directors

FEDERAL POLICY BRIEFS

The IMD Exclusion

The "Institutions for Mental Diseases" Exclusion

Before the 1950s, mental healthcare in the United States was primarily provided in state-run facilities. This began to change in the wake of the "deinstitutionalization movement," which called attention to the poor conditions in these facilities and advocated for a shift to community-based services. When Medicaid was created in 1965, the Social Security Amendments echoed these social changes by implementing the "institutions for mental diseases" (IMD) exclusion, which prevents the federal government from paying for care provided in inpatient psychiatric facilities. The IMD exclusion was also intended to prevent states from shifting the cost of psychiatric care to the federal government.

Today, the IMD exclusion bars Medicaid from receiving federal dollars to pay for mental health and substance use care provided in facilities with more than 16 beds. This leads to a stark inequity in access to care: unlike in Medicare or private insurance, Medicaid cannot cover many inpatient psychiatric services, even when they are recommended by a physician or mental health professional.

Per the IMD exclusion, Medicaid cannot pay for care provided in institutions with more than

16 beds

Impact on Medicaid Members

The IMD exclusion can make it challenging for state Medicaid programs to meet the behavioral health needs of their members. Specifically, the IMD exclusion leads to:

- **Challenges accessing inpatient services.** Since the IMD exclusion's enactment in 1965, our nation's understanding of mental health has evolved significantly, and states have shifted away from institutional models of care. However, there are times when inpatient or residential care is clinically indicated. Without access to inpatient services, Medicaid members may experience clinically inappropriate stays in emergency rooms or long wait times for care.
- **Contradictions with other policy goals**. States and the federal government have launched major efforts to build out crisis services, including a new state plan option in Medicaid for mobile crisis services. However, the IMD exclusion limits the ability of states to create crisis stabilization centers, which provide short-term stays as an alternative to hospitalization or incarceration. Similarly, the IMD exclusion has prevented states from implementing Qualified Residential Treatment Facilities (QRTPs), a setting that Congress created in 2018 to help reform the child welfare system. In these instances, the IMD exclusion directly impedes federal and state efforts to improve the behavioral healthcare system.

It's important to note that state Medicaid programs can still cover services in IMDs through a handful of pathways, including Section 1115 demonstration waivers, a 1915(I) state plan option (authorized through the SUPPORT Act) to provide substance use services, or in-lieu-of payments in managed care. As of 2019, most states used at least one of these options. However, these pathways only cover some services for some members, and are often administratively burdensome, representing an incomplete solution to the challenges posed by the IMD exclusion.

The IMD Exclusion

Opportunities for Federal Action

- **Repeal the IMD exclusion.** A repeal of the IMD exclusion would support states in providing access to the full continuum of care – including inpatient and residential treatment – to Medicaid members. Although inpatient care is sometimes clinically necessary, the United States' history of institutionalization creates concerns about backsliding if the IMD exclusion were repealed. To mitigate these concerns, Congress could consider: 1) establishing quality of care and programmatic standards that ensure members are placed in the least restrictive settings that meet their clinical needs and that stays in institutions are short-term; 2) requiring states to maintain full continuums of care with robust community-based options; and 3) instituting mechanisms to ensure providers deliver care that meets national standards. These types of requirements are already included in current 1115 demonstration waivers that allow state Medicaid programs to cover IMDs in certain situations.
- **In the absence of a full repeal, create exceptions to the IMD exclusion for specific settings.** Concerns around the impact of an IMD repeal on the federal budget, along with concerns about a return to institutionalization, make it unlikely that Congress will fully repeal the IMD exclusion. Congress could, however, create narrow exceptions for specific settings, including QRTPs and crisis stabilization centers, where the IMD exclusion directly contradicts other policy goals. Importantly, QRTPs and crisis stabilization centers often function to *prevent* institutionalization: QRTPs are subject to strict regulatory standards, including robust quality, length-of-stay, and discharge planning requirements, aimed at ensuring young people experience high-quality and short-term treatment. Similarly, crisis stabilization centers provide short-term care by definition, with the aim of preventing hospitalization or incarceration.
- **Support states in developing robust community-based services and integrated behavioral healthcare.** IMDs should be situated within a continuum of care that includes robust community-based options and behavioral healthcare that is integrated into other physical health and social services. You can read more about federal opportunities to support behavioral health integration here.

Supporting State Innovation

Many states have launched efforts to increase access to specialized inpatient care for mental health and substance use. As of April 2022, 32 states have approved Section 1115 waivers for substance use treatment, and 8 states have approved 1115 waivers for mental health treatment. For example, the District of Columbia launched an 1115 demonstration project to provide access to inpatient care for people with substance use and/or serious mental illness, along with robust mobile crisis services, transition planning, and recovery services. West Virginia has an 1115 waiver to provide residential substance use treatment, peer recovery supports, and withdrawal management services. Although 1115 waivers are a useful tool to provide services that would otherwise be subject to the IMD exclusion, they are also subject to strict administrative requirements – including budget neutrality rules.

You can read more about state actions to provide specialized inpatient care in NAMD's Medicaid Forward: Behavioral Health report.