



*County Leadership in Mental Health:*

# **Overcoming Barriers for Equitable Care Access**

*How the IMD Exclusion Impacts Counties*

**FEBRUARY 2024**



# TABLE *of* CONTENTS

Policy Summary .....	2
Background .....	2
Impact .....	3
County Case Study: Los Angeles, California .....	4
County Case Study: Washington County, Oregon .....	6
Policy Solutions .....	7

## POLICY SUMMARY

Section 1905(a)(30)(B) of the Social Security Act prohibits Medicaid funds from covering an individual's care at an institution of mental disease (IMD), defined as a facility with more than 16 beds with the primary function to diagnose or treat people with behavioral health disorders. This policy, referred to as the IMD exclusion, limits a county's ability to build healthcare systems that have the capacity to adequately serve their communities, while also perpetuating patient inequities by limiting access to services in the most appropriate settings.

## BACKGROUND

The IMD exclusion was created as part of the deinstitutionalization movement, shifting responsibility for funding inpatient psychiatric services from the federal level to individual states<sup>i</sup>. An IMD is defined as any facility with more than 16 beds with the primary function to diagnose or treat people with behavioral health disorders, including substance use disorder (SUD). This rule applies to beneficiaries between age 21 and 64<sup>ii</sup>, barring Medicaid from covering mental health care if the individual is a patient at an IMD.

Specifically, IMDs are defined by the U.S. Department of Health and Human Services (HHS)<sup>iii</sup> as:

- a licensed or accredited as a psychiatric facility;
- a facility that is under the jurisdiction of the state's mental health authority;
- a facility that is specialized in delivering psychiatric or psychological care and treatment. (specialization can be determined by reviewing patient records, noting if a significant portion of the staff has specialized training in psychiatry or psychology, or if the primary purpose of the facility is to care for and treat individuals with mental illnesses)
- or has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases



# IMPACT

While localized control was intended to protect patients from maltreatment that occurred due to mass institutionalization, the policy instead has disempowered localities from administering adequate behavioral health care by severely restricting Medicaid reimbursement. As a result of this policy:



**Medicaid beneficiaries are functionally discriminated against and individuals' access to behavioral health services is complicated by their Medicaid-eligibility**



**Medicaid patients experience delays in treatment due to the arbitrary bed cap**

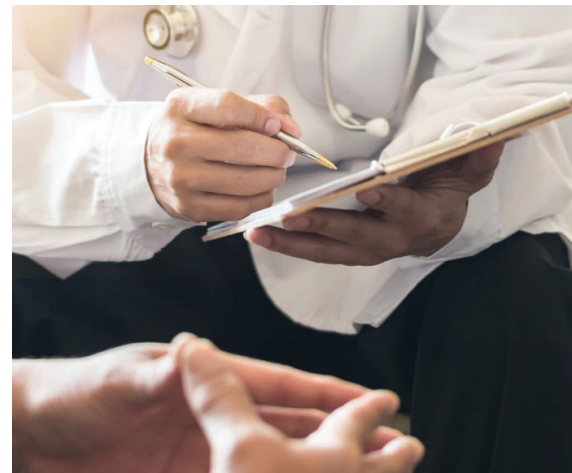


**Patients are diverted away from capable mental healthcare institutions, causing an overreliance on emergency departments or resulting in no care at all<sup>iv</sup>**



**Levies financial burden onto counties while creating administrative complexities, exacerbating inequities between medical and behavioral healthcare at the local level**

Though the demand for behavioral healthcare is growing, capacity is not. The COVID-19 pandemic has increased unmet need for mental healthcare and SUD treatment; providers have reported institutional and infrastructure limits have prevented the adequate treatment of patients<sup>v</sup>. Given that Medicaid is the largest payer of behavioral health services<sup>vi</sup> and accounts for 24% of all health spending for both SUD treatment and mental health services<sup>vii</sup>, it is imperative to further bolster Medicaid's strength to close behavioral health treatment gaps.





County Case Study

## LOS ANGELES, CALIFORNIA

Population size: 38,965,193

**Subacute behavioral health facilities<sup>xi</sup>** offer inpatient services that are less intense than those required for severe illnesses needing acute hospitalization, but more intense than conditions requiring partial or no hospitalization. These facilities focus on short-term, intensive, recovery-oriented services to stabilize patients, especially those whose conditions are too severe for outpatient care. They also provide a stable environment for individuals without housing during their treatment period.

A 2019 report by the Los Angeles County Department of Mental Health identified a shortage of 3,000 subacute mental health beds<sup>viii</sup>. As a result, long waitlists have caused patients to remain in acute inpatient facilities for at least two months or longer awaiting placement<sup>ix</sup>. In total, approximately three-quarters of all Department of Health patients are awaiting placement in lower-level care facilities and receiving minimal to no reimbursement for the cost associated with those days<sup>x</sup>. Despite growing needs for subacute beds, increasing the supply is difficult under the IMD exclusion policy's bed-number limit.

This restriction complicates the administration of care, including increased construction costs, as counties must pay more to build multiple, small facilities. Olive

View-UCLA Medical Campus demonstrates this inequality between behavioral health and physical health treatment capacity. To remain compliant with federal IMD restrictions, the county spread 80 subacute beds across 5 Residential Treatment Programs (RTPs). Conversely, the physical health Recuperative Care Center (RCC) is in a single facility with 48 beds.

The approximate cost per bed in the RTPs was \$636,200.00, nearly 1.5 times the price of construction as the RCC's, showing that the construction of separate buildings significantly increased the cost levied onto Los Angeles County. To remain compliant with federal IMD restrictions, the **county spread 80 subacute beds across 5 different Residential Treatment Programs (RTPs).**

## IMD Impact by The Numbers<sup>xii</sup>

- Over **90%** of State Hospital clients are committed by court systems. The Department of Mental Health only has about **320** clients in State Hospitals, with an estimated **25** more in the county's acute hospitals and another **150** in jail waiting for placement.
- Los Angeles County has a shortage of **3,000** subacute mental health beds.
- The average wait time for transfer to a subacute facility is **two months** or more if the patient is high need.
- The cost per bed of building of **5** Residential Treatment Programs with **16** beds or less was nearly **1.5** the cost (or **\$208,345.83** less) than building a single Recuperative Care Center with **48** beds.



<sup>1</sup>The budget for the Residential Treatment Programs project was \$50,896,000 (<https://file.lacounty.gov/SDSInter/bos/supdocs/141555.pdf>), the approximate cost per each of the 80 beds was \$636,200.00. The total cost of the Recuperative Care Center's 48-bed facility was \$20,537,000 (<https://www.treasurer.ca.gov/chffa/meeting/2020/20200730/staff/7-csi-la.pdf>), bringing the cost per bed to approximately \$427,854.17.

## County Case Study

# WASHINGTON COUNTY, OREGON

Population Size: 600,176

The IMD exclusion has complicated treatment options for Medicaid beneficiaries with multiple diagnoses. The rule's 16-bed cap applies to residential care facilities or skilled nursing facilities if a majority of their population possess a behavioral health diagnosis. This means that individuals with medical conditions affecting their daily life may not be eligible for placement in licensed housing facilities if their primary diagnosis is a behavioral health disorder. Behavioral health diagnoses account for 47.1% of all stays in Oregon's nursing facilities<sup>xiii</sup>.

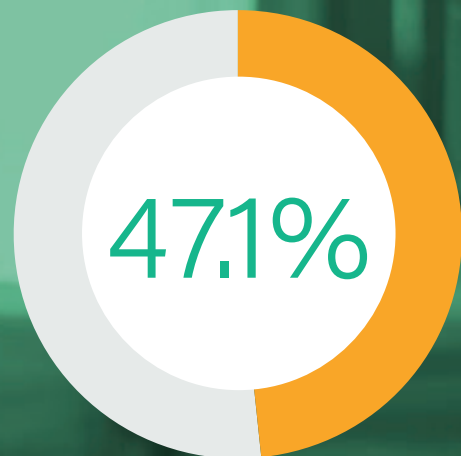
Given Medicaid is the primary payer in Oregon nursing facilities, accounting for 65% of resident days<sup>xvi</sup>,

**Medicaid beneficiaries ages 21-64 needing intensive residential care for neurocognitive or other medical conditions have fewer treatment options solely due to their behavioral health status.**

In an example shared by *Chance Wooley, Forensic Mental Health Supervisor at Washington County Health and Human Services*, a Medicaid beneficiary, under the age of 65, in Washington County was unable to be placed into residential care facility or skilled nursing facility. Although Huntington's Disease compromised their ability to live independently, their primary diagnosis of Schizophrenia disqualified them from being eligible to be placed into the available facilities, as they had over 16 beds. While some waivers offer pathways to increase access to supportive housing for populations with behavioral health diagnoses, it is restricted to home and community-based care, excluding facilities like hospitals which may be the appropriate fit for patient care.

*Medicaid beneficiaries ages 21-64 needing intensive residential care for neurocognitive or other medical conditions have fewer treatment options **solely due to their behavioral health status.***

Behavioral health diagnoses account for 47.1% of nursing facilities stays in Oregon.





# POLICY SOLUTIONS

Since 1965, Section 1905(a)(30)(B) of the Social Security Act has prohibited the federal government from providing Medicaid funds to states to cover eligible individuals' care in an institution of mental disease (IMD), known as the IMD exclusion. Despite numerous opportunities for Congress to modify or eliminate it, the IMD exclusion has remained a significant part of the Medicaid program. The regulations overseeing the IMD exclusion have not been revised since 1988. Amending the Social Security Act to eliminate this exclusionary policy would empower counties to connect their community members with appropriate treatment and ease administrative burdens while allowing for federal Medicaid reimbursement for services provided in an IMD.

State Medicaid waiver innovations, which provide regulatory flexibility, have proposed temporary solutions to the structure of behavioral health treatment as outlined in the table below. However, the full mitigation of the IMD exclusion's negative impact is hindered by restrictions on the total treatment days, the primary diagnosis, and the implementation process of these waivers. Strategies to address this policy could include doubling the bed limit, excluding unlocked facilities, or eliminating the restriction completely along with policies to promote the full continuum of care at the local level.

## State Medicaid Waiver Options and Limitations<sup>xv</sup>

WAIVER TYPE	STATE FLEXIBILITY	LIMITS
SMI/SUD Demonstration Opportunity	Section 1115 waivers can allow states to receive federal reimbursements for treatments for Medicaid enrollees who are patients in IMDs for mental health and/or substance use care.	States must meet specific criteria and commit to milestones all while following broad reaching, ridged restrictions on treatment plans like length of stay.
SUPPORT Act State Plan Option for SUD Services	Under the SUPPORT Act, Medicaid was allowed to pay for enrollees aged 21 through 64 with at least one SUD who are patients in an eligible IMD.	This waiver was only available to SUD treatment and has since expired. Treatment periods were capped at 30 days during a 12-month period.
Medicaid Disproportionate Share Hospital (DSH) Payments	Through Medicaid DSH Payments, states can provide lump sum payments to IMDs for the facilities, rather than for services.	Costs are covered indirectly.
Medicaid Managed Care	CMS allows states to make monthly payments to managed care organizations	Lengths of stay can be no longer than 15 days.

## SOURCES

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<sup>i</sup>Congressional Research Services. (2023). *Medicaid's Institution for Mental Diseases (IMD) Exclusion* (CRS Report No. IF10222). <https://crsreports.congress.gov/product/pdf/IF/IF10222>.

<sup>ii</sup>Congressional Research Services. (2023, October 5). *Medicaid's Institution for Mental Diseases (IMD) Exclusion*. (CRS Report No. IF10222). <https://crsreports.congress.gov/product/pdf/IF/IF10222>.

<sup>iii</sup>Centers for Medicare & Medicaid Services. (2015). *The State Medicaid Manual Chapter 4 Services Section 4270 to Section 4390.1*. <https://www.hhs.gov/guidance/document/state-medicaid-manual-chapter-4-services-section-4270-section-43901>.

<sup>iv</sup>Centers for Medicare & Medicaid Services. (n.d.). *Medicaid Emergency Psychiatric Demonstration*. <https://www.cms.gov/priorities/innovation/innovation-models/medicaid-emergency-psychiatric-demo>.

<sup>v</sup>Substance Abuse and Mental Health Services Administration. (2022). *Adaptations and Innovations for Delivering Mental Health and Substance Use Disorder Treatment Services During the COVID-19 Pandemic*. <https://www.samhsa.gov/sites/default/files/dtac-adaptations-innovations-covid-19-pandemic.pdf>.

<sup>vi</sup>Medicaid and CHIP Payment and Access Commission. (2015). *Behavioral Health in the Medicaid Program—People, Use, and Expenditures*. <https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/>.

<sup>vii</sup>Substance Abuse and Mental Health Services Administration. (2019). *Behavioral Health Spending & Use Accounts 2006—2015*. <https://store.samhsa.gov/sites/default/files/bhsua-2006-2015-508.pdf>.

<sup>viii</sup>Sherin, Jonathan E. (2019). *Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response*. County of Los Angeles Department of Mental Health. [https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm\\_content=&utm\\_medium=email&utm\\_name=&utm\\_source=govdelivery&utm\\_term=](https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=).

<sup>ix</sup>Sherin, Jonathan E. (2019). *Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response*. County

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<sup>x</sup>Sherin, Jonathan E. (2019). *Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response*. County of Los Angeles Department of Mental Health. [https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm\\_content=&utm\\_medium=email&utm\\_name=&utm\\_source=govdelivery&utm\\_term=](https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=).

<sup>xi</sup>Sherin, Jonathan E. (2019). *Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response*. County of Los Angeles Department of Mental Health. [https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm\\_content=&utm\\_medium=email&utm\\_name=&utm\\_source=govdelivery&utm\\_term=](https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=).

<sup>xii</sup>Sherin, Jonathan E. (2019). *Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response*. County of Los Angeles Department of Mental Health. [https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm\\_content=&utm\\_medium=email&utm\\_name=&utm\\_source=govdelivery&utm\\_term=](https://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=).

<sup>xiii</sup>Luck, J., Zhang, W., Scarborough, N., Kaiser, A., Bahl, A., Mendez-Luck, C. (2022). *The State of Nursing Facilities in Oregon, 2021*. OSU College of Public Health and Human Sciences. <https://health.oregonstate.edu/sites/health.oregonstate.edu/files/skilled-nursing-facilities/pdf/2021-oregon-nursing-facilities-report.pdf>.

<sup>xiv</sup>Luck, J., Zhang, W., Scarborough, N., Kaiser, A., Bahl, A., Mendez-Luck, C. (2022). *The State of Nursing Facilities in Oregon, 2021*. OSU College of Public Health and Human Sciences. <https://health.oregonstate.edu/sites/health.oregonstate.edu/files/skilled-nursing-facilities/pdf/2021-oregon-nursing-facilities-report.pdf>.

<sup>xv</sup>Congressional Research Services. (2023). *Medicaid's Institution for Mental Diseases (IMD) Exclusion* (CRS Report No. IF10222). <https://crsreports.congress.gov/product/pdf/IF/IF10222>.

## ABOUT NACo

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The **National Association of Counties (NACo)** strengthens America's counties, serving nearly 40,000 county elected officials and 3.6 million county employees. Founded in 1935, NACo unites county officials to:

- Advocate county priorities in federal policymaking
- Promote exemplary county policies and practices
- Nurture leadership skills and expand knowledge networks
- Optimize county and taxpayer resources and cost savings, and
- Enrich the public's understanding of county government.

## ABOUT NACBHDD

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The **National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)** is the premier national voice for county behavioral health and intellectual/developmental disability authorities in Washington, DC. Through our work in policy, advocacy, and education, NACBHDD elevates the voices of local leaders on the federal level in Congress and the Executive Branch. NACBHDD is incorporated as a non-profit 501(c)(3).



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