August 2025

Report

U.S. Psychiatric Hospitals Under Medicaid's Institutions for Mental Diseases (IMD) Exclusion

Carolyn D. Gorman

Paulson Policy Analyst
Manhattan Institute

Executive Summary

Many Americans with serious mental illness lack access to inpatient psychiatric care. For decades, Medicaid's "institutions for mental diseases" (IMD) exclusion has been a major barrier to expanding psychiatric hospital bed capacity, but the ongoing mental-health crisis has recently led some policymakers to consider repealing or modifying the IMD exclusion.

This report analyzes the size, ownership, and percentage of Medicaid discharges from freestanding U.S. psychiatric hospitals to show that to meaningfully increase Medicaid beneficiaries' access to care in this setting, the IMD exclusion should be either completely repealed or significantly reformed.

Key findings include:

- The average size of a U.S. psychiatric hospital is 108 beds—smaller than the average general hospital—and 95% of all psychiatric hospitals are under 305 beds. Perceptions of psychiatric hospitals as very large-scale institutions are therefore misrepresentative.
- Less than 8% of psychiatric hospitals have 16 beds or fewer, the limit for federal financial participation. The vast majority of psychiatric hospitals are therefore not covered settings for Medicaid beneficiaries under the IMD exclusion.

About Us

The Manhattan Institute is a community of scholars, journalists, activists, and civic leaders committed to advancing economic opportunity, individual liberty, and the rule of law in America and its great cities.

- Since its establishment in 1965, the IMD exclusion has been repeatedly modified. Yet changes have not increased beneficiaries' access to psychiatric hospital treatment at scale. The number of public psychiatric beds, which are most likely to serve Medicaid patients, is down by over 97% since its peak and remains low despite a decade of exemptions that allow greater Medicaid coverage.

- Analysis of hospital data and prior reforms suggests that further modest modifications of the IMD exclusion will not suffice to increase bed supply. Full repeal would be ideal, but if that's not politically feasible, IMDs should, at a minimum, be defined as facilities with more than 108 beds (up from the current 16 beds). This would allow as many as 332 existing psychiatric hospitals (with more than 20,000 beds) to receive Medicaid reimbursement for their services.

Introduction

Medicaid is an important publicly funded health-care program for many of the 14.6 million U.S. adults with serious mental illnesses.[1] Among non-elderly adult Medicaid enrollees, 10% have a serious mental illness.[2] Medicaid enrollees are 90% more likely to a have a serious mental illness than privately insured Americans.[3]

Those with serious mental illnesses sometimes require inpatient care at specialty hospitals to meet clinical and safety needs.[4] However, the U.S. faces a shortage of psychiatric inpatient beds.[5] The number of public beds, in particular, has declined by over 97% since peak levels in 1955, accounting for population change.[6]

The bed shortage was first catalyzed, and has since been maintained, by a 1965 statutory provision known as the "institutions for mental diseases" (IMD) exclusion, which bars Medicaid from paying federal matching funds for psychiatric hospital treatment. The IMD exclusion—which mirrored preexisting rules excluding persons with psychosis from Social Security old-age assistance[7]—was intended to prevent states from shifting to the federal government the cost of mental-health-care treatment, which in the 1960s was almost entirely provided by state asylums.[8]

The Medicaid program defines an "institution for mental disease" 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."[9] Generally, the "overall character" of a facility is how the federal government assesses whether a facility is an IMD.[10]

Outside Medicaid, the term "IMD" has no meaning. IMDs are not a specific provider type recognized by insurers, state licensure agencies, or accrediting bodies.[11] IMDs are regulated under a variety of federal and state rules, but generally, facilities licensed or accredited as psychiatric hospitals are considered IMDs. Residential treatment facilities that treat both mental-health and substance-abuse disorders—often a step down from more intensive hospital care—are also typically considered IMDs.

The IMD exclusion prevents such facilities from providing mental-health care to Medicaid beneficiaries by banning federal financial participation (FFP)[12] to such providers for services rendered. States can elect to cover IMD services under Medicaid, but the state is responsible for the full cost of that care—unlike in virtually all other settings, in which the federal government covers at least half (and as much as 83%[13]) of the cost.

Perhaps the clearest sign of the shortage of psychiatric beds is that in nearly every state, there is a waiting list for such beds for forensic patients (those who receive psychiatric treatment as a result of being charged with or convicted of criminal behavior, typically to evaluate or restore competency to stand trial, or if found not guilty by reason of insanity).[14] As the number of state hospital beds has hit historic lows, a majority of them are now occupied by forensic patients, leaving few beds available for civil patients who need hospital-level psychiatric care.

The total number of forensic patients in state hospitals increased by 76% between 1999 and 2014, increasing from about 13,394 patients on a given day to more than 23,574 (in 37 states reporting), even as the overall number of psychiatric beds fell.[15] Inmates across 26 states wait a median of 60 days for a bed for competency restoration, according to research by the Treatment Advocacy Center, and at least 12 states have been sued for failing to provide timely competency restoration.[16]

The shortage of inpatient psychiatric care is evident in several other ways: high rates of mental illness among the homeless[17] and incarcerated;[18] greater average utilization rates in psychiatric inpatient settings compared with other health-care inpatient settings;[19] and the widespread practice of boarding mentally ill patients in emergency departments (EDs).[20] This last issue is especially costly, but without sufficient psychiatric beds, mentally ill individuals end up in EDs more often and for longer than nonpsychiatric patients. Psychiatric patients wait up to three times as long for a transfer from an ED to an inpatient unit, compared with patients with other conditions.[21] Of people with at least 18 ED visits per year in San Francisco, 87% had a mental illness or substance-use disorder.[22]

The lack of psychiatric beds—along with a continued recognition of the importance of inpatient treatment in the full continuum of mental-health care—has led Congress to limit the IMD exclusion in various ways.[23] But in recent years, amid a worsening mental-health crisis, support for more wholesale change has been growing:[24] the 118th Congress saw the introduction of legislation that would either fully repeal the IMD exclusion[25] or change the definition of an IMD to allow FFP at facilities with 36 or fewer beds, up from 16 beds.[26]

Current Landscape of Psychiatric Hospitals

To understand how repealing or reforming the IMD exclusion would help expand access to psychiatric care, it is first important to understand the supply of existing freestanding psychiatric hospitals, which are distinct from psychiatric units in general hospitals (which are not considered IMDs).[27] Psychiatric hospitals tend to offer more specialty mental-health services and more robust programming, such as youth-specific services.[28] Psychiatric hospitals can also provide services at lower costs than general hospital psychiatric units.[29] Further, some patients can be served appropriately only in psychiatric hospitals, as opposed to general hospital psychiatric units, because psychiatric hospitals—especially public psychiatric hospitals—are equipped to care for those who may become violent.[30]

Even though they are not subject to the IMD exclusion, general hospitals have also been cutting back on inpatient psychiatric services: federal survey data show that 612 general hospitals had 24-hour inpatient psychiatric units in 2022, down from 1,290 in 2012.[31] For general hospitals, psychiatric services are less lucrative than nearly all other services. Research finds that fewer than one in four general hospitals report having inpatient psychiatric beds.[32] Absent significant increases

in reimbursement rates for psychiatric services, general hospital psychiatric beds are always at risk of being repurposed for more profitable uses.[33] This speaks to the importance of freestanding psychiatric hospitals' role in providing inpatient mental-health care.

The data most commonly used to estimate inpatient psychiatric bed capacity come from the National Mental Health Services Survey (N-MHSS)—as of 2021, it's called the National Substance Use and Mental Health Services Survey (N-SUMHHS)[34]—which provides an annual census of behavioral-health treatment facilities in the United States.[35] While the survey includes some information about facility characteristics, it does not report bed counts per hospital.[36]

An alternative source, the Centers for Medicare and Medicaid Services (CMS) Hospital Provider Cost Report offers more granular data on U.S. psychiatric hospitals, including specific bed counts per hospital and other details such as ownership. This granularity provides greater insight into the effect of the IMD exclusion's 16-bed threshold on hospitals. **Table 1** shows summary statistics for psychiatric hospitals in the 2022 CMS data.

Table 1

Summary Statistics of Freestanding Psychiatric Hospitals, by Ownership

Group	Hospitals	Beds	Mean No. of Beds	STD	Min	25%	50%	75%	Max
All	580	62,439	108	93	3	48	88	130	639
For-Profit	352	31,693	90	52	12	49	86	119	315
Public	156	24,921	160	140	14	56	110	232	639
Nonprofit	72	5,825	81	72	3	16	65	113	335

Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

Most psychiatric hospitals are small to midsize, with an average of 108 beds and a median of 88 beds.[37]

It is worth noting that the average psychiatric hospital has fewer beds than the average short-term acute-care hospital (i.e., general hospital), as well as the average children's hospital, Veterans Affairs hospital, and Department of Defense hospital.[38] Perceptions of psychiatric hospitals as very large-scale institutions are therefore misrepresentative, and these hospitals exist, on average, on the smaller side of other hospital types, including general hospitals where FFP is not barred for care in psychiatric units.

Although not shown in the table, just under 8% of psychiatric hospitals have 16 beds or fewer, accounting for 1% of all beds. Ninety-five percent of all psychiatric hospitals have fewer than 305 beds, although the largest 5% of hospitals account for 19% of total beds. There are 29 hospitals with over 305 beds, and 26 of them are public hospitals that serve forensic patients.

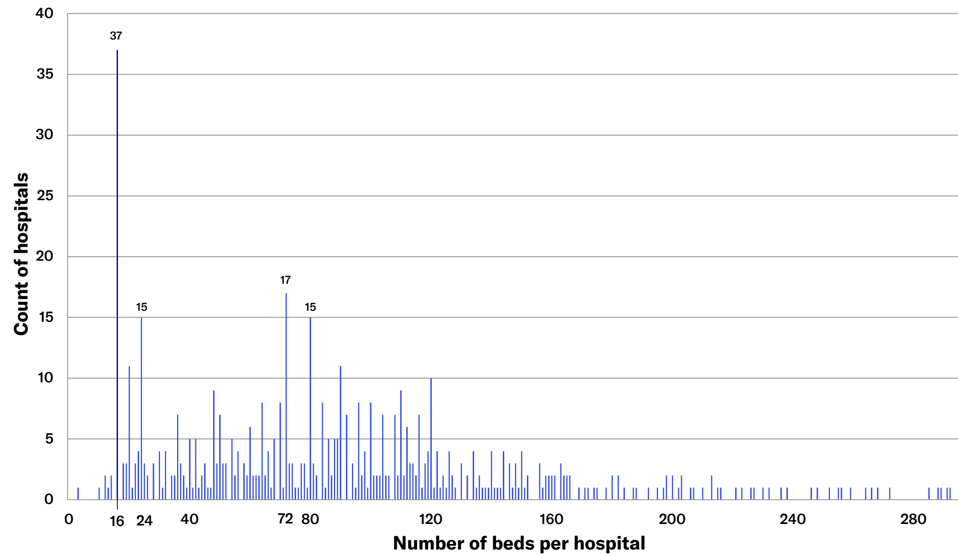
Nearly 61% of psychiatric hospitals are for-profit; 27% are public (primarily state-run). Note, however, that although this report groups hospitals by ownership type, any discussion about the differences in the quality of care between ownership types is outside the scope of this report.

Figures 1 through **4** show distributions of hospitals by size and ownership. (For visual clarity, only hospitals with fewer than 305 beds are shown.) Public hospitals tend to be the largest, while for-profits are predominantly midsize hospitals and nonprofits are predominantly smaller hospitals. All distributions are right-skewed, meaning that more hospitals are smaller than the average hospital, rather than larger.

Figure 1 shows psychiatric hospitals of all ownership types by number of beds per hospital. A notable spike is seen at hospitals with exactly 16 beds, the size cap for FFP imposed by the IMD exclusion.

Figure 1

Distribution of All Psychiatric Hospitals by Hospital Size, 2022



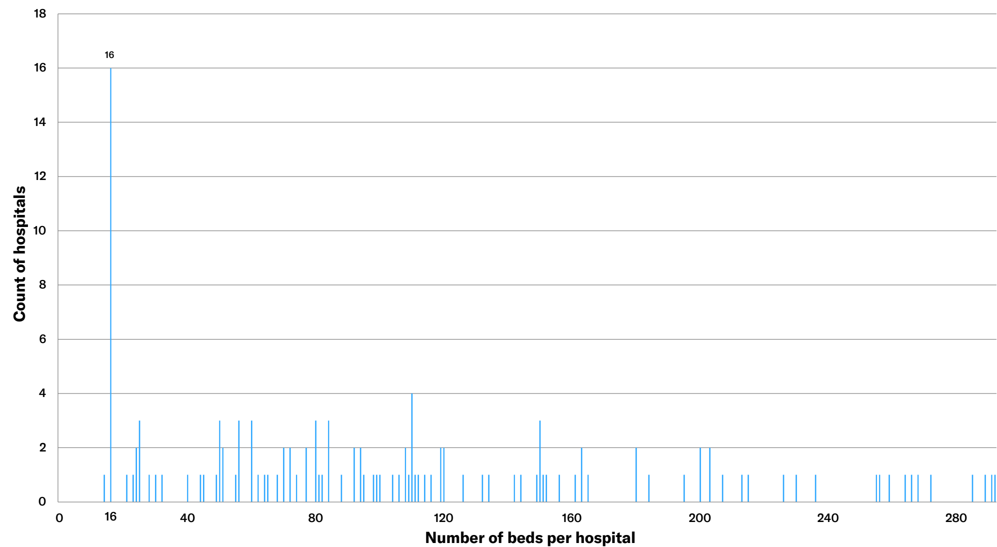
Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

The 16-bed spike is most pronounced among public and nonprofit hospitals (shown in **Figures 2** and **3**, respectively), which suggests that these providers are most sensitive to the IMD exclusion.

Public hospitals have the longest right-tail distribution. As providers of last resort, these mostly state-run hospitals can be least flexible on size. Some minimum inpatient capacity must be provided by states to treat forensic patients, given legal obligations for competency restoration.

Figure 2

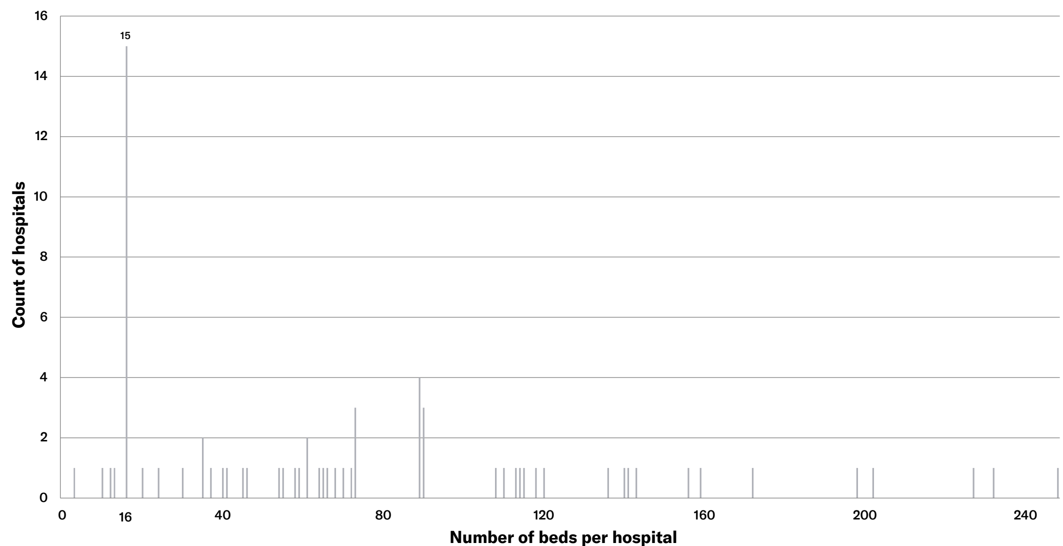
Distribution of Public Psychiatric Hospitals by Hospital Size, 2022



Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

Figure 3

Distribution of Nonprofit Psychiatric Hospitals by Hospital Size, 2022

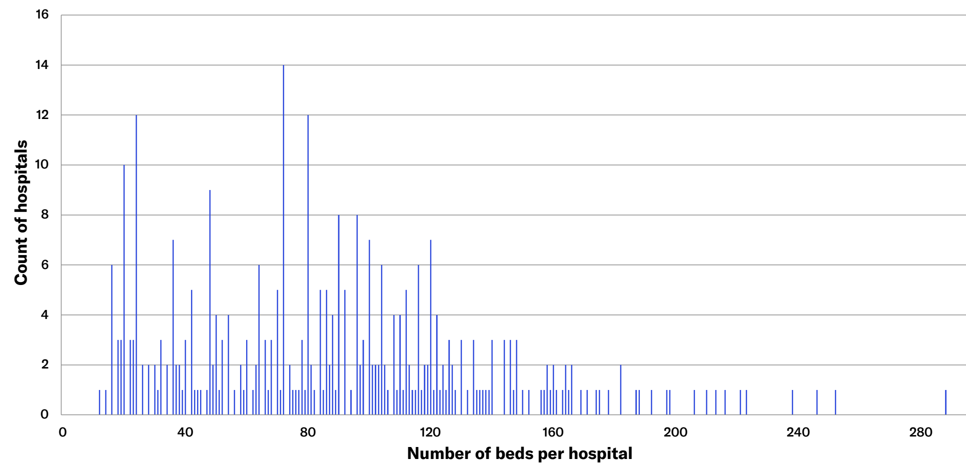


Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

Figure 4 shows for-profit psychiatric hospitals, which greatly outnumber public and nonprofit hospitals. Their distribution peaks at 72 beds. For-profits are least subject to the IMD exclusion and least reliant on Medicaid patients, as they can attract privately insured patients whose care is often reimbursed at higher rates. Other spikes appear among for-profit providers, representing clusters of certain hospital sizes.

Figure 4

Distribution of For-Profit Psychiatric Hospitals by Hospital Size, 2022



Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

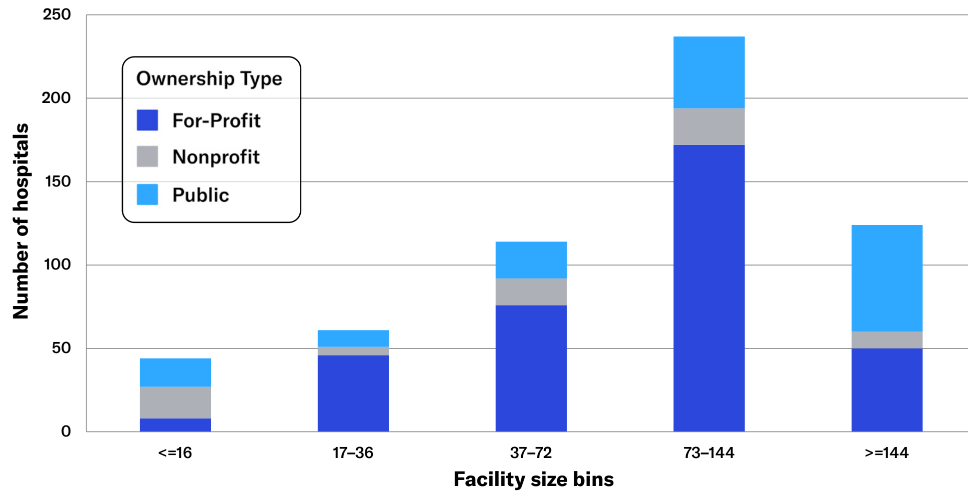
The size distributions for all ownership types are spiky rather than smooth due to the ways in which psychiatric hospitals are financed and regulated, affecting the optimal scale at which providers operate. The spikes in the figures at 16 beds clearly reflect a response to the IMD exclusion. Hospitals are likely to scale in fixed increments due to required staffing ratios and licensing constraints, among other factors. Some states have thresholds for licensing fees or certifications that might incentivize hospitals to organize around these requirements.[39]

Psychiatric hospitals also face fixed costs. For example, they have to invest to meet ligature risk requirements (that is, removing all physical points by which a cord, rope, or other object could be attached for the purpose of hanging or strangulation). There are also extensive conditions of participation for psychiatric hospitals to be Medicare- and/or Medicaid-certified providers, [40] which are more onerous than what is required of general hospitals.[41] Some of these conditions were issued in the 1960s and no longer reflect today's health-care delivery.[42] For example, Medicare-certified psychiatric hospitals are required to complete and maintain extensive clinician-drafted individualized treatment plans for each patient, updated more frequently and in greater detail than what is required at general hospitals. This may have been warranted in decades past, when patients were sometimes hospitalized for months or years, [43] but this requirement is now impractical and provides limited benefit to patients, given today's average length of stay of under nine days.[44]

Figure 5 provides an alternative view of this distribution by grouping hospitals in size bins. Most hospitals have more than 16 beds, which is noteworthy for two reasons. First, Medicaid beneficiaries will not be covered at most existing psychiatric hospitals based on the IMD exclusion's size restriction. Were the exclusion repealed, tens of thousands of existing beds would become available and covered immediately for beneficiaries. Second, because most hospitals operate with 73 to 144 beds, providers may have a revealed preference for this size in the current financial and regulatory environment.

Figure 5

Distribution of Psychiatric Hospitals by Size Bin and Ownership, 2022



Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

Most public hospitals have 144 beds or more, whereas that number of beds makes up the smallest share of nonprofit hospital capacity. To the extent that the IMD exclusion aims to avoid federal funding for the kind of custodial care more likely to occur in large state-run hospitals, the IMD-exclusion size threshold could still be significantly increased. A restriction on Medicaid funding for facilities with more than 144 beds would effectively continue to exclude those state hospitals without restricting other providers from being reimbursed for serving Medicaid patients.

Medicaid's IMD exclusion means that hospital size dictates whether psychiatric hospital services can be *covered*. Repealing the IMD exclusion would allow Medicaid coverage for inpatient treatment at hospitals of any size—which is a necessary first step for increasing access. However, coverage alone does not guarantee that Medicaid beneficiaries will be served because hospitals can serve patients with Medicare or private health insurance, both of which typically reimburse hospitals at higher rates than Medicaid. To understand the extent to which IMD repeal may actually lead to more beneficiaries receiving treatment, it helps to examine how providers above and below the size threshold for FFP are currently serving Medicaid patients.

A high percentage of psychiatric hospitals in the N-SUMHHS data report accepting Medicaid.[45] Congruently, in the 2022 CMS Cost Report data, nearly 71% of all psychiatric hospitals (411 of 580) document at least one Medicaid-related discharge, meaning that a Medicaid beneficiary was discharged from an inpatient stay.[46] **Table 2** shows the percentage and number of psychiatric hospitals reporting at least one Medicaid discharge for 2022.

Table 2

Hospitals Reporting at Least One Medicaid Discharge, by Size and Ownership

Size	Ownership	% Reporting at least one Medicaid discharge	Number of hospitals
≤ 16 beds	All	75%	33
	Public	94%	16
	For-Profit	38%	3
	Nonprofit	74%	14
17+ beds	All	71%	536
	Public	76%	106
	For-Profit	72%	38
	Nonprofit	68%	106

Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

Although less than 8% of hospitals have 16 or fewer beds (and thus are eligible for Medicaid coverage), most hospitals report at least one Medicaid discharge. One explanation for this is the existence of various exceptions to the IMD exclusion, which will be described in the following section.

Another explanation for these discharges is the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA), which requires Medicare-certified providers to furnish emergency services regardless of patients' ability to pay. Most psychiatric hospitals participate in Medicare,[47] which under Part A covers treatment at psychiatric inpatient facilities with a 190-day lifetime limit, using a per-diem prospective payment system (IPF PPS) that adjusts for patient and facility characteristics.[48] Thus, the practical effect of EMTALA is that most psychiatric hospitals must admit or accept transfers of Medicaid patients with psychiatric emergency conditions (being homicidal, suicidal, or a danger to oneself or others). For hospitals with more than 16 beds, the result is uncompensated care.

While most psychiatric hospitals report at least one Medicaid discharge in 2022, Medicaid discharges are a small fraction of all discharges. **Table 3** shows the percentage of Medicaid discharges among hospitals reporting at least one. (Medicare discharges are also shown for comparison.) Medicaid discharges make up 20% of all discharges among ≤16-bed psychiatric hospitals but only 4% of all discharges in larger hospitals.

Table 3

Median Percentage of Medicaid and Medicare Discharges Among Hospitals Reporting at Least One Medicaid Discharge, 2022

Payer Type	Size	Ownership			
		All	Public	For-Profit	Nonprofit
Medicaid	≤ 16 beds	20%	61%	47%	9%
	17+ beds	4%	11%	2%	10%
Medicare	≤ 16 beds	10%	13%	8%	8%
	17+ beds	6%	7%	6%	8%

Note: The high percentage of Medicaid discharges at small for-profit hospitals shown in Table 3 reflects a group of only three hospitals.

Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022.

Past Experience of IMD Exclusion Modifications

Since its 1965 enactment, the IMD exclusion has been modified several times, including the regulatory definition (codified in 1988) allowing FFP at hospitals with 16 or fewer beds.[49] This size restriction represented a preference for short-term stays in community-based settings, rather than longer-term stays more typical of nursing homes and mental hospitals.[50]

The Social Security Amendments of 1972 exempted children under 21 from the IMD exclusion (and states have always had the option to exempt patients over 64).[51] Allowing IMD coverage for youth initially resulted in a significant expansion of psychiatric hospitals, given the new revenue potential.[52] However, patients with age-based exemptions account for very few psychiatric hospitalizations in IMDs or otherwise; 83.8% of psychiatric hospitalizations are for patients 18 to 64 years old,[53] and the rate of stays for the nonexempt age group is at least twice as high as for those who are exempt.[54]

There have been several recent (and bipartisan) changes to the IMD exclusion, including many since the first Trump administration. First, states with Medicaid managed-care plans can now make capitation payments to managed-care organizations (MCOs) for IMD care "in lieu of" services covered under a state plan if services are a clinically appropriate and cost-effective substitute, and if the IMD stay is under 15 days during the month of payment.[55]

Second, states can seek demonstration waivers under Section 1115 of the Social Security Act to cover short-term IMD stays for substance-use disorder (SUD)—made available by CMS in 2015, with guidance updated in 2017—and for serious mental illness (SMI) and serious emotional disturbances (SED) in youth, since late 2018.[56]

Third, since October 2019, the SUPPORT Act has allowed for a state option for Medicaid plans to cover SUD treatment in IMDs, for up to 30 days per year if several conditions are met.[57] Finally, while not technically an exemption, states can use a portion of Medicaid disproportionate share hospital (DSH) payments—which offset the cost of uncompensated care—to make lump-sum payments to psychiatric hospitals.[58]

Nearly every state makes use of at least one of these mechanisms (and some states make use of several) to draw down federal dollars for IMD services.[59] For example, among 41 states with Medicaid managed care, 31 used "in lieu of" authority in fiscal year 2020.[60] Fifteen states have Section 1115 waivers for SMI, and 37 have waivers for SUD.[61] Across 33 states, $2.9 billion in DSH payments were made to mental-health treatment facilities including IMDs in FY 2019.[62]

In 2023, a Congressional Budget Office (CBO) report examined Medicaid claims for SUD patients, finding that among states with Section 1115 SUD waivers, more IMD stays were reimbursed and more providers accepted Medicaid.[63] SMI waivers have been implemented more recently, and evaluations will be possible in the coming years.

Between 2012 and 2015, a federal demonstration project called the Medicaid Emergency Psychiatric Services Demonstration (MEPD) allowed FFP at participating private psychiatric facilities, which would otherwise be excluded under the IMD rule, across 11 states and the District of Columbia for services rendered to beneficiaries with emergency psychiatric conditions.[64]

The evaluation of MEPD faced data limitations: in most states, only six months of data were available, which was insufficient to determine whether the program had led to increased inpatient access for Medicaid beneficiaries. However, in the one state with 18 months of available data, beneficiaries' admission rates rose toward the end of the period—suggesting a genuine increase in inpatient access, albeit after a delay, possibly as providers became aware of, or adjusted to, the change.

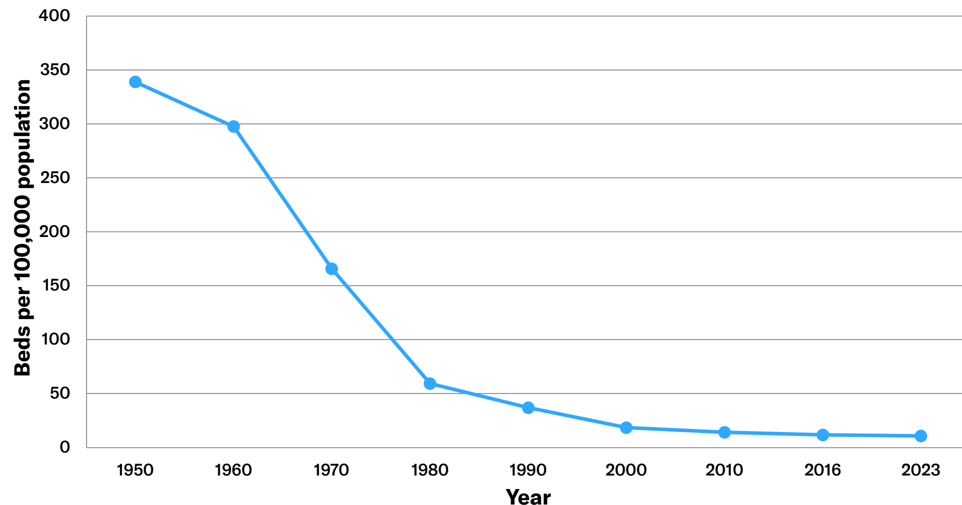
Interviews with IMD staff during MEPD provided additional insight. In most states, staff said that they could not infer whether the demonstration affected discharge patterns, but only because "the facilities typically did not admit adult Medicaid beneficiaries before MEPD"[65]—a response that suggests that the demonstration did lead to greater access.

The MEPD evaluation also shed light on the limited effectiveness of waivers versus that of a full repeal. Many states stopped demonstration enrollment months in advance of the scheduled end out of fear that expected reimbursement might be withheld or that funding had run out. The changing (and political) nature of CMS decisions may prevent hospitals from opting to serve Medicaid patients—or add bed capacity—if there is lingering uncertainty about reimbursement.

In summary, over the decades, there have been several modifications to the IMD exclusion that—despite being motivated by a desire for more inpatient capacity—have failed to reverse the downward trend of psychiatric hospital bed capacity. [66] This is especially clear among public providers, which serve the greatest share of Medicaid patients.[67] **Figure 6** shows the decline in state psychiatric hospital beds per 100,000 from a peak in the 1950s.[68]

Figure 6

Number of State Psychiatric Hospital Beds per 100,000 Population



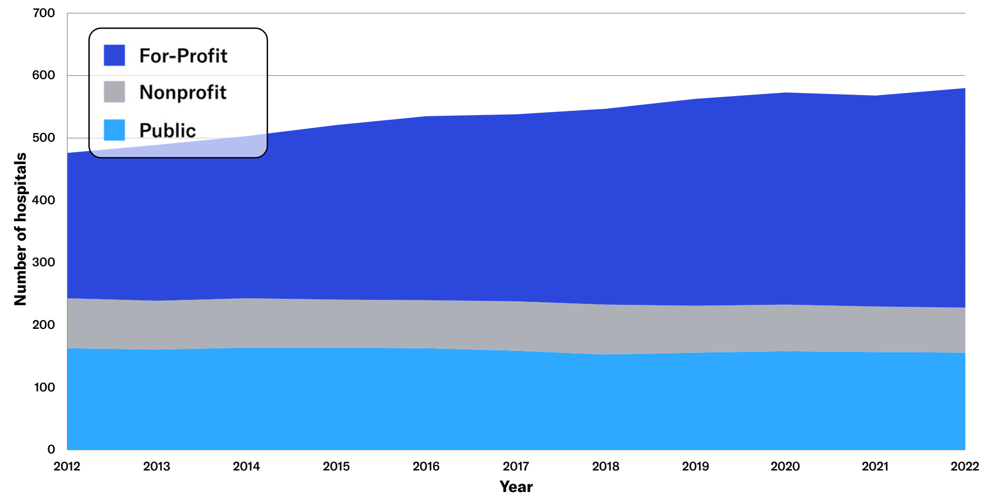
Source: Treatment Advocacy Center

Ownership Dynamics of Psychiatric Hospitals

There is one exception to the general trend of declining inpatient psychiatric beds: the for-profit sector.[69] The number of for-profit psychiatric hospitals increased between 2012 and 2022 (shown in **Figure 7**), as did the number of for-profit beds (shown in **Figure 8**). Indeed, the growth of for-profit psychiatric hospitals—the most numerous ownership type—has led to an overall increase in the number of psychiatric hospital beds. However, other research has found that this growth in for-profit psychiatric hospitals has occurred alongside the decline in general hospital psychiatric bed capacity since 2004, suggesting that the total number of psychiatric beds across both psychiatric hospitals and general hospital psychiatric units has not increased.[70]

Figure 7

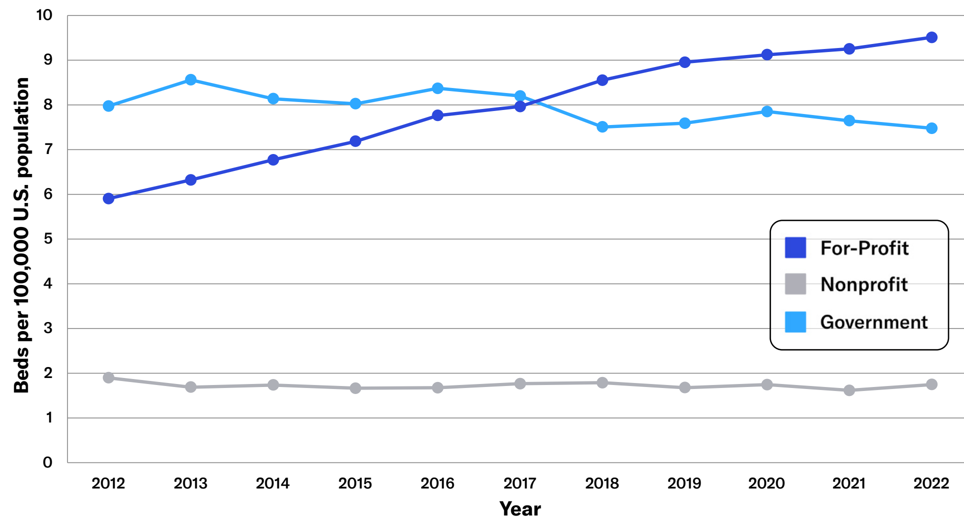
Number and Ownership Composition of Psychiatric Hospitals, 2012–22



Source: Author's calculations based on CMS Hospital Provider Cost Reports data, 2012–22

Figure 8

Beds per 100,000 U.S. Population by Ownership, 2012–22



Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2012–22; Population estimates from the U.S. Census Bureau

Usually, it is good to have more providers of inpatient psychiatric care, but a greater number of for-profit hospitals does not guarantee increased access to hospital care for seriously mentally ill Medicaid beneficiaries, the homeless, or the incarcerated. Over the last decade, as for-profit psychiatric hospitals have expanded, their share of Medicaid discharges has declined (**Table 4**). The overall share of psychiatric hospitals with more than 16 beds (hospitals directly affected by past-decade exemptions) that report at least one Medicaid discharge declined between 2012 and 2022, from 74% to 71%; among for-profit hospitals, that figure dropped from 72% to 68% (see **Appendix Table A**). Among the now-smaller share of over-16-bed hospitals reporting at least one Medicaid discharge, Medicaid discharges as a fraction of total discharges have also declined (**Table 4**).

Table 4

Median Percentage of Medicaid Discharges Among Hospitals Reporting at Least One Medicaid Discharge

	Psychiatric hospitals with 17+ beds			
Ownership	**All**	**Public**	**For-Profit**	**Nonprofit**
2022	4%	11%	2%	10%
2021	6%	10%	3%	10%
2020	6%	10%	3%	9%
2019	7%	10%	5%	9%
2018	7%	10%	5%	12%
2017	8%	8%	5%	9%
2016	7%	7%	6%	8%
2015	7%	7%	7%	13%
2014	8%	8%	7%	13%
2013	8%	7%	7%	12%
2012	8%	5%	9%	12%

Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2012–22

As Table 4 shows, as for-profits served proportionately fewer Medicaid beneficiaries, public hospitals served proportionately more. However, it is important to emphasize that fewer than half of all beds are in public hospitals.

Inpatient psychiatric care is not a lucrative business. At least 37% of all psychiatric hospitals operate with negative net-profit margins—and patients on Medicaid are less lucrative than patients with other means to pay.[71] For-profit providers are essential to the mental-health system, but if policymakers want to expand inpatient access to seriously mentally ill Americans who are currently homeless or incarcerated, for example, for-profit provision will be of limited benefit.

To be sure, repealing the IMD exclusion does not change low Medicaid reimbursement rates, other than effectively "raising" them from the current rate of $0 (minus the cost to psychiatric hospitals of serving beneficiaries without compensation). Both repeal *and* increased Medicaid reimbursement rates may ultimately be necessary to encourage psychiatric hospital providers to add beds, let alone maintain current capacity.

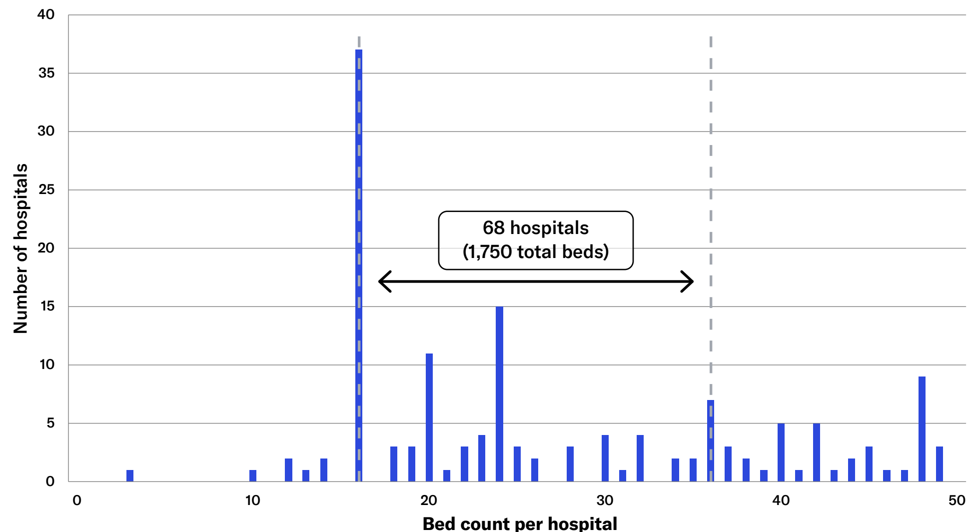
Evaluating Current Proposals for Reform

Many policymakers now agree on the need for more psychiatric beds and that changing Medicaid's IMD exclusion is necessary to make that happen.

One such change to the IMD exclusion—featured in a bill that was previously introduced in the House of Representatives—would increase the size threshold for an IMD from more than 16 beds to more than 36 beds. But as **Figure 9** shows, such a change would likely have little impact on Medicaid beneficiaries' access to inpatient services because there are few hospitals with 36 beds or fewer that could benefit from such a proposal.

Figure 9

Psychiatric Hospitals Newly FFP-Eligible Under a 36-Bed Definition of IMD



Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

Assuming that psychiatric hospitals are still operating at the same size as in 2022, raising the threshold to 36 beds would result in only 68 additional psychiatric hospitals (with 1,750 beds) gaining access to Medicaid funds, at most.[72] Fifteen of those hospitals (401 beds) are public (10 hospitals) or nonprofit (5 hospitals). While it's uncertain how many providers would enter the market anew under such a threshold, expectations should be tempered, given that few hospitals operate within this size range.

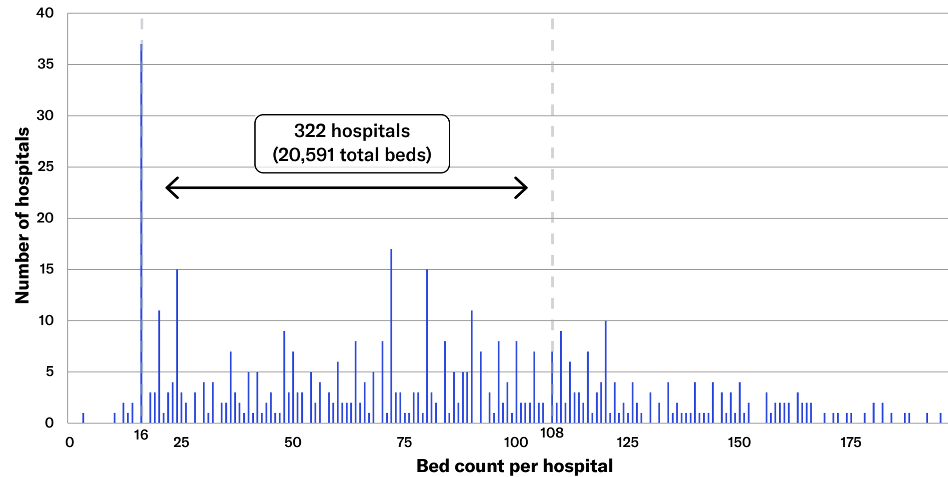
If all hospitals with between 16 beds (exactly on the cusp of the current restriction) and 35 beds increased in size to meet the new threshold—an overly generous assumption—the result would be only 594 additional beds (on top of the newly covered 1,750). Furthermore, these already-minimal benefits may be further reduced if hospitals with just over 36 beds took beds offline to meet the new threshold. Fourteen hospitals have between 36 and 41 beds, with a total of 40 beds that could be reduced across facilities to meet the 36-bed threshold.

Given that there are more than 100,000 seriously mentally ill homeless Americans[73] and hundreds of thousands of incarcerated seriously mentally ill Americans, it is doubtful that several hundred more beds serving Medicaid beneficiaries would make a noticeable impact on America's mental-health crisis.

Because the vast majority of psychiatric hospitals have between 73 and 144 beds, a hypothetical definition change allowing FFP at IMDs within this higher range is worth examining. **Figure 10** shows the number of hospitals that would become covered under a hypothetical 108-bed threshold—the midpoint of 73 and 144 and the average size of all psychiatric hospitals.

Figure 10

Psychiatric Hospitals Newly FFP-Eligible Under a 108-Bed Definition of IMD



Source: Author's calculations based on CMS Hospital Provider Cost Report data, 2022

An increase in the size threshold to 108 beds would allow a far greater number of hospitals to become covered settings—322 hospitals total, including 58 public hospitals and 33 nonprofit hospitals, for a total of 20,591 beds newly covered under Medicaid. If all hospitals operating in 2022 with between 16 (inclusive) and 107 beds were to increase their size to meet the new 108-bed threshold—again, an overly generous assumption—the result would be an additional 15,439 beds (on top of the 20,591).[74] This reform is far more likely to meaningfully increase Medicaid beneficiaries' access to necessary inpatient care, though still inferior to full repeal.

Figures 9 and 10 represent rough estimates of the number of psychiatric hospitals and beds that would no longer be excluded from Medicaid based on size. Hospital ownership and other factors affect the extent to which beds that become newly available to Medicaid patients would ultimately serve them—as well as the extent to which current providers would expand or new providers would enter the market. These ranges, therefore, are not definitive, but they do represent the potential impact of broader IMD exclusion reforms, if full repeal is not possible.

Considering the Cost of Repeal

The best argument for modifying, rather than simply repealing, the IMD exclusion is the fiscal impact of the latter.[75] Rising Medicaid costs are a challenge about which policymakers are right to be concerned, and policymakers may want to consider ways less effective mental-health spending can be reduced to offset costs to IMD exclusion repeal. While a full cost analysis of repeal is beyond the scope of this report, some considerations are worth discussing.

In fiscal year 2019, the U.S. spent $43.2 billion on all IMD- and non-IMD-based inpatient treatment for mental health and substance abuse. Medicaid accounted for $19.3 billion of that spending.[76] For 135,502 individuals treated in state psychiatric hospitals in fiscal year 2019, Medicaid contributed $2.1 billion (of combined state and federal Medicaid funds) out of a total of $11.5 billion spent. State revenue from general funds and special funds account for essentially all the rest ($9.3 billion).[77] (The total per-patient cost in state hospitals that year was $84,748, on average.) In the 2012–15 MEPD, the average amount claimed per admission to a private psychiatric hospital was $6,766.[78]

Absent explicit cost-neutrality requirements, repealing the IMD exclusion would mean new costs for the federal government because services not previously eligible for FFP would become eligible. But the important question is whether these costs are outweighed by the benefits. There is an obvious cost to society of leaving serious mental illnesses inadequately treated: greater homelessness, incarceration, public disorder, and violence. Policymakers wary of IMD-exclusion repeal due to the cost may find that inaction presents less cost savings than expected.

In 2023, CBO estimated the cost to the federal government of IMD-exclusion repeal for mental-health stays to be about $3.3 billion per year over 10 years.[79] However, even absent repeal, CBO noted that the federal government would still incur much of this cost, as states increasingly make use of waivers to cover patients. At the time of CBO's estimate, one state had a Section 1115 waiver for mental health, and 25 states had an 1115 waiver for SUD, with 73% of Medicaid enrollees aged 21 to 64 living in states with waivers. Today, 15 states have mental-health waivers, and 37 states have SUD waivers, both of which allow for coverage of short-term IMD stays.

Another reason that IMD repeal would be less expensive than many assume is that the vast majority of IMD stays are short-term. The median length of stay for Medicaid beneficiaries in the MEPD demonstration was seven days (with an average of 8.6 days). Nearly 90% of all stays were under 32 days. These metrics are consistent with CBO's admission that many IMD stays will become covered and paid for with federal dollars absent any legislative action. Only 1,300 Medicare beneficiaries reached the 190-day lifetime limit in 2023,[80] so for the vast majority of Medicaid patients, stays will be short-term.[81] Shorter lengths of stay are, in part, a function of Medicaid plans increasingly operating under managed-care models,[82] which act as a check against unnecessarily long inpatient stays.[83]

Furthermore, although inpatient treatment for serious mental illness is inherently expensive, IMDs can provide more cost-effective services. For patients with psychiatric emergency conditions, for example, the average price of all emergency-room services in 2021 was over $5,550 per admission.[84] Multiple or repeated stays in the ER may cost more than a single admission to a psychiatric hospital, which is a more effective and clinically appropriate setting. For this reason, CBO estimated that reductions in ER use would partially offset some of the cost of IMD repeal.

As the number of dedicated psychiatric beds in general hospitals decreases, patients are increasingly treated in "scatter beds," which are not dedicated to or equipped for psychiatric treatment. More treatment in scatter beds will only further increase the cost of treatment in general hospitals as compared with specialty hospitals.

Finally, it's worth noting that the IMD exclusion was intended to prevent cost-shifting of mental-health care from states to the federal government, but it has failed to do so: the federal share of spending on mental health has vastly increased compared to state spending since the enactment of the IMD exclusion.[85] States have simply shifted spending away from psychiatric hospitals and toward Medicaid-covered services that capture federal dollars and meet states' federally required matching payments.[86] Because patients with serious mental illness are most likely to need hospitalization not covered by Medicaid, mental-health dollars have instead been spent on those with less serious functional impairment. In short, the result has been to encourage greater utilization of mental-health services by a population less in need.[87]

In terms of cost-shifting, repealing the IMD exclusion need not happen in a vacuum. Proposals have been made to eliminate the open-ended federal matching that currently exists.[88] Capping the federal matching allocation to states for Medicaid-covered services—but removing the discrimination against the IMD setting—would do more to contain Medicaid costs overall than keeping the IMD exclusion in place.

A combination of repealing the IMD exclusion and placing an upper-limit cap on Medicaid matching would be a reasonable scenario: repealing the IMD exclusion would remove any distortion it creates in dictating service setting—distortions that clearly exist, given the many work-arounds that states take advantage of currently to draw down federal dollars for IMD care—but growth of the overall Medicaid program would be necessarily reined in. To the extent that IMD care is less expensive than other settings, such as general hospital psychiatric units, this would also provide a more economical option for care. Finally, a cap with no IMD exclusion would allow states better discretion to prioritize services most needed in each individual state; this may help allocate resources toward seriously mentally ill individuals most in need.

Conclusion

The IMD exclusion restricts Medicaid beneficiaries from receiving inpatient psychiatric treatment in IMDs such as psychiatric hospitals—a limitation that does not exist for any other type of treatment setting. As of 2018, half of all beneficiaries with serious mental illness reported unmet needs.[89] Not meeting those needs has consequences not only for patients themselves but also for the public in the form of higher rates of homelessness, incarceration, public disorder, and violence.

The amount of public disorder and violence that comes from untreated mental illness is a policy choice. There are psychiatric hospitals currently operating that could serve individuals with serious mental illnesses if doing so were financially feasible. But prohibiting reimbursement for treatment in psychiatric hospitals—without any clinical justification—exposes hospitals to financial losses from uncompensated care, a risk that becomes unavoidable as hospitals grow beyond 16 beds.

Over the past decade, various mental-health reforms have garnered bipartisan support, suggesting that congressional action on the IMD exclusion is politically feasible. While appetite for full repeal has been limited in the past, momentum appears to be growing: lawmakers, researchers, practitioners, and advocacy organizations—across partisan lines—have called for repeal.[90] The Trump administration has also publicly indicated support for addressing the IMD exclusion and expanding the use of psychiatric hospital settings.[91]

Coverage for serious mental illness *at scale* is necessary to address the lack of access to inpatient psychiatric care. The slow but steady rate of decline among public and nonprofit hospitals over the last 15 years suggests that IMD-exclusion repeal may be necessary simply to keep hospitals in operation at their current capacity.

Acknowledgments

The author would like to thank Ken Locey, especially, for guidance and assistance related to CMS Hospital Provider Cost Report data. The author would also like to thank Stephen Eide, Scott Dziengelski, Sherry Glied, Judge Glock, Chris Pope, Elizabeth Sinclair Hancq, Cheryl Roberts, and Ryan Aminloo for their valuable insights.

Appendix

Data Description

This report examines *freestanding psychiatric hospitals,* as CMS Hospital Provider Cost Report data do not cover all IMD-designated facilities, such as residential-treatment facilities. Some residential treatment facilities are present in the data if they operate inpatient units accredited or licensed as psychiatric hospitals. However, distinguishing residential-treatment facilities from psychiatric hospitals, which require manual corroboration against public information, is not done here.[92] Non-IMD general hospital psychiatric beds (FFP-eligible) are also excluded, as they are indistinguishable within bed counts of each general hospital record.

Cost-report data are generated via annual forms that all Medicare-certified institutional providers submit to CMS.[93] CMS requires all Medicare-certified institutional providers to complete cost reports or risk losing federal funds. The data describe characteristic information for hospitals, including type (corresponding to the primary health-care services provided—children's hospitals, psychiatric hospitals, etc.), ownership (e.g., public versus private), and size (e.g., number of beds). The vast majority of psychiatric hospitals are Medicare-certified, making the cost report data relevant and useful. [94]

This report primarily uses publicly available 2022 CMS Hospital Provider Cost Report data, with some analyses drawing on data back to 2012.[95] A total of 630 psychiatric hospital records are included in the 2022 data, 580 of which are unique hospitals with non-null bed counts reporting at least one inpatient discharge (used to confirm that inpatient services are provided). Those 580 psychiatric hospitals account for 62,439 beds in operation. Compared with other benchmarks, total hospital and bed counts are in line with American Hospital Association reports[96] and higher than the 2022 N-SUMHHS (481 hospitals, 48,038 beds), possibly due to inclusion of some residential-treatment facilities, which are counted separately in the N-SUMHHS.[97]

A record was deleted from data analyzed if it: (1) was not identified as a psychiatric hospital, (2) did not have a total bed count listed per hospital or facility, (3) did not have at least one inpatient program day, or (4) was a duplicate hospital within any given reporting year. In time series analyses, not all hospitals were present each year. Hospital ownership was determined as "for-profit," "nonprofit," or "government" based on a created grouped indicator of ownership types. An indicator was created for records where at least one Medicaid-related discharge was reported (Title XIX). All records had at least one Medicare-related discharge (Title XVIII), so no indicator was needed. The percentage of Medicaid discharges per record was calculated as the number of Medicaid-related discharges (Title XIX discharges) reported in a given record over the number of total discharges reported in a given hospital record. Analyses were conducted using Python.

Appendix Table A

Percentage and Number of Hospitals Reporting at Least One Medicaid Discharge, by Size and Ownership

	<= 16 beds				17+ beds			
	All	Public	Nonprofit	For-Profit	All	Public	Nonprofit	For-Profit
2022	75% (33)	94% (16)	74% (14)	38% (3)	71% (536)	76% (106)	72% (38)	68% (106)
2020	72% (33)	88% (15)	71% (15)	38% (3)	70% (367)	72% (101)	70% (38)	69% (228)
2018	78% (39)	94% (16)	75% (18)	56% (5)	70% (348)	74% (100)	64% (36)	70% (212)
2016	79% (42)	94% (16)	83% (19)	54% (7)	66% (316)	75% (109)	61% (33)	62% (174)
2014	76% (39)	94% (17)	67% (14)	67% (8)	70% (317)	77% (112)	69% (40)	67% (165)
2012	80% (37)	93% (14)	76% (16)	70% (7)	74% (319)	79% (117)	71% (42)	72% (160)

Source: Author’s calculations based on CMS Hospital Provider Cost Report data, 2012–22

Endnotes

1. Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey of Drug Use and Health, 2023.

2. Heather Saunders et al., "5 Key Facts About Medicaid Coverage for Adults with Mental Illness," Kaiser Family Foundation (KFF), Feb. 21, 2025.

3. Medicaid and CHIP Payment and Access Commission (MACPAC), *March 2021 Report to Congress on Medicaid and CHIP* (March 2021).

4. This is especially true for patients at risk of self-harm or suicide, or who pose a danger to others and need intensive oversight.

5. American Psychiatric Association (APA), "The Psychiatric Bed Crisis in the U.S.: Understanding the Problem and Moving Toward Solutions," May 2022; Ryan K. McBain, Jonathan H. Cantor, and Nicole K. Eberhart, "Estimating Psychiatric Bed Shortages in the U.S.," *JAMA Psychiatry* 79, no. 4 (February 2022): 279–80; Zoe Lindenfeld et al., "Inpatient Psychiatric Bed Capacity Within CMS-Certified U.S Hospitals, 2011–2023: A Cross-Sectional Study," *Plos Medicine* 22, no. 7 (July 23, 2025): e1004682; Doris A. Fuller et al., "Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds," Treatment Advocacy Center, June 2016; Adrian P. Mundt et al., "Need Estimates of Psychiatric Beds: A Systematic Review and Meta-Analysis," *Psychological Medicine* 54, no. 14 (September 2024).

6. Doris A. Fuller et al., "Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds," Treatment Advocacy Center, June 2016; Dominic A. Sisti et al., "Improving Long-Term Psychiatric Care: Bring Back the Asylum," *JAMA* 313, no. 3 (January 2015): 243–44.

7. Richard Frank and Sherry Glied, *Better but Not Well* (Baltimore, MD: Johns Hopkins University Press, 2006), 64–6: "Both the creation of Medicaid and the establishment of the modern SSI program resulted in significantly higher rates of state mental health care spending and lower rates of use of state mental hospitals. …States have shifted the design of public mental health services in order to capture federal matching dollars. One element of this strategy has been to use state direct spending as state match contributions for Medicaid. Thus, … those dollars were increasingly tied to Medicaid policy in terms of allocation choices."

8. Ibid.

9. Social Security Act (SSA) §1905(i).

10. Legal Action Center, "The Medicaid IMD Exclusion: An Overview and Opportunities for Reform," Dec. 8, 2021.

11. MACPAC, *Report to Congress on Oversight of Institutions for Mental Diseases* (December 2019).

12. SSA §1905(a)(30)(B).

13. KFF, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier."

14 Shanti Silver and Elizabeth Sinclair Hancq, "Prevention over Punishment: Finding the Right Balance of Civil and Forensic State Psychiatric Hospital Beds," Treatment Advocacy Center, January 2024.

15 Amanda Wik, Vera Hollen, and William H. Fisher, "Forensic Patients in State Psychiatric Hospitals: 1999–2016," National Association of State Mental Health Program Directors, August 2017.

16 Ibid.; Silver and Hancq, "Prevention over Punishment."

17 Hope Parker and Shanti Silver, "Homelessness and Serious Mental Illness: Research Summary," Treatment Advocacy Center, November 2024.

18 Risdon N. Slate et al., *The Criminalization of Mental Illness: Crisis and Opportunity for the Justice System* (Durham, NC: Carolina Academic Press, 2013).

19 Silver and Hancq, "Prevention over Punishment." 73% of reporting states reported occupancy rates above the recommended 85%.

20 American College of Emergency Physicians (ACEP), "Definition of Boarded Patients," September 2018; ACEP, "Care of the Psychiatric Patient in the Emergency Department—A Review of the Literature," October 2014, 4: "Boarding is a significant problem in emergency medicine. For psychiatric patients, the problem is significantly worse, with psychiatric patients remaining in the ED far longer than medical patients."

21 Alex V. Barnard, *Conservatorship* (New York: Columbia University Press, 2023), 75.

22 Ibid., 76.

23 Lisa B. Dixon and Howard H. Goldman, "Introduction to Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate," *Psychiatric Services* 70, no. 1 (January 2019): 2–3; see also Jeffrey L. Geller, "Excluding Institutions for Mental Diseases from Federal Reimbursement for Services: Strategy or Tragedy?" *Psychiatric Services* 51, no. 11 (November 2000): 1397–1403.

24 Tarun Bastiampillai, Steven S. Sharfstein, and Stephen Allison, "Increase in U.S. Suicide Rates and the Critical Decline in Psychiatric Beds," *JAMA* 316, no. 24 (December 2016): 2591–92; National Alliance on Mental Illness, "Medicaid IMD Exclusion"; National Association of State Mental Health Program Directors, "Position Statement on Repeal of the Medicaid IMD Exclusion," 2022; Dixon and Howard H. Goldman, "Introduction to 'Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule.

25 "Congressman Ritchie Torres Introduces the 'Repealing the IMD Exclusion Act,'" press release, Dec. 6, 2024.

26 "Congressman Dan Goldman Introduces Michelle Go Act to Help Alleviate Mental Health Crisis," press release, May 23, 2024.

27 Inpatient psychiatric beds primarily refer to beds in freestanding psychiatric hospitals, general hospital psychiatric units, and residential treatment facilities offering 24-hour inpatient services. Determining inpatient psychiatric bed supply is complicated. There is no national census of beds by IMD status, and the circumstances under which a facility may be

reimbursed by Medicaid, regardless of IMD status, can differ by state. A further description of challenges to determining supply can be found in MACPAC, *Report to Congress on Oversight of Institutions for Mental Diseases* (December 2019).

28 Janet R. Cummings et al., "Availability of Youth Services in U.S. Mental Health Treatment Facilities," *Administration and Policy in Mental Health and Mental Health Services Research* 43 (October 2015): 717–27: "More than half of psychiatric hospitals offered youth services, compared only to three-tenths of general hospitals with an inpatient psychiatric unit."

29 See Morgan C. Shields et al., "Increases in Inpatient Psychiatry Beds Operated by Systems, For-Profits, and Chains, 2010–2016," *Psychiatric Services* 73, no. 5 (May 2022): 561–64: "General acute care hospitals likely do not have the expertise or focus necessary to efficiently manage psychiatric patients, and more profitable service lines could be deemed as more worthy of investment. Additionally, general acute care hospitals might not have comparable negotiating power, especially if they are negotiating with a managed behavioral health organization. Freestanding psychiatric facilities could also offer lower rates as a result of lower per diem Medicare rates, against which negotiations are benchmarked."

30 Elizabeth M. La et al., "Increasing Access to State Psychiatric Hospital Beds: Exploring Supply-Side Solutions," *Psychiatric Services* 67, no. 5 (May 2016): 523–28.

31 SAMHSA, National Substance Use and Mental Health Services Survey (N-SUMHSS) (2022), table MH4; SAMHSA, National Mental Health Services Survey (N-MHSS) (2012) table 2.1; Ted Lutterman and Ron Manderscheid, "Trends in Total Psychiatric Inpatient and Other 24-Hour Mental Health Residential Treatment Capacity, 1970 to 2014," presentation at NASMHPD Commissioners Meeting, July 31, 2017.

32 Zoe Lindenfeld et al., "Inpatient Psychiatric Bed Capacity Within CMS-Certified U.S Hospitals, 2011–2023: A Cross-Sectional Study," *Plos Medicine* 22, no. 7 (July 23, 2025): e1004682.

33 During the Covid-19 pandemic, many general hospital psychiatric beds were taken offline and have yet to be reinstated. See Jill R. Horwitz and Austin Nichols, "Hospital Service Offerings Still Differ Substantially by Ownership Type," *Health Affairs* 41, no. 3 (March 2022): 331–40; Ryan K. McBain, Jonathan H. Cantor, and Nicole K. Eberhart, "Estimating Psychiatric Bed Shortages in the U.S.," *JAMA Psychiatry* 79, no. 4 (February 2022): 279–80; Maya Kaufman, "Hospitals Blame Psych Bed Reopening Delay on Suicide Precautions, Staff Shortages," *Politico*, Mar. 23, 2023; Roger Rapoport, "'Every Day Is an Emergency': The Pandemic Is Worsening Psychiatric Bed Shortages Nationwide," *Stat News*, Dec. 23, 2020; Massachusetts Health & Hospital Association, "The Crisis Continues: The Effect of Behavioral Workforce Shortages on the Availability of Inpatient Psychiatric Services," September 2022.

34 See SAMHSA, N-SUMHSS. The survey was updated in 2021 to include mental-health treatment facilities and substance-use-disorder treatment facilities.

35 SAMHSA's National Mental Health Services Survey (N-MHSS) and National Survey of Substance Abuse Treatment Services (N-SSATS), which surveyed facilities providing mental-health and substance-use-disorder services, respectively, were combined in 2021 into the N-SUMHSS.

36 Historically, aggregate counts of patients served on a given day by facility have been reported as facility-size ranges (i.e., 1 to 10 beds, 11 to 20 beds, and so on). N-SUMHHS offered non-aggregate bed counts per facility in 2022, but among records for psychiatric hospitals and residential treatment facilities providing 24-hour inpatient treatment, only 115 had non-null-bed counts.

37 As a comparison, in the 2022 N-SUMHSS, the median number of clients per state hospital was 145, and the number per private psychiatric hospital was 50 on March 31.

38 Definitive Healthcare, "What Is the Average Number of Beds in a U.S. Hospital?"

39 See, for example: Texas Administrative Code Title 25, Part 1, Chapter 133, Subchapter A, Rule §133.26; Florida Administrative Code Rule 59A-3.253; Minnesota Statutes 144.50 hospital license fee; Joint Commission, Hospital Accreditation Fact Sheet.

40 See Centers for Medicare & Medicaid Services (CMS), "Psychiatric Hospitals."

41 National Association for Behavioral Healthcare (NABH), "The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities," Mar. 19, 2019.

42 Ibid.

43 See Gerald N. Grob, "Psychiatry's Complex History," *Health Affairs* 34, no. 9 (September 2015): 1605–07, which notes that, contrary to popular belief, long-stay patients in nineteenth-century mental hospitals were still "the exception instead of the rule."

44 Omolola E. Adepoju, Lyoung H. Kim, and Steven M. Starks, "Hospital Length of Stay in Patients with and Without Serious and Persistent Mental Illness: Evidence of Racial and Ethnic Differences," *Healthcare* 10, no. 6 (June 2022); American Psychiatric Association (APA), "The Psychiatric Bed Crisis in the U.S.: Understanding the Problem and Moving Toward Solutions," May 2022, 31.

45 N-SUMHHS, 2022.

46 Author's calculations based on 2022 CMS Hospital Cost Report data.

47 In fiscal year 2020, Medicare spent $3.4 billion on inpatient psychiatric care compared with $19.3 billion spent by Medicaid in 2019 on all inpatient mental-health and substance-abuse care (including at non-IMD inpatient settings like general hospitals). See Betty Fout and Ledia Tabor, "Congressional Request: Medicare and Inpatient Psychiatric Facility Care," Medicare Payment Advisory Commission (MedPac), Sept. 30, 2022; Nathaniel Counts, "Medicaid's Role in Mental Health and Substance Use Care," Commonwealth Fund, May 7, 2025. Medicaid payment for psychiatric inpatient treatment varies by state but involves a combination of fee-for-service and managed-care models. See MACPAC, "Medicaid Inpatient Hospital Services Fee-for-Service Payment Policy," December 2018.

48 As with Medicaid, treatment in general hospital psychiatric units is not limited under Medicare. An estimated one-third of all beneficiaries dually eligible for Medicaid and Medicare under age 65 are seriously mentally ill. When dually eligible patients are treated at psychiatric hospitals, Medicaid often covers Medicare Part A deductibles and other cost-sharing. See Caterina Hill et al., "Serving People with Severe Mental Illness Who Are Dually Eligible for Medicare and Medicaid," *Healthcare* 6, no. 2 (June 2018): 139–43; Betty Fout and Pamina Mejia, "Medicare's Coverage Limits on Stays in Freestanding Inpatient Psychiatric Facilities," MedPac, Nov. 8, 2024.

49 The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) codified the regulatory definition of an IMD, creating an exception for facilities with 16 beds or fewer.

50 Dixon and Goldman, "Introduction to Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate,"

[51] All states must cover youth inpatient psychiatric treatment if it is determined to be medically necessary through mandatory screening as part of early and periodic screening, diagnosis, and treatment (EPSDT); at least 42 states offered IMD benefits to the elderly as of 2018. See KFF, "Medicaid Benefits: Services in Institutions for Mental Disease, Age 65 and Older."

[52] Eileen Salinsky, "Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?" National Health Policy Forum, Aug. 1, 2007.

[53] Pamela L. Owens et al., "Inpatient Stays Involving Mental and Substance Use Disorders, 2016," Agency for Healthcare Research and Quality, statistical brief no. 249, March 2019.

[54] See Adepoju, Kim, and Starks, "Hospital Length of Stay in Patients with and Without Serious and Persistent Mental Illness." Patients over 65 are also eligible for Medicare, which offers a 190-day lifetime limit for inpatient psychiatric care. Prior to Medicaid's enactment, about one-third of all psychiatric hospital patients were elderly. The IMD exclusion was enacted, in part, to shift these elderly patients to less restrictive settings. See Frank and Glied, *Better but Not Well*, 54: "The reasons behind the IMD exclusion were both economic and humanitarian. First, Congress wanted to prevent cost shifting from state budgets onto the federal budget. …Second, Congress wanted to encourage elderly people with mental disorders to be treated in less restrictive settings than specialty mental hospitals (US HCFA, 1992). One major effect of Medicaid and its IMD exclusion was to prompt states to shift care from state mental hospitals to nursing homes. Economics was paramount, for the states knew that costs would be largely assumed by the federal government. The daily spending for an inpatient in a public mental hospital in 1971 was about thirty dollars. The daily spending on nursing home care was lower and, under Medicaid, a state paid only 20 to 50 percent of the cost. So states saved a large amount of money by discharging patients from mental hospitals to nursing homes."

[55] 42 C.F.R. § 438.6(e) (2025); SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018). The "in lieu of" option was codified in the regulation in July 2016, though it had existed previously in sub-regulatory guidance. See MaryBeth Musumeci, Priya Chidambaram, and Kendal Orgera, "State Options for Medicaid Coverage of Inpatient Behavioral Health Services," KFF, November 2019.

[56] These waivers have been available for several decades, though CMS clarified guidance to encourage use during the first Trump administration. Ten states had CMS-approved §1115 waivers between 1997 and 2007, for example (MACPAC, *Report to Congress on Oversight of Institutions for Mental Diseases*, 6). As of May 2025, 15 states had a waiver for IMD payment exclusion for mental-health treatment, and 10 states had waivers pending. See KFF, Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State; Vikki Wachino, letter to state Medicaid directors, "Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder," CMS, SMD no. 15-003, July 27, 2015; Brian Neale, letter to state Medicaid directors, "RE: Strategies to Address the Opioid Epidemic," CMS, SMD no. 17-003, Nov. 1, 2017; Mary C. Mayhew, letter to state Medicaid directors, "Re: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," CMS, SMD no. 18-011, Nov. 13, 2018.

[57] SUPPORT Act; Margo Sharp, "SSA §1915(l)—State Plan Authority Option for SUD Treatment in an IMD," *Health Policy News*, Feb. 27, 2025.

[58] DSH payments for uncompensated care in psychiatric hospitals and other IMD facilities cannot exceed the lesser of the amount of DSH funds the state paid IMDs in FY 1995, or 33% of total FY 1995 DSH allotment per state. Two states, Massachusetts and Maine, dedicate all DSH payments to IMDs. See MACPAC, "Disproportionate Share Hospital Payments," July 26, 2023.

[59] Ibid., 6.

[60] KFF, State Options for Medicaid Coverage of Behavioral Health Services.

[61] CMS, "Serious Mental Illness Section 1115 Demonstration Opportunity"; KFF, Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State.

[62] KFF, State Options for Medicaid Coverage of Inpatient Behavioral Health Services.

[63] Congressional Budget Office (CBO), "Budgetary Effects of Policies to Modify or Eliminate Medicaid's Institutions for Mental Diseases Exclusion," April 2023.

[64] Emergency psychiatric conditions constituted patients who were homicidal, suicidal, or at risk of serious bodily harm to themselves or others.

[65] Crystal Blyler et al., "Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report," Mathematica Policy Research, prepared for CMS (Aug. 18, 2016), 54.

[66] To be clear, this study does not include a causal design, so the precise reasons behind changes in capacity cannot be fully described. However, it can be said that the timeframe in which more exemptions to the IMD exclusion were made was not associated with an increase in public or private nonprofit beds. Other research has also found that states with 1115 waivers did not have a statistically significantly greater number of inpatient psychiatric hospital beds, suggesting that low Medicaid payment rates likely do not justify providers expanding beds. See Lindenfeld et al., "Inpatient Psychiatric Bed Capacity Within CMS-Certified U.S Hospitals, 2011–2023: A Cross-Sectional Study."

[67] As originally enacted, Medicaid exempted from the IMD exclusion individuals aged 65 and older. The Social Security Amendments of 1972 (P.L. 92-603) exempted children under the age of 21, which is commonly referred to as the "Psych Under 21" benefit. At this size threshold, providers may be more encouraged to enter the market, which would add additional bed capactiy for Medicaid patients.

[68] Silver and Hancq, "Prevention over Punishment."

[69] Shields et al., "Increases in Inpatient Psychiatry Beds Operated by Systems, For-Profits, and Chains, 2010–2016."

[70] APA, "The Psychiatric Bed Crisis in the U.S.," 23; Lindenfeld et al., "Inpatient Psychiatric Bed Capacity Within CMS-Certified U.S Hospitals, 2011–2023: A Cross-Sectional Study."

[71] Author's calculations based on 2022 CMS data.

[72] Because some hospitals may serve forensic patients within this size, those hospitals would still be ineligible for non-forensic Medicaid beneficiaries.

[73] U.S. Dept. of Housing and Urban Development (HUD), "HUD 2024 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations," Dec. 9, 2024.

74 If hospitals with up to 118 beds were to reduce bed count to meet the 108-bed threshold, only 192 beds would be taken offline.

75 Other concerns have been raised by a small number of advocates that repeal will result in mass reinstitutionalization. This argument ignores (1) a robust mental-health-care infrastructure that now exists but did not in the 1950s and 1960s, (2) the implementation of Medicaid managed care, which provides a check against costly inpatient care when unnecessary, and (3) the humanitarian argument that mentally ill patients are currently institutionalized in non-therapeutic settings such as carceral settings.

76 Nathaniel Counts, "Medicaid's Role in Mental Health and Substance Use Care." Medicare accounted for $6.8 billion of inpatient spending on mental health and substance abuse across IMD and non-IMD providers.

77 National Association of State Mental Health Program Directors Research Institute (NRI), "FY 2019 State Mental Health Agency Revenues and Expenditures," January 2022.

78 Blyler et al., "Medicaid Emergency Psychiatric Services Demonstration Evaluation," 9.

79 CBO, "Budgetary Effects of Policies to Modify or Eliminate Medicaid's Institutions for Mental Diseases Exclusion."

80 Fout and Mejia, "Medicare's Coverage Limits on Stays in Freestanding Inpatient Psychiatric Facilities."

81 Ibid.

82 Between 1998 and 2017, since managed care has become widespread, the average length of stay for mental-health and substance-abuse disorders in short-term facilities has remained stable, about seven days. See APA, "The Psychiatric Bed Crisis in the U.S.," 13.

83 Stephen Eide and Carolyn D. Gorman, "Medicaid's IMD Exclusion: The Case for Repeal," Manhattan Institute, Feb. 23, 2021.

84 John Hargraves, "Emergency Room Spending, Price, and Use Trends, 2012–2021," Health Care Cost Institute, Oct. 26, 2023.

85 Frank and Glied, *Better but Not Well*, 49.

86 APA, "The Psychiatric Bed Crisis in the U.S."

87 The prevalence rate of serious mental illness has remained stable over time, suggesting that the need for inpatient services for this population will remain stable. Increasing use of outpatient services, in contrast, reflects growing supply and demand for services from those who are not seriously mentally ill.

88 Chris Pope, "Slowing Optional Medicaid Spending Growth," Manhattan Institute, Nov. 26, 2024.

89 Jane M. Zhu et al., "Medicaid Reimbursement for Psychiatric Services: Comparisons Across States and with Medicare," *Health Affairs* 42, no. 4 (April 2023): 556–65.

[90] National Association of Medicaid Directors, "The IMD Exclusion"; National Association for Behavioral Healthcare (NABH), "Repeal the Medicaid Program's IMD Exclusion," Summer 2024; American Hospital Association (AHA), letter to Chairman Walden and Ranking Member Pallone; TAC, "Research Weekly: New Report Supports Repeal of IMD Exclusion," Mar. 3, 2021; AHA, "AHA Comment Letter on Reauthorization of the SUPPORT Act," June 14, 2023; Congressman Ritchie Torres, "Congressman Ritchie Torres Introduces the 'Repealing the IMD Exclusion Act' " press release, Dec. 6, 2024; NABH, "IMD Exclusion"; National Association for Children's Behavioral Health, "Legislation We're Tracking: IMD Exclusion Repeal"; Sisti et al., "Improving Long-Term Psychiatric Care: Bring Back the Asylum"; Aaron Glickman and Dominic A. Sisti, "Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate—Argument to Repeal the IMD Rule," *Psychiatric Services* 70, no. 1 (January 2019); Jeffrey L. Geller, "2021 Annual Meeting: Presidential Address," *American Journal of Psychiatry* 178, no. 8 (August 2021).

[91] *Hearing to Consider the Nomination of Robert F. Kennedy, Jr., of California, to Be Secretary of Health and Human Services*, Before the Select Comm. on Finance, 119th Cong. (Jan. 29, 2025) (testimony of Robert F. Kennedy, Jr.); Exec. Order No. 202514391, *Ending Crime and Disorder on America's Streets*, 90 Fed. Reg. 35817 (July 24, 2025).

[92] See, for example, Tarzana Treatment Centers and Porter Starke Services.

[93] See CMS, Hospital 2552-2010 form.

[94] SAMHSA, N-SUMHSS, 2022, table MH20b: Mental health treatment facilities that accept a specific type of payment or funding source, by facility type: Row percent distribution. See MACPAC, *Report to Congress on Oversight of Institutions for Mental Diseases*, xii: "Federal guidance notes that state Medicaid agencies must, at a minimum, use Medicare certification standards for providers recognized by Medicare. However, states have flexibility in how they regulate all other providers, including freestanding SUD treatment facilities and residential mental health treatment programs."

[95] Data files are also available for 2023 and 2024 but are less comprehensive for those years as of June 2025, which are likely to be updated retroactively.

[96] American Hospital Association, "Fast Facts on U.S. Hospitals, 2025."

[97] SAMHSA, N-SUMHSS, 2022, table MH12: Median number of clients per mental health treatment facility, by facility type.