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August 2017

# MEDICAID

## States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies

# GAO Highlights

Highlights of [GAO-17-652](#), a report to the Co-Chair, Caucus on International Narcotics Control, U.S. Senate

## Why GAO Did This Study

Medicaid is the largest source of national funding for behavioral health services—mental health and substance use services—with nearly \$71 billion in projected 2017 spending. However, Medicaid excludes payments for beneficiaries aged 21-64 who are residents of IMDs. As a result, questions have been raised about adult Medicaid beneficiaries' access to services typically provided in IMDs—namely inpatient or residential behavioral health treatments.

GAO was asked to examine questions related to any potential effects of the IMD exclusion on adult beneficiaries. Among other things, this report describes (1) recent trends in the capacity of facilities that provide inpatient and residential behavioral health services; (2) how CMS policies related to the IMD exclusion have changed over time; and (3) how selected states finance IMD services for adult Medicaid beneficiaries. GAO examined federal laws, regulations, and guidance, interviewed officials in the Department of Health and Human Services (HHS), the department that includes CMS, and analyzed the most current data from three national HHS surveys. GAO also interviewed Medicaid officials in six states selected based on geography and use of options to provide care in IMDs for adult Medicaid beneficiaries. Additionally, GAO interviewed representatives of nine behavioral health facilities in the six states referred to GAO by state Medicaid officials and a hospital association. Selected states' and facilities' experiences are not generalizable. HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View [GAO-17-652](#). For more information, contact Katherine Iritani at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov).

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## What GAO Found

Between 2010 and 2015, inpatient and residential behavioral health services capacity has gone up for adult mental health treatment and stayed about the same for substance use treatment. GAO found that for adult mental health treatment, inpatient and residential capacity increased from about 61 to 69 beds per 100,000 adults between 2010 and 2014. For adult substance use treatment, inpatient and residential capacity remained fairly constant between 2010 and 2015, increasing from 57 to about 58 beds per 100,000 adults. In both types of behavioral health services there was significant variation across states.

GAO also found that over time, the Centers for Medicare & Medicaid Services' (CMS)—the agency that oversees state Medicaid programs—changed policies to allow some states to finance care for adult Medicaid beneficiaries in institutions for mental disease (IMD), in certain circumstances. IMDs are generally facilities larger than 16 beds that primarily provide inpatient, residential, or other services to individuals with behavioral health conditions. These policy changes included the following:

- **Medicaid demonstrations.** Beginning in 1993, CMS officials said they approved demonstrations in nine states, allowing federal funds to cover behavioral health services in IMDs; these demonstrations were largely phased out by 2009. In July 2015, CMS announced a demonstration that would allow states to use Medicaid funds to cover substance use services in IMDs. As of May 2017, CMS had approved these demonstrations in four states. CMS has also approved applications from some, but not all, states for demonstrations that allow states to pay for substance use or mental health services in IMDs.
- **Medicaid managed care.** In May 2016, CMS issued a final rule that codified a policy, known as the “in lieu of” policy, under which managed care plans may provide alternative services or services in alternative settings, such as IMDs, under certain circumstances. In the rule, CMS set a 15-day per month limit on the number of days an adult beneficiary may receive behavioral health services in an IMD for which managed care plans will receive payment. According to CMS estimates, at least 17 states had likely been allowing such coverage before the rule was issued.

Even with multiple funding sources, selected states reported some problems with adult access to IMD services. While CMS does not collect national data on how states finance services for adults in IMDs, officials in six selected states GAO interviewed stated they used between two to four strategies to fund services for adults in IMDs in recent years, including under Medicaid managed care and demonstrations. State officials said that when their states were unable to use Medicaid funds to finance IMD services, they relied on other options, such as state-only funding, or providing services in smaller non-IMD facilities. Officials from each of the six states shared examples of access problems; for instance, one state reported long waits for inpatient mental health services. In addition, some facility officials said they regularly turned away patients and maintained waitlists.

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**Abbreviations**

AHRQ	Agency for Healthcare Research and Quality
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	emergency department
HCUP	Healthcare Cost and Utilization Project
HHS	Department of Health and Human Services
IMD	institutions for mental disease
MEPD	Medicaid Emergency Psychiatric Demonstration
MMC	Medicaid managed care
NHAMCS	National Hospital Ambulatory Medical Care Survey
N-MHSS	National Mental Health Services Survey
NSDUH	National Survey on Drug Use and Health
N-SSATS	National Survey of Substance Abuse Treatment Services
PPACA	Patient Protection and Affordable Care Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SSA	Social Security Act

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August 9, 2017

The Honorable Dianne Feinstein  
Co-Chair  
Caucus on International Narcotics Control  
United States Senate

Dear Senator Feinstein:

Individuals enrolled in Medicaid experience a higher rate of behavioral health conditions—mental health and substance use conditions—than those with private insurance.<sup>1</sup> Although Medicaid, a joint federal-state program that finances health care coverage for low-income and medically needy individuals, is the largest source of funding for behavioral health services nationally, with spending projected to be nearly \$71 billion in 2017, our prior work has shown that Medicaid beneficiaries may have difficulty accessing services.<sup>2</sup> Beginning in 1965 when the program was enacted, Medicaid excluded federal payments for services provided to most residents of institutions for mental disease (IMD)—generally facilities larger than 16 beds that primarily provide inpatient, residential, or other services to persons with behavioral health conditions.<sup>3</sup> Today the

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<sup>1</sup>We define mental health and substance use conditions as all mental, emotional, and behavioral health conditions that are included in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*; studies we cite may use different terms and include other diagnoses. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: 2013). The *DSM* is the standard classification system of behavioral health conditions, published by the American Psychiatric Association, for use by mental health professionals. Examples of mental health conditions that are included are anxiety conditions, including post-traumatic stress disorder; mood disorders, including depression and bipolar disorder; and schizophrenia. Examples of substance use conditions are alcohol use disorder and opioid use disorder.

<sup>2</sup>See Substance Abuse and Mental Health Services Administration, *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020*, Department of Health and Human Services Publication No. SMA 14-4883 (Rockville, Md.: October 2014). See also GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, [GAO-13-55](#) (Washington, D.C.: Nov. 15, 2012).

<sup>3</sup>Federal law defines an IMD 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.” 42 U.S.C. § 1396d(i).

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IMD exclusion applies only to adult Medicaid beneficiaries aged 21-64.<sup>4</sup> Little is known about how those beneficiaries access needed inpatient or residential behavioral health care or how much the federal government pays for these types of services.

Over the last several decades, changes in the delivery of behavioral health treatments, which included reductions in the number of inpatient beds, came about largely because of concerns about poor living conditions in large institutions, advances in behavioral health treatment options, including prescription drugs, and the rights of individuals to receive care in the setting most integrated in the community.<sup>5</sup> From 1990 to 2008, the number of adult inpatient mental health hospital beds and residential beds decreased by 35 percent, dropping from 290,359 beds in 1990 to 188,951 beds in 2008.<sup>6</sup> As the number of beds has decreased, questions have been raised as to whether sufficient capacity for inpatient and residential services exists. Additionally, the abuse of prescription opioid pain relievers and illicit opioids, such as heroin, have contributed to increasing numbers of overdose deaths in the United States and calls for more substance use treatment.<sup>7</sup>

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Inpatient hospital services are more intensive than other types of services, with 24-hour nursing care, and physicians and counselors available as needed. Residential services are considered less intensive than inpatient hospitalization, with individual and group activities provided in a structured 24-hour live-in facility with care provided by trained counselors. States generally rely on medical necessity criteria to determine what level of care is appropriate for individuals in need of behavioral health services such as the Level of Care Utilization System or the criteria developed by the American Society of Addiction Medicine.

<sup>4</sup>For the purposes of this report, unless otherwise noted, when we use the term adults we are referring to individuals aged 21-64.

<sup>5</sup>In addition, the federal government has made efforts to improve and encourage the provision of behavioral health and other covered services in the setting most integrated with the community to comply with the Supreme Court's 1999 decision in *Olmstead v. L.C.*, which stated that individuals should be treated in the least restrictive setting possible. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>6</sup>Substance Abuse and Mental Health Services Administration, *Behavioral Health, United States, 2012*, Publication No. SMA 13-4797 (Rockville, Md.: 2013).

<sup>7</sup>According to Centers for Disease Control and Prevention data, 52,404 people died of drug overdoses in the United States in 2015—more than any previous year on record. Opioids—primarily heroin and synthetic opioids such as fentanyl—are the main drugs associated with overdose deaths; over 63 percent of 2015 drug overdoses (33,091) involved an opioid. See Centers for Disease Control and Prevention, "Increases in Drug and Opioid Overdose Deaths—United States, 2010-2015," *Morbidity and Mortality Weekly Report*, vol. 65, no. 50 and 51(2016)1445-1452.



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The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicaid program within the Department of Health and Human Services (HHS). The agency has stated that due to the IMD exclusion, many Medicaid beneficiaries with acute mental health conditions, such as those expressing suicidal or homicidal thoughts, are diverted to general hospital emergency departments (ED), which often lack the resources or expertise to care for these patients. Access to behavioral health services, including inpatient hospital and residential services, is important because of the harmful consequences of untreated conditions.

While IMDs provide inpatient or residential behavioral health services, these same types of services also may be provided in settings that do not meet the definition of an IMD, such as a facility offering inpatient or residential services with 16 beds or less.<sup>8</sup> For purposes of this report, we examine all facilities that provide inpatient and residential mental health and substance use services, whether or not they are IMDs, as IMD determinations are made on a facility-specific basis.<sup>9</sup> Throughout the report, we refer to inpatient and residential mental health and substance use services as IMD-type services, even if the services are provided in a facility that does not meet the standard definition of an IMD.

You asked us to provide information about IMD exclusion polices and access for Medicaid beneficiaries to IMD services. This report describes

1. trends, since 2010, in the capacity of facilities that provide IMD-type services;
2. what is known about adult access to IMD-type services;
3. how CMS policies related to the IMD exclusion have changed over time; and

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<sup>8</sup>The CMS State Medicaid Manual outlines criteria which are applied to each facility to determine whether a facility is an IMD, including an assessment of the patient population. State Medicaid Manual, § 4390.

<sup>9</sup>CMS officials said that facilities with more than 16 beds providing services other than inpatient and residential mental health and substance use services, such as personal care services, may also be IMDs because a key IMD determination criterion is based on whether more than half of the individuals in the facility are there because of their mental health or substance use condition.

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4. how selected states finance services provided in IMDs for adult Medicaid beneficiaries, and their perspectives on beneficiaries' access to services.

To describe the trends in the capacity of facilities that provide IMD-type services, since 2010, we obtained and analyzed the most recently available data from two Substance Abuse and Mental Health Services Administration (SAMHSA) surveys: the 2010 and 2014 National Mental Health Services Survey (N-MHSS) and the 2010 and 2015 National Survey of Substance Abuse Treatment Services (N-SSATS).<sup>10</sup> Both surveys are a census of facilities that provide either mental health services or substance use services, respectively. Because IMD designations are not limited to facilities that provide behavioral health services, the survey does not include all facilities that are potentially IMDs. SAMHSA tabulated data for us from N-MHSS and N-SSATS on the facilities that provided inpatient and residential services, which was the focus of our analysis. We analyzed SAMHSA's data to assess the capacity of facilities from both surveys. We ensured the reliability of the N-MHSS and N-SSATS data used in this report by performing appropriate electronic data checks, reviewing relevant documentation, and interviewing SAMHSA officials knowledgeable about the data. We found

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<sup>10</sup>SAMHSA is a federal agency within HHS that leads the federal government's public health efforts related to behavioral health.

Beginning in 2013, SAMHSA alternated the years that the full questionnaires of the two surveys were fielded and collected information on clients. Therefore, since 2013 the N-SSATS has been fielded in odd years and the N-MHSS has been fielded in even years.

For the purposes of our study, we defined capacity as the number of facilities that offered services, the bed utilization rate of facilities, and the number of beds per 100,000 adults.

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the data were sufficiently reliable for the purpose of our analyses.<sup>11</sup> For more information on the analysis of the N-MHSS and N-SSATS, see appendix I.

To describe what is known about adult access to IMD-type services, we conducted a literature search to identify original research that addressed the topic. Specifically, we searched for relevant articles published from January 2010 through October 2016 that addressed the need for, use of, or access to inpatient or residential mental health or substance use services, including articles that addressed indicators such as ED use and length of stay. We also identified articles through searches of government agency websites and through a bibliographic search based on relevant articles already identified. We screened abstracts and articles and excluded international research, research that included no data later than 2005, and research focused on children or elderly adults. The articles we identified clustered around several key themes, including receipt of services, self-reported unmet need, use of and length of stay in hospital EDs, and inpatient readmissions. We focused our review on studies based on national data, when available, and considered studies that were more limited in scope when those were the only studies available, as was the case for ED boarding studies. All estimates we present from the relevant articles have margins of error at the 95 percent confidence level

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<sup>11</sup>Based on how SAMHSA collects data, for the 2010 data, our analysis included facilities that accepted adults aged 18-64, or if that information was missing, facilities that had inpatient or residential clients aged 18-64. The 2014 data included young adults aged 18-25 and adults aged 26-64 for inpatient or residential mental health treatment. The analysis of the 2010 substance use treatment data excluded cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 substance use treatment analysis also excluded cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. For some questions, SAMHSA allowed facilities to report information for affiliated facilities as well. For other questions, facilities could only report for themselves. We note where data only includes those facilities reporting for themselves. For the purposes of the Medicaid program, individuals under the age of 21 are considered children and are eligible for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit, which covers comprehensive health screenings, preventive health services, and all medically necessary services, including IMD services, to correct or improve health conditions discovered through screenings. The medically necessary treatment services must be covered for an individual child regardless of whether the service is covered under the state's Medicaid plan. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r).

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of plus or minus 10 percent or less, unless otherwise noted.<sup>12</sup> For details on the literature review and a list of the articles selected, see appendix II.

To describe how CMS's policies related to the IMD exclusion have changed over time, we reviewed relevant federal regulations and guidance provided to states related to the IMD exclusion. We also interviewed CMS officials regarding the reasons for changes in policy.

To describe how states finance the type of behavioral health services provided in IMDs for adult Medicaid beneficiaries, and states' perspectives on beneficiaries' access to such services, we spoke with officials in six states: California, Maryland, Minnesota, Missouri, New Jersey, and Washington. We selected these states based on geographic distribution and use of four Medicaid options to provide funds for the care of adult Medicaid beneficiaries in IMDs. In each state we interviewed officials from the state Medicaid agency. In addition, we interviewed representatives of nine behavioral health treatment facilities located within our selected states that were referred to us by state Medicaid officials and a hospital association. We also reviewed relevant federal laws, including the Social Security Act, the Patient Protection and Affordable Care Act (PPACA), as well as relevant federal regulations and guidance related to the IMD exclusion.<sup>13</sup> The experiences of the Medicaid officials in the selected states and the representatives of the behavioral health treatment facilities in the selected states are not generalizable to all facilities in the states or to other states. In addition, when there were available data on the use of specific Medicaid options by all states, we included such information. To obtain contextual information about behavioral health services under Medicaid, we interviewed representatives from behavioral health professional and advocacy groups.

We conducted this performance audit from January 2016 to August 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

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<sup>12</sup>For example, if an estimate is 12, we will report the margin of error if it is more than plus or minus 1.2.

<sup>13</sup>Pub. L. No. 111-148, 124 Stat.119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029, which we refer to collectively as PPACA.

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the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

CMS and states jointly finance and administer the Medicaid program, which finances health care, including behavioral health services, for low-income individuals and families.<sup>14</sup> In fiscal year 2016, Medicaid provided health coverage to an estimated 72.2 million people and had \$575.9 billion in estimated outlays, of which \$363.4 billion was financed by the federal government and \$212.5 billion by the states.<sup>15</sup> States have flexibility within broad federal parameters for designing and implementing their Medicaid programs. States must cover certain mandatory services, including inpatient hospital, outpatient hospital, and physician services and states may elect to cover additional optional services, such as physical and occupational therapies for adults. States may deliver health care services to certain Medicaid beneficiaries through fee-for-service payments to participating providers or through Medicaid managed care, through which states typically contract with Medicaid managed care plans to provide a specific set of Medicaid-covered services to beneficiaries.<sup>16</sup> Under Medicaid managed care, states pay the plans a set amount per beneficiary per month—referred to as capitation payments—to provide those services. In addition, the Secretary of HHS may use discretion to waive certain federal Medicaid requirements and allow costs not otherwise eligible for federal funds for experimental, pilot, or other demonstrations that are likely to assist in promoting Medicaid objectives.

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<sup>14</sup>CMS generally uses the term “mental diseases” in relation to IMDs. For purposes of this report, we used the term behavioral health conditions, which includes both mental health and substance use conditions.

<sup>15</sup>See CMS, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Baltimore, Md.).

<sup>16</sup>According to an analysis by the Medicaid and CHIP Payment and Access Commission of CMS data, in fiscal year 2013, 50.9 percent of adult Medicaid beneficiaries aged 19 to 64 were enrolled in comprehensive managed care plans. Some states carve out certain types of services from their comprehensive managed care plans, such as behavioral health services, and provide those services separately, while other states include those services. See Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book* (Washington, D.C.: Dec. 2016).

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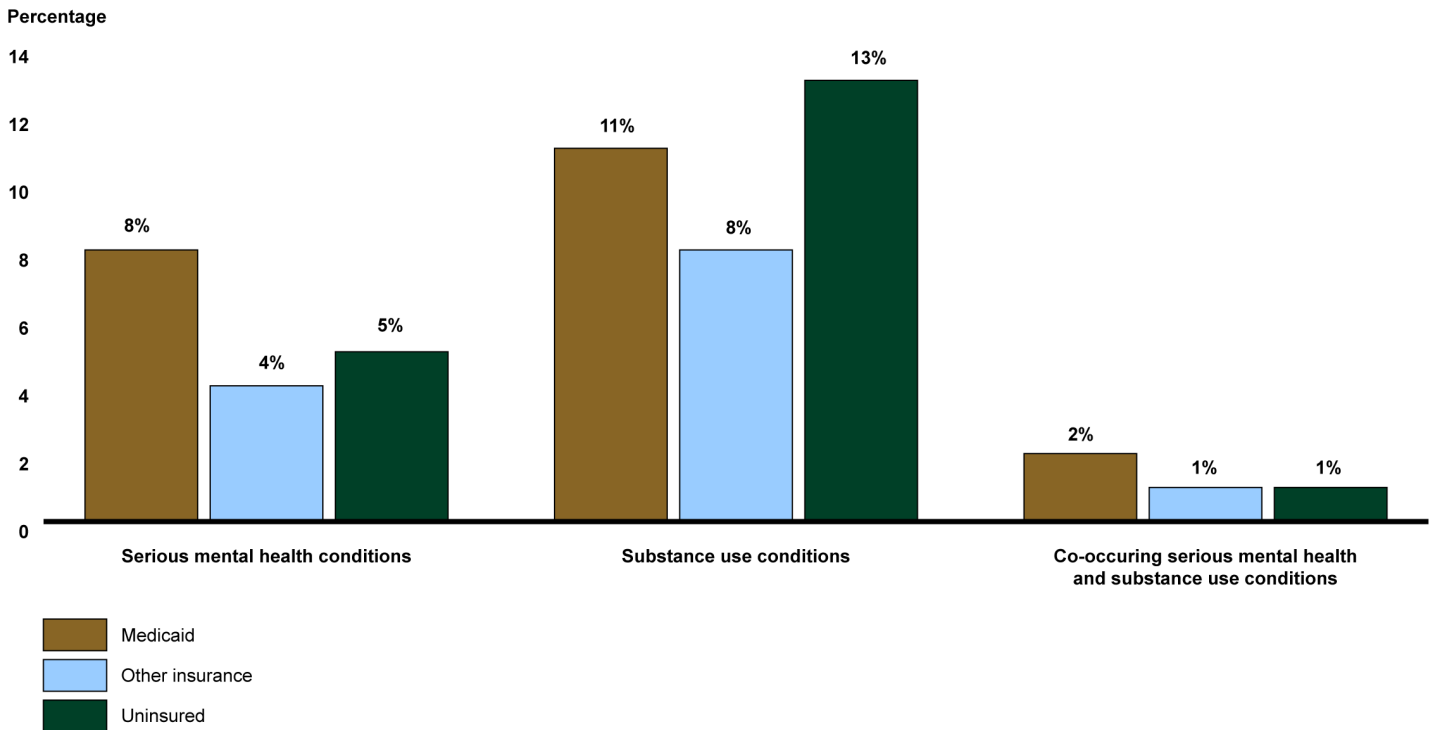
## Rates of Mental Health and Substance Use Conditions in Adult Medicaid Beneficiaries

Medicaid beneficiaries have higher rates of serious mental health conditions than the general population. Serious mental health conditions are defined as behavioral health conditions that substantially interfere with, or limit one or more major life activities. Specifically, nearly 8 percent of adults aged 22-64 enrolled in Medicaid reported having a serious mental health condition compared to the nearly 4 percent of those with another type of insurance and almost 5 percent of those who are uninsured.<sup>17</sup> (See fig. 1) Adult Medicaid beneficiaries had similar rates of substance use conditions as those who were uninsured, 11 percent as compared to 13 percent among the uninsured. The rate of substance use conditions among those with another type of insurance was about 8 percent.

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<sup>17</sup>Estimates are from SAMHSA's 2015 National Survey on Drug Use and Health (NSDUH), a nationally representative survey that provides estimates of alcohol and illicit drug use and mental health conditions. NSDUH defines adults with mental health conditions as having any mental, behavioral, or emotional condition in the past year that met criteria in the *DSM* (4th edition). Individuals were defined as having a serious mental health condition if they had any mental, behavioral, or emotional condition that substantially interfered with or limited one or more major life activities. The NSDUH defines individuals as having a substance use condition if they met the criteria for dependence or abuse for alcohol or illicit drugs in the past 12 months based on criteria specified in the *DSM*, 4th edition. When an individual has both a mental health and substance use condition this is referred to as co-occurring conditions.

**Figure 1: Percentage of Adults with Serious Mental Health Conditions, Substance Use Conditions, or Co-occurring Serious Mental Health and Substance Use Conditions, by Insurance Status, 2015**



Source: Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health, 2015. | GAO-17-652

Note: The National Survey on Drug Use and Health identifies individuals as having a serious mental health or substance use condition based on answers to a series of questions regarding the individual's mental or emotional state, and use of drugs and alcohol. We defined adults as individuals aged 22-64 because in certain circumstances, Medicaid beneficiaries who are 21 years old are allowed to receive services in institutions for mental disease (IMD).

## Medicaid IMD Exclusion

The Medicaid IMD exclusion, which we refer to as the “exclusion” for purposes of this report, has been in effect since the program was established in 1965. The exclusion prohibits federal payments to states for services provided to most adult Medicaid beneficiaries who are residents of IMDs, whether services are provided inside or outside the IMD.<sup>18</sup> Currently the exclusion applies only to Medicaid beneficiaries aged 21-64; the Social Security Act Amendments of 1965 and 1972 allowed

<sup>18</sup>For example, when an adult Medicaid beneficiary needs medically necessary services that are provided outside of the IMD, such as surgery to repair a broken bone, those services also are not eligible for federal payment by Medicaid.

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Medicaid beneficiaries age 65 and older and under age 21, respectively, to receive services in IMDs.<sup>19</sup> In addition to encouraging treatment in small community-based group living arrangements, the exclusion was intended to ensure that states, and not the federal government, are primarily responsible for funding inpatient and residential behavioral health services.

According to CMS officials, state Medicaid officials are responsible for ensuring that they do not claim federal Medicaid payments for services provided to IMD residents between the ages of 21 and 64, and for applying the IMD statutory and regulatory requirements. Per the statutory definition, an IMD is “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.”<sup>20</sup> CMS’s guidance on how to determine when the IMD exclusion applies is included in its State Medicaid Manual, which contains criteria for determining whether a facility is an IMD. Also, according to CMS officials, if needed, CMS is available to provide technical assistance so states can make IMD determinations. The State Medicaid Manual lays out IMD criteria that include

- an assessment of the type of licensure or accreditation the facility or group of facilities holds;
- an assessment of the patient population; and

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<sup>19</sup>See 42 U.S.C. § 1396d(a)(16), (29)(B). In certain circumstances, Medicaid beneficiaries who turn 21 years old while they are an IMD resident are allowed to continue to receive services in an IMD. 42 U.S.C. § 1396d(h)(1)(C).

<sup>20</sup>See The Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 4119, 102 Stat. 683, 798-99 (1988) (codified at 42 U.S.C. § 1396d(i)). The statute and CMS guidance use the term “mental diseases” in relation to IMDs.

CMS’s guidance defines “mental disease,” to include the mental diseases in the *International Classification of Diseases*, with the exception of mental retardation, senility, and organic brain syndrome. The *DSM* is a subsection of the *International Classification of Diseases*.

Centers for Medicare & Medicaid Services, *State Medicaid Manual*, (Baltimore, Md.), Part 4, §4390. CMS’s State Medicaid Manual states that any diagnosis or disorder in the *DSM* is considered to be a mental disease for purposes of classifying whether a facility is primarily engaged in treating these conditions. For purposes of this report, we used the term behavioral health conditions, which includes both mental health and substance use conditions.



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- whether the facility or group of facilities was established primarily for the care and treatment of individuals with behavioral health conditions.

Understanding which facilities are subject to the exclusion also requires an understanding of what constitutes a “facility.” In determining if states have applied the exclusion correctly, CMS also takes into consideration whether a group of facilities has a common owner or governing body. If one owner operates multiple facilities in a state and together the facilities have more than 16 beds, the facilities jointly may qualify as an IMD and would therefore be subject to the exclusion.<sup>21</sup>

In 2015, Congress considered, but did not pass, legislation to fully lift the IMD exclusion. The Congressional Budget Office (CBO) estimated that this legislation would cost the federal government \$40 to 60 billion over 10 years (2016-2025).<sup>22</sup> CBO stated that its estimate was highly uncertain and based on limited data.<sup>23</sup> CBO officials said that they did not take into account existing or recently available options states have to finance Medicaid services for adult Medicaid IMD residents, such as Medicaid disproportionate share hospital (DSH) payments to IMDs, demonstrations, or care provided by managed care plans.<sup>24</sup> They also did not account for any offsets, such as those for potential decreases in ED use, which could happen if the IMD exclusion were lifted.

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<sup>21</sup>For example, if three behavioral health inpatient facilities located near each other have a single owner and each facility has eight beds, it may qualify as an IMD because together the owner operates a total of 24 beds. When making IMD determinations, CMS officials said that after states apply the criteria in CMS’s State Medicaid Manual to each facility, the decision is ultimately based on whether the commonly owned facilities are operating as a single unified facility. See Centers for Medicare & Medicaid Services, State Medicaid Manual, (Baltimore, Md.), Part 4, §4390.

<sup>22</sup>Congressional Budget Office, *Direct Spending Effects of Title V of H.R. 2646, Helping Families in Mental Health Crisis Act of 2015, Cost Estimate* (Nov. 3, 2015).

<sup>23</sup>Data on states’ spending for IMD services for adult Medicaid beneficiaries are largely not available. According to CMS officials, CMS and the states generally do not track this information.

<sup>24</sup>Federal law requires states to make DSH payments to offset uncompensated care costs experienced by certain hospitals serving large numbers of low-income uninsured and Medicaid patients and establishes state-specific limits, or allotments, for this purpose. States are allowed, within certain federal payment limits, to make these payments to mental health treatment facilities, including IMDs. 42 U.S.C. §§ 1396a(a)(13), 1396r-4.

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## Since 2010, Facility Capacity Nationwide Has Increased for Mental Health Treatment and Remained Constant for Substance Use Treatment, with Variation Across States

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### The Capacity of Mental Health Treatment Facilities Increased Nationally from 2010 to 2014, although There Was Significant Variation Across States

Capacity for inpatient or residential mental health services for the adult population increased from 2010 to 2014, as measured by numbers of facilities providing services, the number of beds designated for these services, and the number of beds per 100,000 adults, according to N-MHSS data from those years.<sup>25</sup> Between 2010 to 2014

- The total number of mental health treatment facilities increased by about 19 percent, from 2,888 to 3,427.
- The number of beds designated for adult mental health inpatient or residential services increased by 17 percent between April 30, 2010, and April 30, 2014, from 119,527 to 139,885 beds.<sup>26</sup>

By 2014, there were about equal numbers of facilities that provided either inpatient or residential mental health services (see fig. 2). There was greater growth in the number of mental health treatment facilities that

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<sup>25</sup>The N-MHSS considers inpatient treatment facilities to be 24-hour hospitals, including mental health hospitals or hospitals with separate mental health units. Residential settings are defined by N-MHSS as 24-hour services in a residential non-inpatient setting, such as residential treatment centers for adults or multi-service community mental health centers.

Based on how SAMHSA collects and analyzes N-MHSS data, adults refers to individuals aged 18-64.

<sup>26</sup>These data are based only on facilities that reported for themselves as of April 30 of each year.

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offered residential services than those facilities that offered inpatient services.<sup>27</sup> From 2010 to 2014, the number of facilities offering residential mental health services increased by 33 percent, compared to an increase of 7 percent in facilities offering inpatient mental health services.<sup>28</sup> On April 30, 2010, and April 30, 2014, more than two-thirds of residential mental health treatment facilities had a bed utilization rate, the percentage of a facility's beds occupied on a given day of the year, of more than 90 percent.<sup>29</sup>

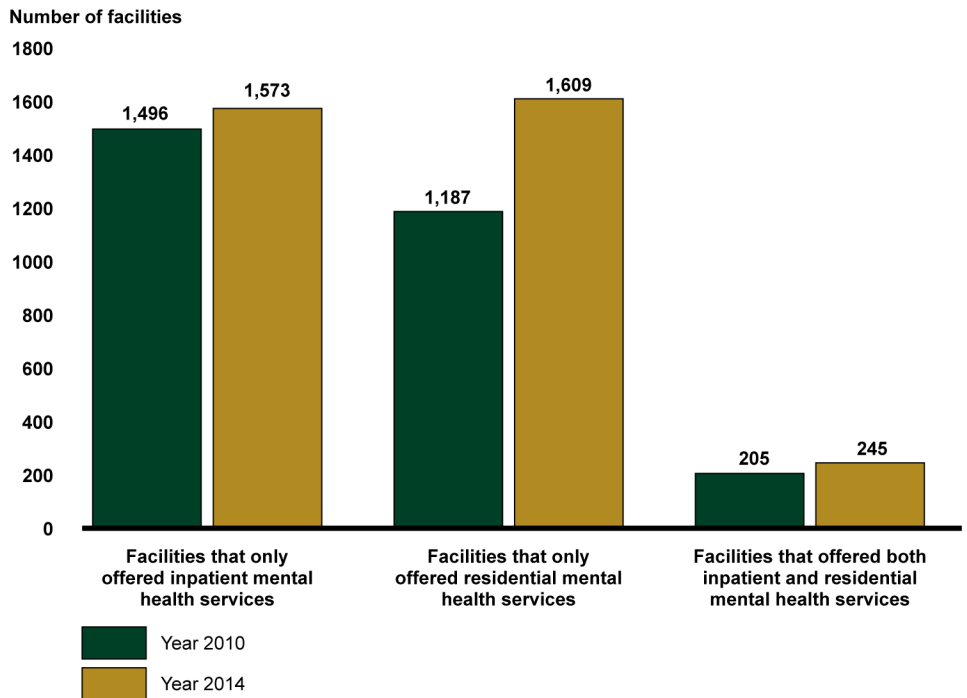
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<sup>27</sup>Inpatient hospital services are more intensive than other types of services, with 24-hour nursing care, and physicians and counselors available as needed. Residential services are considered less intensive than inpatient hospitalization, with individual and group activities provided in a structured 24 hour live-in facility with care provided by trained counselors. States generally rely on medical necessity criteria to determine what level of care is appropriate for individuals in need of behavioral health services such as the Level of Care Utilization System or the criteria developed by the American Society of Addiction Medicine.

<sup>28</sup>Numbers include facilities that offer both inpatient and residential settings.

<sup>29</sup>These data are based only on facilities that reported for themselves as of April 30 of each year.

**Figure 2: Number of Facilities That Offered Adult Mental Health Inpatient, Residential Services, or Both in 2010 and 2014**



Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: The 2010 data presented includes facilities that accepted adults (aged 18-64) for treatment, or if that information was missing, facilities that had inpatient or residential clients aged 18-64. The 2014 data presented in this figure includes facilities that accepted young adults aged 18-25 and adults aged 26- 64. Data from both years exclude facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."

The national number of beds per 100,000 adults designated for mental health inpatient or residential services increased from 61.1 to 69.5 from 2010 to 2014.<sup>30</sup> The number of residential beds per 100,000 adults increased from 2010 to 2014, but the number of inpatient beds decreased slightly during the same time period, even though inpatient beds were more common in both years. In 2010 the number of beds designated for inpatient mental health services per 100,000 adults was 48.6 compared to the rate of 12.5 beds per 100,000 adults designated for residential mental

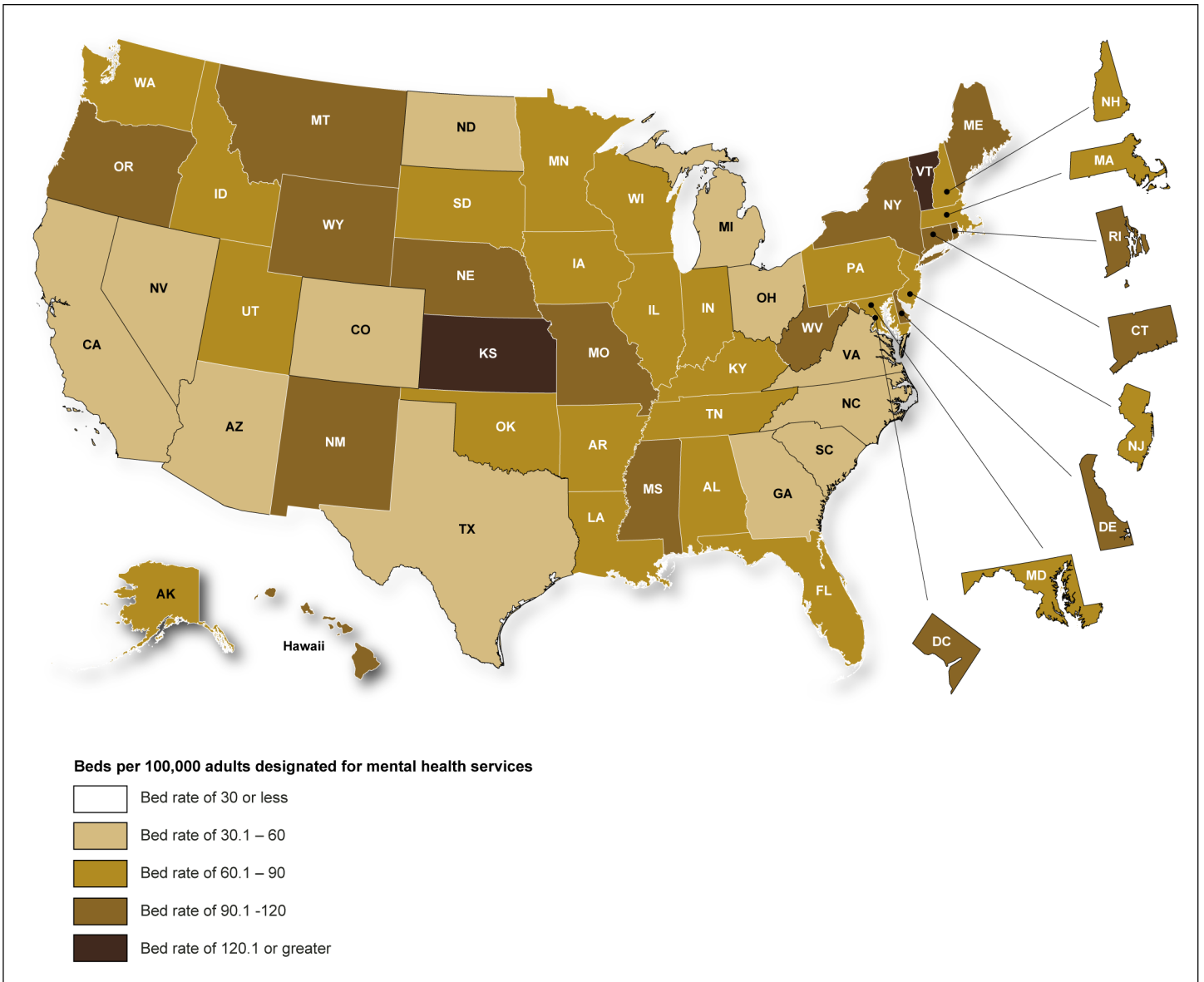
<sup>30</sup>We calculated the number of beds per 100,000 adults by using the N-MHSS data and U.S. Census Bureau data for adults aged 18 to 64 for the given years. The data on the number of beds was based only on facilities that reported for themselves.

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health services. By 2014, inpatient beds had decreased to 47.9 per 100,000 adults and residential beds increased to 21.6 per 100,000 adults.

Significant variation exists in the number of beds designated for mental health services per 100,000 adults across states, as illustrated in figure 3. In 2014, for example, the number of beds per 100,000 adults was 43.8 in Colorado, 73.5 in Maryland and 114.2 in Missouri. Significant change also occurred during the time period within some states. For example, the number of beds designated for mental health services per 100,000 adults in Hawaii increased from 59.4 in 2010 to 107.6 in 2014, but the number of mental health treatment facilities decreased by 1. Comparatively, the number of beds designated for mental health services per 100,000 adults in Wyoming decreased from 150.2 in 2010 to 100.5 in 2014, though the number of facilities that provided inpatient services remained constant and there was one additional facility that offered residential services.

**Figure 3: Number of Inpatient and Residential Beds per 100,000 Adults Designated for Mental Health Services, by State, 2014**



Sources: Substance Abuse and Mental Health Services Administration's 2014 National Mental Health Services Survey and U.S. Census Bureau 2014 Population Estimate (data); Map Resources (map). | GAO-17-652

Note: In April 2014, the number of mental health beds per 100,000 adults in Puerto Rico was 68.0.

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Bed utilization for inpatient and residential mental health services increased between 2010 and 2014. The percentage of inpatient mental health treatment facilities with a bed utilization rate greater than 90 percent increased from nearly 34 to 41 percent in that time period. The percentage of residential mental health treatment facilities with a bed utilization rate greater than 90 percent increased from about 65 percent to 67 percent.

The overall capacity for mental health inpatient and residential services may not have increased for Medicaid beneficiaries between 2010 and 2014. This is because we estimate that approximately one-quarter of the inpatient and residential mental health treatment facilities may have been IMDs in 2010, and this increased to about a third in 2014, and federal Medicaid reimbursement for services provided by these facilities would be unavailable for adult Medicaid patients of these facilities due to the IMD exclusion.<sup>31</sup> More information on the facilities that offered inpatient and residential mental health services based on data from N-MHSS is in appendix III.

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### The Capacity of Substance Use Treatment Facilities Did Not Change Significantly Between 2010 and 2015, but There Was Significant Variation Within and Among States

The capacity of facilities that offered inpatient or residential services for adult substance use treatment had little change between 2010 and 2015, according to the N-SSATs data.

- The total number of facilities that offered services to adults decreased slightly, about 2 percent, from 4,026 to 3,931.
- More than 80 percent of the total inpatient or residential substance use treatment facilities offered residential services in both years.
- The total number of beds designated for inpatient or residential substance use services increased by 4 percent between March 31, 2010, and March 31, 2015, from 115,336 to 119,600.<sup>32</sup>

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<sup>31</sup>Due to the nuances in CMS's criteria for determining whether a facility is an IMD, and limitations of the N-MHSS data, it was not possible to definitively determine which facilities were IMDs. We considered inpatient or residential mental health treatment facilities with more than 16 beds that are not general hospitals as facilities that may have been an IMD. General hospitals are not typically classified as IMDs unless the primary reason for the current stay for more than half of the facility's patients results from a behavioral health condition.

<sup>32</sup>These data are based only on facilities that reported for themselves as of March 31 of each year.

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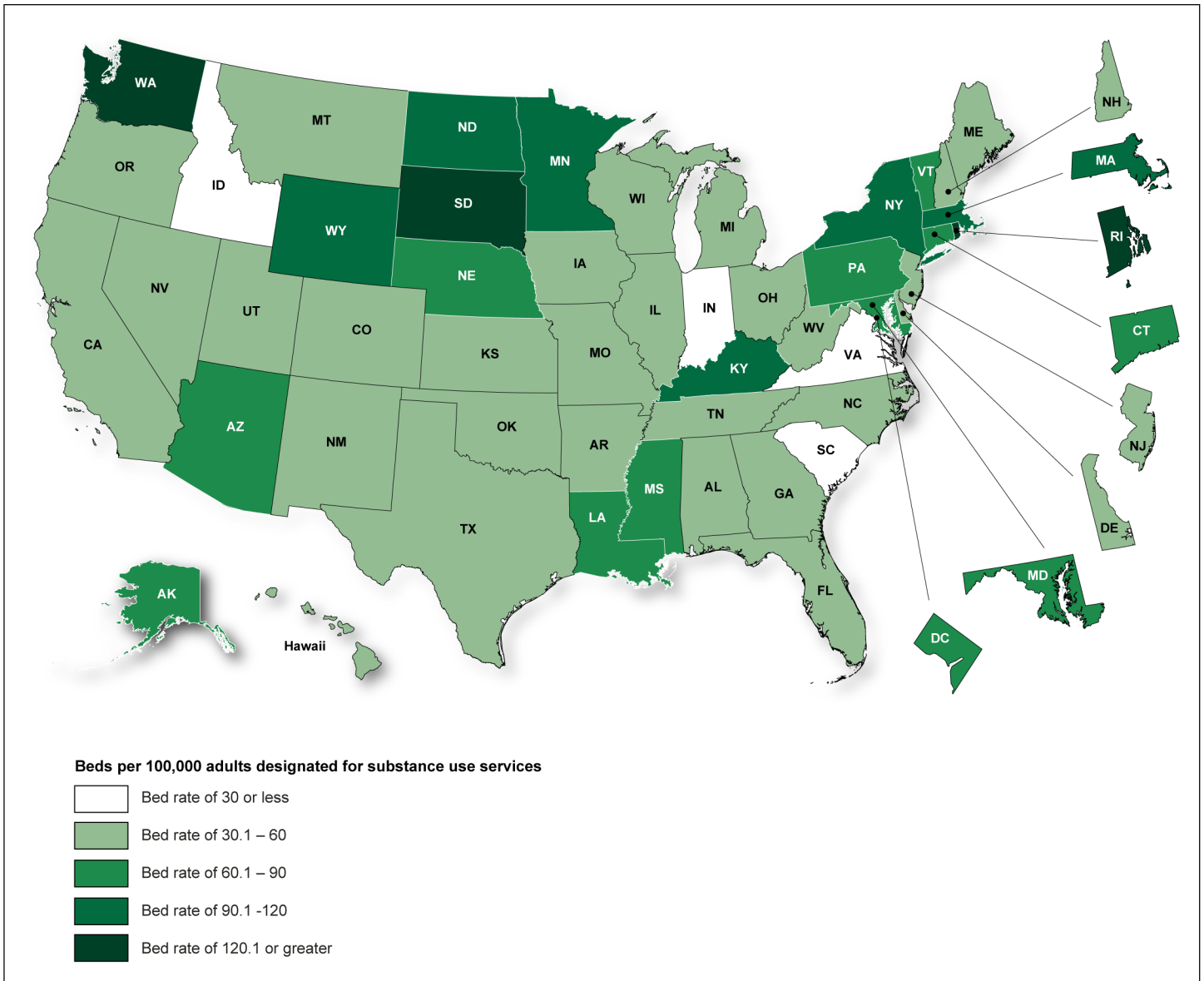
The number of beds designated for inpatient or residential substance use services per 100,000 adults increased slightly, from 57 to 58.4 between 2010 and 2015.<sup>33</sup> As a result of a larger number of substance use treatment facilities offering residential services, as opposed to inpatient services, in 2010, the number of beds designated for residential substance use services per 100,000 adults nationwide was 50.7, significantly higher than the 6.3 beds designated for inpatient substance use services. In 2015, the number of residential beds per 100,000 adults remained at 50.7 and there were 7.7 inpatient beds for every 100,000 adults. There was significant variation across states as shown in figure 4. For example, in 2015 the number of beds per 100,000 adults was 28.7 in Indiana, 50 in Tennessee, and 130.9 in Washington.

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<sup>33</sup>These data are based only on facilities that reported for themselves.



**Figure 4: Number of Inpatient and Residential Beds per 100,000 Adults for Substance Use Services, by State, 2015**



Sources: Substance Abuse and Mental Health Services Administration's 2015 National Survey of Substance Abuse Treatment Services and U.S. Census Bureau 2015 Population Estimate (data); Map Resources (map). | GAO-17-652

Note: In March 2015, the number of substance use beds per 100,000 adults in Puerto Rico was 130.9.

Bed utilization, the percentage of a facility's beds occupied on a given day of the year, for residential substance use treatment did not change

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significantly from 2010 to 2015. In both years, about 56 percent of residential substance use treatment facilities had a bed utilization rate greater than 90 percent. Comparatively, the percentage of inpatient substance use treatment facilities that had a bed utilization rate greater than 90 percent increased from 40 percent in 2010 to 45 percent in 2015.

Access to substance use services was potentially limited for those with Medicaid in both 2010 and 2015. Based on size and type of facility, we estimated that nearly half of the inpatient and residential substance use treatment facilities in 2010 and 2015 may have been IMDs, and thus federal Medicaid funding would be unavailable for adult Medicaid beneficiaries due to the IMD exclusion.<sup>34</sup> More information and data from N-SSATS on facilities that offered inpatient and residential substance use services is in appendix IV.

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## Evidence Suggests Gaps in Adult Access to IMD-Type Services

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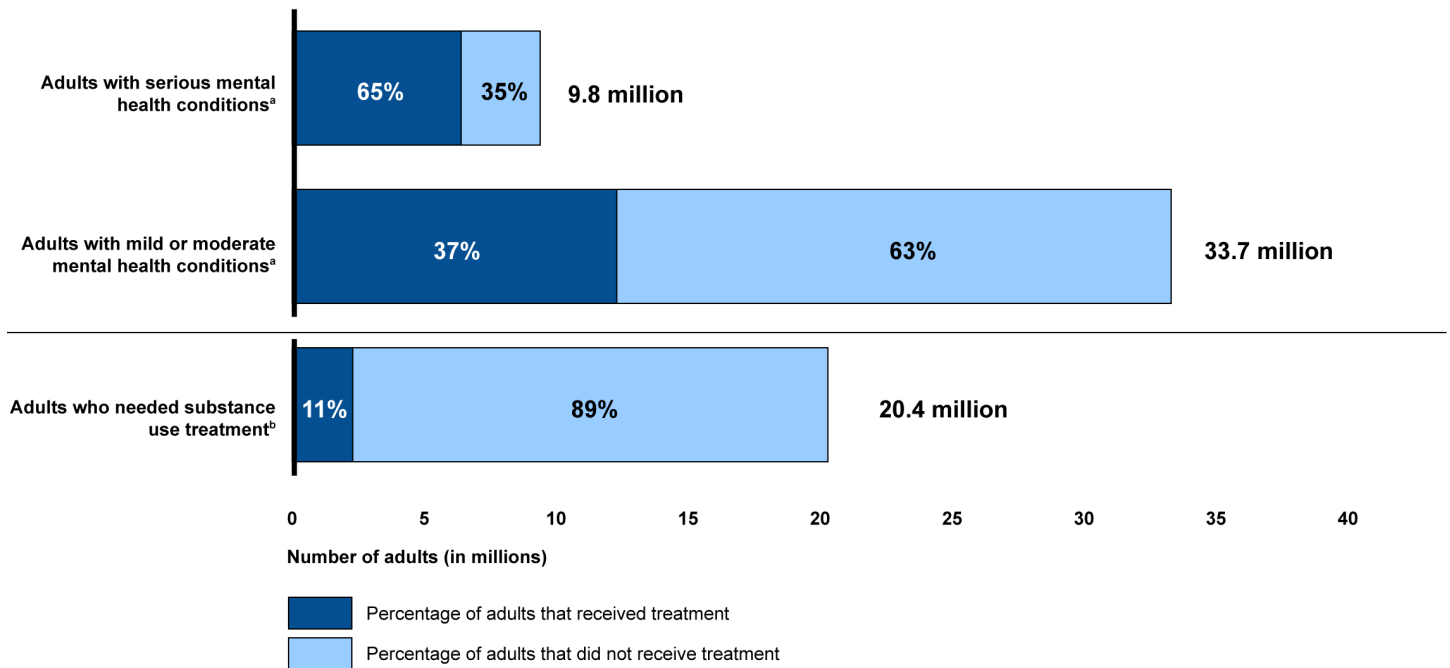
### National Surveys Identify Unmet Need for Behavioral Health Services, Which May Include IMD-Type Services

National health surveys conducted by HHS indicate that tens of millions of U.S. adults, including more than 3 million adults with serious mental health conditions, have behavioral health conditions but are not receiving treatment. Although the surveys do not identify the level of care needed, the findings generally suggest a large unmet need for treatment services in the United States. For example, the most recent data from the National Survey on Drug Use and Health (NSDUH) show that, in 2015, the majority of adults with mental health conditions and/or who needed substance use treatment did not receive services in the prior year. (See fig. 5.)

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<sup>34</sup>The data used for the estimation were based on only on facilities that reported for themselves.

**Figure 5: Adults with Mental Health or Substance Use Conditions Who Did and Did Not Receive Behavioral Health Treatment in the Past Year, 2015**



Source: GAO analysis of data from the Center for Behavioral Health Statistics and Quality. *2015 National Survey on Drug Use and Health: Detailed Tables*. Substance Abuse and Mental Health Services Administration (Rockville, Md: September 8, 2016). | GAO-17-652

Notes: These National Survey on Drug Use and Health (NSDUH) estimates are based on projections from a subsample. All estimates are for adults aged 18 or older. About 8.1 million adults were identified as having both a mental health condition and a substance use condition and are counted in both groups. About half of these individuals with co-occurring conditions received no treatment for either condition.

<sup>a</sup>Adults were identified as having any mental health condition if they currently or at any time in the prior year had a diagnosable mental, behavioral, or emotional disorder (excluding developmental or substance use disorders) of sufficient duration to meet the criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). Mental health conditions were further defined in terms of whether they resulted in mild, moderate, or substantial (serious) impairment in carrying out major life activities. Receipt of mental health treatment is defined as having received inpatient or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health; it does not include treatment for alcohol or substance use.

<sup>b</sup>Adults were identified as needing treatment for a substance use problem (illicit drug or alcohol use) if they met the criteria for substance use disorder as defined in the DSM-IV or received substance use treatment at a specialty facility in the prior year. Receipt of substance use treatment is defined as having received treatment for illicit drug or alcohol use at a specialty facility: drug or alcohol rehabilitation center (inpatient or outpatient), hospital (inpatient only), or mental health center.

Many adults with behavioral health conditions also reported they had experienced an unmet need for services. According to the 2015 survey:

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- About one in five adults with any mental health condition—and almost two in five adults with serious mental health conditions—reported that they had needed mental health services, such as counseling, in the prior year but did not receive the care they needed.
  - Fewer than one in ten adults who needed but did not receive substance use services at a specialty facility perceived a need for such services, and fewer than 3 percent made an effort to get them.<sup>35</sup>

While services for these conditions are commonly delivered on an outpatient rather than inpatient basis, inpatient or residential services of the type provided in IMDs may be needed in some instances, particularly for individuals with serious mental health conditions experiencing an acute episode or for individuals with substance use conditions. It is not known how much of the reported unmet need is for IMD-type services.<sup>36</sup>

Findings from national surveys and other studies suggest that financial factors, such as cost and lack of insurance coverage, are among the primary barriers to receipt of behavioral health services, which could include IMD-type services. For example, an analysis of 2011 NSDUH data found that individuals with any mental health condition who had private insurance were 1.63 times more likely than uninsured individuals to have received services during the prior 12 months, and those with Medicaid were 2.66 times more likely to have done so.<sup>37</sup> Individuals with any mental health condition who had either private insurance or Medicaid were also less likely than uninsured individuals to report unmet need for services. In our analysis of 2015 NSDUH data, we found that, among adults ages 22 through 64 with any mental health condition, those with

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<sup>35</sup>While some people classified as needing substance use treatment may receive treatment at a nonspecialty facility, such as an emergency room, private doctor's office, jail, or self-help group, the majority may not receive any substance use treatment. For example, about 679,000 people aged 12 or older who needed substance use treatment in 2015 received nonspecialty treatment, while 18.6 million people received no treatment at all.

<sup>36</sup>We refer to inpatient and residential mental health and substance use services as IMD-type services, even if the services are provided in a facility that does not meet the standard definition of an IMD.

<sup>37</sup>E.R. Walker, J.R. Cummings, J. M. Hockenberry, and B.G. Druss, "Insurance Status, Use of Mental Health Services, and Unmet Need for Mental Health Care in the United States," *Psychiatric Services*, vol. 66, no. 6 (2015). The analysis controlled for other factors that might influence receipt of services, including racial or ethnic group, age, education, employment status, income, and self-reported health. For private insurance, the confidence interval around 1.63 was 1.29 to 2.06; for Medicaid, the confidence interval around 2.66 was 2.04 to 3.46.

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only Medicaid coverage were somewhat more likely than those with other insurance coverage to report unmet need for services (26.4 percent versus 19.8 percent).<sup>38</sup> However, among those with serious mental health conditions, the proportion of individuals reporting unmet need did not differ significantly by insurance status.

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### Millions with Behavioral Health Conditions Obtained Care in Emergency Departments, and Some Evidence Shows They Had Longer Stays Than Some Other Patients

Individuals seeking care primarily for behavioral health conditions made approximately 4.7 million visits to EDs in 2013, accounting for around 3 to 4 percent of all ED visits, according to the most recently published data from the National Hospital Ambulatory Medical Care Survey (NHAMCS).<sup>39</sup> Many of these individuals turn to EDs for care because they lack access to alternatives, including psychiatric facilities. However, care at the ED may be less than optimal, as ED staff often lack the training, skills, and resources to deal effectively with behavioral health conditions, and patients may experience long waits for more appropriate care. Long stays in the ED, particularly the portion of time spent waiting for an inpatient bed—referred to as “boarding”—are widely regarded as symptomatic of insufficient inpatient capacity, although other causes, such as inefficient transitions between the ED and inpatient placement, are also cited in the literature.

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<sup>38</sup>The 95 percent confidence intervals around these estimates were 23.1 to 29.7 percent and 18.0 to 21.7 percent, respectively.

<sup>39</sup>Rui, K. Kang, and M. Albert, “National Hospital Ambulatory Medical Care Survey: 2013 Emergency Department Summary Tables,” National Center for Health Statistics (Atlanta, Ga.: Dec. 2016). The NHAMCS collects data through an annual nationally representative sample survey of visits to EDs, outpatient departments, ambulatory surgical centers of nonfederal short-stay and general hospitals and freestanding ambulatory surgical centers. The estimated number of ED visits reported here does not include ED visits for which a behavioral health diagnosis (i.e., the ICD-9-CM disease category “mental disorders”) was listed but was not the primary diagnosis and thus may be an underestimate of the number of ED visits that involved a behavioral health diagnosis.

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## Overall ED Length of Stay

Multiple studies show that behavioral health patients experienced longer overall stays in the ED than other patients or were more likely to have long stays.<sup>40</sup> For example:

- An analysis based on 2008 NHAMCS data found that, controlling for other variables including patient age and expected source of payment, patients with behavioral health conditions were almost 5 times more likely than other patients to remain in the ED 6 hours or longer.<sup>41</sup>
- An analysis based on 10 years of NHAMCS data (2002 through 2011) found that whether adults with a primary behavioral health diagnosis had longer ED stays—measured as the time from triage to departure from the ED—depended on where they went from the ED.<sup>42</sup> For patients admitted to the hospital that housed the ED, mean length of ED stay was about the same for patients with and without a primary behavioral health diagnosis; but for those discharged, admitted for observation, or transferred to another facility, mean length of stay was

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<sup>40</sup>For example, one study conducted at an urban, academic ED found that while only 0.5 percent of the 34,988 patients seen between October 2009 and May 2010 remained in the ED 24 hours or longer, the vast majority (88 percent) of those who did were patients whose chief complaint was a behavioral health condition. See R.J. Stephens, S.E. White, M. Cudnik and E.S. Patterson, “Factors Associated with Longer Length of Stay for Mental Health Emergency Department Patients,” *The Journal of Emergency Medicine*, vol. 47, no. 4 (2014).

<sup>41</sup>J. M. Nolan, C. Fee, B.A. Cooper, S.H. Rankin, and M.A. Blegen, “Psychiatric Boarding Incidence, Duration, and Associated Factors in United States Emergency Departments,” *Journal of Emergency Nursing*, vol. 41, no. 1 (2015). This study included children as well as adults and categorized ED visits as behavioral health-related if the record contained any behavioral health diagnosis. The 95 percent confidence interval surrounding this estimated odds ratio of almost 5 (4.78) was 2.63 to 8.66. The difference between the two groups was significant at the 0.001 level.

<sup>42</sup>J.M. Zhu, A. Singhal, and R.Y. Hsia, “Emergency Department Length-of-Stay for Psychiatric Visits Was Significantly Longer Than for Nonpsychiatric Visits, 2002-11,” *Health Affairs*, vol. 35, no. 9 (2016).

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longer for behavioral health patients in almost every year.<sup>43</sup> In addition to waiting longer for transfer—almost 3 hours longer in 2011—behavioral health patients were also transferred six times as often as other patients. For those with the longest waits, differences were even greater: At the ninetieth-percentile, ED lengths of stay for behavioral health patients who were transferred were about 12 hours in 2011, compared with about 7 hours for other patients who were transferred.<sup>44</sup>

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<sup>43</sup>The differing ways in which studies identified patients with behavioral health conditions may partly explain some differences in their findings. For example, a study based on data from 10 Massachusetts hospitals that identified ED patients with behavioral health conditions as those who received a mental health evaluation—rather than those with a primary behavioral health diagnosis—found that behavioral health patients waited longer than patients with medical or surgical complaints to be admitted as well as transferred. See M.D. Pearlmutter, K.H. Dwyer, L.G. Burke, N. Rathghev, L. Maranda, and G. Volturo, “Analysis of Emergency Department Length of Stay for Mental Health Patients at Ten Massachusetts Emergency Departments,” *Annals of Emergency Medicine*, in press, published online Jan. 4, 2017, at [http://www.annemergmed.com/article/S0196-0644\(16\)31217-3/fulltext](http://www.annemergmed.com/article/S0196-0644(16)31217-3/fulltext), accessed Jan. 6, 2017.

<sup>44</sup>Ninetieth-percentile lengths-of-stay for behavioral health patients who were discharged or admitted for observation were also significantly longer than for others (in 2011, approximately 8 and 23 hours versus 6 and 9 hours, respectively).

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## ED Boarding

Direct evidence regarding the amount of time behavioral health patients spend boarding—waiting for a bed after a decision had been made to admit or transfer them, as opposed to total time in the ED—is limited, and findings varied.<sup>45</sup> The relatively few studies that isolated ED boarding time for patients with behavioral health conditions were based on data from a small number of mostly large hospitals, and only two of the studies compared these patients' boarding times with those of other patients.<sup>46</sup> Differences in the studies' settings and methodologies, including in how they identified behavioral health patients, may explain the widely varying findings regarding mean or median ED boarding times for these patients, which ranged from about 3 hours to more than 27 hours. We identified two studies that compared boarding times for patients with behavioral health conditions to boarding times for patients with other diagnoses. One study found that patients who required inpatient care primarily for a behavioral health condition waited significantly longer to be admitted or transferred compared to patients with other conditions, while the other study did not find a significant difference in boarding times for patients whose chief complaint was a behavioral health condition compared to a general symptoms category.

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<sup>45</sup>Definitions of boarding vary. Our definition reflects the 2008 performance measure endorsed by the National Quality Forum, which assesses the median time between the decision to admit the patient and his or her departure from the ED. Some studies defined boarding as ED length of stay in excess of a certain number of hours (e.g., 6); we did not include these as studies that isolated boarding time.

<sup>46</sup>An item designed to capture national-level data on boarding—defined as the time between the inpatient bed request and when the patient left the ED—was added to the NHAMCS in 2009/2010. We did not identify any studies that used this item to compare boarding times for patients with inpatient stays for behavioral health conditions to those of patients with stays for other conditions.



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## Hospital Readmission Rates Were Higher Among Individuals with Behavioral Health Diagnoses Compared with Some Other Diagnoses

Millions of individuals with behavioral health conditions have obtained inpatient services, but higher-than-average hospital readmission rates for patients with certain conditions could suggest unmet need for ongoing services.<sup>47</sup> Hospital readmission within 30 days of discharge is generally seen as representing a negative clinical outcome for patients. While readmission of patients with behavioral health conditions may reflect the chronic, relapsing course of these conditions, other factors may also contribute. According to a technical brief from HHS's Agency for Healthcare Research and Quality (AHRQ), these factors may include insufficient inpatient care to stabilize the patient's condition, inadequate transition planning, and lack of access after discharge to outpatient services or to short-term alternatives to rehospitalization, such as partial hospitalization and crisis residential services.<sup>48</sup>

An analysis of 2012 data from the State Inpatient Database readmissions analysis file, part of a collection of health care databases sponsored by AHRQ, found disproportionately high estimated 30-day readmission rates among patients with the two most common behavioral health diagnoses among hospitalized patients.<sup>49</sup> Compared with patients admitted for a non-behavioral-health condition, patients admitted for mood disorders were more than twice as likely to be readmitted for the same principal diagnosis within 30 days (9.0 vs. 3.8 percent), and patients admitted for schizophrenia were more than four times as likely to be readmitted for the

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<sup>47</sup>For example, in 2012, 8.6 million inpatient stays at community hospitals involved at least one diagnosis for a mental health or substance use condition, and nearly 1.8 million inpatient stays were primarily for these conditions, accounting for 32.3 and 6.7 percent of all stays, respectively. See K.C. Heslin, A. Elixhauser, and C.A. Steiner, "Hospitalizations Involving Mental and Substance Use Disorders Among Adults, 2012," *Healthcare Cost and Utilization Project (HCUP) Statistical Brief #191*, Agency for Healthcare Research and Quality, (Rockville, Md.: June 2015).

<sup>48</sup>B.N. Gaynes, C. Brown, L.J. Lux, M. Ashok, E. Coker-Schwimmer, V. Hoffman, B. Sheitman, and M. Viswanathan. *Management Strategies to Reduce Psychiatric Readmissions*. Agency for Healthcare Research and Quality (Rockville, Md.: May 2015).

<sup>49</sup>The State Inpatient Database readmissions analysis file, which provides weighted national estimates based on sample data from 18 states that represent over 95 percent of all U.S. community hospital discharges, is one of the health care databases developed through a federal-state-industry partnership as part of the HCUP, the largest national collection of longitudinal hospital care data. Other databases in the HCUP family include the National Inpatient Sample and the Nationwide Emergency Department Sample.

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same diagnosis (15.7 vs. 3.8 percent).<sup>50</sup> This study also found that patients with these conditions who were covered by Medicaid or Medicare had higher 30-day readmission rates than privately insured or uninsured patients.

Other studies have shown that some behavioral health conditions are a common diagnosis or a contributing factor in repeat hospitalizations, including among patients with Medicaid coverage. For example, another study of Healthcare Cost and Utilization Project (HCUP) data found that the two most common principal diagnoses for hospital stays among non-elderly Medicaid patients who had four or more stays in 2012 were mood disorders and schizophrenia, while the sixth most common principal diagnosis among these patients was alcohol-related conditions.<sup>51</sup>

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## CMS's IMD Policies Have Changed Over Time to Allow Payments in Certain Circumstances

Over time, CMS policies have changed to allow some states to finance the provision of care for adult Medicaid beneficiaries in IMDs, in certain circumstances. Nationally, the total amount of federal payments for IMD-type services for adult Medicaid beneficiaries is unknown. (See app. V for a timeline of changes related to the Medicaid IMD exclusion.)

**Section 1115 demonstrations.** HHS has allowed states to pay for IMD services in certain circumstances in Medicaid demonstrations, but HHS has discretion over when to approve such coverage and has done so for some but not all requesting states. Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive certain traditional federal Medicaid requirements and allow costs that would not otherwise be eligible for federal payments for demonstrations that, in the Secretary's view, are likely to promote Medicaid objectives. Under this authority, since 1993 HHS has approved demonstrations allowing certain states to provide mental health services and substance use services in IMDs. The

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<sup>50</sup>K.C. Heslin and A.J. Weiss, "Hospital Readmissions Involving Psychiatric Disorders, 2012," *HCUP Statistical Brief #189*, Agency for Healthcare Research and Quality (Rockville, Md.: May 2015). When the definition of readmission was expanded to include mood disorders or schizophrenia as either a principal or a secondary diagnosis, readmission rates were estimated to be 12.6 and 18.6 percent, respectively, compared to 8.7 percent for non-behavioral health conditions as a principal or secondary diagnosis. The authors did not report confidence intervals around estimates.

<sup>51</sup>H.J. Jiang, M.L. Barrett, and M. Sheng, "Characteristics of Hospital Stays for Nonelderly Medicaid Super-Utilizers, 2012," *HCUP Statistical Brief #184*, Agency for Healthcare Research and Quality (Rockville, Md.: Nov. 2014).

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demonstrations typically last 3 to 5 years, but can be renewed, and allow federal payments for adult behavioral health services provided in IMDs.

According to CMS officials, beginning with Tennessee in 1993, HHS approved section 1115 demonstrations in 9 states that allowed states to pay for behavioral health services in IMDs.<sup>52</sup> In addition to Tennessee, CMS officials said that Arizona, Delaware, Maryland, Massachusetts, New York, Oregon, Rhode Island, and Vermont also had approved behavioral health demonstrations between 1993 and 2009. By 2009, CMS officials said that the authority to pay for IMD costs in all of the states was phased out, except in Massachusetts. CMS officials said the demonstrations that were phased out were no longer considered “innovative or experimental.” CMS officials also said that Massachusetts’s 2005 demonstration was renewed, most recently in November 2016, because it was innovative and included behavioral health services reforms.

In addition to Massachusetts’s demonstration, CMS has recently approved applications from some, but not all states, for section 1115 demonstrations that allow states to pay for substance use or mental health services provided in IMDs.

- **Substance use:** In July 2015, CMS issued a state Medicaid Director letter informing states that they may seek approval of section 1115 demonstrations to receive federal payments for demonstrations that provided substance use services to adults in IMD settings as part of a comprehensive initiative to reform states’ delivery of substance use services.<sup>53</sup> In the letter to states describing this opportunity, CMS said the demonstrations would allow states to address the historical lack of substance use treatment capacity, including inpatient and residential treatment, particularly in light of the national opioid epidemic, improve the quality of substance use services, and ensure Medicaid beneficiary’s access to a full continuum of care for substance use conditions. Specifically, the demonstration initiative allows federal payments for short-term residential substance use treatment in IMDs,

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<sup>52</sup>CMS said that while most of these demonstrations were limited to inpatient mental health services, one included both inpatient mental health and substance use treatment services.

<sup>53</sup>See Centers for Medicare & Medicaid Services, State Medicaid Director Letter; Re: New Service Delivery Opportunities for Individuals with Substance Use Disorder (July 27, 2015; SMD#15-003).

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limited to an average length of stay of 30 days. According to CMS officials, as of May 4, 2017, California, Maryland, Massachusetts, and Virginia had sought and received approval for substance use demonstrations. CMS officials also said that they were working with four other states in the process of applying for or obtaining such approval for substance use demonstrations.<sup>54</sup>

- **Mental health:** CMS has approved some, but not all, demonstration applications to provide mental health services in IMDs. For example, although Maryland was approved to provide substance use treatment services in IMDs under the substance use demonstration guidance issued in July 2015, the state had applied at the same time to provide mental health services in IMDs. According to Maryland Medicaid officials, CMS denied this part of the request. However, in October 2016, CMS approved a section 1115 demonstration for Vermont that allows the state to pay for acute inpatient mental health services provided in an IMD, though the state is required to phase out that coverage completely by December 31, 2025.<sup>55</sup>

**Medicaid managed care.** Historically, Medicaid managed care plans had the flexibility to provide covered services in alternate settings under certain conditions, such as behavioral health services in IMDs. In May 2016, CMS issued a final rule designed to modernize its Medicaid managed care regulations. The rule codified this policy, known as the “in lieu of” policy, under which managed care plans may provide alternative services or services in alternative settings, such as IMDs, in lieu of covered services or settings if they are medically appropriate and a cost-effective substitute for covered services or settings.<sup>56</sup> CMS set a 15-day per month limit on the number of days a beneficiary may receive behavioral health services in an IMD for which managed care plans will

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<sup>54</sup>According to CMS officials, the agency does not plan to limit the number of states eligible to obtain approval to participate in a substance use demonstration. In the state Medicaid director letter CMS said that states participating in the demonstrations will be permitted to undertake significant substance use delivery system reform, including offering a comprehensive set of substance use services, with the goal of increasing access to care.

<sup>55</sup>As part of Vermont’s demonstration, CMS is requiring that Vermont conduct an evaluation of the IMD component including its impact on access to care; ED utilization and lengths of stay; lengths of stay in acute inpatient care settings; quality of care and discharge planning; readmissions for acute inpatient treatment; and costs of care provided.

<sup>56</sup>81 Fed. Reg. 27,498, 27,856, 27,861 (May 6, 2016) (codified at 42 C.F.R. §§ 438.3(e), 438.6(e)).

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receive payment. It is unknown how many states have allowed managed care plans in their states to cover services provided in IMDs because CMS does not currently collect such information.<sup>57</sup> However, CMS actuaries estimated that in 2010, 17 states were likely using the Medicaid managed care in lieu of authority for services provided in IMDs, and another 9 were potentially using the authority and that this change would cost \$66 million (\$42 million federal; \$24 million state) over 5 years (2016-2020).<sup>58</sup>

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<sup>57</sup>The 21st Century Cures Act requires HHS to conduct a study of IMD services provided by Medicaid managed care plans under the Medicaid managed care final rule by December 2019. Pub. L. No. 114-255, § 12002, 130 Stat. 1033, 1272 (2016).

<sup>58</sup>CMS actuaries said that the estimate does not account for reductions in other expenditures either directly, with IMD services replacing inpatient hospital services, or indirectly, with the use of IMD services potentially preventing other utilization in the future. CMS actuaries also noted that the estimate comes with significant uncertainty, even more so than other estimates, because of the limitations of the data.

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**Selected States Use Multiple Approaches to Provide Inpatient and Residential Behavioral Health Services to Adult Medicaid Beneficiaries, and Reported Some Access Challenges**

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**Selected States Use a Variety of Options to Provide Inpatient and Residential Behavioral Health Services to Adult Medicaid Beneficiaries, Including Medicaid and State Funds**

While there are no national data on how states finance services provided to adult Medicaid beneficiaries in IMDs, officials in our six selected states told us they used or reported using between 2 to 4 approaches to provide inpatient and residential behavioral health services to adult Medicaid beneficiaries from 2012 to 2016 (see table 1). Most of these state Medicaid officials said that when their states were unable to use Medicaid funds to finance services in IMDs, they relied on other funding sources, including state-only funding, or facility officials said they provided uncompensated care.

**Table 1: Selected States Used Multiple Approaches to Provide Inpatient and Residential Behavioral Health Services to Adult Medicaid Beneficiaries**

State	Medicaid managed care <sup>a</sup>	Disproportionate Share Hospital payments	Medicaid Emergency Psychiatric Demonstration (from 2012 to 2015)	Substance use Section 1115 Demonstrations	Facilities with 16 or fewer beds	Total number of funding options
California	—	✓	✓	✓	✓	4
Maryland	—	✓	✓	✓	✓	4
Minnesota	✓	✓	—	Plan to apply	✓	3
Missouri	✓	✓	✓	—	✓	4
New Jersey	Considering	✓	—	Application in progress	✓	2
Washington	✓	✓	✓ <sup>b</sup>	Considering	✓	4

Source: GAO analysis of fiscal year 2015 Disproportionate Share Hospital payments to mental health facilities. GAO interviews with Medicaid officials from six states from July to October 2016. | GAO-17-652

Note:

<sup>a</sup>The Medicaid managed care “in lieu of” authority allows managed care plans to provide alternative services or services in alternative settings, such as institutions for mental disease (IMD), in lieu of covered services or settings if they are medically appropriate and a cost-effective substitute for covered services or settings.

<sup>b</sup>Washington withdrew from the Medicaid Emergency Psychiatric Demonstration early, on September 30, 2014.

**Medicaid managed care “in lieu of” authority:** Nationally, in fiscal year 2013, the most recent data available, nearly 54 percent of Medicaid beneficiaries were enrolled in comprehensive managed care plans.<sup>59</sup> States with adults enrolled in managed care plans may opt to use the Medicaid managed care “in lieu of” authority, and some states were already doing so. Of our six selected states, officials in three states (Minnesota, Missouri, and Washington) reported using the Medicaid managed care “in lieu of” authority before the final rule became effective in July 2016. Officials from these three states said their states used this authority to pay managed care plans for individuals who were in an IMD for more than the 15 days per month allowed by the new final rule. These officials could not provide estimates of the amount spent on these services because the plans received the same capitation payments regardless of the services actually provided. These officials expressed concerns about implementing the new rule, including increasing states’

<sup>59</sup>As mentioned previously, states may also opt to carve out behavioral health services from their comprehensive managed care plans and provide these services separately. For example, they may offer these services through a behavioral health organization.

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costs for beneficiaries in need of IMD stays longer than the allowable 15 days per month because they would no longer be able to rely on Medicaid managed care plans to cover longer IMD stays.

**DSH:** Federal law requires states to make DSH payments to offset uncompensated care costs experienced by certain hospitals serving large numbers of low-income uninsured and Medicaid patients and establishes state-specific limits, or allotments, for this purpose.<sup>60</sup> States are allowed, within certain federal payment limits, to make these payments to mental health treatment facilities, including IMDs.<sup>61</sup> Within these limits, states have broad flexibility in deciding how to allocate DSH payments among eligible hospitals, including IMDs. CMS data showed that nationally, states provided DSH payments to mental health treatment facilities, including IMDs, totaling nearly \$2.92 billion in fiscal year 2015 (see app. VI for DSH payments to mental health treatment facilities by state). Among our six selected states, DSH payments to mental health treatment facilities in fiscal year 2015 ranged from \$26,766 in California to nearly \$357.4 million in New Jersey. Officials from one Missouri IMD we spoke with said that the facility is very dependent on DSH payments, which make up about two-thirds of their operating costs.

**Medicaid Emergency Psychiatric Demonstration (MEPD):** The MEPD allowed 11 states and the District of Columbia to reimburse certain private IMDs for care provided to adult Medicaid beneficiaries to stabilize emergency mental health conditions.<sup>62</sup> PPACA authorized \$75 million in federal funds for the demonstration, which ran from July 1, 2012 to June 30, 2015, and total federal and state expenditures on IMD claims totaled approximately \$113 million by the end of the demonstration. A CMS sponsored evaluation of the MEPD found little to no effect on ED boarding or other measures of access for individuals with mental health conditions; however, the researchers acknowledged that this finding may

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<sup>60</sup>42 U.S.C. §§ 1396a(13)(A), 1396r-4.

<sup>61</sup>States' IMD limits are the lesser amount of the DSH allotment the state paid to IMDs and other mental health treatment facilities in fiscal year 1995 or 33 percent of the state's fiscal year 1995 DSH allotment. See 42 U.S.C. § 1396r-4(h).

<sup>62</sup>The demonstration was authorized in the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, § 2707, 124 Stat. 119, 326 (2010) (codified at 42 U.S.C. § 1396a note). In addition to the District of Columbia, the following states participated in the MEPD: Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia.



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have been attributable to data limitations.<sup>63</sup> Following completion of the MEPD, the Improving Access to Emergency Psychiatric Care Act of 2015 law was enacted, which included a provision to allow for possible continuation and expansion of the MEPD through 2019, if the Secretary of HHS and the Chief Actuary of CMS certified that the MEPD would not increase program spending.<sup>64</sup> In July 2016, CMS actuaries determined that they could not make this certification based on the available data and the MEPD ended in 2015 after 3 years, as required by PPACA.<sup>65</sup> Additionally, the 21st Century Cures Act, signed into law in December 2016, requires HHS to further study and produce a report on the MEPD by December 2018.<sup>66</sup>

Of our six selected states, four states participated in the MEPD: California, Maryland, Missouri, and Washington. Washington Medicaid officials said they withdrew from the MEPD early, in 2014, after the state received approval to cover the costs of IMD services through managed care. California officials said the two counties that participated in the MEPD had positive experiences with the demonstration and one county reported improved access to care, and reduced re-hospitalizations for beneficiaries with psychiatric diagnoses. Officials from two of the states expressed frustration and concern that CMS actuaries did not determine that the demonstration would not increase program spending and, as a result, the demonstration did not continue.

Despite the CMS actuaries' determination, two state officials provided data showing the average cost of a day in an IMD was less than the average cost in a non-IMD. One state official told us that IMDs cost less

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<sup>63</sup>C. Blyler, M. Azur, B. O'Day, P. Anand, A. Barrett, K. Choudhry, K. Contreary, S. Croake, M. Crofton, N. Denny-Brown, B. Johnston, J. Little, J. Lyons, B. Natzke, S. Peterson, M. Rubinstein, A. Siegwarth, J. Woerheide, and K. Zivin, *Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report, Vol. 1* (Baltimore, Md.: Centers for Medicare & Medicaid Services, Aug. 18, 2016). See <https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf>.

<sup>64</sup>PPACA did not impose such a requirement on the original demonstration.

<sup>65</sup>For their analyses, CMS's actuaries examined information provided by five participating MEPD states (Alabama, Maine, Missouri, Maryland, and North Carolina), and the August 2016 MEPD Evaluation Final Report. CMS's actuaries said that the data in the states' submissions and the MEPD reports were limited and the final MEPD evaluation found that the demonstration would "likely come at a cost to the federal government." Based on the information available, CMS actuaries said they were unable to certify that an extension would not increase overall program spending.

<sup>66</sup>See Pub. L. No. 114-255, §12004, 130 Stat. at 1273.

to operate than a hospital since they do not have to purchase or maintain equipment used in a typical hospital such as lab or surgical equipment. For example, Missouri Medicaid officials provided data showing that in 2014, IMD daily rates were about 45 percent less than a non-IMD (see Table 2). Likewise, Maryland Medicaid officials provided data showing that in 2015, the IMD daily rate was about 24 percent less than the average daily rate for two non-IMDs in the state.

**Table 2: Per Patient Per Day Costs for Mental Health Treatment as Reported by Two States for Institutions for Mental Disease (IMD) and Non-IMDs**

State	Facility type	2011 <sup>a</sup>	2012 <sup>b</sup>	2013	2014	2015
Maryland <sup>c</sup>	IMD facilities	\$894	\$892	\$1,045	\$1,077	\$1,061
	Non-IMD <sup>d</sup> facility 1	\$1,580	\$1,554	\$1,533	\$1,540	\$1,457
	Non-IMD <sup>d</sup> facility 2	\$1,415	\$1,152	\$1,152	\$1,195	\$1,344
Missouri	IMD facilities	N/A	\$486	\$474	\$502	N/A
	Non-IMD <sup>d</sup> facilities	N/A	\$882	\$882	\$894	N/A

Source: State Medicaid agencies from Maryland and Missouri. | GAO-17-652

Notes:

<sup>a</sup>Maryland provided fiscal year data and Missouri provided calendar year data.

<sup>b</sup>For 2012, Missouri's IMD per patient per day costs are based on 6 months of data.

<sup>c</sup>Maryland excluded 1- and 2-day facility stays from the per patient per day data for both IMD and non-IMD hospitals.

<sup>d</sup>Like IMD facilities, non-IMD facilities provide inpatient mental health treatments.

**Section 1115 substance use services demonstrations:** CMS officials said that nationally, as of May 4, 2017, 4 states have sought and received approval for substance use services demonstrations (California, Maryland, Massachusetts, and Virginia). CMS officials also said that, as of April 20, 2017, 5 other states have applied for such demonstrations, and a few states are in the preliminary stages of applying for substance use services demonstrations.

Of our six selected states, California and Maryland had approved substance use services demonstrations. California Medicaid officials told us the substance use services demonstrations will allow participating counties to offer beneficiaries substance use services in more settings, providing a continuum of treatment options.<sup>67</sup> According to CMS officials,

<sup>67</sup>In California, counties are responsible for administering behavioral health services to Medicaid beneficiaries who are residents. Therefore, under its substance use services demonstration, each county within the state can choose whether to participate.

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Minnesota, Missouri, New Jersey and Washington had not, as of April 13, 2017, applied for a demonstration, although the Minnesota Medicaid agency had been directed by their state legislature to apply, New Jersey officials said they have an application in progress, and Washington state officials were still considering whether to apply.

**Facilities with 16 or fewer beds:** Another way states have avoided the IMD exclusion is through the creation of 16-bed facilities that are eligible for federal Medicaid payments due to their small size. While CMS officials said they do not track national data on facilities that have 16 or fewer beds, officials in each of our six selected states said they had such facilities in their state and several state and facility officials said they created inpatient 16-bed or smaller facilities specifically to obtain Medicaid funding without triggering the IMD exclusion.

While 16-bed facilities are able to receive federal Medicaid payments for the same services an IMD may provide, state and facility officials noted challenges with facilities this size. Some state and facility officials noted that facilities with 16 or fewer beds, as opposed to larger facilities, may experience financial challenges because it costs more to offer the same breadth of services to a smaller number of patients, or because smaller facilities may not be able to offer certain services larger ones can. For example, officials from one state said that costs per patient increased when the state reduced the number of beds in its inpatient 24- to 40-bed substance use treatment facilities to 16-bed facilities.

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### Selected States Reported Access Challenges, but Lacked Data on Extent of Problem

The six states we selected generally did not have data to document access challenges for adult Medicaid beneficiaries seeking IMD-type services, but state or facility officials from each of these selected states shared examples of access problems. Although state officials often did not characterize the prevalence of the problems, some facility officials we spoke with said they regularly turned away patients, maintained waitlists, and that enough demand existed to warrant expanding capacity. For example:

- **California:** Prior to California's substance use services demonstration, which was approved in December 2015, Medicaid officials said that residential substance use treatment services were not covered for Medicaid beneficiaries. Medicaid officials said that residential substance use services would be available in counties that chose to participate in the demonstration, but access to these services would be difficult in counties that chose not to participate in

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the demonstration. When beds are not available, an official at one California facility said that they keep a waitlist and offer the next best level of care available, typically outpatient care, until an appropriate bed becomes available.

- **Maryland:** Medicaid officials said that while they were not aware of systematic access problems, they had heard anecdotally that some hospitals had trouble finding beds for Medicaid beneficiaries outside of EDs and other acute-care hospital settings. Officials also reported that stays in acute-care hospital settings, which are covered by Medicaid, may be longer than stays at lower levels of care in IMDs.
- **Minnesota:** Medicaid officials said that it may be more difficult for Medicaid beneficiaries with acute mental health needs to access inpatient services than it is for beneficiaries seeking outpatient mental health services.
- **Missouri:** More than 61 percent of hospitals that responded to a survey by the Missouri Hospital Association (38 of 62 hospitals) reported boarding behavioral health patients in EDs during a specific week in May 2016 and 76 percent of those boarded patients were between the ages of 21 to 64.<sup>68</sup> The survey data also showed that of the hospitals that reported boarding behavioral health patients, 94.7 percent said that they boarded patients because they could not identify a facility with a mental health bed that would accept the patient. Other reasons reported for boarding included not having an in-house mental health bed available (47.4 percent) and not having access to appropriate transportation services (23.7 percent).
- **New Jersey:** Medicaid officials said that accessing behavioral health services can be challenging. For example, officials said there is a problem with ED boarding in the state and there are oftentimes waitlists for substance use services. Additionally, officials said it can be difficult to qualify for a bed in a substance use treatment facility. To address the shortage of inpatient treatment beds, in January 2017, the governor announced plans to increase the number of beds allowed for individuals with co-occurring mental health and substance use conditions by almost 40 percent, adding 864 beds.<sup>69</sup> Up to 5

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<sup>68</sup>Data are from a survey conducted by the Missouri Hospital Association of member hospitals. We did not independently verify these data.

<sup>69</sup>According to a state document, in order for a facility to be granted approval to add or create inpatient beds in New Jersey, the state must first issue a call for applications. Next, interested facilities apply for the available beds, and state officials decide which facilities are granted approval. Applicants must also demonstrate that if approved, the beds can be licensed within two years.

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percent of the new beds are to be available for Medicaid beneficiaries and the uninsured population.

- **Washington:** Medicaid officials said that there is not enough capacity to meet the demand for services within the state even though over 100 additional beds opened statewide in 2014. Officials at two Washington facilities reported turning away patients because of a lack of available beds and patients were sometimes sent to geographically distant treatment facilities. Officials at one 15-bed facility said that demand would justify an expansion to 20 to 25 beds in their facility if it were not for the IMD exclusion; these officials also noted that they were in the process of building two new 16-bed treatment facilities. Officials at another Washington facility said that they are building one 16-bed treatment facility and planning to build two additional treatment facilities—each with 16 beds—to meet the demand.

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## Agency Comments

We provided a draft of this report to HHS for review. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to our requestor, the Secretary of the Department of Health and Human Services, and other interested parties. The report is also available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VII.

Sincerely yours,



Katherine M. Iritani  
Director, Health Care

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# Appendix I: Scope and Methodology for Data Analyses

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## Analyses of Facilities That Offered Mental Health and Substance Use Services

To analyze the capacity of facilities that offer mental health and substance use services, we obtained data from two Substance Abuse and Mental Health Services Administration (SAMHSA) surveys: the National Mental Health Services Survey (N-MHSS) and the National Survey of Substance Abuse Treatment Services (N-SSATS). To identify recent trends, we obtained the 2010 and 2014 data for the N-MHSS and the 2010 and 2015 data for the N-SSATS.<sup>1</sup> The N-MHSS and the N-SSATS are both censuses of facilities offering mental health and substance use services, respectively.<sup>2</sup> Both surveys include data on the number of beds available and facility characteristics, such as ownership and type of facility, for inpatient and residential care. Due to our focus on the implications of the IMD exclusion, SAMHSA provided us tabulated data on the capacity and characteristics of facilities that offered services to adults when possible, based on our specifications. Based on how SAMHSA collects data, for the 2010 data we included facilities that accepted adults aged 18 to 64, or if that information was missing, facilities that had inpatient or residential clients aged 18 to 64.<sup>3</sup> The 2014 data included young adults aged 18 to 25 and adults aged 26 to 64 for inpatient or residential mental health treatment. The 2010 substance use treatment data excluded cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 substance use treatment analysis also excluded cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of

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<sup>1</sup>Beginning in 2013, SAMHSA alternated the years that the full questionnaires of the two surveys were fielded and collected information on clients. Since 2013, the N-MHSS has collected the client information in even years and the N-SSATS has collected the information in odd years.

<sup>2</sup>The response rate across all facility types—not just inpatient and residential facilities—was 91 percent for both 2010 N-MHSS and 2010 N-SSATS. The response rate for the 2014 N-MHSS was 88 percent and the 2015 N-SSATS response rate was 92 percent.

<sup>3</sup>For the purposes of the Medicaid program, individuals under the age of 21 are considered children and are eligible for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit, which covers comprehensive health screenings, preventive health services, and all medically necessary services to correct or improve health conditions discovered through screenings. The medically necessary treatment services must be covered for an individual child regardless of whether the service is covered under the state's Medicaid plan. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r).

residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. We excluded facilities which reported that their main function was to provide services to children.

For the purposes of our review, we defined capacity as the number of facilities that offered services, the number of beds for services offered, number of beds per 100,000 adults, and the bed utilization rate, which is the percentage of beds being used at a facility on a given day. To determine the number of beds per 100,000 adults, both nationally and by state, we obtained data from the U.S. Census Bureau. We used the U.S. Census Bureau 2010 population data for adults 18 to 64 and the population projections for 2014 and 2015.<sup>4</sup> We calculated the number of beds per 100,000 adults nationally, for each state, the District of Columbia, and Puerto Rico using this data and the number of beds from the N-MHSS and N-SSATS.

Additionally, we assessed the reliability of the data we obtained from SAMHSA, including discussing the reliability of the data with SAMHSA officials, reviewing relevant documentation, and comparing the data to data from published sources. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

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<sup>4</sup>U.S. Census Bureau, Population Division, *Annual Estimates of the Resident Population for Selected Age Group by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015*, June 2016, accessed July 6, 2017, [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP\\_2015\\_PEPAGESEX&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPAGESEX&prodType=table).

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## Analysis of Adults That Obtained Mental Health or Substance Use Services, or Had an Unmet Need for Services

To analyze the prevalence of mental health and substance use conditions for adults, including Medicaid beneficiaries, we analyzed data from SAMHSA's National Survey on Drug Use and Health (NSDUH) from 2015, the most recently available data. NSDUH is a representative person-level survey that provides national use of alcohol and illicit drugs, mental health status, and mental health and substance use treatment utilization rates.<sup>5</sup>

We restricted our analysis to adults aged 22 to 64. We focused on this age group because the law excludes from coverage adults aged 21 to 64, though there are certain circumstances in which the law provides coverage of 21 year olds who receive care in IMDs, and because Medicaid beneficiaries age 65 and older and under age 21 may receive services in IMDs. We also analyzed our data by insurance type, focusing on individuals enrolled in Medicaid only, other types of insurance, and the uninsured population. We excluded individuals that had Medicaid in combination with another type of insurance, such as Medicare or private insurance. We analyzed these data by insurance status and by self-reported unmet need for mental health and substance use services, as well as the reasons for the unmet need.

We assessed the reliability of the data we obtained from SAMHSA including discussing the reliability of the data with SAMHSA officials, reviewing relevant documentation, and comparing our analysis with data from published sources. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

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<sup>5</sup>SAMHSA defines adults as having a mental health condition as having any mental, behavioral, or emotional condition in the past year that met the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, 4th edition, criteria. Individuals were defined as having a serious mental health condition if they had any mental, behavioral, or emotional condition that substantially interfered with or limited one or more major life activities. SAMHSA defines individuals as having a substance use condition if they met the criteria for dependence or abuse for alcohol or illicit drugs in the past 12 months based on criteria specified in the *DSM*, 4th edition. When an individual has both a mental health and substance use condition this is referred to as co-occurring conditions.



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# Appendix II: Scope and Methodology for Literature Review

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To describe what the literature shows regarding adult access to IMD-type services, we conducted a literature search to identify original research that addressed the topic. Specifically, we searched for articles published from January 2010 through October 2016 that addressed the need for, use of, or access to inpatient or residential mental health or substance use services, including articles that addressed generally accepted access indicators such as emergency department (ED) use and length of stay. We conducted structured searches of various databases for relevant peer-reviewed and industry journals, including ProQuest, MEDLINE, SCOPUS, and PsycINFO. Key search terms included various combinations of terms identifying the level of care under study (for example, “residential,” “inpatient,” and “institution”); the conditions of interest (for example, “mental health,” “psychiatric,” “substance abuse,” and “substance use”); and the focus of our objective (for example, “access,” “availability,” “capacity,” and “unmet need,” as well as potential access indicators, such as “emergency department boarding,” “delay,” and “wait list”).

We identified additional articles through a “snowballing” process, including a bibliographic search based on relevant articles already identified. All abstracts were screened by two analysts and any differences reconciled through discussion. In screening, we sought to identify original research articles that (1) focused on the U.S. non-elderly adult population, (2) included at least some data from within the past 10 years (2006 or later), and (3) provided measures of the availability of IMD-type services or of met or unmet need for such services. We excluded articles that focused on services available only to certain populations, such as services provided by the Veterans Administration or the Indian Health Service. We identified additional articles through searches of the websites of government agencies, including the Substance Abuse and Mental Health Services Administration and the Agency for Healthcare Research and Quality.

The articles we identified clustered around several key themes, including receipt of services, self-reported unmet need, use of and length of stay in hospital EDs, and inpatient readmissions. Two analysts screened each article for methodological soundness. We focused our review on studies based on national data, when available, and considered studies that were more limited in scope when those were the only studies available, as was the case for ED boarding studies. The key articles included in our review are listed below. In reporting sample data, we considered the margin of error (confidence intervals) around estimates. All estimates we present have margins of error at the 95 percent confidence level or plus or minus

10 percent or less, unless otherwise noted. The articles included in our literature review follow.

Center for Behavioral Health Statistics and Quality. *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (Rockville, Md.: September 2016)

Ding, R., M. L. McCarthy, J.S. Desmond, J.S. Lee, D. Aronsky, and S.L. Zeger. "Characterizing Waiting Room Time, Treatment Time, and Boarding Time in the Emergency Department Using Quantile Regression." *Academic Emergency Medicine*, Vol.17, No. 8 (2010).

Fee, C, H. Burstin, J. H. Maselli, R. Y. Hsia, "Association of Emergency Department Length of Stay With Safety-Net Status." *JAMA*, Vol. 307, No. 5 (Feb. 2012).

Heslin, K.C., A.Elixhauser, and C.A. Steiner, "Hospitalizations Involving Mental and Substance Use Disorders Among Adults, 2012." *Healthcare Cost and Utilization Project (HCUP) Statistical Brief #191*, Agency for Healthcare Research and Quality. Rockville, Md.: June 2015. ).

Heslin, K.C., and A.J. Weiss, "Hospital Readmissions Involving Psychiatric Disorders, 2012." *HCUP Statistical Brief #189*, Agency for Healthcare Research and Quality. Rockville, Md: May 2015.

Jiang, H.J., M.L. Barrett, and M. Sheng. "Characteristics of Hospital Stays for Nonelderly Medicaid Super-Utilizers, 2012." *HCUP Statistical Brief #184*. Agency for Healthcare Research and Quality. Rockville, Md.: Nov. 2014 .

Misek, R.K, A.E. DeBarba, A. Brill. "Predictors of Psychiatric Boarding in the Emergency Department." *Western Journal of Emergency Medicine*:, vol. 16, no 1, Jan. 2015.

Nicks, B.A. and D.M. Manthey. "The Impact of Psychiatric Patient Boarding in Emergency Departments." *Emergency Medicine International*, vol. 2012 (2012).

Nolan, J.M., C. Fee, B.A. Cooper, S.H. Rankin, and M.A. Blegen. "Psychiatric Boarding Incidence, Duration, and Associated Factors in United States Emergency Departments." *Journal of Emergency Nursing*, vol. 41, no. 1 (2015).

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Park-Lee, E., R.N. Lipari, S.L. Hedden, A.P. Copello and L.A. Kroutil. "Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2015 National Survey on Drug Use and Health." *NSDUH Data Review* (September 2016).

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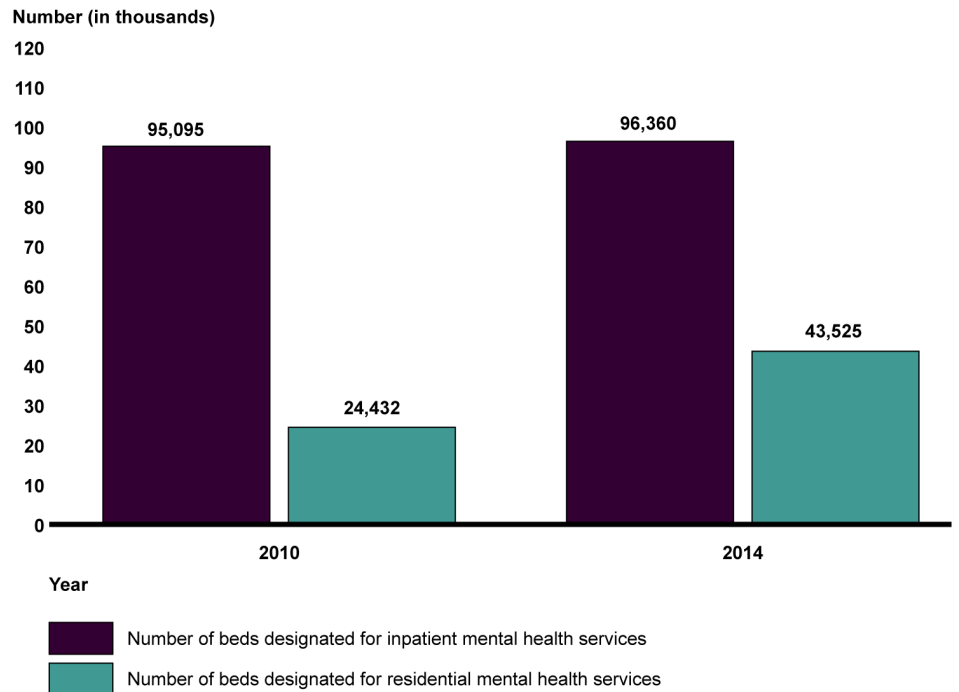
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# Appendix III: Information on Mental Health Inpatient and Residential Treatment Facilities

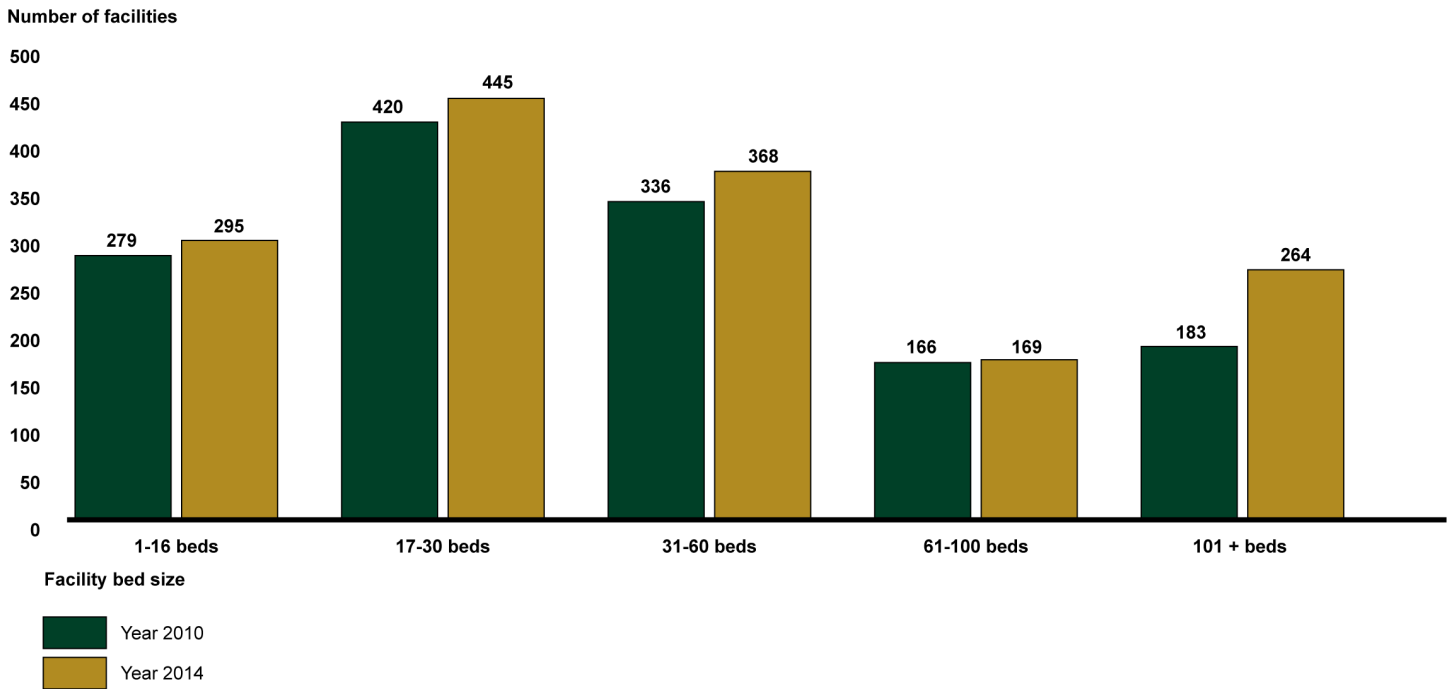
**Figure 6: Number of Beds Specifically Designated for Mental Health Inpatient and Residential Services, April 30, 2010, and April 30, 2014**



Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: The 2010 data presented includes facilities that accepted adults (aged 18-64) for treatment, or if that information was missing, facilities that had inpatient or residential clients aged 18-64. The 2014 data presented in this figure includes facilities that accepted young adults aged 18-25 and adults aged 26-64 for inpatient or residential mental health treatment. Data from both years exclude facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."

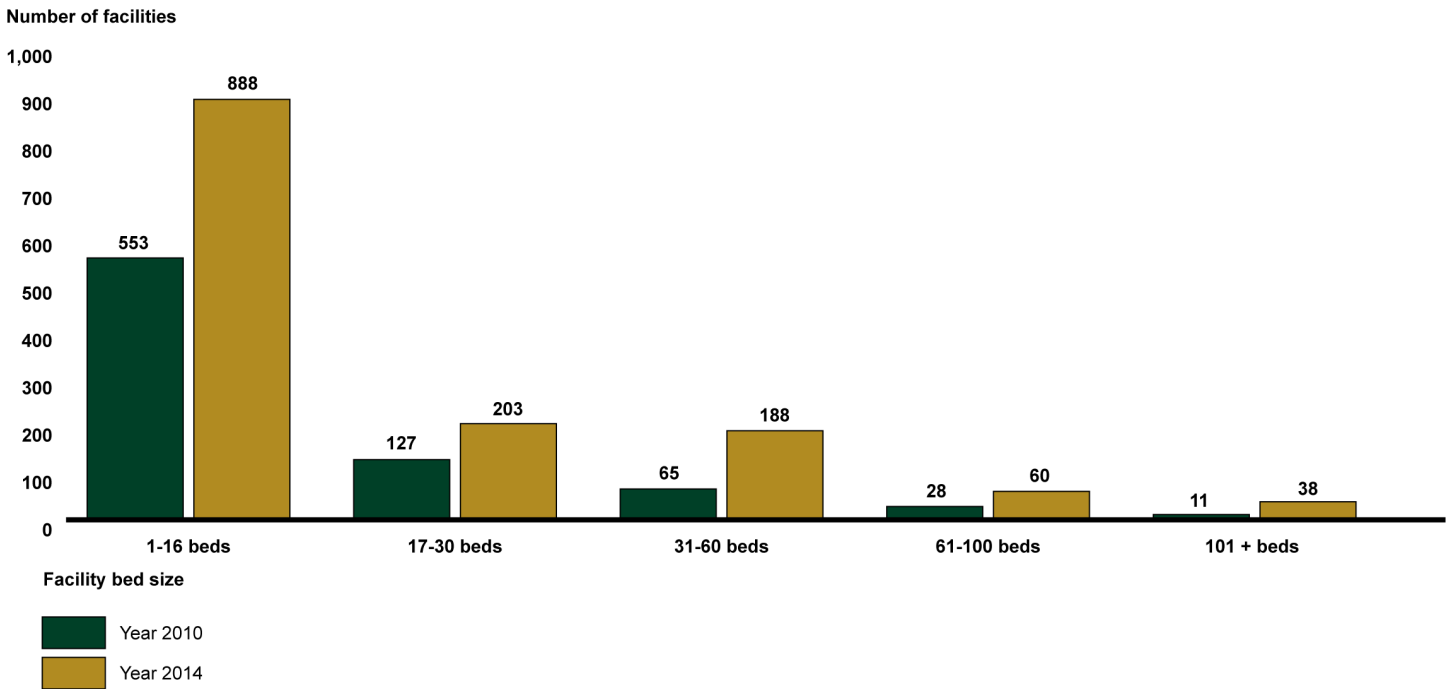
**Figure 7: The Number of Facilities That Offered Only Inpatient Mental Health Services by Facility Bed Size, 2010 and 2014**



Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: The 2010 data presented in this figure includes facilities that accepted adults aged 18-64, or if that information was missing, facilities that had inpatient clients aged 18-64. The 2014 data presented in this figure includes young adults aged 18-25 and adults aged 26-64 for inpatient mental health treatment. Also, the data in both years understates the number of facilities because the data only include facilities that reported client/patient counts for themselves. Data for both years excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only." The data are not comprehensive to facilities that offer inpatient services, as there are facilities that provide both inpatient and residential services.

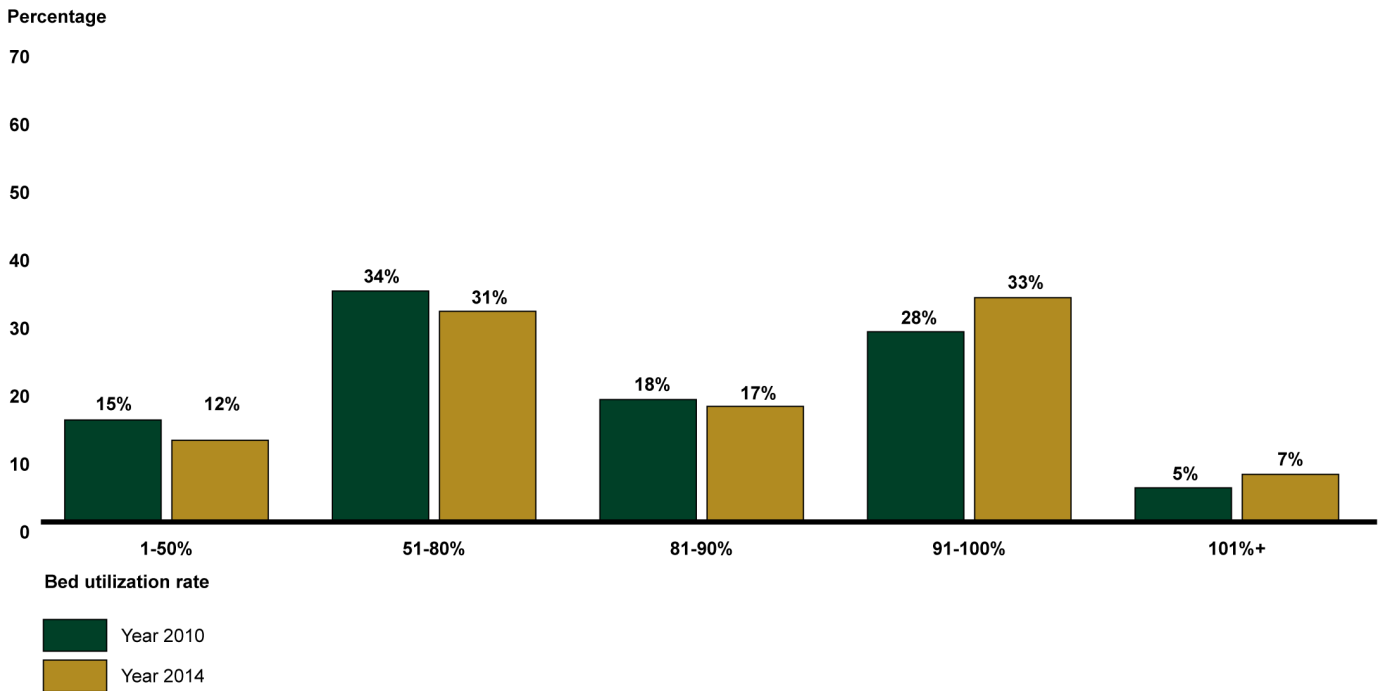
**Figure 8: The Number of Facilities That Offered Only Residential Mental Health Services by Facility Bed Size, 2010 and 2014**



Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: The 2010 data presented in this figure includes facilities that accepted adults aged 18-64, or if that information was missing, facilities that had residential clients aged 18-64. The 2014 data presented in this figure includes facilities that accepted young adults aged 18-25 and adults aged 26-64 for residential mental health treatment. Also, the data in both years understates the number of facilities because the data only include facilities that reported client/patient counts for themselves. Data for both years excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only." The data are not comprehensive to facilities that offer inpatient services, as there are facilities that provide both inpatient and residential services.

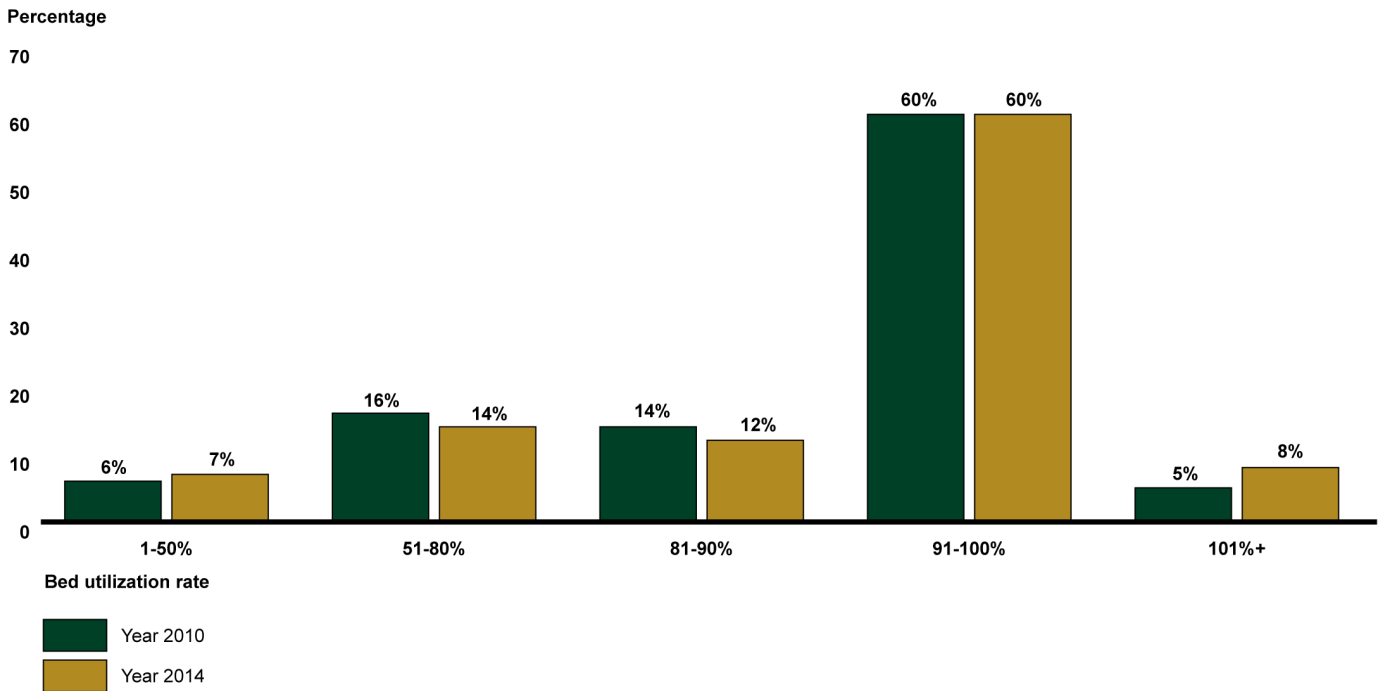
**Figure 9: Bed Utilization Rates Among Facilities That Offered Inpatient Mental Health Services, 2010 and 2014**



Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: Bed utilization rate is based on the percentage of available beds that were occupied on April 30, 2010, and April 30, 2014. The 2010 data includes facilities that accepted adults aged 18-64 for treatment, or if that information was missing, facilities that had inpatient clients aged 18-64. The 2014 data presented in this figure includes facilities that accepted young adults aged 18-25 and adults aged 26-64. Also, data from both years understates the number of facilities because the data only includes facilities that reported client/patient counts for themselves. Data for both years excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."

**Figure 10: Bed Utilization Rates Among Facilities That Offered Residential Mental Health Services, 2010 and 2014**

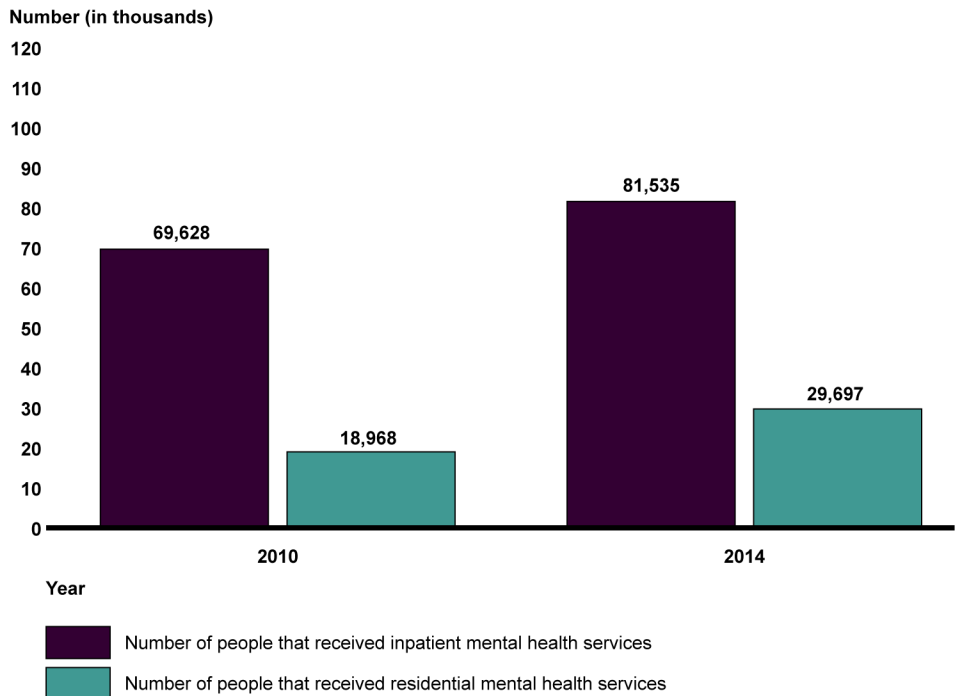


Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: Bed utilization rate is based on the percentage of available beds that were occupied on April 3, 2010, and April 30, 2014. The 2010 data includes facilities that accepted adults aged 18-64 for treatment, or if that information was missing, facilities that had residential clients aged 18-64. The 2014 data presented in this figure include facilities that accepted young adults aged 18-25 and adults aged 26-64. Also, data from both years understates the number of facilities because the data only includes facilities that reported client/patient counts for themselves. The data for both years excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."



**Figure 11: The Number of People That Received Mental Health Inpatient and Residential Services, as of April 30, 2010, and April 30, 2014**



Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014.  
| GAO-17-652

Note: The 2010 data presented in this figure include facilities that accepted adults aged 18-64 for treatment, or if that information was missing, facilities that had inpatient or residential clients aged 18-64. The 2014 data presented in this figure includes facilities that accepted young adults aged 18-25 and adults aged 26-64. Also, the data from both years understates the number of individuals receiving services because the data only include facilities that reported client/patient counts for themselves. The data from both years also excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children."

**Appendix III: Information on Mental Health  
Inpatient and Residential Treatment Facilities**

**Table 3: Ownership of Facilities That Offered Inpatient and Residential Mental Health Services, 2010**

	Percent of facilities that offered inpatient services	Percent of facilities that offered residential services
Private for-profit organization	19	8
Private non-profit organization	53	72
State mental health agency	9	7
Other state government	5	2
Regional/district authority	2	2
Local, county, or municipal government	7	5
U.S. Dept. of Veteran's Affairs	5	4
Other	0	0

Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010. | GAO-17- 652

Note: The data presented in this table include facilities that accepted young adults aged 18-64 for treatment, or if that information was missing, facilities that had inpatient or residential clients aged 18-64. The data excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."

**Appendix III: Information on Mental Health  
Inpatient and Residential Treatment Facilities**

**Table 4: Ownership of Facilities That Offered Inpatient and Residential Mental Health Services, 2014**

	Percent of facilities that offered inpatient services	Percent of facilities that offered residential services
Private for-profit organization	24	16
Private non-profit organization	53	70
State mental health agency	6	3
Other state government	5	3
Regional/district authority/ Local, county, or municipal government	6	4
Tribal government	0	0
U.S. Dept. of Veteran's Affairs	5	4
Indian Health Service	0	0
Other	1	1

Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2014. | GAO-17- 652

Note: The data presented in this table include facilities that accepted young adults aged 18-25 and adults aged 26-64 for inpatient or residential mental health treatment. The data excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."

**Appendix III: Information on Mental Health  
Inpatient and Residential Treatment Facilities**

**Table 5: Facilities That Offer Inpatient and Residential Mental Health Services by Facility Type, 2010 and 2014**

	Facilities that provide inpatient services		Facilities that provide residential services	
	2010 (%)	2014 (%)	2010 (%)	2014 (%)
Psychiatric hospital	34	32	9	6
Unit in general hospital	63	56	5	2
Residential treatment center for adults only	1	1	61	64
Multi-setting mental health facility	0	2	19	13
Other	3	9	7	15

Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and 2014. | GAO-17-652

Note: The 2010 data presented in this table includes facilities that accepted adults aged 18-64 for treatment, or if the information was missing, facilities that had inpatient or residential clients aged 18-64. The 2014 data includes facilities that accepted young adults aged 18-25 and adults aged 26-64. In both years, the data excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children only."

**Table 6: The Number of Beds per 100,000 Adults for Beds Designated for Inpatient and Residential Mental Health, 2010**

State	Mental health inpatient bed rate	Mental health residential bed rate	Overall mental health bed rate
Alabama	49.8	51.6	101.5
Alaska	29.7	6.0	35.7
Arizona	34.7	9.0	43.7
Arkansas	58.3	15.7	74.0
California	39.8	7.5	47.3
Colorado	25.8	9.0	34.8
Connecticut	63.4	18.9	82.3
Delaware	76.0	24.9	100.9
District of Columbia	124.0	6.2	130.3
Florida	48.4	15.9	64.3
Georgia	41.4	11.6	53.0
Hawaii	48.4	11.0	59.4
Idaho	59.3	13.9	73.2
Illinois	46.2	16.7	62.8
Indiana	51.2	15.9	67.1

**Appendix III: Information on Mental Health  
Inpatient and Residential Treatment Facilities**

<b>State</b>	<b>Mental health inpatient bed rate</b>	<b>Mental health residential bed rate</b>	<b>Overall mental health bed rate</b>
Iowa	38.5	18.9	57.4
Kansas	66.5	0.9	67.3
Kentucky	69.5	9.2	78.7
Louisiana	51.1	0.0	51.1
Maine	59.2	31.2	90.4
Maryland	53.2	29.9	83.1
Massachusetts	45.4	13.9	59.3
Michigan	41.4	10.1	51.5
Minnesota	33.0	28.5	61.6
Mississippi	81.5	33.4	114.8
Missouri	77.4	8.4	85.8
Montana	44.9	18.4	63.3
Nebraska	75.9	14.0	89.9
Nevada	12.3	0.7	13.0
New Hampshire	57.2	9.2	66.4
New Jersey	78.7	9.9	88.6
New Mexico	38.2	13.1	51.3
New York	55.3	12.2	67.5
North Carolina	41.4	4.3	45.7
North Dakota	143.9	5.6	149.6
Ohio	40.9	10.9	51.8
Oklahoma	49.9	17.1	67.0
Oregon	17.2	31.7	48.8
Pennsylvania	67.9	10.4	78.2
Rhode Island	64.7	44.8	109.5
South Carolina	32.7	10.9	43.6
South Dakota	87.7	53.0	140.7
Tennessee	49.8	2.2	52.0
Texas	40.4	2.9	43.3
Utah	37.3	14.7	52.0
Vermont	60.7	69.6	130.2
Virginia	51.2	10.3	61.5
Washington	59.9	13.9	73.8
West Virginia	45.4	8.3	53.7
Wisconsin	40.1	17.8	57.9

**Appendix III: Information on Mental Health  
Inpatient and Residential Treatment Facilities**

<b>State</b>	<b>Mental health inpatient bed rate</b>	<b>Mental health residential bed rate</b>	<b>Overall mental health bed rate</b>
Wyoming	101.4	48.9	150.2

Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2010 and U.S. Census data 2010. | GAO-17- 652

Note: The data presented in this table includes facilities that accepted adults aged 18-64 treatment, or if that information was missing, facilities that had inpatient or residential clients aged 18-64. Also, the data only includes facilities that reported client/patient counts for themselves. The data excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children." The population data used to calculate the number of beds per 100,000 adults aged 18-64 was obtained from the U.S. Census Bureau 2010 population data.

**Table 7: Beds per 100,000 Adults for Inpatient and Residential Mental Health Services, 2014**

<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>All mental health beds</b>
Alabama	38.2	37.2	75.4
Alaska	27.5	35.6	63.0
Arizona	39.5	19.2	58.6
Arkansas	53.0	35.2	88.2
California	35.5	16.5	52.0
Colorado	32.6	11.2	43.8
Connecticut	61.5	39.4	100.9
Delaware	74.4	18.0	92.3
District of Columbia	104.3	0.0	104.3
Florida	53.1	22.4	75.5
Georgia	27.0	7.7	34.7
Hawaii	43.1	64.4	107.6
Idaho	51.6	11.8	63.5
Illinois	47.0	16.6	63.6
Indiana	55.6	25.8	81.5
Iowa	36.5	33.5	70.0
Kansas	54.4	126.6	180.9
Kentucky	57.8	11.7	69.6
Louisiana	68.0	3.9	72.0
Maine	63.0	46.4	109.4
Maryland	45.3	28.1	73.5
Massachusetts	46.8	25.2	72.1
Michigan	39.8	14.6	54.4
Minnesota	38.5	29.5	68.0

**Appendix III: Information on Mental Health  
Inpatient and Residential Treatment Facilities**

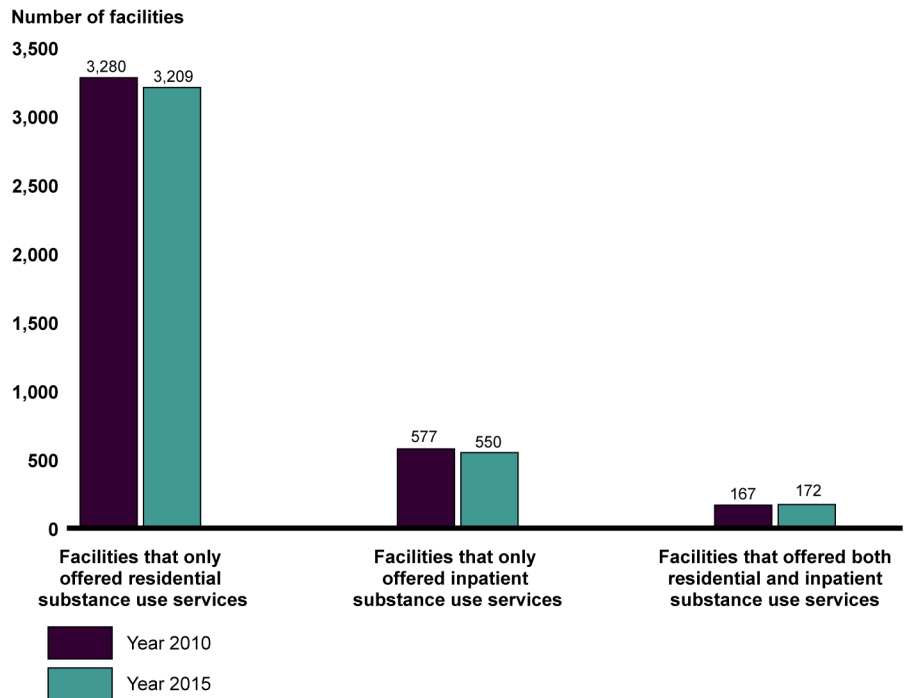
<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>All mental health beds</b>
Mississippi	77.7	32.9	110.6
Missouri	88.1	26.1	114.2
Montana	59.0	50.9	109.9
Nebraska	69.6	48.1	117.7
Nevada	35.7	1.9	37.5
New Hampshire	44.5	31.1	75.6
New Jersey	68.7	17.4	86.0
New Mexico	59.4	30.7	90.2
New York	76.3	36.0	112.3
North Carolina	40.9	13.6	54.5
North Dakota	42.7	4.1	46.7
Ohio	34.7	18.0	52.6
Oklahoma	63.1	21.9	85.0
Oregon	32.4	58.7	91.0
Pennsylvania	64.4	23.8	88.1
Rhode Island	71.4	40.7	112.1
South Carolina	43.9	13.8	57.7
South Dakota	26.5	43.5	70.0
Tennessee	52.9	17.1	70.0
Texas	34.9	4.3	39.2
Utah	38.6	25.7	64.4
Vermont	42.4	89.2	131.6
Virginia	44.0	9.8	53.8
Washington	40.1	20.0	60.1
West Virginia	81.7	32.5	114.2
Wisconsin	33.7	29.4	63.1
Wyoming	58.8	41.8	100.5

Source: Substance Abuse and Mental Health Services Administration's National Mental Health Services Survey, 2014 and U.S. Census data 2014. | GAO-17- 652

Note: The data presented in this table includes facilities that accepted young adults aged 18-25 and adults aged 26-64. Also, the data only includes facilities that reported client/patient counts for themselves. The data excludes facilities that indicated that the best category to describe the facility type was a "Residential treatment center for children." The population data used to calculate the number of beds per 100,000 adults aged 18-64 was obtained from the U.S. Census Bureau 2014 population projections data.

# Appendix IV: Information on Substance Use Inpatient and Residential Treatment Facilities

**Figure 12: Number of Facilities That Offered Inpatient, Residential or Both Types of Substance Use Services, 2010 and 2015**

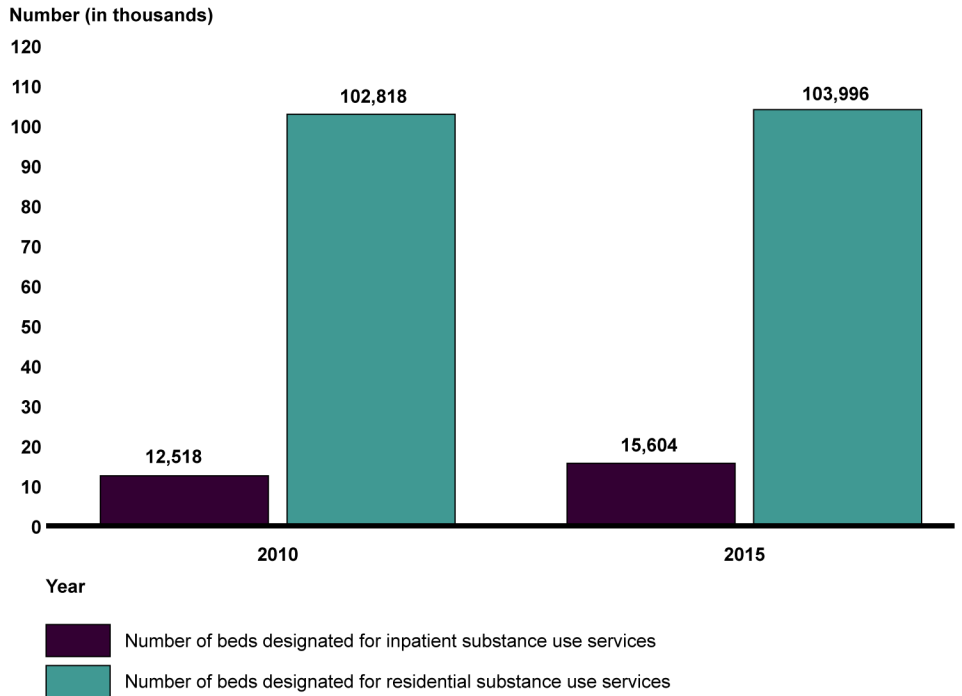


Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: The 2010 data presented in this figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data presented excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services.



**Figure 13: Number of Beds Specifically Designated for Inpatient and Residential Substance Use Services, as of March 31, 2010, and March 31, 2015**

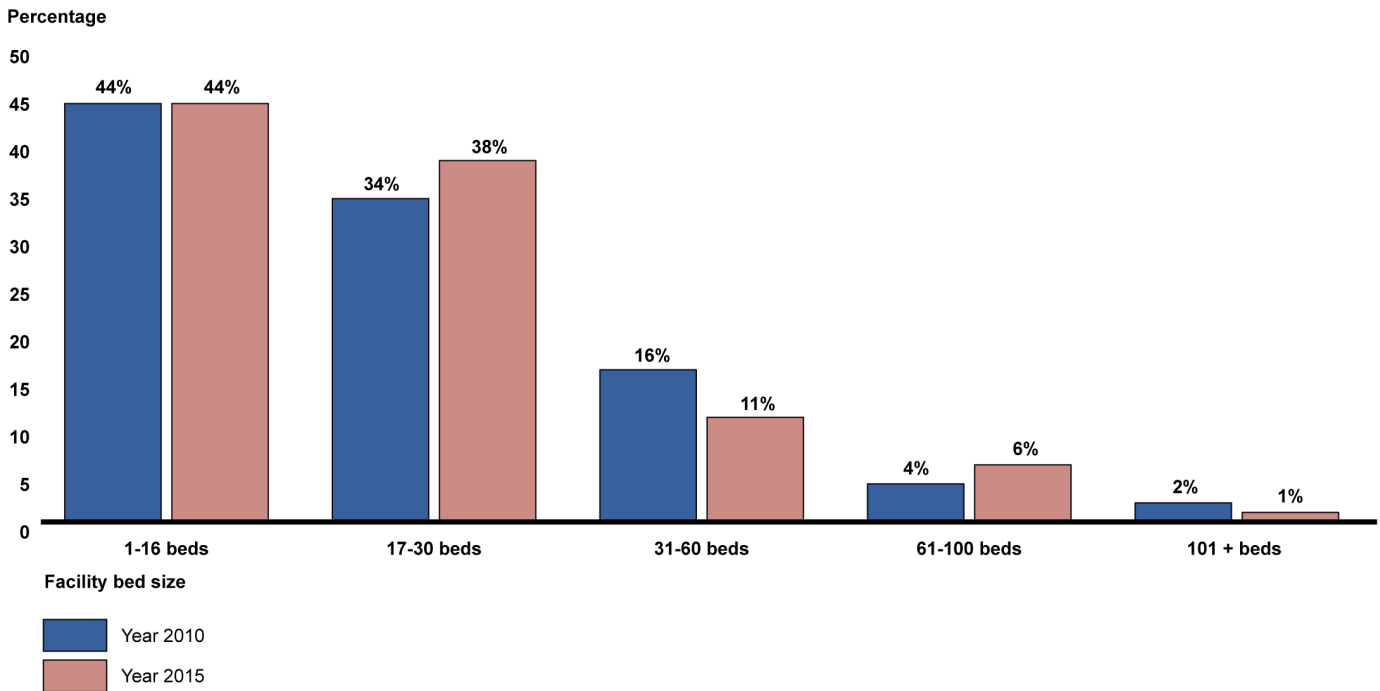


Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: The 2010 data presented in this figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, the data for both years understates the number of beds because the data only include facilities that reported client counts for themselves.

Appendix IV: Information on Substance Use  
Inpatient and Residential Treatment Facilities

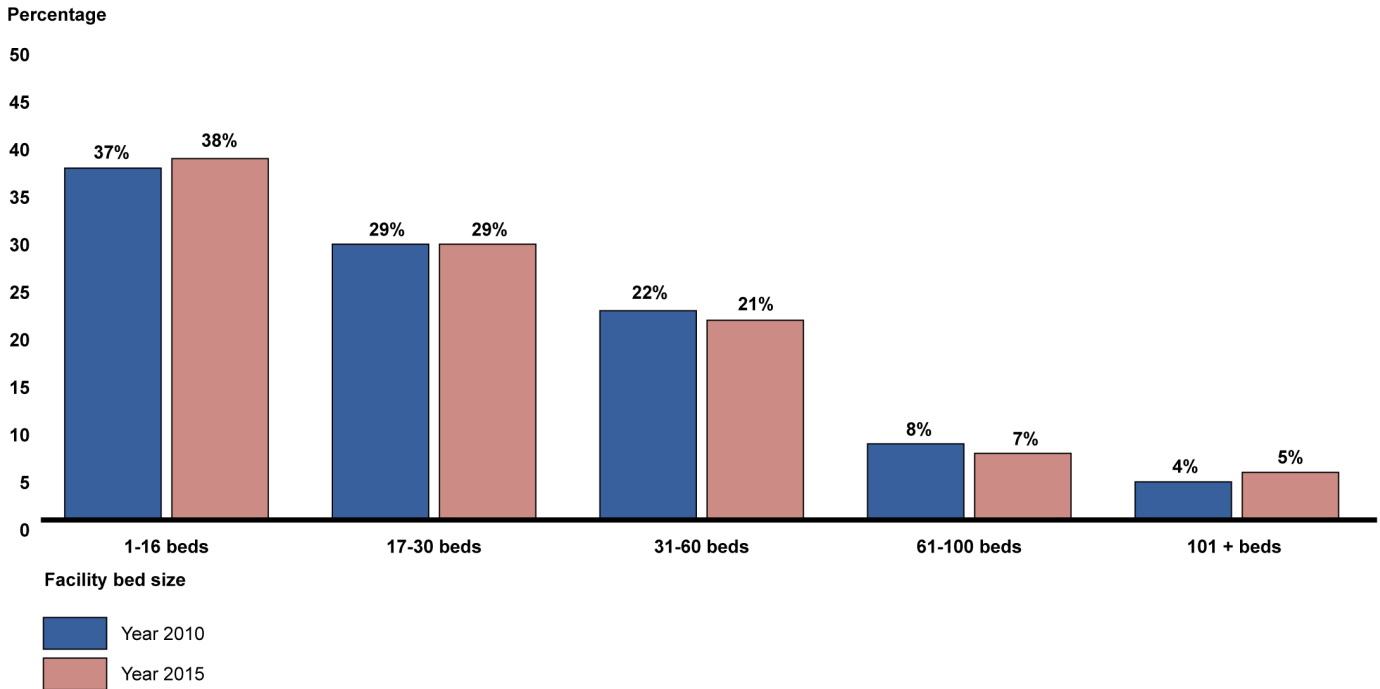
**Figure 14: Percent of Facilities That Offered Only Inpatient Substance Use Services by Bed Size of Facility, 2010 and 2015**



Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: The 2010 data presented in this figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, data from both years understates the number of facilities because the data only include facilities that reported client counts for themselves. The data are not comprehensive to facilities that offer inpatient services, as there are facilities that provide both inpatient and residential services.

**Figure 15: Percent of Facilities That Offered Only Residential Substance Use Services, by Bed Size of Facility, 2010 and 2015**



Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: The 2010 data presented in this figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, data from both years understates the number of facilities because the data only include facilities that reported client counts for themselves. The data are not comprehensive to facilities that offer inpatient services, as there are facilities that provide both inpatient and residential services.

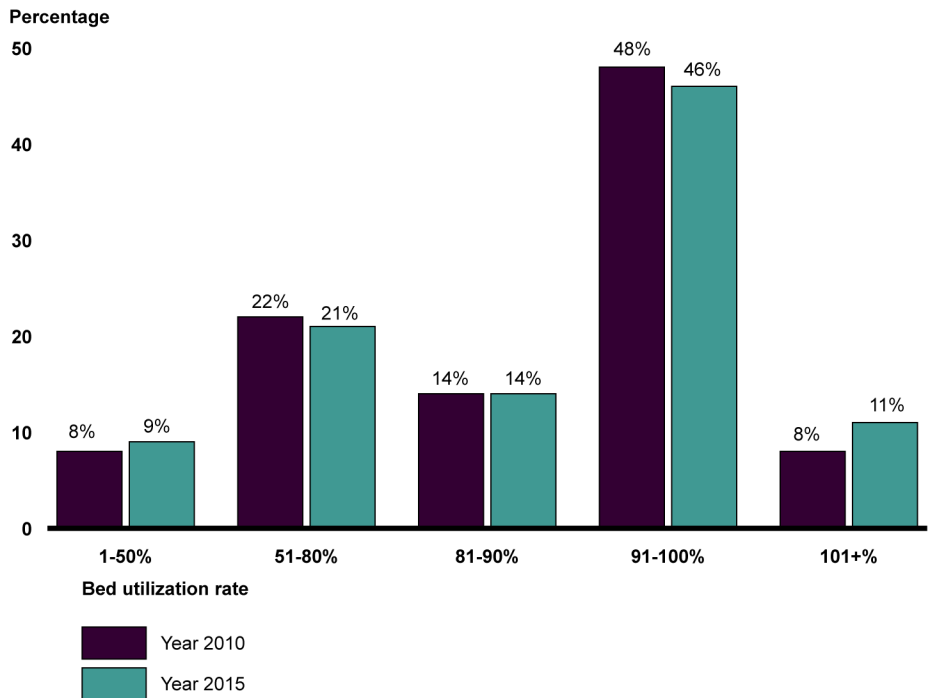
**Figure 16: Percent of Facilities That Offered Inpatient Substance Use Services by Bed Utilization Rate, 2010 and 2015**



Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: Bed utilization rate is based on the percentage of available beds that were occupied on March 31, 2010, and March 31, 2015. The 2010 data presented in this figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, for both years the data understates the number of facilities because the data only include facilities that reported client counts for themselves.

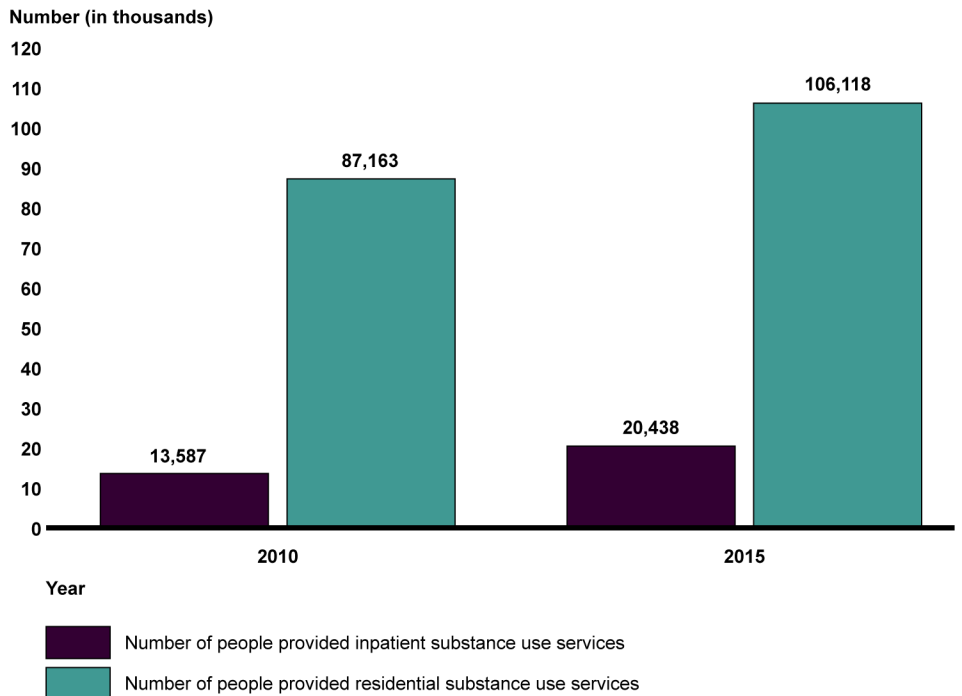
**Figure 17: Percent of Facilities That Offered Residential Substance Use Services by Bed Utilization Rate, 2010 and 2015**



Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: Bed utilization rate is based on the percentage of available beds that were occupied on March 31, 2010, and March 31, 2015. The 2010 data presented in the figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, the data for both years understates the number of facilities because the data only include facilities that reported client counts for themselves.

**Figure 18: Number of People That Received Inpatient and Residential Substance Use Services, as of March 31, 2010, and March 31, 2015**



Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015. | GAO-17-652

Note: The 2010 data presented in this figure excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, the data from both years understates the number of individuals receiving services because it only includes facilities that reported client counts for themselves.

**Table 8: Ownership of Facilities That Offer Inpatient and Residential Substance Use Treatment, 2010 and 2015**

	Facilities that provide inpatient services		Facilities that provide residential services	
	2010 (%)	2015 (%)	2010 (%)	2015 (%)
Private for-profit organizations	24	30	14	17
Private non-profit organizations	57	50	76	73
State government	6	7	3	3
Local, county or community government	5	5	3	3
Tribal government	0	0	1	1
Federal government	8	7	3	3

Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015 | GAO-17-652

Note: The 2010 data presented excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. The 2015 data excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services.

**Table 9: Types of Facilities That Offer Inpatient and Residential Substance Use Treatment, 2010 and 2015**

	Facilities that provide inpatient services		Facilities that provide residential services	
	2010 (%)	2015 (%)	2010 (%)	2015 (%)
General hospitals	55	48	5	5
Psychiatric hospitals	21	27	2	2
Other specialty hospitals	2	4	0	1
Non-hospitals	21	21	93	93

Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and 2015 | GAO-17-652

Note: The 2010 data presented excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18. The 2015 data excludes cases where the number of inpatient clients equaled the number of clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services.

**Appendix IV: Information on Substance Use  
Inpatient and Residential Treatment Facilities**

**Table 10: The Number of Beds per 100,000 Adults for Beds Designated for Inpatient and Residential Substance Use Treatment, 2010**

<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>Overall substance use beds</b>
Alabama	1.7	31.7	33.4
Alaska	0.0	84.6	84.6
Arizona	3.1	39.1	42.2
Arkansas	2.3	36.3	38.6
California	3.4	66.2	69.6
Colorado	3.8	46.8	50.6
Connecticut	11.5	57.1	68.6
Delaware	16.0	36.6	52.6
District of Columbia	10.6	73.4	84.0
Florida	7.7	51.9	59.7
Georgia	5.4	31.7	37.0
Hawaii	0.0	49.6	49.6
Idaho	3.7	22.9	26.6
Illinois	6.1	41.5	47.6
Indiana	11.2	12.3	23.5
Iowa	0.6	39.0	39.7
Kansas	0.6	47.1	47.7
Kentucky	10.0	64.1	74.1
Louisiana	2.8	65.3	68.1
Maine	6.9	38.1	45.0
Maryland	10.9	67.8	78.7
Massachusetts	17.3	72.5	89.8
Michigan	3.2	49.7	52.8
Minnesota	2.6	106.3	108.9
Mississippi	11.2	62.2	73.5
Missouri	1.6	38.5	40.1
Montana	4.2	60.7	64.9
Nebraska	0.0	73.9	73.9
Nevada	2.6	33.4	36.1
New Hampshire	0.0	33.6	33.6
New Jersey	5.3	42.8	48.1
New Mexico	6.2	49.6	55.8



**Appendix IV: Information on Substance Use  
Inpatient and Residential Treatment Facilities**

<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>Overall substance use beds</b>
New York	17.7	99.5	117.2
North Carolina	7.4	38.5	45.9
North Dakota	9.9	84.0	93.8
Ohio	6.8	26.0	32.9
Oklahoma	3.3	72.2	75.6
Oregon	0.4	53.8	54.2
Pennsylvania	6.0	62.7	68.8
Rhode Island	8.3	52.0	60.3
South Carolina	7.9	15.2	23.1
South Dakota	19.4	91.1	110.5
Tennessee	4.8	44.9	49.7
Texas	5.0	30.8	35.8
Utah	4.4	63.5	67.8
Vermont	28.6	34.3	62.9
Virginia	1.4	15.4	16.7
Washington	5.3	43.7	49.0
West Virginia	10.8	36.7	47.5
Wisconsin	5.5	26.3	31.8
Wyoming	5.0	70.6	75.7

Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2010 and U.S. Census Bureau 2010 | GAO-17-652

Note: The data presented excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18, or the facility did not offer inpatient services and did not offer residential services. Also, only includes facilities that reported client counts for themselves. The population data used to calculate the number of beds per 100,000 adults was obtained from the 2010 U.S. Census Bureau data.

**Table 11: The Number of Beds per 100,000 Adults for Beds Designated for Inpatient and Residential Substance Use Treatment, 2015**

<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>Overall substance use beds</b>
Alabama	1.7	34.5	36.2
Alaska	0.0	72.4	72.4
Arizona	7.3	54.7	62.0
Arkansas	2.6	38.2	40.8
California	1.9	53.9	55.8
Colorado	5.3	33.3	38.6
Connecticut	9.7	66.0	75.7

**Appendix IV: Information on Substance Use  
Inpatient and Residential Treatment Facilities**

<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>Overall substance use beds</b>
Delaware	5.2	45.1	50.3
District of Columbia	2.5	83.0	85.5
Florida	6.6	51.8	58.4
Georgia	6.4	30.2	36.6
Hawaii	5.4	52.7	58.2
Idaho	1.5	14.7	16.2
Illinois	3.1	35.7	38.9
Indiana	13.5	15.2	28.7
Iowa	1.6	50.2	51.8
Kansas	1.6	40.8	42.4
Kentucky	12.0	82.6	94.6
Louisiana	9.3	61.5	70.8
Maine	14.3	31.2	45.6
Maryland	9.0	54.2	63.2
Massachusetts	18.6	75.5	94.1
Michigan	2.8	48.8	51.6
Minnesota	2.8	105.7	108.5
Mississippi	12.5	53.0	65.5
Missouri	2.0	32.5	34.5
Montana	12.4	35.3	47.7
Nebraska	0.0	65.2	65.2
Nevada	7.9	30.2	38.1
New Hampshire	1.8	46.0	47.8
New Jersey	5.5	50.5	56.0
New Mexico	9.9	38.4	48.3
New York	14.8	80.2	95.1
North Carolina	5.9	41.6	47.5
North Dakota	17.4	92.5	109.9
Ohio	7.9	27.4	35.2
Oklahoma	4.8	50.8	55.6
Oregon	2.1	50.6	52.7
Pennsylvania	4.9	70.2	75.2
Rhode Island	524.7	254.9	779.5
South Carolina	6.9	23.0	29.9
South Dakota	19.1	121.5	140.6
Tennessee	3.2	46.8	50.0

**Appendix IV: Information on Substance Use  
Inpatient and Residential Treatment Facilities**

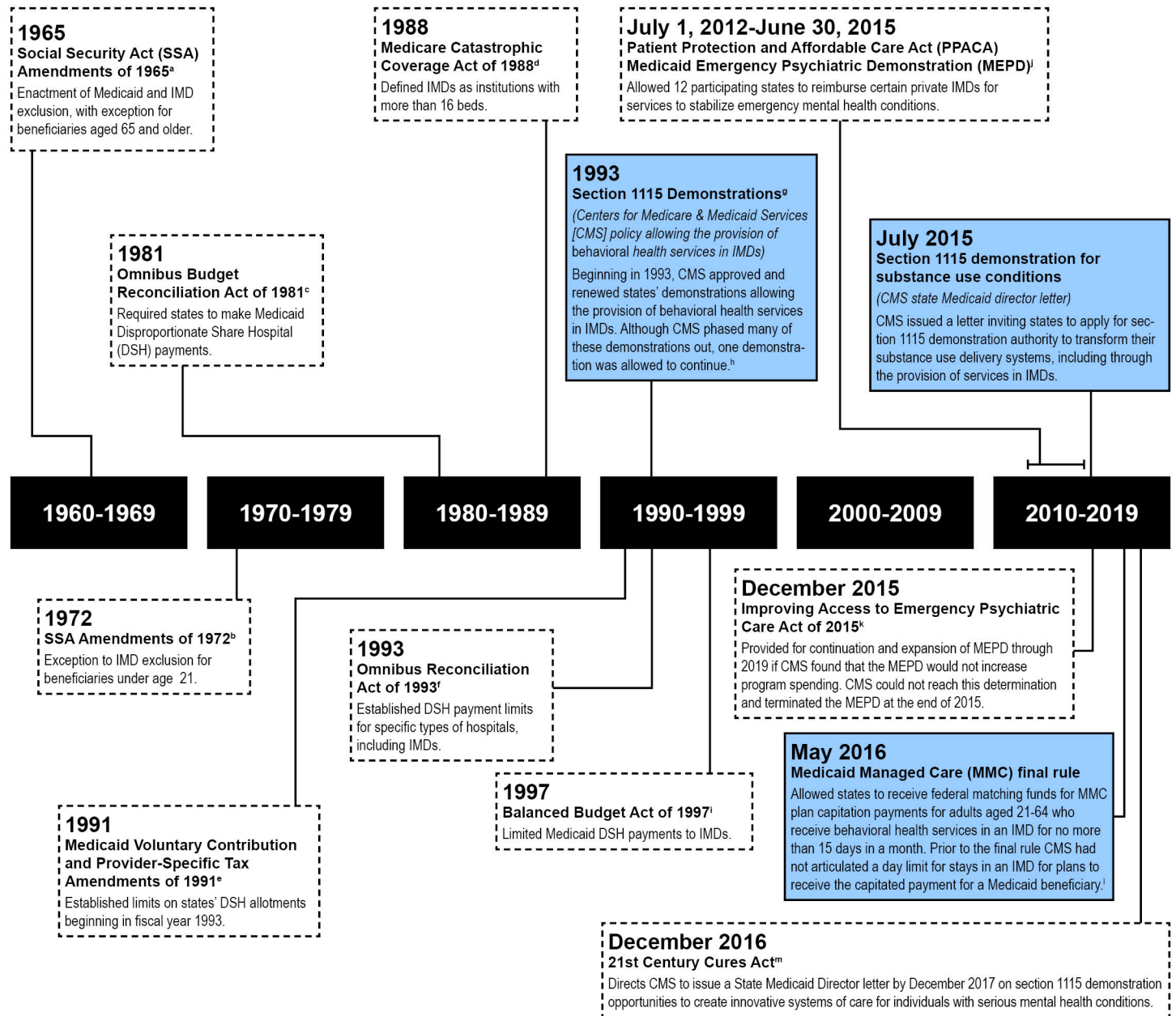
<b>State</b>	<b>Inpatient beds</b>	<b>Residential beds</b>	<b>Overall substance use beds</b>
Texas	2.4	28.2	30.6
Utah	2.8	52.3	55.0
Vermont	29.3	53.8	83.0
Virginia	5.2	19.9	25.1
Washington	4.2	126.7	130.9
West Virginia	6.6	48.9	55.5
Wisconsin	7.3	25.3	32.6
Wyoming	4.4	107.0	111.4

Source: Substance Abuse and Mental Health Services Administration's National Survey of Substance Abuse Treatment Services, 2015 and U.S. Census Bureau 2015 Population Projections | GAO-17-652

Note: The data presented in this table excludes cases where the number of inpatient clients equaled the number of inpatient clients under the age of 18 and the number of residential clients equaled the number of residential clients under the age of 18 and the maximum age for males and females is 17, or the facility did not offer inpatient services and did not offer residential services. Also, only includes facilities that reported client counts for themselves. The population data used to calculate the number of beds per 100,000 adults was obtained from the U.S. Census Bureau 2015 population projections.

# Appendix V: Information on Changes Related to the Medicaid Institutions for Mental Disease (IMD) Exclusion

Figure 19: Timeline of Changes Related to the Medicaid Institutions for Mental Disease (IMD) Exclusion



■ Guidance, policy, and regulations implemented by CMS. □ Enacted law

Source: GAO Analysis of selected laws, regulations, and guidance/policy. | GAO-17-652

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**Appendix V: Information on Changes Related  
to the Medicaid Institutions for Mental Disease  
(IMD) Exclusion**

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Notes:

<sup>a</sup>Pub. L. No. 89-97, § 1905(a)(v)(1), (4), (14), 79 Stat. 286, 351-52 (1965) (codified at 42 U.S.C. §§ 1396d(a)(14), (29)(B)).

<sup>b</sup>Pub. L. No. 92-603, § 299B, 86 Stat. 1329, 1460-61 (1972) (codified at 42 U.S.C. § 1396d(a)(16), (h)). In some cases, beneficiaries aged 21 also qualify for IMD services under the SSA Amendments of 1972. 42 U.S.C. § 1396d(h)(1)(C).

<sup>c</sup>States are required to make DSH payments to hospitals that care for a disproportionate share of Medicaid and low-income uninsured patients, and are allowed to make DSH payments to IMDs. Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808 (1981) (codified at 42 U.S.C. § 1396a(a)(13)).

<sup>d</sup>Pub. L. No. 100-300, § 4119, 102 Stat. 683, 798-99 (1988) (codified at 42 U.S.C. § 1396d(i)).

<sup>e</sup>Pub. L. No. 102-234, § 3(b), 105 Stat. 1793, 1799-1803 (1991) (codified at 42 U.S.C. § 1396r-4(f)).

<sup>f</sup>Pub. L. No. 103-66, § 13621, 107 Stat. 312, 629-32 (1993) (codified at 42 U.S.C. § 1396r-4(a)).

<sup>g</sup>Section 1115 of the SSA gives the Secretary of the Department of Health and Human Services (HHS) authority to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstrations that promote the objectives of the Medicaid program. Demonstrations are granted (or renewed) for 3- or 5-year periods and are administered by the Centers for Medicare & Medicaid Services (CMS).

<sup>h</sup>According to CMS officials, the agency approved behavioral health IMD demonstrations in 9 states: Arizona, Delaware, Maryland, Massachusetts, New York, Oregon, Rhode Island, Tennessee, and Vermont. The section of the Massachusetts demonstration allowing payment for mental health services provided in IMDs expired June 30, 2017.

<sup>i</sup>Pub. L. No. 105-33, § 4721(b), 111 Stat. 251, 513 (1997) (codified at 42 U.S.C. § 1396r-4(h)).

<sup>j</sup>Pub. L. No. 111-148, § 2707, 124 Stat. 119, 326 (2010) (codified at 42 U.S.C. § 1396a note). Participating states included Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia; the District of Columbia, which we refer to as a state, also participated in the demonstration.

<sup>k</sup>Pub. L. No. 114-97, § 2, 129 Stat. 2194 (2015) (codified at 42 U.S.C. § 1396a note). The 21st Century Cures Act requires HHS to study and report on the MEPD by December 2018. Pub. L. No. 114-255, §12004, 130 Stat. 1033, 1273 (2016).

188 Fed. Reg. 27, 498, 27,861 (May 6, 2016) (codified at 42 C.F.R. § 438.6(e)). The 21st Century Cures Act requires HHS to conduct a study of IMD services provided by MMC plans under the MMC final rule by December 2019. Pub. L. No. 114-255, §12002, 130 Stat. at 1272.

<sup>m</sup>Pub. L. No. 114-255, §12003, 130 Stat. at 1273.

# Appendix VI: Disproportionate Share Hospital Payments to Mental Health Treatment Facilities

**Table 12: Disproportionate Share Hospital (DSH) Payments to Mental Health Treatment Facilities in Fiscal Year 2015**

<b>State</b>	<b>DSH Payments to Mental Health Treatment Facilities</b>	<b>Percent of Total National DSH Payments that Went to Mental Health Treatment Facilities</b>
Alabama	\$0	0.00%
Alaska	\$10,925,271	0.37%
Arizona	\$28,474,900	0.98%
Arkansas	\$819,350	0.03%
California	\$26,766	0.00%
Colorado	\$0	0.00%
Connecticut	\$105,573,725	3.62%
Delaware	\$6,026,019	0.21%
District of Columbia	\$6,291,897	0.22%
Florida	\$119,098,224	4.08%
Georgia	\$0	0.00%
Hawaii	\$0	0.00%
Idaho	\$0	0.00%
Illinois	\$82,725,199	2.83%
Indiana	\$0	0.00%
Iowa	\$0	0.00%
Kansas	\$26,045,571	0.89%
Kentucky	\$37,692,279	1.29%
Louisiana	\$125,597,759	4.30%
Maine	\$42,093,817	1.44%
Maryland	\$55,969,470	1.92%
Massachusetts	\$0	0.00%
Michigan	\$82,888	0.00%
Minnesota	\$25,068,066	0.86%
Mississippi	\$0	0.00%
Missouri	\$207,234,582	7.10%
Montana	\$0	0.00%
Nebraska	\$1,438,706	0.05%
Nevada	\$0	0.00%
New Hampshire	\$40,366,108	1.38%
New Jersey	\$357,370,460	12.24%
New Mexico	\$0	0.00%
New York	\$610,821,188	20.92%
North Carolina	\$160,312,154	5.49%
North Dakota	\$988,475	0.03%
Ohio	\$93,432,758	3.20%
Oklahoma	\$3,273,248	0.11%
Oregon	\$19,903,373	0.68%
Pennsylvania	\$231,766,737	7.94%

**Appendix VI: Disproportionate Share Hospital  
Payments to Mental Health Treatment Facilities**

<b>State</b>	<b>DSH Payments to Mental Health Treatment Facilities</b>	<b>Percent of Total National DSH Payments that Went to Mental Health Treatment Facilities</b>
Rhode Island	\$0	0.00%
South Carolina	\$52,323,601	1.79%
South Dakota	\$751,299	0.03%
Tennessee	\$0	0.00%
Texas	\$303,496,529	10.40%
Utah	\$934,586	0.03%
Vermont	\$0	0.00%
Virginia	\$11,572,492	0.40%
Washington	\$132,220,168	4.53%
West Virginia	\$18,869,278	0.65%
Wisconsin	\$0	0.00%
Wyoming	\$0	0.00%
<b>Total</b>	<b>\$2,919,586,943</b>	<b>NA</b>

Source: Centers for Medicare & Medicaid Services (CMS) form CMS-64 data. | GAO-17-652

Note: The form CMS-64 is titled the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. States are required to submit aggregate total quarterly Medicaid expenditures on the form CMS-64 no later than 30 days after the end of each quarter.

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# Appendix VII: GAO Contact and Staff Acknowledgments

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## GAO Contact

Katherine Iritani, Director, (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Dawn Nelson, Analyst-in-Charge; Nancy Fasciano; Ada Nwadugbo; and Jessica L. Preston made key contributions to this report. Also contributing were Jennie Apter; Sandra George; and Vikki Porter.



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