August 26, 2025

Hon. Brett Guthrie
Chair
House Energy and Commerce Committee
2161 Rayburn House Office Bldg.
Washington DC 20515

Hon. Frank Pallone
Ranking Member
House Energy and Commerce Committee
2107 Rayburn House Office Bldg.
Washington DC 20515

Re: Opposition to HR 4022

Dear Chair Guthrie and Ranking Member Pallone:

The undersigned members and allies of the Consortium for Constituents with Disabilities (CCD) Rights Task Force write in opposition to H.R. 4022, the Increasing Behavioral Health Treatment Act. This bill, if enacted, would direct tens of billions of dollars to institutional care for people with mental health disabilities and substance use disorders at a time when state Medicaid budgets are being cut to the bone and the community services needed to avoid institutionalization are likely to be significantly reduced. It has the potential to upend decades of federal policy and legislative initiatives designed to help states support community services, undermining the rights of people with disabilities to receive services in the most integrated setting appropriate. CCD is the largest coalition of national organizations advocating for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

While we support efforts to increase the availability of and access to quality mental health and substance use disorder services, repealing Medicaid's Institutions for Mental Diseases (IMD) rule has the potential to do the opposite, particularly at a time when Medicaid community services are expected to shrink considerably as a result of the One Big Beautiful Bill Act.

Background

The IMD exclusion generally prevents states from using federal Medicaid funds to pay for care for individuals ages 21 to 64 who are in freestanding mental health and substance use disorder

(SUD) facilities with more than 16 beds. Medicaid *does* allow coverage of inpatient psychiatric care for these individuals in a general hospital, where patients can receive integrated care that addresses both medical and psychiatric needs. The IMD exclusion is not a prohibition on payment for any specific kind of service but rather a limitation on *where* services are provided. Because Medicaid reimbursement is available for mental health and SUD services in the community, the IMD exclusion has provided important incentives for states to develop community-based services.

The IMD exclusion has been part of the Medicaid program since it was established in 1965, against the backdrop of an unprecedented rise in the rate of individuals confined to psychiatric institutions with horrifying conditions.[1] Congress made clear that the IMD exclusion reflected its determination to promote and encourage community-based alternatives to large treatment settings.[2] The policy of shifting resources away from psychiatric hospitals and toward community services was a deliberate effort to ensure better care and better lives.

The Bill Would Divert Resources Away from Community Services and Would Not Reduce Barriers to Behavioral Health Care

While we strongly support efforts to remove barriers to services, repealing the IMD exclusion is not likely to achieve this goal. Institutional care is the most expensive intervention, costing many times what it costs to serve people in the community, where they can be served with greater dignity and autonomy. Spending tens of billions of dollars on institutional care may create more inpatient beds but will do nothing to address the root cause of the problem fueling demand for hospital beds: severe gaps in community services. Indeed, it is likely to increase those gaps in community services, fueling more demand for hospitalization.

Investment in community-based services such as permanent supportive housing, mobile crisis teams, assertive community treatment, supported employment, and peer support reduces the need for inpatient beds by reducing inpatient admissions and lengths of stay, and also allows for many more individuals to be served.[3] Time and again, large-scale efforts to expand community mental

[1] Ari Ne'eman, *Another Tragedy, Another Scapegoat*, THE AMERICAN PROSPECT (Feb. 27, 2018).

[2] Medicaid was established in 1965, just two years after the Community Mental Health Centers Act of 1963 was passed. In adopting the IMD rule, Congress explained that community mental health centers were "being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963," that "[o]ften the care in [psychiatric hospitals] is purely custodial," and that Medicaid would provide for "the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals." Committee on Finance, S. Rep. 404 to accompany H.R. 6675, at 46, 144, 146 (June 30, 1965).

[3] Martha Shumway et al., *Impact of Capacity Reductions in Acute*

health services have significantly reduced the census of psychiatric hospital beds as the need for hospitalization decreases.[4]

Expanding institutional care will do little to increase these community services and will likely reduce their availability. The proposed bill would be extraordinarily expensive, requiring substantial offsets that could jeopardize other Medicaid funding. According to CBO estimates, repealing the IMD rule would cost approximately $40 billion and potentially significantly more.[5] It is hard to imagine a worse time to divert scarce federal resources to the most costly interventions as states face historic shortfalls in their Medicaid and behavioral health service systems. Faced with budget shortages in the past, states have repeatedly cut community-based services.[6]

While the bill would require vague commitments from states to do a plan to increase community-based services, we know from many years of experience that such nebulous plans do not typically translate to available and funded community-based services. Further, the bill does not require that those services be made available to prevent admissions to IMDs where such admissions could be prevented with the availability of community-based services, or to enable individuals in IMDs to be discharged to the community.

Moreover, a large, federally directed three-year demonstration program allowing states to claim federal Medicaid reimbursement for services in IMDs found that doing so did not result in any of

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Public-Sector Inpatient Psychiatric Services, 63 PSYCHIATRIC SERVS. 135 (2012); Nat'l Ass'n. of State Mental Health Prog. Directors (NASMHPD), *The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity* (August 2017).

[4] For example, expansion of community services under an *Olmstead* settlement agreement between the Justice Department and Delaware resulted in a decrease in the average census of the state psychiatric hospital by more than 55% over a five-year period, and expansion of community services under a settlement between Disability Rights New Jersey and New Jersey resulted in reductions of admissions to state psychiatric hospitals by one third over a four-year period. Bazelon Center for Mental Health Law, *I am Olmstead: Services and Strategies*, at 9, 11 (2019).

[5] Cong. Budget Office, *Direct spending effects of title V of H.R. 2626, the Helping Families in Mental Health Crisis Act of 2015* (Nov. 3, 2015) (estimating that repeal of IMD rule would cost between $40 and $60 billion); Cong. Budget Office, *Budgetary Effects of Policies to Modify or Eliminate Medicaid's Institutions for Mental Diseases Exclusion* (Apr. 2023) (estimating that full repeal of IMD rule would cost $38 billion net, offsetting costs already being incurred in states with IMD demonstration waivers that effectuate partial elimination of the IMD rule).

[6] Jessica Schubel et al., *History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People*, HEALTH AFFAIRS (Apr. 16, 2025).

the benefits hypothesized: it did not decrease psychiatric emergency room visits or the length of emergency room boarding and did not increase access to psychiatric hospital services.[7]

Undermining Civil Rights and Federal Policy Initiatives

Repealing the IMD exclusion could seriously undermine decades of federal policy and legislative initiatives designed to help states rebalance their Medicaid spending to support more integrated settings, as well as hard-won civil rights for people with disabilities.[8] Many IMDs are quite large, and the size of such facilities increases the risks of segregation and isolation. For example, the average bed capacity of an IMD participating in the three-year federal IMD demonstration was over 100 beds, and one had a capacity of over 400 beds.[9]

In passing the Americans with Disabilities Act, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[10] The disability community has worked for decades to improve implementation of the ADA's integration mandate and the Supreme Court's *Olmstead* decision concluding that the ADA requires public entities to administer their services to people with disabilities in the most integrated setting appropriate.[11] The Justice Department has found violations of *Olmstead* in states across the country due to states' overreliance on psychiatric institutions and insufficient community-based services, including in Georgia, Delaware, North Carolina, New York, New Hampshire, Louisiana, West Virginia, Alameda County California, South Carolina, Missouri, Kentucky, Oklahoma, Nebraska, Nevada, Alaska, Maine, and Rhode Island. For the reasons described above, directing billions of dollars to psychiatric institutions is

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[7] The Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration authorized by Section 2707 of the Affordable Care Act, allowed twelve states to claim federal financial participation (FFP) in certain private IMDs. The only major finding was that allowing FFP for IMDs increased costs to the federal government. The demonstration did not show that FFP for IMDs shortened stays in emergency departments, reduced inpatient psychiatric treatment in non-psychiatric units of general hospitals, or increased access to psychiatric hospital treatment. Crystal Blyer et al, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf.

[8] President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.

[9] Blyler, *supra* note 7.

[10] 42 U.S.C. § 12101.

[11] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

likely to increase avoidable institutionalization and decrease available community services, undercutting progress in implementing the ADA's integration mandate.

Further, federal Medicaid dollars are already being directed to finance care for people 21-64 in IMDs through a variety of mechanisms. Those include, among others, Medicaid demonstration waivers allowing federal reimbursement for services provided to individuals in IMDs where the average length of stay does not exceed 30 days, and CMS's Medicaid managed care rule, which allows reimbursement for services provided to managed care enrollees in IMDs for up to 15 days in a month.[12] All of these carveouts to the IMD rule were deliberately designed to ensure that there are *limits* on federal reimbursement for institutional care and to avoid encouraging *long-term institutionalization*. Removing these limitations and paving the way to revert to the long-term institutionalization of people with disabilities poses particularly serious civil rights concerns.

For these reasons, we urge you not to move this bill forward.

Sincerely,

Access Ready, Inc.

Alabama Disabilities Advocacy Program

Alliance for Rights and Recovery

American Association of People with Disabilities

American Association on Health and Disability

American Civil Liberties Union

The Arc of the United States

Autistic Self Advocacy Network

Autistic Women & Non-Binary Network

Bazelon Center for Mental Health Law

Cal Voices

[12] Medicaid and CHIP Payment and Access Commission, *Report to Congress on Oversight of Institutions for Mental Diseases* (Dec. 2019);

Caring Across Generations

Center for Public Representation

CommunicationFIRST

Communication 4ALL

Connecticut Legal Rights Project

Corporation for Supportive Housing

Disability Belongs

Disability Law Center of Utah

disAbility Law Center of Virginia

Disability Rights Arizona

Disability Rights Arkansas

Disability Rights California

Disability Rights Center – New Hampshire

Disability Rights Connecticut

Disability Rights Delaware of Community Legal Aid Society, Inc.

Disability Rights Education and Defense Fund

Disability Rights Florida

Disability Rights Idaho

Disability Rights Iowa

Disability Rights Kansas

Disability Rights Kentucky

Disability Rights Louisiana

Disability Rights Maine

Disability Rights Michigan

Disability Rights New Jersey

Disability Rights New York

Disability Rights North Carolina

Disability Rights Ohio

Disability Rights Oregon

Disability Rights Pennsylvania

Disability Rights Vermont

Disability Rights Washington

Disability Rights Wisconsin

Epilepsy Foundation of America

Georgia Advocacy Office

Indiana Disability Rights

Keep the Promise Coalition

Lakeshore Foundation

Mental Health America of North Dakota

National Association of the Deaf

National Association for Rights Protection and Advocacy

National Coalition for Mental Health Recovery

National Disability Rights Network

National Health Law Program

National Mental Health Consumers' Self-Help Clearinghouse

North Dakota Federation of Families

North Dakota Protection and Advocacy Project

Perkins School for the Blind

Psychiatric Rehabilitation Association

TDIforAccess

World Institute on Disability