

THE OUTDATED INSTITUTION FOR MENTAL DISEASES EXCLUSION:
A CALL TO RE-EXAMINE AND REPEAL THE MEDICAID IMD EXCLUSION

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I. INTRODUCTION AND OVERVIEW OF THE MEDICAID IMD EXCLUSION

*a. Importance Of Medicaid For Persons With Serious Mental
Illness And The IMD Exclusion*

Approximately five million persons in the United States, or about 2.8 percent of the adult population and 3.2 percent of children, suffer from severe and persistent mental illnesses, or "serious mental illnesses",¹ consisting of schizophrenia,² bipolar

¹ NATIONAL ADVISORY MENTAL HEALTH COUNCIL, HEALTH CARE REFORM FOR AMERICANS WITH SEVERE MENTAL ILLNESSES 7 (1993) (hereinafter NAMHC REP.). The NAMHC REP. was requested by Senate Appropriations Committee, in S. Rep. No. 102-397, and the executive summary of the report has been republished in 150 AM. J. PSYCHIATRY 1447-1465 (Oct. 1993). It is estimated that approximately 5.6 million Americans suffer from a serious mental illness today, based upon a 1995 total population estimate of 262 million persons in the United States. See E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 6 (1996) (hereinafter OUT OF THE SHADOWS).

² It has been estimated that each year in the United States, approximately one in a hundred persons, or 2.0 to 2.62 million persons are diagnosed as having schizophrenia based upon the above mentioned 1995 United States population estimate of 262 million persons. CENTER FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH & HUMAN SERVICES, DHHS PUB. NO. (SMA) 94-3011, A NEW FEDERAL FOCUS FOR THE PREVENTION AND TREATMENT OF MENTAL ILLNESS 7 (1994) (hereinafter CMHS 1994 pamphlet). In addition, it is estimated that approximately 3.7 million Americans have or will develop schizophrenia during their lifetime. See E. FULLER TORREY, SURVIVING SCHIZOPHRENIA 6 (3rd ed. 1995).

It is noteworthy that schizophrenia, (originally called *dementia praecox*), is the most prevalent serious mental illness which requires long-term hospitalization or institutional psychiatric care. Interviews with E. Fuller Torrey, M.D., a research psychiatrist at the National Institute of Mental Health, Neuro-Science Center at Saint Elizabeth's Hospital, in Washington, D.C. (Oct. 27, 1995; Mar. 15, 1996) (hereinafter Interviews with Dr. Torrey) and with Roger Peele, M.D., the past superintendent and chairperson of the psychiatric department at Saint Elizabeth's Hospital and current President of Washington Psychiatric Society, in Washington, D.C. (April 9, 1996) (hereinafter Interview with Dr. Peele). See *infra* notes 13-17 and accompanying text for a

disorder (formerly called "manic-depressive illness"),³ major depression, obsessive compulsive disorder, and panic disorder. These illnesses can have a significant and a devastating impact on the individuals' lives and their families. Fortunately, treatment is now available which allows the majority of persons affected by these disorders to be treated on an outpatient basis, allowing these individuals to participate more fully in society and become more productive at work, at home, and in the community.⁴

Due to financial barriers limiting access to private health insurance coverage, the federal program entitled "Grants to States for Medical Assistance Programs" (commonly called "Medicaid")⁵ has evolved into an important source of funding for treatment of mental illness.⁶ Medicaid does not impose any special or

discussion of the estimated number of persons with schizophrenia requiring long-term hospitalization or institutional psychiatric care.

³ Estimates indicate that at least 1.1 million people are affected by bipolar (affective) disorder or manic-depression. See TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 6. Also, it is not uncommon for patients with the most severe forms of bipolar disorder to be treatment-resistant and require long-term residential or institutional psychiatric care. Interviews with Dr. Torrey and Dr. Peele, *supra* note 2.

⁴ NAMHC REP., *supra* note 1, at 5-6.

⁵ Title XIX of the Social Security Act, enacted as part of the Social Security Amendments of 1965, established the federal Medicaid program. 42 U.S.C. § 1396 et seq. (1994). A complete overview and discussion of the relevant statutory and regulatory Medicaid provisions is set forth in part II.A of this article, *infra* notes 54-87.

⁶ See CONGRESSIONAL RESEARCH SERVICE (CRS), *MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 913* (January 1993) (App. E: *Medicaid Services For The Mentally Ill*) (hereinafter CRS, *MEDICAID SOURCE*

additional requirements that persons with mental illnesses must meet in order to be eligible for covered services.⁷ Thus, Medicaid has increased accessibility to mental health and psychiatric care services for mentally ill persons in general hospitals and nursing facility settings, as well as individuals who receive outpatient mental health services in their communities.⁸ Since the early 1980s, Medicaid has been recognized

BOOK, *Medicaid Services For The Mentally Ill*).

⁷ States participating in the federal medical assistance program must cover persons who are deemed under the Act to be "categorically needy". 42 U.S.C. § 1396a(a)(10) (1994). Persons with severe mental illness typically qualify for Medicaid services based upon eligibility for Supplemental Security Income (SSI), by virtue of being determined to be "disabled" within the meaning of the Social Security Act. The other main classification of "categorically needy" individuals who are eligible for Medicaid services are recipients of "Aid to Families with Dependent Children" (AFDC). 42 U.S.C. § 1396a(a)(10) and § 1396d(a) (1994) and 42 CFR 435.100 et seq., 435.500 et seq., 435.600 et seq., and 435.700 et seq. (1995). The relevant statutory and regulatory provisions of the federal medical assistance program are set forth in part II of this article, *infra* notes 54-87.

Additionally, Medicaid does not distinguish between expenditures made for treatments for mental versus physical conditions. CRS, MEDICAID SOURCE BOOK, *Medicaid Services For The Mentally Ill*, *supra* note 6, at 913. As a result, estimates of the total number of eligible persons with mental illness covered under Medicaid have been difficult to pinpoint. However, using Social Security Administration research data regarding SSI benefits, reveal that 26.4 percent of SSI recipients had a primary diagnosis of a mental disorder, (other than mental retardation). *Id.* at 915.

⁸ CRS, MEDICAID SOURCE BOOK, *Medicaid Services For The Mentally Ill*, *supra* note 6, at 913.

In comparison to Medicaid coverage of on-going mental health services, Medicare's hospital insurance, (Medicare Part A), covers 90 days of inpatient hospital care and 100 days of extended care services in a skilled nursing facility (for rehabilitation), per "spell of illness". Beyond these "spell of illness" coverage limitations, Medicare allows for an additional 60 days of inpatient hospitalization under a lifetime reserve policy, which may only be used once. Also, Medicare places a lifetime limitation of 190 days on inpatient treatment in psychiatric

as "the largest single mental health program in the country",⁹ and it is estimated that fifteen percent of total Medicaid dollars are spent on care and treatment of persons with mental illnesses.¹⁰

The majority of persons with serious mental illnesses can now be treated on an outpatient basis with psychotropic medications which have been developed over the past four decades. Medications such as clozapine, risperidone and lithium, used by themselves or in combination with other medications and nonpharmacologic therapies, are being used successfully to treat the majority of persons (approximately 80 percent) with serious mental illnesses, such as schizophrenia and bipolar disorder, allowing these

hospitals; no similar lifetime coverage limitations are imposed for services provided in other types of hospital settings. See Section 1812(a) and (b)(1)-(3) of the Social Security Act, 42 U.S.C. § 1395d(a) and (b)(1)-(3) (1994). Nevertheless, this article will strictly focus on Medicaid because it is the primary source of federal funding for ongoing psychiatric care and mental health services.

⁹ TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 93 citing Kiesler, *Mental Health Policy as a Field of Inquiry for Psychology*, 35 AMERICAN PSYCHOLOGIST 1066-1080 (1980).

Bruce C. Vladeck, the Administrator of the Health Care Financing Administration (HCFA), stated during questioning before a House subcommittee that Medicaid is now the number one source of funding for expenditures for treatment of mental illness. See testimony of HCFA Administrator Bruce Vladeck, before the U.S. House of Representatives, Committee On Governmental Reform and Oversight, Subcommittee on Human Resources and Intergovernmental Relations, on January 18, 1996, regarding *Unfunded Mandates in Medicaid*, 1996 FEDERAL DOCUMENT CLEARING HOUSE, INC., FEDERAL DOCUMENT CLEARING HOUSE CONGRESSIONAL TESTIMONY, (January 18, 1996), (hereinafter Testimony of HCFA Administrator Vladeck). This House subcommittee hearing was televised on C-SPAN.

¹⁰ See C.A. Taube et al., *Medicaid Coverage for Mental Illness*, HEALTH AFFAIRS, Spring 1990, at 5-18.

individuals to reside and remain in their communities.¹¹ State Medicaid agencies are required to cover psychotropic medications if the state Medicaid plan incorporates a prescription drug benefit.¹² Maintaining successful long-term outpatient

¹¹ Patient success rates with antipsychotic medications can vary greatly. However, the Center for Mental Health Services (CMHS) estimates that medication can help up to 80 percent of persons diagnosed with bipolar disorder and can relieve acute symptoms in 80 percent of persons diagnosed with schizophrenia. See CMHS 1994 pamphlet, *supra* note 2, at 5. During interviews with Dr. Torrey, *supra* note 2, he stated that on average 80 to 85 percent of all patients with schizophrenia and bipolar disorder (after stabilization) can now be treated and cared for on an outpatient basis with the proper medications and monitoring.

Clozapine and risperidone are examples of two recently approved drugs by the Federal Food and Drug Administration (FDA) which have been successful in treating patients with schizophrenia and related disorders. Lithium, discovered in Australia in 1948 but not introduced in the United States until the 1970's, has become the standard form of treatment of persons with bipolar disorders. Lithium has proven to be an effective treatment for bipolar disorders in approximately 75 to 80 percent of all cases.

See TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 190-216. See also A. Gelenberg, *Report on the Efficacy of Treatments for Bipolar Disorder*, published in the NAMHC REP., *supra* note 1, at 75-85.

Another useful treatment employed to treat some medication-resistant patients with schizophrenia and bipolar disorder(s), (short of long-term hospitalization), is electroconvulsive therapy (ECT or "shock therapy"). See NAMHC REP., *supra* note 1, at 10 and TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 108, 218.

Furthermore, research studies based upon clinical trials have verified the efficacy of modern treatments for serious mental disorders and have provided a scientific basis for clinical decision-making. The efficacy of many treatments for severe mental disorders is now recognized as being comparable to or exceeding that of other medical procedures, such as angioplasty and atherectomy. See NAMHC REP., *supra* note 1, at 8-12. See also OFFICE OF TECHNOLOGY ASSESSMENT (OTA), U.S. CONGRESS, PUB. NO. OTA-BA-538, *THE BIOLOGY OF MENTAL DISORDERS* (Sept. 1992), (hereinafter OTA REP., *BIOLOGY OF MENTAL DISORDERS*).

¹² Prescription drug coverage is an optional benefit under the federal Medicaid program, set forth in Section 1905(a)(12) of the Social Security Act, 42 U.S.C. § 1396d(a)(12) (1994). However, once a State decides to cover prescription drugs in its state Medicaid plan, it cannot discriminate on the basis of type of prescription medication or condition. See *Visser v. Taylor*, 756

psychiatric treatment, however, depends upon several other factors such as the patient's compliance with medications and the availability of good community mental health and rehabilitative care programs.

Unfortunately, not all individuals who suffer from these disorders are able to receive satisfactory benefits from psychotropic medications. Persons whose symptoms and disease processes are exceedingly severe and who do not respond to medications and nonpharmacologic therapies may require extended hospitalization(s) or long-term institutional / residential psychiatric care.¹³ Because of the nature of these illnesses, it

F. Supp. 501 (D. Kan. 1990), *citing* 42 CFR 440.230(c); *see also* Alexander L. v. Cuomo, 588 N.Y.S. 2d 85 (N.Y. App. 1992). Prescription drugs covered by Medicaid must, however, be approved by the federal Food and Drug Administration (FDA) as being safe and effective.

¹³ See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 91; TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 248-250; Roger Peele, *The Indispensable St. Elizabeths*, THE WASHINGTON POST, February 11, 1996, at C8, (hereinafter Peele, *The Indispensable St. Elizabeths*); and Roger Peele, *In Pursuit of the Promise: The Needs of Washington's Psychiatrically Ill and Saint Elizabeths*, 4, 18-23 (March 22, 1996), (unpublished manuscript, on file with the Washington Psychiatric Society), (hereinafter Peele, *In Pursuit of the Promise*). In interviews with both Dr. Torrey and Dr. Peele, *supra* note 2, these psychiatrists expressed their professional opinions that for the most severely disabled mentally ill individuals repeated short-term hospitalizations in psychiatric units of general hospitals fail to yield satisfactory long-term solutions for their chronic conditions and problems. Additionally, nursing facilities and small board and care facilities generally do not have professionally trained staff, such as a full-time psychiatrist on site, nor the capacity to provide specialized psychiatric and other mental health services to these severely disabled individuals, which would allow them to function at their optimum functioning level on a continual basis. Therefore, even with the advanced medicines of today, long-term care in asylums offers chronic and severely mentally ill individuals who are

is difficult to ascertain at any given time a firm estimate of the number of such persons, often referred to as "the forgotten population",¹⁴ who are unable to receive satisfactory benefits from medications and need long-term institutional or residential psychiatric care. Conservative estimates indicate that ten percent of individuals with schizophrenia are treatment-resistant and require long-term (often life-long) institutional care, even in communities with the best outpatient psychiatric care and mental health service programs.¹⁵ Additionally, a greater number

unable to protect or fend for themselves the best hope and possibility of achieving their maximum functioning potential, in terms of overall quality of life. *Id.* See also *infra* note 15.

Further note, Dr. Peele prefers to use the terms "psychiatrically ill" and "psychiatric illness", in place of "mentally ill" and "mental illness". However, in an effort to maintain consistency, this analysis will use the traditional term "serious mental illness" in reference to this category of psychiatric disorders.

¹⁴ Rose Marie Friedrich and Curtis B. Flory, *The Need for a Policy on Long Term Care*, (January 1996), (unpublished manuscript, on file with The National Alliance for the Mentally Ill) (NAMI).

¹⁵ This ten percent figure is based upon the treatment-resistant population in areas with the best outpatient psychiatric services and mental health programs, like the "Program Assertive Community Treatment" (PACT) in Dane County (Madison), Wisconsin. See TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 249. Beyond this, in interviews, Dr. Torrey stated that, on average, between 15 to 20 percent of persons with schizophrenia and bipolar disorder do not receive satisfactory benefits from medication for treatment on an outpatient basis and will continue to require long-term hospitalization or residential psychiatric care. Interviews with Dr. Torrey, *supra* note 2. This 15 to 20 percent figure is the inverse of the 80 to 85 percent estimate that patients with these disorders (after stabilization) can be maintained on an outpatient basis with the proper medications and monitoring, cited in *supra* note 11.

These professional views and contentions are supported by Dr. Peele, who stated that there is a small proportion, but a significant number, of chronic psychiatrically ill persons who, even with the most modern treatment approaches, are unable to live in the community and will require indefinite care at Saint

of persons with bipolar disorder and schizophrenia (approximately 20 percent)¹⁶ respond only minimally to standard psychotropic medications and would be better served through inpatient hospitalization or residential treatment programs than through outpatient community mental health services available in many communities in the United States today.¹⁷ A significant number of persons suffering from these disorders tend to be treatment-resistant to standard psychotropic medications at the onset of

Elizabeths (Saint Elizabeth's Hospital) (or other psychiatric hospitals or institutions). Interview with Dr. Peele, *supra* note 2. See also Peele, *The Indispensable St. Elizabeths* and Peele, *In Pursuit of the Promise*, *supra* note 13, at 4 and 18-24.

¹⁶ This 20 percent estimate is based on the inverse of CMHS's estimate that medication can help up to 80 percent of persons diagnosed with bipolar disorder and can relieve acute symptoms in 80 percent of persons diagnosed with schizophrenia. See *supra* note 11, citing the CMHS 1994 pamphlet, at 5.

Additionally, the National Advisory Mental Health Council (NAMHC) stated, in its 1993 report, *supra* note 1, at 9, that clinical trials over the last 30 years reveal that antipsychotic medications initially reduce psychotic symptoms in 60 percent of patients with schizophrenia and in 70 to 85 percent of patients experiencing symptoms for the first time. Nevertheless, even when medication is sustained, 60 percent of patients will relapse to the point of requiring inpatient care. *Id.* Adding in psychosocial treatment programs to medication regimens can reduce the rehospitalization rate to 25 to 30 percent within a 2 year period. *Id.* Also, the NAMHC mentioned that new medications, such as clozapine and risperidone, are effective in nearly one-third of patients who were previously unresponsive to all treatments. *Id.*

However, this still leaves approximately 26.6 percent, (40 percent minus one-third), of persons with schizophrenia who are treatment-resistant to standard antipsychotic medications.

¹⁷ Dr. Torrey stated in his book, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 249, that in areas with few outpatient services less than half of all seriously mentally ill persons would fare better living in the community than in an institutional setting. He further stated that, based upon his professional experience, at least one-quarter of the patients discharged from Saint Elizabeth's (Hospital) are worse off living in the community in terms of quality of life than if they had remained in the hospital. *Id.*

their illness and initial intervention and need extended psychiatric hospitalization(s), before they are stabilized on the appropriate treatment regimen and can be discharged. Repeated psychiatric hospitalizations are often necessary for persons whose conditions relapse after they are discharged.¹⁸

State psychiatric institutions and freestanding psychiatric hospitals are generally better suited to provide this type of care than psychiatric units in a general hospital. Psychiatrists on the medical staff at psychiatric hospitals generally maintain their offices on site rather than in the community, which allows for more interaction with the patients and a closer working relationship with the nursing staff. These on-site physicians are better situated to evaluate and/or modify treatment programs if the patient fails to respond to the prescribed treatment plan. Psychiatric hospitals offer more specialized services, such as individual and group therapy sessions, art therapy programs, and other beneficial psychosocial activities tailored to the individual patient's condition and level of functioning. Furthermore, psychiatric hospitals are able to provide a continuum of psychiatric care services with transitions, supervised by the same medical and mental health professionals, from inpatient psychiatric care to partial hospitalization services and/or outpatient-based services and, if need be, residential psychiatric

¹⁸ See *supra* note 16, *citing* the NAMHC REP., *supra* note 1, stating that, even when medication is sustained, 60 percent of patients will relapse and will require inpatient care.

care. These inherent advantages of psychiatric hospitals promote a greater continuity of care for patients than can be received through inpatient psychiatric care in general hospitals and separate aftercare services furnished by other organizations or agencies in the community.¹⁹

Nevertheless, the federal Medicaid statute specifically excludes federal payment for services provided to otherwise-qualified individuals, twenty-two to sixty-four years of age, in institutions for mental diseases (IMDs).²⁰ The term "institution for mental diseases" was statutorily defined in 1988 as "a hospital, nursing facility or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services."²¹ This statutory definition, therefore, denies federal payment for

¹⁹ See part III.C, *supra* notes 211-213 and accompanying text, for a further discussion of the treatment advantages in freestanding (specialty) psychiatric hospitals versus inpatient treatment in psychiatric units in general hospitals.

²⁰ Pursuant to Section 1905(a) of the Social Security Act [42 U.S.C. § 1396d(a) (1994)], the term "medical assistance" specifically excludes federal payment for services provided in an "institution for mental diseases" (IMD). However, sections 1902(a)(20) and 1905(a)(14) [42 U.S.C. §§ 1396a(a)(20) and 1396d(a)(14) (1995)] provide an exception to the IMD exclusion for individuals sixty-five years of age and older if covered under the State's Medicaid plan. Subsections 1905d(a)(16) and (h) [42 U.S.C. § 1396d(a)(16), (h) (1994)], added in 1972, provide for federal Medicaid payments to cover services provided to individuals 21 years of age or younger in psychiatric hospitals.

²¹ Section 1905(i) of the Social Security Act, 42 U.S.C. § 1396d(i) (1994).

services furnished to otherwise Medicaid-eligible recipients in traditional state mental hospitals and in more modern freestanding psychiatric hospitals and other facilities with more than sixteen beds which specialize in or are primarily engaged in the care and treatment of persons with psychiatric disorders (other than mental retardation and related conditions).²²

*b. Rationale For The IMD Exclusion
And An Overview Of Why It Should Now Be Repealed*

The IMD exclusion was originally premised upon the notion in the Social Security Act and other federal social welfare programs dating back to 1950²³ and before²⁴ that the care of persons in

²² An in-depth discussion and analysis pertaining to the medical institutions and facilities which constitute an "IMD", under the statutory definition of an "IMD", and other relevant legal issues are set forth in part II.C of this article, *infra* notes 98-114 and accompanying text.

Also, the contentions raised in this analysis, for abolishing the Medicaid IMD exclusion, will strictly focus on inpatient and/or residential psychiatric care for otherwise-eligible recipients who require such institutional care due to neurobiological psychiatric disorders. See further discussion in this part at notes 44-49 and accompanying text. Discussion concerning prospective Medicaid coverage of institutional treatment for persons with alcohol and substance abuse disorders is beyond the scope of this analysis. See the discussion in *infra* note 205, in part III.C of this analysis, for an examination of the legal distinctions between persons receiving treatment for serious mental illnesses and those receiving treatment for alcohol and substance abuse disorders.

²³ See H.R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949) pertaining to Congressional deliberations concerning the federal program entitled "Grants To States For Aid To The Permanently And Totally Disabled", enacted as Title XIV of the Social Security Act, Pub. L. No. 81-64, 64 Stat. 555 (1950), 42 U.S.C. . 1351 et seq. (1994), (*repealed by* Pub. L. 92-603, §303, effective January 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands). See the discussion in the legislative history subsection in part II.B of this analysis, *infra* notes 88-97 and accompanying text.

state mental institutions [and tuberculosis (TB) hospitals]²⁵ was considered to be a traditional responsibility of the States.²⁶ By the 1960s, however, the Federal Government has wanted to promote the use of outpatient community mental health services in the belief that with the development of new treatment techniques, namely more effective psychotropic drugs and an increased number of psychiatric beds in general hospitals, community mental health services would ultimately replace the often maligned state mental

²⁴ Prior to 1950, federal funds administered under the Social Security Act were denied to individuals who were deemed to be "inmates of public institutions", which covered patients in public medical facilities, including public general hospitals and state mental and TB hospitals, as well as inmates in penal institutions. See further discussion in part II.B, *infra* note 88.

²⁵ Originally, this institutional exclusion also covered services provided in tuberculosis institutions or sanatoriums. However, in 1984, the federal Medicaid statute was amended to abolish the exclusion of individuals in institutions for tuberculosis as being no longer necessary, inasmuch as "TB sanatoriums" were no longer used for treatment of tuberculosis. The TB amendments to Section 1905(a) of the Social Security Act, [42 U.S.C. § 1396d(a)], were incorporated into Section 2335 of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, 1090-1091 (1984). Since issues relating to the denial of federal Medicaid for services provided in tubercular institutions are now moot, this analysis strictly pertains to the exclusion of federal medical assistance for services provided to individuals between the ages of twenty-two and sixty-four in institutions for mental diseases (IMDs).

²⁶ See *Schweiker v. Wilson*, 450 U.S. 221, 237, n. 19 (1981) citing H.R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949); S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147 (1965). See also the discussion of the federal program entitled "Grants To States For Aid To The Permanently And Totally Disabled", Pub. L. No. 81-64, 64 Stat. 555 (1950), [42 U.S.C. § 1351 et seq. (1994)], in the legislative history subsection of the statutory section, in part II.B, *infra* notes 88-89 and accompanying text, for an in-depth analysis of the "traditionally a state responsibility" rationale for the Medicaid IMD exclusion.

institutions.²⁷

With this in mind, President Kennedy and Congress worked together to enact the Community Mental Health Centers Act (CMHCA)²⁸ as part of the Mental Retardation Facilities and

²⁷ See the legislative history to the Community Mental Health Centers Act of 1963, Pub. L. No. 88-164, 77 Stat. 282, 290-294 (1963), *published in* H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), *reprinted in* 1963 U.S.C.C.A.N. 1054, at 1064-66.

The Committee on Interstate and Foreign Commerce for the House of Representatives, in the above cited Congressional report, discounted the need for long-term institutional psychiatric care by citing a research study which indicated that seven out of ten schizophrenic patients were able to be discharged within a year. *Id.* at 1065. The committee report noted that half of the nation's hospital beds were occupied by psychiatric patients and cited two programs existing at that time where the average psychiatric hospital stays in general hospitals were between sixteen to twenty-one days. *Id.* at 1064-65. This Congressional report also referred to outpatient mental health programs in which half of the psychotic patients, who would otherwise have been institutionalized, were being treated in the community, and a large number of such patients were also able to return to work within six weeks. *Id.*

These studies and the potential for success of the community mental health centers in treating the majority of individuals with schizophrenia and other serious mental illnesses, on an outpatient basis, in the community are not disputed. However, Congress failed to recognize the fact that a significant number of persons with severe forms of schizophrenia and other serious mental illnesses were (and remain) treatment-resistant to medications and need institutional or residential psychiatric care.

²⁸ Pub. L. No. 88-164, 77 Stat. 282, 290-294 (1963), 42 U.S.C. § 2689 (repealed 1981).

The legislative history to the Community Mental Health Centers (CMHCs) Act referred to mental illness as being the nation's most serious public health problem (during the 1950s and 1960s). H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), *reprinted in* 1963 U.S.C.C.A.N. 1054, 1064.

In 1981, the CMHCs program was replaced by federal block grants to the States to provide public mental health services covering alcohol, drug abuse, and mental health (ADM) services. Pub. L. No. 97-35, tit. 9, §902(e)(2)(B), 95 Stat. 560 (1981). See discussion of the ADM block grant programs in *infra* note 35 and contentions raised in *infra* note 205.

Community Mental Health Centers Construction Act of 1963.²⁹ The enactment of the Community Mental Health Centers Act started a dynamic shift in public funding for mental health services from the States to the Federal Government and promoted the utilization of outpatient-based community mental health services and discouraged the use of institutional psychiatric care.³⁰

The same rationale underlying the CMHCA was used to allow States to provide generous coverage of outpatient community mental health services under state Medicaid plans, while at the same time excluding federal financial participation³¹ or federal medical

²⁹ Pub. L. No. 88-164, 77 Stat. 282 (1963). Title I covered "Construction of Research Centers and Facilities for the Mentally Retarded", and Title II pertained to the "Construction of Community Mental Health Centers".

³⁰ Prior to the enactment of the CMHCA in 1963, public funding for the treatment and care of persons with mental illnesses was almost exclusively done at the state and local level. In 1963 and before, 98 percent of public funding for care and services for mentally ill persons was at the state and local levels, with only 2 percent being funded by the Federal Government. By 1985, 38 percent of the costs for public services furnished to persons with mental illness was paid for at the federal level, and by 1994, 62 percent of this fiscal responsibility was paid for by the Federal Government. In 1994, the Federal Government spent a total of \$38 billion for care and services for mentally ill individuals, including \$8.6 billion Medicaid dollars. The other federal dollars came from the Veterans Administration budget, the Supplemental Security Income (SSI) and the Social Security disability insurance (SSDI) programs, the "alcohol, drug abuse and mental health" block grant (ADM) programs, and housing and other subsidies. See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 98-99.

³¹ Federal financial participation (FFP) or federal medical assistance (Medicaid) is available for state expenditures for Medicaid services provided to eligible recipients, whose coverage is required or allowed under Title XIX of the Social Security Act. See 42 U.S.C. §§ 1396a(a), 1396b and 1396d(b) (1994) and 42 CFR 430.10 et seq. and 42 CFR 435.1002 (1995). See also discussion in part II.A of this analysis, *infra* notes 66-67 and accompanying

assistance for services furnished to individuals under sixty-five years of age in IMDs.³² The legislative history of the Social Security Amendments of 1965, pertaining to the federal public assistance provisions³³ as well as the Medicaid amendments, states that it is anticipated that this legislation would give States further encouragement to continue the trend of discharging patients from mental hospitals in an effort to serve them through alternative settings, such as in nursing homes, foster homes, community mental health centers, and short-term treatment in general hospitals.³⁴

text, pertaining to federal financial participation (FFP).

³² Sections 1902(a)(10) and 1905(a) of the Social Security Act, 42 U.S.C. § 1396a(a)(10) and § 1396d(a) (1994). The statutory provisions underlying the Medicaid IMD exclusion are examined in greater detail in part II.A of this analysis, *infra* notes 58-87.

³³ The 1965 Amendments to the Social Security Act of 1935 not only established the federal Medicare and Medicaid programs, but also amended the federal public assistance program, which later evolved into the Supplemental Security Income program, Title XVI of the Social Security Act. See discussion in part II.A, *infra* notes 54-61 and accompanying text.

³⁴ S. Rep. No. 404, 89th Cong. 1st Sess., pt. 1, at 145 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2085.

In enacting Medicaid, Congress believed that it was important for States to move forward in developing comprehensive mental health plans as contemplated by the Community Mental Health Centers Act. *Id.* at 146 and 2085-86, respectively. Thus, in order to accomplish these policy goals, Congress made approval of federal public assistance and medical assistance for eligible individuals age sixty-five and older in IMDs [and TB hospitals] contingent upon the State's demonstrating satisfactory progress toward developing and implementing a comprehensive mental health program, which included the utilization of community mental health centers, nursing homes, and other alternatives to institutional care. *Id.* and 42 U.S.C. § 1396a(a)(21) (1994). Note, coverage of services provided to individuals sixty-five years of age and older in IMDs is an optional benefit which individual States may elect, but are not required, to cover under their state Medicaid plans.

Consequently, federal Medicaid coverage of alternatives to institutional psychiatric care, used in conjunction with CMHC programs³⁵ and other federal entitlement programs available to eligible individuals residing in the community,³⁶ provided considerable financial inducements for States to discharge patients from state mental institutions. Collectively, these federal funding incentives have been the principal catalysts behind the "deinstitutionalization" movement in the United States from the 1960s and beyond.³⁷

42 U.S.C. § 1396d(a)(14) (1994). This statutory coverage issue and the optional benefit covering inpatient psychiatric hospital services for individuals under 21 are discussed in part II.A of this analysis, *infra* notes 81-82 and accompanying text.

³⁵ The original CMHC program was replaced, in 1981, by federal block grants to the States for alcohol, drug abuse, and mental health (ADM) treatment services. The Omnibus Budget Reconciliation Act of 1981 (OBRA of 81), Pub. L. No. 97-35, tit. 9, § 902(e)(2)(B), 95 Stat. 560 (1981). The ADM block grants represented a 25 percent cut in federal funding for mental health and substance abuse services, in exchange for greater control at the state and local levels.

³⁶ Other social welfare entitlement programs which are available to eligible persons living in the community include Social Security disability, Supplemental Security Income (SSI), Housing and Urban Development (HUD) housing vouchers, and food stamps. However, States cannot receive federal reimbursement under these programs for similar services provided to persons in state mental institutions. Nonetheless, the primary financial incentive for States to deinstitutionalize patients has been the exclusion of federal Medicaid payments for services provided to individuals between the ages of 22 and 64 in IMDs. See *supra* note 30, citing TORREY, OUT OF THE SHADOWS, *supra* note 1, at 98-99.

³⁷ These federal funding incentives have created enormous financial inducements to deinstitutionalize patients from state psychiatric hospitals. As a result, States have tried quite consciously to discharge the majority of psychiatric patients from state hospitals over the past several years (rightfully or wrongfully) in an attempt to treat these individuals on an

To illustrate the magnitude of deinstitutionalization in America, at the height of institutionalization (1955), an estimated 559,000 persons were in public psychiatric hospitals (IMDs).³⁸ Today, there are fewer than 90,000 individuals in the United States remaining in public psychiatric hospitals.³⁹

outpatient basis, or transfer them to other medical facilities which are eligible to receive federal Medicaid funds. See E. Fuller Torrey, *Economic Barriers to Widespread Implementation of Model Programs for Seriously Mentally Ill*, 41 HOSPITAL AND COMMUNITY PSYCHIATRY 530-531 (1990), citing W. Gronfein, *Incentives and Intentions in Mental Health Policy: a comparison of the Medicaid and community mental health programs*, 26 J. OF HEALTH & SOCIAL BEHAVIOR 192-206 (1985); and C. Kieler, *Mental Hospitals and alternative Care*, 37 AMERICAN PSYCHOLOGIST 349-360 (1982). See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 24-26, and the testimony of E. Fuller Torrey before the United States Senate, Committee on Finance, on *Deinstitutionalization*, FEDERAL NEWS SERVICE, (May 10, 1994), (hereinafter Dr. Torrey's Congressional Testimony).

Other significant contributing factors behind the deinstitutionalization movement include misunderstanding of the causes of serious mental illnesses portrayed in books and movies, such as T. SZASZ, MYTH OF MENTAL ILLNESS (1961) and KEN KESEY, ONE FLEW OVER THE CUCKOO'S NEST (1962) and legal causes of action based upon the "least restrictive environment" and individual liberty interests of psychiatric patients. See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 24-25.

³⁸ TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 24.

³⁹ *Id.* Also a recent figure from the National Institute of Mental Health (NIMH), released on December 21, 1994, indicated that the number of persons in state psychiatric hospitals was 71,619. See TORREY, OUT OF THE SHADOWS, *supra* note 1, at 8.

Today, individuals suffering from mental illness who have private health insurance coverage or can otherwise afford it, can receive on-going treatment in private freestanding psychiatric hospitals. However, due to the Medicaid IMD exclusion, the vast majority of persons with chronic and severe forms of schizophrenia and other serious mental illnesses reside in or receive on-going or periodic care and treatment in other types of settings, such as "board and care facilities" and "semi-hospitals" (with 16 or fewer hospital beds, and thus exempt from the IMD exclusion under the Medicaid statute), inpatient units at mental health centers, nursing home facilities, and psychiatric wards of general and Veterans Administration hospitals. Parts II.C and III.B of this

With the advent of psychotropic medications, deinstitutionalization has provided greater opportunities for many mentally ill persons who would have otherwise been unable to participate in or experience these freedoms by virtue of being confined to a psychiatric hospital. At the same time, however, deinstitutionalization has contributed to or exacerbated problems for a significant portion of individuals with chronic and severe forms of schizophrenia and other mental illnesses who continue to be treatment-resistant and need extended inpatient hospitalization or long-term residential or institutional psychiatric care.⁴⁰ Instead of being able to make a successful adjustment or transition to life in the community, a significant number of severely mentally ill individuals find themselves caught up in a perpetual cycle of homelessness, living in shelters, revolving door hospitalizations, and confinement in jails and prisons.⁴¹ At best, severely mentally ill, treatment-resistant individuals often end up or reside in nursing facilities or smaller board and care facilities or group homes with sixteen or fewer beds, thus

analysis, at *infra* notes 100-112 and 189-201 and accompanying text, respectively, discuss in greater detail the types of facilities and patient populations which are exempted from the IMD exclusion.

⁴⁰ See the discussion regarding the treatment-resistant populations and need for extended inpatient psychiatric care or long-term residential or institutional psychiatric care, in *supra* notes 13-18 and accompanying text.

⁴¹ Part III.B of this analysis, *infra* notes 179-188 and accompanying text, discusses the recurrent social problems resulting from deinstitutionalization.

preserving their eligibility to receive Medicaid services.⁴² These individuals require ongoing treatment and need a highly structured living environment and would be better served through institutions and residential facilities which specialize in the care and treatment of persons with psychiatric disorders.⁴³

The Federal Government, through its administration of public mental health funding policies, is partly responsible for the problems resulting from deinstitutionalization and the deficiencies in the public mental health systems in the United States today. Early federal mental health policies were developed based upon a fundamental misunderstanding of the nature and causes of serious mental illnesses.⁴⁴ Federal policymakers during the

⁴² The general scheme by which severely mentally ill persons are transferred to or placed in nursing facilities and smaller residential care facilities eligible to receive Medicaid payment who otherwise would require institutional psychiatric care other is referred to as "transinstitutionalization". See a discussion of transinstitutionalization and inappropriate placements in parts II.C and III.B of this analysis, *infra* notes 100-114 and 190-201 and accompanying text.

⁴³ See parts II and III of this analysis, *infra* notes 112-114 and 211-212 and accompanying text, for a discussion of the advantages of psychiatric institutions and specialized residential care facilities for persons with mental illnesses in terms of "continuity of care" and specialized psychiatric and mental health services furnished to patients which are not readily available to residents of other nonspecialized nursing facilities or smaller residential care facilities. Also, as will be discussed in part II, *infra* notes 100-110 and accompanying text, if a nursing facility becomes too specialized in caring for persons with psychiatric disorders, it runs the risk of being classified as an "IMD", and thus losing its eligibility to receive federal Medicaid payments for services provided to these patients between the ages of 22 and 64.

⁴⁴ As will be discussed in part III.A, *infra* notes 148-158 and

1950s and 1960s were slow to recognize the fact that schizophrenia and other serious mental illnesses are neurobiological disorders of the brain.⁴⁵ There continues to be a lack of appreciation on the part of federal policymakers that, even with today's advanced medications and the best available outpatient treatment services, a small but significant number of persons with these psychiatric illnesses are treatment-resistant and require residential or institutional psychiatric care. Consequently, federal funding incentives emphasizing the use of community-based mental health services, while at the same time denying federal Medicaid payment for services provided in institutions and freestanding psychiatric hospitals, have led to uncoordinated psychiatric care services for the most severe patients and a disjointed public mental health system in many localities in the United States today.

Therefore, this analysis adopts the position that the Medicaid program should no longer deny federal medical assistance for medical necessary care and services furnished to individuals between the ages of twenty-two and sixty-four in institutions or facilities which specialize in the care and treatment of

accompanying text, Freudian psychoanalysis and other nonbiologically-based theories dominated American psychiatry and public perceptions of serious mental illnesses for the better part of the twentieth century. These misconceptions regarding serious mental illness greatly influenced and impacted upon the development and evolution of federal public mental health policy during the post World War II period.

⁴⁵ Issues pertaining to the modern neurobiological understanding of serious mental illnesses, and the Federal Government's recent recognition of this, are addressed in part III.A, *infra* notes 154-166 and accompanying text.

psychiatric disorders (IMDs). No other institutional exclusions involving other types of specialized hospital services or long-term care are imposed under Title XIX of the Social Security Act (the Medicaid statute) altering the provision of care and treatment services for patients with other medical conditions.⁴⁶

As will be discussed in greater detail in part II of this analysis,⁴⁷ Section 1902(a)(19) of Title XIX states that a State plan for medical assistance must "provide such safeguards as may be necessary to assure that ... care and services ... will be provided in ... the best interests of the recipients".⁴⁸ The Medicaid Regulations build upon this principle by providing that State Medicaid agencies may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise

⁴⁶ Pursuant to Section 1905(a)(1), (4) and (15) of the Social Security Act, federal medical assistance is available to cover inpatient hospital services (other than services in an IMD), nursing facility services (other than services in an IMD), and services provided in "intermediate care facilities for the mentally retarded" (ICF/MR) for persons who suffer from other types of conditions, including other brain diseases such as Alzheimer's disease, Parkinson's disease, multiple sclerosis, mental retardation, and autism, (if they are determined to be in need of such care). 42 U.S.C. § 1396d(a)(1), (4) and (15) (1994). See also the discussion in *supra* note 25 regarding the old TB institution or sanitarium exclusion which was eliminated in 1984.

⁴⁷ See discussion in *infra* notes 73-76 and accompanying text.

⁴⁸ Section 1902(a)(19) of the Social Security Act, 42 U.S.C. § 1396a(a)(19) (1994). The full text of sub-section 19 of Section 1902(a) reads "A State plan for medical assistance must-" "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."

eligible recipient solely because of the diagnosis, type of illness, or condition.⁴⁹ These customary coverage requirements should be applied equally across the board for all medical or biological disorders. Therefore, if a physician determines that an otherwise-eligible Medicaid patient (between the ages of twenty-two and sixty-four) with a severe case of schizophrenia or other biologically-based mental illness is in need of specialized psychiatric care provided through a psychiatric hospital or a state psychiatric institution, this professional judgment should be respected and accorded federal Medicaid reimbursement.

As will be discussed in part II of this analysis,⁵⁰ judicial challenges to strike down the IMD exclusion brought under the Equal Protection Clause of the Fourteenth Amendment to the Constitution⁵¹ have so far been unsuccessful. If reviewed today, it is unlikely that the Supreme Court would abolish this Medicaid exclusion.

To rectify the consequences of this policy, Congress should take it upon itself to reexamine and repeal the Medicaid IMD exclusion and cover all "medically necessary" care and services furnished to all otherwise Medicaid-eligible individuals who require inpatient hospitalization in psychiatric hospitals and/or

⁴⁹ 42 CFR 440.230(c) (1995). This is discussed in greater detail, in part III, *infra* notes 172-177 and accompanying text.

⁵⁰ See discussion in notes 116-140 and accompanying text.

⁵¹ U.S. CONST. amend. XIV § 1, last clause.

residential treatment in specialized psychiatric institutions, due to a serious mental illness or other neurobiological disorder of the brain.

In spite of the modern medical understanding of serious mental illnesses as neurobiological disorders of the brain and the unintended consequences and problems resulting from the Medicaid IMD exclusion, the primary rationale today for maintaining this exclusion appears to be economic considerations regarding fears of a cost explosion if this exclusion is lifted, especially in a time of tight budgetary constraints on the federal Medicaid program.⁵²

To address these budgetary concerns, reasonable nondiscriminatory proposals to contain federal Medicaid expenditures for inpatient psychiatric hospital services and residential psychiatric care are set forth in part III.C of this analysis, if the IMD exclusion were to be abolished.⁵³ These cost containment proposals are comparable to federal Medicaid coverage and payment restrictions for inpatient hospital services, nursing facility services, inpatient psychiatric hospitalization services for persons under twenty-one years of age, and services provided in intermediate care facilities for persons with mental retardation.

⁵² See HEALTH CARE FINANCING ADMINISTRATION (HCFA), U.S. DEP'T OF HEALTH AND HUMAN SERVICES (HHS), HCFA PUB. NO. 03339, REPORT TO CONGRESS: MEDICAID AND INSTITUTIONS FOR MENTAL DISEASES, chs. ES & VII (December 1992). The findings in this HCFA report are summarized in part III.C, *infra* notes 204-210 and accompanying text.

⁵³ See the discussion in *infra* notes 214-225 and accompanying text.

II. LEGAL ANALYSIS OF THE MEDICAID IMD EXCLUSION

a. Statutory Issues Governing Medicaid And The IMD Exclusion

Congress substantially amended the Social Security Act in 1965.⁵⁴ The most significant statutory changes to the Act were the Medicare⁵⁵ and the Medicaid⁵⁶ Amendments. Congress enacted these historic public health care amendments in an effort to provide a coordinated approach for health insurance and medical care for aged (sixty-five and older), blind or disabled persons and needy families with dependent children.⁵⁷

The federal Medicaid program, officially entitled "Grants to

⁵⁴ Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965), 42 U.S.C. § 301 et seq. (1994). Besides the Medicare-Medicaid Amendments, the 1965 Amendments, taken as a whole, modified the Social Security Act in three other very important areas. First, it expanded services for needy children. Secondly, it revised the benefit and coverage provisions significantly improving the financing mechanism and structure of the federal old age, survivors, and disability insurance programs. Thirdly, the 1965 Amendments provided for greater access to the federal public assistance programs.

⁵⁵ Title XVIII of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 290 (1965), 42 U.S.C. § 1395a et seq. (1994).

⁵⁶ Title XIX of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 343 (1965), 42 U.S.C. § 1396a et seq. (1994).

⁵⁷ The Medicare-Medicaid Amendments, effective January 1, 1966, established three health care programs consisting of: 1) a compulsory hospital-based program (Medicare Part A), 2) a voluntary supplementary plan to cover physicians' services and other supplementary health services (Medicare Part B) and 3) a federal grant program for States, officially named "Grants to States for Medical Assistance Programs", to provide medical assistance for the categorically needy and medically needy aged, blind, disabled persons and families with dependent children. S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 2 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943.

States for Medical Assistance Programs", enacted as Title XIX of the Social Security Act,⁵⁸ is a federal-state cooperative funding program for medical assistance, in which the Federal Government approves State plans for funding of medical services for "categorically needy"⁵⁹ and "medically needy"⁶⁰ individuals, and then agrees to subsidize a significant portion of the financial obligations the State has agreed to assume.⁶¹ The purpose of the

⁵⁸ 42 U.S.C. § 1396a et seq. (1994).

⁵⁹ Participating States, in the Federal medical assistance program, must provide medical coverage of "mandatory services", [set forth in Sections 1902(a)(10) and 1905(a) of the Social Security Act], for individuals deemed under the Act to be "categorically needy". The two main categories of "categorically needy" individuals who qualify for Medicaid benefits are recipients of "Aid to Families with Dependent Children" (AFDC) or Supplemental Security Income (SSI) beneficiaries. 42 U.S.C. § 1396a(a)(10) and § 1396d(a) (1994) and 42 CFR 435.100 et seq., 435.500 et seq., 435.600 et seq., and 435.700 et seq. (1995).

⁶⁰ States, at their option, may provide medical coverage of services for individuals classified under their Medicaid plans to be "medically needy", as provided for in Sections 1902(a)(10) and 1905(a) of the Act. 42 U.S.C. § 1396a(a)(10) and § 1396d(a) (1994) and 42 CFR 435.301 et seq. and 435.800 et seq. (1995). The "medically needy" category covers individuals who do not meet the income eligibility or other requirements to be classified as "categorically needy", but who, in practical terms, are economically strapped due to extraordinary medical expenses, such as those for nursing facility care.

⁶¹ *Alexander v. Choate*, 469 U.S. 287, 289, n. 1 (1985) *citing* *Harris v. McRae*, 448 U.S. 297, 301 (1980).

The Medicaid program expanded and ultimately replaced the Kerr-Mills Act, enacted in 1960, which enabled States to receive federal funds to provide medical care for needy elderly persons who did not have sufficient income and resources to pay for the cost of their medical care.

Payment and eligibility provisions under Medicaid are closely aligned with the provisions under the public assistance amendments of the Social Security Act of 1965, especially in regards to the "institution for mental diseases" (IMD) exclusion. In fact, the only recorded legislative history regarding Congressional intent for incorporating the IMD exclusion into the 1965 Social Security Act Amendments is found within the

Medicaid program is to enable States to provide medical assistance for or on behalf of families with dependent children, the blind, disabled persons, and the aged whose income and resources are insufficient to meet the costs of necessary medical services and to help such families and individuals attain or retain a capacity for independence or self-care.⁶² The intended goal of Medicaid is to furnish services to program recipients to the same extent, or as nearly to that extent as possible, as those services are available to the general public.⁶³

State participation in the federal Medicaid program is voluntary.⁶⁴ However, once a State chooses to participate in the program, it must comply with the statutory and regulatory

Congressional committees' comments pertaining to the public assistance amendments. See S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147 (1965), *reprinted in* 1965 U.S.C.C.A.N. at 2083-2087. The Supreme Court, in *Schweiker v. Wilson*, 450 U.S. 221 (1981), cited this section of the legislative history in its interpretation of Congressional intent and rationale for incorporating the Medicaid IMD exclusion into the 1972 Supplemental Security Income (SSI) Act. 450 U.S. at 237-238. See discussion of *Schweiker v. Wilson* in *infra* notes 130-140 and accompanying text.

⁶² Section 1901 of the Social Security Act, 42 U.S.C. § 1396 (1994).

⁶³ 42 CFR 447.204 (1995). However, many States pay considerably less under their Medicaid programs than the providers' costs or customary charges. As a result, many medical providers refuse to accept Medicaid patients. Nevertheless, Medicaid patients appear to have significantly greater access to health care services than uninsured persons. See the CRS, MEDICAID SOURCE BOOK, *supra* note 6, (ch. 1: Overview).

⁶⁴ This voluntary participation in the federal Medical Assistance Program follows the tradition established by the Kerr-Mills Act, *supra* note 61, and earlier amendments to the Social Security Act.

requirements of Title XIX, starting with approval from the Department of Health and Human Services (HHS) of its "state plan for medical assistance" (a.k.a., a "state Medicaid plan").⁶⁵

For its part, the Federal Government then agrees to pay a specified percentage of the costs of the mandatory and optional

⁶⁵ Section 1902 of the Social Security Act sets forth the statutory provisions that a state plan for medical assistance must comply with before the State is eligible to receive federal medical assistance under its Medicaid plan. See 42 U.S.C. § 1396a et seq. (1994) and 42 CFR Parts 430 - 498 (1995).

First, a participating State must submit a (proposed) Medicaid plan to the United States Department of Health and Human Services (HHS), and receive the Federal Government's approval before it can begin receiving federal assistance under the plan.

The state plan must include reasonable standards for medical assistance, in accordance with the standards prescribed by the Secretary of H.H.S. with respect to income levels for eligibility.

42 U.S.C. § 1396a(a)(17) (1994). Section 1902(a)(10) of the Act mandates that the services covered under the state plan must be sufficient in amount, duration, and scope to reasonably achieve their purpose. 42 U.S.C. § 1396a(a)(10) (1994) and 42 CFR 440.230(b) (1995). Section 1902(a)(10) also imposes a "comparability" requirement which mandates that services available to any "categorically needy" recipient may not be less in amount, duration, and scope than those services available to "medically needy" individuals, and that services available to any individual in either the categorically needy group or the medically needy group are equal in amount, duration, and scope for all recipients within that group. 42 U.S.C. § 1396a(a)(10) (1994) and 42 CFR 440.240 (1995).

Additionally, the Social Security Act mandates that the state Medicaid plans establish procedures for professional review of the services furnished to the recipients to assure appropriateness and quality of care. 42 U.S.C. § 1396a(a)(30) (1994). Furthermore, the Medicaid statute requires that the state plans provide utilization review procedures and inpatient hospital and nursing facility services certification of need requirements to safeguard against unnecessary utilization of services. 42 U.S.C. § 1396a(a)(30) and (44) (1994). These same nondiscriminatory utilization control and review procedures can be employed to contain costs of institutional psychiatric care, if the IMD exclusion is lifted. See discussion in part III.C, *supra* notes 220-225 and accompanying text, for examples of possible cost control measures to contain the costs of Medicaid expenditures for institutional psychiatric care.

services covered under the state plan. Federal financial participation (FFP) or federal medical assistance is available for state expenditures for Medicaid services provided to eligible recipients, whose coverage is required or allowed under Title XIX of the Social Security Act.⁶⁶ The statutory requirements governing Medicaid have significance beyond the amount of federal financial participation because the United States Supreme Court has ruled that Title XIX of the Social Security Act does not require States participating in the program to unilaterally pay for medical services for which federal Medicaid reimbursement is unavailable.⁶⁷

A state Medicaid plan must offer medical coverage of nine "mandatory services" for categorically needy persons.⁶⁸ These

⁶⁶ The Federal Government's share of a State's Medicaid payments for mandatory and optional services, covered under a state plan for medical assistance, is called the "federal medical assistance percentage" (FMAP). FMAPs are calculated annually based upon the State's per capita income. No State may receive lower than a 50 percent rating or higher than an 83 percent rating. See 42 U.S.C. §§ 1396a(a), 1396b and 1396d(b) (1994) and 42 CFR 430.10 et seq. and 42 CFR 435.1002 (1995).

⁶⁷ *Harris v. McRae*, 448 U.S. 297, 308, 65 L. Ed. 2d 784, 100 S. Ct. 2671, 2684 (1980) *citing* S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 83-85 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess., at 72-74 (1965), *reprinted in* 1965 U.S.C.C.A.N., 1943.

Harris v. McRae was an abortion case, decided in 1980, which held that States did not have to unilaterally pay for abortions under their Medicaid plan, when federal Medicaid funds were unavailable due to the Hyde Amendment. The Hyde Amendment barred federal Medicaid funding to pay for abortions, except where the life of the mother would be endangered if the fetus was carried to term. Later versions of the Hyde Amendment added exceptions for victims of rape and incest.

⁶⁸ 42 U.S.C. § 1396a(a)(10) and § 1396d(a) (1994).

Besides hospital and nursing facility services, discussed in *infra* note 69 and accompanying text, other mandatory services include physician services; laboratory and X-ray services; early

mandatory services include inpatient and outpatient hospital services for all eligible persons and nursing facility services (originally called "skilled nursing home services") for qualified individuals twenty-one years old or older.⁶⁹ There are no categorical coverage exclusions based upon specific diagnoses or conditions under these hospital and nursing facility provisions.⁷⁰

and periodic screening; diagnosis and treatment services for individuals under 21 years of age; family services and supplies; rural health services; and nurse-midwife services. Also, States have the option of covering and receiving federal Medicaid reimbursement for mandatory services to "medically needy" individuals. See 42 U.S.C. §§ 1396a(a)(10) and 1396d(a) (1994); 42 CFR 440.10 - 440.70, 440.165, and 440.210-220 (1995).

⁶⁹ 42 U.S.C. § 1396d(a)(1), (2) and (4) (1994).

The 1965 Medicaid statute used the terminology "skilled nursing home services" under the definitional section for federal medical assistance in Section 1905(a)(4) of the statute. Pub. L. No. 89-97, 79 Stat. 351 (1965). This was subsequently amended to read "skilled nursing facility services". 42 U.S.C. § 1396d(a)(4). Additionally, the 1971 Amendments to the Social Security Act added coverage of "intermediate care facility (ICF) services", for individuals who are in need of such care. Pub. L. No. 92-223 § 4 (g)(2), 85 Stat. 802, 809 (1971). This 1971 amendment pertaining to coverage of ICF services was originally enacted under Section 1905(a)(16) of the Social Security Act. However in 1972, to make room for Medicaid coverage of treatment in psychiatric hospitals for individuals under age 21, the ICF provision was redesignated as subsection 1905(a)(15). This redesignation deleted the original catch-all provision covering other types of medical care and remedial care recognized under State law and specified by the Secretary (except for care and services for individuals who are inmates of a public institution, other than in public medical institutions). See Pub. L. No. 92-603 § 299B, 86 Stat. 1329, 1709-1710 (1972). Subsequently in 1988, sections 1905(a)(4) and 1905(a)(15) were amended to their present statutory definitions of "nursing facility services" and "services in an intermediate care facility for the mentally retarded", respectively. 42 U.S.C. § 1396d(a)(4) and (15) (1994). Statutory definitional issues concerning Medicaid coverage of institutional care services are discussed in greater detail in *infra* notes 81-85 and 98-110 and accompanying text.

⁷⁰ 42 U.S.C. §§ 1396a(a) and 1396d(a) (1994) and 42 CFR 440.230(c) (1995). This is significant because prior amendments to the Social Security Act specifically denied federal assistance

However, the provisions of the Act specifically exclude coverage of inpatient hospital and nursing services provided in institutions for mental diseases (IMDs).⁷¹

Beyond covering mandatory services and complying with other requisite statutory provisions under the Social Security Act,⁷² States have broad discretion to choose the proper mix of covered services and facially-neutral amount, scope, and duration limits to keep their Medicaid programs within manageable bounds, as long as the care and services are provided in "the best interests of the recipients".⁷³ Therefore, States have the discretion to impose appropriate limits on the use of services based on such criteria as medical necessity or utilization control procedures.⁷⁴

for otherwise qualified persons in medical institutions who were diagnosed as having either tuberculosis or a psychosis (i.e., a mental illness). See discussion of the legislative history behind the IMD exclusion in *infra* notes 88-97 and accompanying text.

⁷¹ 42 U.S.C. § 1396d(a)(1), (2) and (4) (1994). See *supra* notes 21-22 and accompanying text for the statutory definition of an IMD, codified under 42 U.S.C. § 1396d(i) (1994). See also *infra* notes 98-114 and accompanying text for a discussion regarding specific types of facilities covered by or exempted from the statutory definition of an IMD.

⁷² See *supra* note 65.

⁷³ See *Alexander v. Choate*, 469 U.S. 287, 303, 105 S.Ct. 712, 721 (1985) *citing* Section 1902(a)(19) of the Social Security Act, 42 U.S.C. § 1396a(a)(19) (1994). The full text of Section 1902(a)(19) states "A State plan for medical assistance must-" "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."

⁷⁴ See 42 CFR 440.230(d) (1995).

The Medicaid statute provides an array of cost containment

It is thus permissible for States to impose a limit on the number of inpatient hospital days or physician visits covered under the state plan.⁷⁵

One significant limitation upon the States' discretion to select the proper mix of services covered under their state plans is that State Medicaid agencies may not arbitrarily deny or reduce the amount, duration, or scope of required services to an eligible recipient solely because of the diagnosis, type of illness, or condition.⁷⁶ For example, this antidiscrimination regulatory requirement would prohibit coverage limitations on acute general hospital stays for Medicaid patients with psychiatric diagnoses unless the same limitations were imposed across the board for all diagnoses. However, States may define services furnished by a distinct classifications of providers, such as services provided by clinical psychologists and social workers, and subject these types of mental health services to special coverage limitations; or a State may decline to cover these types of services

mechanisms which permits States and the Federal Government to restrict medical assistance payments for services by means of nondiscriminatory medically necessary certification requirements and standard utilization review practices, in an effort to control program costs. 42 U.S.C. § 1396a(a) (10), (30), and (44) (1994).

It is therefore permissible for a state plan to mandate a pre-authorization utilization review requirement before furnishing or covering a medical or mental health service.

⁷⁵ See *Alexander v. Choate*, 469 U.S. 287 and 105 S.Ct. 712 (1985).

⁷⁶ 42 CFR 440.230(c) (1995). See the discussion of *Pinneke v. Preisser*, 623 F. 2d 546 (8th Cir. 1980), and other relevant cases cited in *infra* notes 173-175 and accompanying text.

altogether.

States have the option of covering twelve additional categories of services under their Medicaid plans.⁷⁷ The original Medicaid statute enacted in 1965 gave States the option of covering inpatient hospital and skilled nursing services provided to persons sixty-five years of age and older in institutions for tuberculosis or mental diseases, but denied federal medical assistance for the same services provided to persons under sixty-five in these same institutions.⁷⁸ Also, as noted in part I,⁷⁹ in

⁷⁷ See 42 U.S.C. §§ 1396a(a)(10) and 1396d(a)(10) (1994) and 42 CFR 440.60-181 (1995) for a list of all possible "optional services" for which federal medical assistance is available, if covered under the State's Medicaid plan. Some notable optional services include medical or remedial care furnished by licensed practitioners, prescription drugs, diagnostic, screening, preventive and rehabilitative services, case management, and personal health and respite care services.

⁷⁸ See Section 1905(a)(14) in Pub. L. No. 89-97, 79 Stat. 351-352 (1965).

Recognizing that discharge plans do not always succeed, the Senate Finance Committee called upon the States to devise provisions for prompt readmission of aged Medicaid patients into institutional settings, when needed. Therefore, Section 1902(a)(20) was incorporated into the statute to mandate that participating states opting to cover this optional service develop alternative plans for readmission of Medicaid recipients sixty-five years old or over, who would otherwise require care in a mental institution. 42 U.S.C. § 1396a(a)(20) (1994) and 42 CFR 441.103 (1995). Also, the legislative history of the Medicaid statute clearly states that Congress desired to foster deinstitutionalization by making the approval of this optional service contingent upon the State developing and implementing a comprehensive mental health plan, which utilizes community mental health center services and other alternatives to institutional care. See 42 U.S.C. § 1396a(a)(20) (1994) and S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 146 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2086. See also *supra* notes 27-34 and accompanying text. Finally, Congress believed and estimated that the number of persons sixty-five years old and older with mental illness or tuberculosis was so small that no special safeguards

1984, the federal Medicaid statute was amended to abolish the exclusion of individuals in institutions for tuberculosis as being no longer necessary, inasmuch as "TB sanitoriums" were no longer used for treatment of tuberculosis.⁸⁰

In 1972, the Social Security Act was amended to give States the option of covering inpatient psychiatric hospital services furnished to individuals under age twenty-one in psychiatric institutions under their state Medicaid plans.⁸¹ Recognizing that

were necessary for this group. See S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2083-2087.

⁷⁹ See *supra* note 25.

⁸⁰ The tuberculosis institution repeal amendments to Section 1905(a) of the Social Security Act [42 U.S.C. § 1396d(a)] were adopted as part of the Deficit Reduction Act of 1984, Pub. L. No. 98-369 § 2335, 98 Stat. 1090-1091 (1984). Since issues relating to the denial of federal Medicaid for services provided in institutions for tuberculosis are now moot, this analysis strictly pertains to the exclusion of federal financial participation for services provided to individuals between the ages of 22 and 64 in institutions for mental diseases.

⁸¹ Section 1905(a)(16) and (h) of the Social Security Act, 42 U.S.C. § 1396d(a)(16) and (h) (1994). The effective date for these statutory changes was January 1, 1973. Pursuant to Section 1905(h)(1)(A), [42 U.S.C. § 1396d(h)(1)(A) (1994)], the phrase "inpatient psychiatric hospital services for individuals under age 21" entails inpatient services provided in an institution (or distinct part thereof), defined under the Medicare statute in Section 1861(f) in 42 U.S.C. § 1395x(f), as a psychiatric hospital. Also, the term "psychiatric hospital services" is used place of services provided in "institutions for mental diseases" with regard to institutional psychiatric care for children, but generally speaking these terms are used interchangeably. See the Conference Report, to accompany H.R. Rep. No. 92-1605, 92nd Cong., 2nd Sess., at 65 (1972). However, in order to receive federal medical assistance, these inpatient psychiatric services must involve "active treatment", which meets the standards established by the Secretary of Health and Human Services. 42 U.S.C. § 1396d(h)(1)(B) (1994). Finally, in cases in which an

extended inpatient psychiatric care is sometimes necessary, Congress adopted the position that the nation could not make "a more compassionate and a better investment" under the Medical Assistance Program than restoring mentally ill children to a status in which they might be able to rejoin and contribute to society as productive and active citizens.⁸²

individual is receiving treatment in the period immediately preceding the date which he or she attains the age of twenty-one, federal medical assistance continues until the individual no longer requires such services or until his or her twenty-second birthday, whichever comes first. 42 U.S.C. § 1396d(h)(1)(C) (1994).

Another important component of the 1972 Amendments to the Social Security Act was the enactment of the Supplemental Security Income (SSI) program for aged, blind, and disabled persons, enacted under Title XVI of the Social Security Act. 42 U.S.C. § 1382 et seq. (1994). Section 1611(e) of the Act incorporates Medicaid eligibility criteria and excludes persons or inmates in public institutions from being eligible to receive SSI benefits. 42 U.S.C. § 1382(e) and 42 U.S.C. § 1396d(a)(24)(A) (1994). See also *infra* note 88. This public institution exclusion covers persons in mental institutions (IMDs), as well as inmates in prisons and jails. Congress then granted a partial exception to this public institution exclusion by granting a "comfort allowance" of \$300.00 annually for Medicaid-eligible beneficiaries in hospitals and nursing care facilities. *Id.* This medical institution exception to the public institution exclusion under Section 1611(e) has subsequently been modified to cover institutions whose primary purpose is the provision of medical or psychiatric care. 42 U.S.C. § 1382(e)(E) (1994). See *infra* notes 130-140, pertaining to a discussion of the Supreme Court case *Schweiker v. Wilson*, 450 U.S. 221, 101 S.Ct. 1074 (1981), which upheld the constitutionality of the exclusion of reduced SSI comfort allowance benefits for persons between the ages of 22 and 64 in mental institutions.

⁸² See Senate Finance Report, S. No. 92-1230, to accompany H.R. 1, 92nd Cong., 2nd Sess., at 280-281 (1972).

During the 1972 Medicaid debate, a number of senators believed that the potential social and economic benefits of totally abolishing the IMD exclusion for all otherwise qualified individuals in institutions deserved to be evaluated. *Id.* The Senate Finance Committee proposed that a research project be undertaken to study the possible effects of abolishing the IMD exclusion, but this measure was dropped in the conference

During this same period in the early 1970s, the Medicaid statute was amended to allow States the option of covering of "intermediate care facility services" under their state plans for medical assistance.⁸³ Subsequently, in 1988 the statutory definitions of nursing and institutional care services were amended to their present definitions, which read "nursing facility services"⁸⁴ and "services in an intermediate care facility for the mentally retarded" (ICF/MR).⁸⁵ This inclusion is significant because after the abolishment of the tuberculosis institution exclusion in 1984, the only category of hospital services and nursing care (furnished in "medical institutions"⁸⁶ and/or long-term care facilities) to remain ineligible to receive federal medical assistance is the class of services provided to individuals between the ages of twenty-two and sixty-four in "institutions for mental diseases" (IMDs).⁸⁷

committee with the House on the bill. See the Conference Report, to accompany H.R. Rep. No. 92-1605, 92nd Cong., 2nd Sess., at 65 (1972).

⁸³ Pub. L. No. 92-223 § 4, 85 Stat. 802, 809 (1971). 42 U.S.C. § 1396d(a)(15) (1994). See *supra* note 69.

⁸⁴ Pub. L. No. 100-360 § 411, 102 Stat. 683, 798-799 (1988), 42 U.S.C. § 1396d(a)(4) (1994).

⁸⁵ Pub. L. No. 100-360 § 411, 102 Stat. 683, 798-799 (1988), 42 U.S.C. § 1396d(a)(15) (1994). See *supra* note 69. The 1988 amendments also included a statutory definition of an "institution for mental diseases". 42 U.S.C. § 1396d(i) (1994).

⁸⁶ See discussion in *infra* note 88, citing 42 U.S.C. § 1396d(a)(24)(A) (1994) regarding Social Security Act exclusions of persons considered to be inmates of public institutions, excluding patients in a medical institution.

⁸⁷ No serious legislative initiatives have been undertaken since the early 1970s to eliminate or substantively modify the IMD

b. Legislative History Behind The Medicaid IMD Exclusion

The exclusion of federal funds for services provided in institutions for mental diseases predates the enactment of the 1965 Amendments to the Social Security Act. Congress first excluded federal funds under the Social Security Act for individuals in institutions for mental diseases [and tuberculosis] in 1950 through the enactment of Title XIV to the Act, entitled "Grants To States For Aid To The Permanently And Totally Disabled".⁸⁸ In addition to denying federal funds for services

exclusion because since that time the primary emphasis of subsequent amendments to Title XIX has been the need to contain Medicaid costs. Nevertheless, various technical amendments and regulatory changes have been adopted to better clarify and enforce the IMD exclusion with this purpose in mind. See the discussion in part III.B, *infra* note 197, regarding the "pre-admission screening and annual resident review (PASARR) requirements. See also the discussion of HEALTH CARE FINANCING ADMINISTRATION (HCFA), U.S. DEP'T OF HEALTH AND HUMAN SERVICES (HHS), HCFA PUB. NO. 03339, REPORT TO CONGRESS: MEDICAID AND INSTITUTIONS FOR MENTAL DISEASES (December 1992) in part III.C of this analysis, *infra* notes 204-210 and accompanying text.

⁸⁸ Grants To States For Aid To The Permanently And Totally Disabled, Title XIV of the Social Security Act, Pub. L. No. 81-64, 64 Stat. 555 (1950), codified at 42 U.S.C. § 1351 et seq. (1994), (*repealed by* Pub. L. 92-603, §303, effective January 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands). As signified by its program name, Title XIV of the Social Security Act appropriated federal grant money to States to provide financial aid and assistance for needy persons who were permanently and totally disabled.

Prior to 1950, federal funds administered under the Social Security Act were denied to individuals deemed to be "inmates of public institutions", which covered patients in public medical facilities, including public general hospitals, state mental institutions, and TB hospitals, as well as inmates in penal institutions. Title XIV and the Medicaid statute include an exclusion for an "inmate of a public institution", but exempt patients in "medical institutions". *Id.*; see Section 1905(a)(24)(A) of the Medicaid statute, 42 U.S.C. § 1396d(a)(24)(A) (1994). The purpose behind adopting the medical institution exemption to the public institution exclusion under the Act was to eliminate the inequality in coverage between

provided in IMDs and TB hospitals, Section 1405 of Title XIV covered eligible disabled persons in medical institutions (i.e., general hospitals and convalescent facilities) but specifically excluded patients being treated for either tuberculosis or psychosis.⁸⁹ These mental illness and TB exclusions were based upon the notion that States have generally provided medical care for such individuals.⁹⁰ The Kerr-Mills Medical Assistance Program,⁹¹ enacted in 1960, continued the tradition of denying federal funds for inpatient treatment of mental illness and tuberculosis in general hospitals, as well as in institutional settings.⁹²

Thus, the IMD provisions adopted in the 1965 Amendments

patients receiving treatment in public hospitals and those in private hospitals. However, at the same time, Congress, in 1950, did not want to extend Social Security benefits to individuals in mental and TB hospitals.

As indicated by the above citation, except in regards to United States territories, Title XIV was replaced in 1972 by the enactment of the Supplemental Security Income (SSI) program, Title XVI of the Social Security Act. 42 U.S.C. § 1381 et seq (1994). Issues pertaining to the denial of SSI benefits for persons receiving treatment in psychiatric institutions are addressed in the discussion of *Schweiker v. Wilson*, 450 U.S. 221 (1981), in *infra* notes 130-140 and accompanying text.

⁸⁹ Pub. L. No. 81-64, 64 Stat. 555, 557-558 (1950), 42 U.S.C. § 1355 (1994).

⁹⁰ See H.R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949).

⁹¹ The Kerr-Mills Act, the forerunner to the Medicare and Medicaid programs, enabled States to receive federal funds to provide medical care for needy elderly persons who did not have sufficient income and resources to pay for the cost of their medical care. See S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 73, (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2014-2015.

⁹² *Id.*

expanded federal public assistance and medical assistance⁹³ for recipients with chronic and severe mental illness in two respects, compared to earlier amendments to the Social Security Act. As noted previously, federal public and medical assistance could no longer be denied solely on the basis of diagnosis, (in general hospitals and nursing facility settings).⁹⁴ Secondly, as discussed in the statutory section, the 1965 Amendments to the Social Security Act also gave the States the option of covering persons aged sixty-five and older in institutions for tuberculosis and mental diseases.⁹⁵

Nonetheless, Congress, in the legislative history of the 1965 Amendments, articulated that the denial of federal public assistance and Medicaid funds for individuals under age sixty-five in mental and tubercular institutions was based upon the rationale that the care and maintenance of persons in such institutions was a traditional responsibility of the States.⁹⁶ Furthermore, it is apparent from the legislative history that Congress incorporated the IMD exclusion into the Medicaid statute [and the public

⁹³ See *supra* notes 54 and 61.

⁹⁴ See *supra* note 76, citing 42 CFR 440.230(c) (1995).

⁹⁵ See *supra* note 78, citing Section 1905(a)(14) of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 351-352 (1965), 42 U.S.C. § 1396d(a)(14) (1965).

⁹⁶ See S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 2084; and H.R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949). See also H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), reprinted in 1963 U.S.C.C.A.N. 1054, 1064-66; and *supra* notes 23-26 and accompanying text.

assistance amendments] because "the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions".⁹⁷

c. Covered and Exempt Facilities Under The IMD Exclusion

The original Medicaid statute, enacted in 1965, did not define the term an "institution for mental diseases". This led to much confusion during the 1980s regarding whether a particular institution was entitled to receive federal medical assistance for services provided to otherwise-eligible patients between the ages of twenty-two and sixty-four as being an "intermediate care facility" (ICF)⁹⁸ or be denied Medicaid payment for such services under the IMD exclusion.⁹⁹

⁹⁷ See *Schweiker v. Wilson*, 450 U.S. 221, 242, 101 S.Ct. 1074, 1086 (1981) (Powell, J., dissenting) *citing* S. Rep. No. 404, 89th Cong. 1st Sess. pt. 1, at 20 (1965). See also *infra* notes 148-169 and accompanying text.

⁹⁸ Pre-1988 versions of the Medicaid statute used the terms "skilled nursing facility services" and "intermediate nursing facility services". See *supra* note 69. An intermediate care facility was defined under the Act as an institution licensed under State law to provide health-related care and services to individuals who do not require the degree of care or treatment which a hospital or a skilled nursing facility was designed to provide, but who, because of their mental or physical condition, require care and services beyond room and board, which is available to them only through institutional facilities.

⁹⁹ In 1966, the Department of Health, Education and Welfare (HEW), [now the Department of Health and Human Services (HHS)], issued initial guidelines for determining whether a particular facility is considered to be an "institution for mental diseases" based upon the institution's "overall character". This determination was based on whether the "facility has been established and maintained primarily for the care and treatment of individuals with ... mental diseases", regardless of whether it is licensed as such. See *Connecticut Dept. of Income Maintenance v. Heckler*, 471 U.S. 524, 531, n. 17, *citing* U.S.

This issue came before the United States Supreme Court in 1985 in the case of *Connecticut Department of Income Maintenance v. Heckler*¹⁰⁰. In the mid to late 1970s, the State of Connecticut appeared to be transferring patients between the ages of twenty-two and sixty-four from state psychiatric hospitals to an intermediate care facility.¹⁰¹ The State sought and initially

DEP'T OF HEALTH, EDUCATION, AND WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, *Supplement D: Medical Assistance Programs Under Title XIX of the Social Security Act*, para. D-4620.2 (1966). These guidelines were followed by regulations stating that an IMD is "an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." *Id.* at n. 18 *citing* 45 CFR 248.60(a)(3)(ii) and (b)(7) (1972).

In 1982, the Secretary of HHS revised the IMD regulations and guidelines to better clarify what constitutes "primarily engaged in" and "overall character". 42 CFR 435.1009(e) (1982). The Health Care Financing Administration, within the Department of Health and Human Services, takes into account various factors in making IMD determinations. The most significant considerations under the old regulatory definition include whether the facility in question is licensed as or holds itself out as a facility specializing in psychiatric care, and whether the majority of its patients have a serious mental illness or a disability in mental functioning, as defined by the INTERNATIONAL CLASSIFICATION OF DISEASES (ICD), or frequently or predominantly is used by individuals who either were transferred from mental hospitals or would otherwise be admitted to them. See HCFA, STATE MEDICAID MANUAL, § 4390, *Institutions For Mental Diseases* (1990). See also *Connecticut Dept. of Income Maintenance v. Heckler*, 471 U.S. at 527-528, n. 5; *State of Minnesota v. Heckler*, 718 F. 2d 852, 861-862 (8th Cir. 1983) *citing* letters from HCFA officials to State Medicaid officials.

¹⁰⁰ 471 U.S. 524, 85 L. Ed. 2d 577, 105 S. Ct. 2210 (1985).

Besides the State of Connecticut, the Federal Government, through the Health Care Financing Administration (HCFA), disallowed federal financial participation or medical assistance for services provided in similar facilities in Minnesota, Illinois, and California. See *State of Minnesota v. Heckler*, 718 F. 2d 852 (8th Cir. 1983).

¹⁰¹ The facility in question was Middletown Haven, a privately owned 180-bed facility licensed under Connecticut state

received federal Medicaid reimbursements in excess of 1.6 million dollars for services provided to these patients.¹⁰² After a review, the Federal Government demanded an overpayment refund for these medical assistance payments on the grounds that the ICF fell within the Department of Health and Human Services's interpretation that the facility was "primarily engaged" in providing diagnostic treatment and care for persons with mental diseases and thus was ineligible to receive federal Medicaid funds for services provided to these patients under age sixty-five.¹⁰³ The State sought judicial review of the Department's determination, contending that the terms "intermediate care facilities" and "institutions for mental diseases" were mutually exclusive and that the IMD provisions in the Medicaid statute should be narrowly construed to only cover traditional custodial (state) mental hospitals or institutions. The State also defended its actions as following an enlightened policy of placing psychiatric patients in the least restrictive environment.¹⁰⁴

Rejecting the State's arguments and the interpretation

law as a "Rest Home with Nursing Supervision" with authority to care for persons with certain psychiatric conditions. During the years from 1977 through 1979, 77 percent of its patients suffered from a major mental illness, and the majority of its patients had been transferred from state mental hospitals. 471 U.S. at 526.

¹⁰² *Id.* at 527.

¹⁰³ *Id.* at 527-528.

¹⁰⁴ *Id.* at 526-528 and 536-537. See also discussion in part I.B, *supra* note 27 and accompanying text.

adopted two years earlier by the Eighth Circuit,¹⁰⁵ the Supreme Court ruled in favor of the Federal Government, holding that the terms "intermediate care facilities" and "institutions for mental diseases" were not necessarily mutually exclusive.¹⁰⁶ To support its holding in the case, the Supreme Court noted that the phrase "other than services in an institution for mental diseases" was repeated three times in the Medicaid statute,¹⁰⁷ which demonstrated that Congress did not intend the ICF and IMD categories to be mutually exclusive.¹⁰⁸ In so doing, the Supreme Court upheld the Department's regulations and interpretative guidelines pertaining to the IMD exclusion.¹⁰⁹

To better clarify these definitional issues, Congress in 1988

¹⁰⁵ *State of Minnesota v. Heckler*, 718 F. 2d 852 (8th Cir. 1983). This Eighth Circuit Court of Appeals decision held that the determination of whether a particular facility is considered to be an ICF or an IMD should be primarily based upon the nature of the services provided, rather than the diagnoses or types of illnesses manifested by its patients. *Id.* at 861-866. The Eighth Circuit based its decision upon the statutory definition of an intermediate care facility, which authorizes care of patients in ICFs with either mental or physical conditions, as long as the illnesses involved require a lesser degree of care and treatment than that of a hospital or a skilled nursing facility. 42 U.S.C. § 1396d(c) (1976 & Supp. V 1981).

¹⁰⁶ 471 U.S. at 537-538.

The U.S. District Court in Connecticut set aside the disallowance, but the Second Circuit Court of Appeals reversed the trial court. 731 F. 2d 1052 (2nd Cir. 1984).

¹⁰⁷ 471 U.S. 529-530 *citing* 42 U.S.C. §§ 1396d(a)(1), 1396d(a)(4)(A), and 1396d(a)(15) for hospital services, skilled nursing facility services, and ICF services, respectively.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

adopted a statutory definition of an IMD based upon the Supreme Court's decision in *Connecticut Department of Income Maintenance v. Heckler* and the Department of Health and Human Services's IMD interpretations. As mentioned previously, the term "institution for mental diseases" has now been defined as "a hospital, nursing facility or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services".¹¹⁰

¹¹⁰ Section 1905(i) of the Social Security Act, 42 U.S.C. § 1396d(i) (1994), enacted as part of the Medicare Catastrophic Coverage Act of 1988, § 411(k), Pub. L. No. 100-360, 102 Stat. 683, 798-799 (1988). The Medicare Catastrophic Coverage Act of 1988 was repealed in 1989, but the IMD statutory definition was not repealed and remains in effect today.

The Department of Health and Human Services subsequently modified its regulations by incorporating the "more than sixteen-bed" requirement in accordance with the statutory definition. However, the Department preserved the "overall character" interpretation pertaining to whether a particular institution has been established and maintained for the care and treatment of individuals with mental diseases, regardless of whether it is licensed as such. 42 CFR 435.1009 (1995).

Following the Supreme Court's decision in *Connecticut Department of Income Maintenance v. Heckler*, 471 U.S. 524 (1985), the most crucial criteria in determining whether a particular facility is considered to be an IMD pertains to whether the current need for institutionalization for more than fifty percent of all patients in the facility results from mental diseases as defined in the INTERNATIONAL CLASSIFICATION OF DISEASES (9th edition, modified for clinical applications) (ICD-9CM), excluding disorders involving mental retardation, senility, and organic brain syndrome. Under the Department's interpretation, a diagnosis of a mental disorder (other than mental retardation, Alzheimer's disease or dementia) need not be a patient's primary diagnosis, as long as this condition would independently be significant enough to require nursing facility care or hospitalization. See HCFA, STATE MEDICAID MANUAL § 4390; COMMERCE CLEARING HOUSE, THE MEDICARE-MEDICAID GUIDE, (hereinafter CCH, MEDICARE-MEDICAID GUIDE), Vol. III, Section 14,601, at 6295-4 - 6295-5 (May 1992).

A particular area in which there has been confusion over whether a specific facility is considered to be an IMD pertains

As mentioned, this IMD statutory definition covers not only old traditional state mental institutions but also freestanding psychiatric hospitals and care facilities (specializing in psychiatric care) with more than sixteen beds. However, the 1988 definition of an IMD exempts facilities with sixteen or fewer beds, which includes group homes, small residential "board and care facilities", and other small psychiatric care facilities called "semi-hospitals".¹¹¹ This small facility exemption is a benefit to many persons with serious mental illnesses because categorically and medically needy individuals residing in these facilities are eligible to qualify for Medicaid services.

However, individuals with the most severe and chronic forms of schizophrenia and other serious mental illnesses often require ongoing and intensive treatment and require a highly structured living environment and social services, which these small

to alcohol and substance abuse treatment centers. There is a broad spectrum of care with regard to the treatment of substance abuse disorders. At one end of the spectrum is professional psychiatric care, performed by medical and other licensed and trained personnel who use or combine drug therapy and psychotherapy in an effort to gain control of the patient's addictive disorder. This type of treatment is commonly considered to constitute the treatment of a mental disease, and facilities providing such treatment are generally considered to be IMDs. At the other end of the spectrum are facilities which offer services based upon the Alcoholics Anonymous model. These organizations primarily focus on peer groups and laypersons as counselors to promote support and encouragement for the participants. Facilities providing these types of services are generally not considered to be IMDs. See CCH, MEDICARE-MEDICAID GUIDE, Vol. III, § 14,601, at 6295-5 - 6295-6 (May 1992).

¹¹¹ See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 9-10.

residential board and care facilities and semi-hospitals are incapable of providing. State psychiatric hospitals and privately-owned and operated IMDs have the appropriate medical and other professional personnel on staff and can provide and coordinate necessary services required by persons with very disabling mental illnesses because all of the services are provided through one entity in the institutional setting.¹¹² This results in a greater "continuity of care"¹¹³ furnished to psychiatric patients than can be obtained if the same individuals were to reside in smaller facilities in the community.¹¹⁴ Group homes, board and care facilities, and semi-hospitals are not always able to provide adequate services required by persons with the most severe and disabling forms of serious mental illnesses, thus making it necessary for these individuals to have access to specialized psychiatric care services available through an

¹¹² Institutions provide psychiatric and nonpsychiatric medical services and social programs and welfare services, such as food, shelter and clothing to their patients, all in or through a single setting. This is in stark contrast to the disjointed system of outpatient mental health services and other social services available in many communities across the country. Additionally, persons with these very disabling conditions living in the community frequently have difficulty dealing with various federal, state, and local agencies to obtain necessary social and welfare benefits needed for daily living. Interviews with Dr. Peele and Dr. Torrey, *supra* note 2.

¹¹³ "Continuity of care" is a general term and an important element in the psychiatric and mental health field signifying that a single individual or treatment team is responsible for providing or ensuring that all necessary psychiatric care and other mental health services and program benefits are provided to individuals under his, her or its care. See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 222-225 and 240-245.

¹¹⁴ See discussion in *supra* notes 112-113 and in part I.

institutional setting.

d. Judicial Challenges To The IMD Exclusion

In the early 1970s, two federal district court cases were brought against the Secretary of Health, Education, and Welfare (HEW)¹¹⁵ challenging the IMD exclusion denying Medicaid coverage to persons between the ages of twenty-one and sixty-five.¹¹⁶ The "rational review" equal protection¹¹⁷ standard¹¹⁸ is applied by

¹¹⁵ During President Carter's Administration, HEW was split into two departments: the Department of Health and Human Services (H.H.S.) and the Education Department.

¹¹⁶ *Legion v. Richardson*, 354 F. Supp. 456 (S.D. N.Y. 1973) *aff'd sub nom.*, *Legion v. Weinberger*, 414 U.S. 1058, 94 S.Ct. 564, 38 L. Ed. 2d 465 (1973), *rehearing denied*, 415 U.S. 939, 94 S. Ct. 1459, 39 L. Ed. 2d 498 (1974); *Kantrowitz v. Weinberger* 388 F. Supp. 1127 (D. D.C. 1974), *aff'd* 530 F. 2d 1034 (D.C. Cir. 1976), *cert. denied* 429 U.S. 819 (1976).

¹¹⁷ The Equal Protection Clause of the Fourteenth Amendment to the United States Constitution provides, in pertinent parts, that no State shall deny any person within its jurisdiction equal protection of the law. U.S. CONST. amend. XIV . 1, last clause. Although an equal protection clause is not expressly incorporated in the Fifth Amendment (pertaining to actions of the Federal Government), the United States Supreme Court has held that the Fifth Amendment's Due Process Clause encompasses equal protection principles. *Dandridge v. Williams*, 397 U.S. 471, 90 L.Ed. 2d 491 (1970).

The fundamental principle behind the doctrine of equal protection is that "all persons similarly situated shall be treated alike". *City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S. 432, 439, 105 S.Ct. 3249, 3254, 87 L. Ed. 2d 313 (1985), *citing* *Plyer v. Doe*, 457 U.S. 202, 216, 102 S.Ct. 2382, 2394, 72 L.Ed. 2d 786 (1982).

¹¹⁸ The Supreme Court has interpreted the "rational review" equal protection standard to mean that challenged legislation or other governmental actions will be presumed to be valid and will be upheld unless no rational relationship can be established between the classification and the asserted legitimate governmental objective. *City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S. 432, 105 S. Ct. 3249, 87 L. Ed. 313 (1985).

courts in judicial actions challenging social and economic classifications set forth in the Social Security Act in deciding whether such distinctions are rationally based and free from invidious discrimination.¹¹⁹

Plaintiffs in *Legion v. Richardson*¹²⁰, consisting of a class of one million persons with mental illness confined in public mental institutions, brought an action in U.S. district court in New York challenging the constitutionality of the Medicaid IMD exclusion and Medicare restrictions on treatment in psychiatric hospitals¹²¹ on equal protection grounds. The plaintiffs argued that such limitations in the Medicare and Medicaid statutes were a result of arbitrary and invidious discrimination against patients in public mental institutions.¹²² The plaintiffs claimed that due

¹¹⁹ The Supreme Court has asserted that "The guarantee of equal protection under the Fifth Amendment is not a source of substantive rights or liberties, but rather a right to be free from invidious discrimination in statutory classifications and other governmental activity." See *Harris v. McRae*, 448 U.S. 297, 322, 100 S.Ct. 2671, 2691, 65 L. Ed. 2d 784 (1980). See also *Dandridge v. Williams*, 397 U.S. 471, 90 S. Ct. 1153, 25 L. Ed. 491 (1970); *Schweiker v. Wilson*, 450 U.S. 221, 101 S. Ct. 1074, 67 L. Ed. 2d 186 (1981). Also, a social and economic classification must not be based on a fundamental right, race or national origin suspect classification(s), or gender / illegitimacy or it will lose its presumption of constitutional validity and will be subjected to a higher level of judicial scrutiny.

¹²⁰ 354 F. Supp. 456 (S.D. N.Y. 1973) *aff'd sub nom.*, *Legion v. Weinberger*, 414 U.S. 1058, 94 S.Ct. 564, 38 L.Ed. 2d 465 (1973), *rehearing denied*, 415 U.S. 939, 94 S.Ct. 1459, 39 L.Ed. 2d 498 (1974).

¹²¹ Pursuant to Section 1812(b)(3) of the Social Security Act [42 U.S.C. § 1395d(b)(3) (1994)], Medicare's hospital insurance (Medicare Part A) places a lifetime limit of 190 days on inpatient treatment in psychiatric hospitals.

to this discrimination they received inadequate care in state mental institutions, because no federal funds were available to supplement the inadequate state appropriations.¹²³

Declaring that all that is constitutionally required when a statutory classification is not conceived on peculiarly suspect grounds is that the challenged classification or restriction bear a reasonable relationship to the objectives sought to be achieved by legislation, the district court upheld the IMD exclusion and the Medicare psychiatric care restrictions.¹²⁴ The district court

¹²² 354 F. Supp. 456, 457-459.

¹²³ *Id.*, at 458, *citing* Wyatt v. Stickney, 325 F. Supp. 781 and 334 F. Supp. 1341 (M.D. Ala. 1971 and 1972).

To follow up, in recent years due to budgetary cutbacks on the state level, there have been a number of cases brought by advocates and persons with mental retardation and mental illnesses, challenging the inadequacy of state mental health funding and alleging a right to treatment for persons in state mental institutions and for recently discharged patients of state facilities. See Thomas S. By Brooks v. Flaherty, 902 F. 2d 230 (4th Cir. 1990); Thomas v. Morrow, 781 F. 2d 367 (4th Cir. 1986); Jackson v. Fort Stanton Hospital & Training School, 964 F. 2d 980 (10th Cir. 1192); S.H. & P.F. v. Edwards & Gay, 860 F. 2d 1045 (11th Cir. 1988), *cert. denied* 491 U.S. 905, 109 S. Ct. 3187, 105 L.Ed. 2d (1989). See also Antony B. Klapper, *Finding A Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739 (Dec. 1993); Jonathan P. Bach, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Reform*, 98 YALE L. J. 1153 (Apr. 1989). The plaintiffs in these cases have generally been unsuccessful in their efforts to increase the level of state mental health appropriations. Nevertheless, these cases and articles illustrate the problems with patient care resulting from inadequate state funding of psychiatric and mental health services. Therefore, it is inherently inequitable for Congress or the courts to use the "traditionally, a state responsibility" rationale to continue to deny federal Medicaid funding for services provided to otherwise-qualified individuals in psychiatric institutions.

¹²⁴ *Id.* at 459 *citing* Dandridge v. Williams, 397 U.S. 471, 90

concluded that in enacting the Medicare-Medicaid legislation, Congress believed that the care for patients in state mental hospitals was the responsibility of the State. Also, the court noted that Congress believed that the advances made in treating psychiatric disorders were sufficient to indicate that soon patients with mental illnesses would be treated in outpatient facilities, where remedial benefits would be available.¹²⁵

The plaintiffs appealed the court's determination to the Supreme Court to no avail. The Supreme Court affirmed the lower court's decision on the record, without oral arguments or a written opinion.¹²⁶

The IMD exclusion was again challenged in federal district court in the District of Columbia in 1976. Citing and basing its decision on the same rationale expressed in *Legion v. Richardson*, the court, in *Kantrowitz v. Weinberger*,¹²⁷ held that the IMD exclusion did not violate the equal protection component of the Fifth Amendment.¹²⁸ This district court's decision was also

S.Ct. 1153, 25 L.Ed. 491 (1970).

¹²⁵ *Id.*

¹²⁶ *Legion v. Richardson*, 354 F. Supp. 456 (S.D. N.Y. 1973) *aff'd sub nom.*, *Legion v. Weinberger*, 414 U.S. 1058, 94 S.Ct. 564, 38 L.Ed. 2d 465 (1973), *rehearing denied*, 415 U.S. 939, 94 S.Ct. 1459, 39 L.Ed. 2d 498 (1974).

¹²⁷ 388 F. Supp. 1127 (D. D.C. 1974), *aff'd* 530 F. 2d 1034 (D.C. Cir. 1976), *cert. denied* 429 U.S. 819 (1976).

¹²⁸ *Id.* Besides challenging the IMD exclusion on the grounds that it arbitrarily discriminated against a class of mentally ill

affirmed on appeal.¹²⁹

In neither case did the United Supreme Court listen to oral arguments nor draft a written judicial opinion regarding the constitutionality of the Medicaid statutory exclusion of persons between the ages of twenty-one and sixty-five in institutions for mental diseases.

The Supreme Court first specifically addressed the constitutionality of the IMD exclusion in *Schweiker v. Wilson*¹³⁰ in the context of denial of Supplemental Security Income (SSI) benefits to otherwise-qualified individuals in public mental institutions. Pursuant to Section 1611(e) of the Social Security Act, "inmates" of "public institutions" are ineligible to receive standard SSI benefits under Title XVI of the Act.¹³¹ Congress, however, made a partial exception to this exclusion by granting a small comfort allowance of \$300.00 annually¹³² (\$25.00 per month)

persons in public mental institutions, the plaintiffs also tried to challenge the exclusion on the grounds that it irrationally discriminated against persons who were between the ages of twenty-two and sixty-four. Citing the Supreme Court case of *Jefferson v. Hackney*, 406 U.S. 535, 92 S.Ct. 1724, 32 L.Ed. 285 (1972), the court applied the rational review equal protection standard and struck down this age argument.

¹²⁹ 530 F. 2d 1034 (D.C. Cir. 1976), *cert. denied* 429 U.S. 819 (1976).

¹³⁰ 450 U.S. 221, 101 S.Ct. 1074, 67 L.Ed. 2d 186 (1981).

¹³¹ 42 U.S.C. § 1382(e)(1)(A) (1994). See also 42 U.S.C. § 1396d(a)(24)(A), discussed in *supra* note 88.

¹³² This \$300.00 SSI comfort allowance for persons in medical institutions has since been slightly increased to \$360.00,

to Medicaid-eligible patients in hospitals, nursing facilities, and other extended care facilities covered under an approved state plan for medical assistance.¹³³ However, this statutory provision specifically denied these small comfort allowance benefits to persons between the ages of twenty-two and sixty-four in public mental institutions because they were ineligible to receive federal medical assistance.¹³⁴

The Court, in a five to four decision, upheld the constitutionality of the federal statutory exclusion of SSI comfort benefits to individuals in public mental institutions, even though these limited SSI benefits were granted to patients in other medical institutions and extended care facilities.¹³⁵ The Majority of the Supreme Court reasoned that mentally ill individuals were not improperly excluded or disproportionately disadvantaged as a class on the grounds that the challenged statutory provision did not create a distinction between mentally ill and non-mentally ill individuals, but rather a distinction between residents in public institutions which receive federal Medicaid funding for their care and residents in other

annually. 42 U.S.C. § 1382(e)(1)(B)(i) (1994).

¹³³ 42 U.S.C. § 1382(e)(1)(B) (1994).

¹³⁴ *Id.* However, subsequent to the Supreme Court's decision in *Schweiker v. Wilson*, Congress amended Section 1611(e) of the Social Security Act to allow SSI comfort allowance benefits to inmates of public institutions whose primary purpose is the provision of medical or psychiatric care. 42 U.S.C. § 1382(e)(1)(E) (1994).

¹³⁵ 450 U.S. at 232-239, 101 S.Ct. at 1082-1085.

institutions where no Medicaid reimbursement is available to cover the cost of their care.¹³⁶ The Court's majority opinion stated that the constitutional requirement of equal protection is not an obligation to provide the best governance possible.¹³⁷ This being the case, the Majority agreed with the contention of the Secretary of HHS, who had articulated that the Congressional intention behind the exclusion was to economize the disbursements of federal funds. The Government argued that the decision to limit distribution of the monthly comfort allowances to individuals in public institutions receiving Medicaid funding for their care was rationally related to a legitimate legislative desire to avoid spending federal resources on behalf of individuals whose care and maintenance were already being provided for by the States and local government agencies.¹³⁸

In a dissent by Justice Powell, joined by Justices Stevens, Brennan and Marshall, the characterization that this classification was not based on mental illness was vigorously attacked. Justice Powell stated that, although "it is true that not all mentally ill people are denied the benefit, and that some people denied the benefit are not mentally ill, it is inescapable that the appellees are denied the benefit because they are patients in mental institutions."¹³⁹ Citing the legislative

¹³⁶ 450 U.S. 232-233, 101 S.Ct. 1082. Justice Blackmun wrote the majority opinion in *Schweiker v. Wilson*.

¹³⁷ 450 U.S. at 230, 101 S.Ct. at 1080.

¹³⁸ 450 U.S. at 236-237, 101 S.Ct. at 1084.

¹³⁹ 450 U.S. at 241, 101 S.Ct. at 1086, note 2 (Powell, J.,

history of the 1965 Amendments to the Social Security Act, Justice Powell asserted that the residential exclusion of large state institutions for the mentally ill in federal financial assistance programs rested on two related principles: that "States traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions."¹⁴⁰

If one were to challenge the constitutionality of the IMD exclusion today, he or she might wish to argue that it is no longer rational to continue to make a distinction between

dissenting).

¹⁴⁰ *Schweiker v. Wilson*, 450 U.S. 221, 242, 101 S.Ct. 1074, 1086 (1981) (Powell, J., dissenting) *citing* S. Rep. No. 404, 89th Cong. 1st Sess. pt. 1, at 20 (1965) *reprinted in* 1965 U.S.C.C.A.N. 1943, 2084.

Justice Powell pointed out that the legislative history of the 1972 Social Security Act Amendments sheds no light on why Congress decided to exclude the SSI comfort allowance benefits for persons in public mental institutions based upon the denial of Medicaid eligibility. *Id.* at 243, 101 S.Ct. at 1087, note 3, *citing* H.R. Rep. No. 92-231, at 150 (1971), *reprinted in* 1972 U.S.C.C.A.N. at 5136. He also noted that the only indication of Congressional intent in the legislative history is that "No assistance benefits will be paid to an individual in a penal institution". *Id.* Finally, noting that the purpose behind granting the \$25.00 monthly SSI benefit was for personal comfort needs rather than for maintenance and medical care, Justice Powell stated that it was irrelevant whether the Federal Government or the State is responsible for paying for the individuals' maintenance and medical care because the monetary and comfort needs of patients in general medical and psychiatric institutions are the same. *Id.* at 246-248, 101 S.Ct. at 1089. Thus, Justice Powell concluded that there was no rational reason for Congress' refusing to pay SSI comfort allowances to otherwise eligible patients in state psychiatric hospitals, while at the same time granting such monthly benefits to identically situated disabled individuals in other medical facilities. *Id.*

"institutions for mental diseases" and other medical institutions and long-term care facilities.¹⁴¹ The medical community now recognizes that schizophrenia, bipolar disorder, and other serious mental illnesses to be neurobiological disorders of the brain.¹⁴² In light of this biological revolution in understanding the brain (and these illnesses), the federal medical assistance program should be required to cover the care and treatment of persons with serious mental illnesses on par with other disabilities and illnesses by applying the same nondiscriminatory "medical necessity" coverage criteria and requirements across the board for all medical conditions.¹⁴³ Federal financial participation (FFP)

¹⁴¹ Creating different classifications for "mental diseases" and other medical conditions earlier in the twentieth century could have been considered to be a rational distinction in federal public policy. However, as will be discussed in greater detail in part III.A of this analysis, *infra* notes 154-166 and accompanying text, the care and treatment for persons with serious mental illnesses has evolved tremendously and is now based upon a neurobiological understanding of the brain.

¹⁴² See discussion in part III, *infra* notes 155-166 and accompanying text.

¹⁴³ 42 CFR 440.230(c) (1995).
A legal representative challenging the constitutionality of the IMD exclusion should encourage the Supreme Court to adopt Justice Stevens's "medically necessary" judicial review approach, which he articulated in his dissent in *Harris v. McRae*, discussed in *supra* note 67, 448 U.S. 297, 349-357, 100 S.Ct. 2701, 2712-2716 (1980), (Stevens, J., dissenting). (Justice Stevens joined Justice Powell's dissent in *Schweiker v. Wilson*).

This same "medical necessity" reasoning was used by the Eighth Circuit Court of Appeals in requiring Iowa's state Medicaid agency to cover a sex reassignment surgical procedure for a transsexual Medicaid recipient on the grounds that this procedure was the only available treatment for this individual's transsexual condition. *Pinneke v. Preisser*, 623 F. 2d 546 (8th Cir. 1980). See the discussion of this case and other relevant cases and information pertaining to "medical necessity" coverage issues in part III.A of this analysis, *infra* notes 170-177 and accompanying text.

allocated for medical treatment and long-term (nursing) care of Medicaid patients should be predominantly based upon what is "in the best interests of the recipients".¹⁴⁴ Although legitimate arguments can be made that it is no longer rational to distinguish between IMDs and other medical institutions and long-term care facilities and that the IMD exclusion discriminates against persons with mental illnesses, it is unlikely that the Supreme Court would strike down this Medicaid exclusion, if reviewed today, because Supreme Court precedent indicates that, in the area of social and economic policy, costs and reimbursement exclusions are generally judged to be rational classifications furthering legitimate governmental objectives.¹⁴⁵

¹⁴⁴ See discussion of Section 1902(a)(19) of the Social Security Act, 42 U.S.C. § 1396a(a)(19) (1994), in *supra* note 73 and accompanying text. Also, a legal representative for a class of persons with severe mental illnesses should assert that the Medicaid statute does not exclude federal payment for services provided by other specialized hospitals (e.g., dialysis centers, cancer treatment centers and orthopedic hospitals) and covers other types of long-term care for Medicaid recipients. See discussion in part I.B, *supra* notes 40-49 and accompanying text.

¹⁴⁵ See *Dandridge v. Williams*, 397 U.S. 471, 90 L.Ed. 2d 491 (1970) and the equal protection discussion in *supra* notes 117-119 and accompanying text.

III. PUBLIC POLICY ARGUMENTS FOR CONGRESS TO REPEAL THE IMD EXCLUSION REPLACING IT WITH STANDARD "MEDICALLY NECESSARY" COVERAGE CRITERIA AND REQUIREMENTS

Although the IMD exclusion may not technically violate the Equal Protection Clause of the Constitution,¹⁴⁶ the continued application of this Medicaid exclusion discriminates against persons with severe mental illnesses. Therefore, as a matter of public policy, Congress should take it upon itself to remedy this inherent inequality by repealing the Medicaid IMD exclusion.

a. Historical Perspective On The IMD Exclusion

The evolution in psychiatric medicine, particularly in regards to understanding the nature and causes of serious mental illnesses, provides a good reason for revisiting the issue regarding the continued existence of the IMD exclusion.

The "institution for mental diseases" exclusion was first incorporated into the Social Security Act in 1950 based upon the rationale that States generally provided for the care and maintenance of persons in such institutions.¹⁴⁷ This, however, was

¹⁴⁶ U.S. CONST. amend. XIV § 1, last clause. See discussion in part II.D, *supra* notes 116-138 and accompanying text.

¹⁴⁷ These individuals were considered to be wards or inmates of the State. See discussion regarding the legislative history of the IMD exclusion in part II.B, *supra* notes 88-96 and accompanying text, *citing* H.R. Rep. No. 1300, 81st Cong., 1st Sess., at 42 (1949); H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), *reprinted in* 1963 U.S.C.C.A.N., 1954, 2064-66; and S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147 (1965), *reprinted in* 1965 U.S.C.C.A.N., 1943, 2084.

during the height of Freudian-based psychoanalysis¹⁴⁸ and other non-biologically-based theories¹⁴⁹ to explain mental illnesses which dominated American psychiatry and public perceptions of mental disorders in the United States for the better part of the twentieth century.¹⁵⁰

¹⁴⁸ The predominant view of mental illness in the United States for the better part of the twentieth century was based primarily upon Sigmund Freud's psychoanalytical or psychodynamic theories of the mind or "psyche". Freud believed that the mind possessed a certain amount of psychic energy which could be understood by examining the interplay between the psychic forces striving to maintain an equilibrium. See NANCY C. ANDREASEN, *THE BROKEN BRAIN: THE BIOLOGICAL REVOLUTION IN PSYCHIATRY* 20-22 (1984) (hereinafter *Andreasen, The Broken Brain*). The aim of Freudian psychoanalysis was to strive for a fundamental change in a disturbed individual's personality through a slow cure releasing the patient from neurotic fears in his or her subconscious. See NATHAN G. HALE, JR., *THE RISE AND CRISIS OF PSYCHOANALYSIS IN THE UNITED STATES: FREUD AND THE AMERICANS 1917-1985* 293 (1995) (hereinafter *HALE, THE RISE AND CRISIS OF PSYCHOANALYSIS*).

¹⁴⁹ Another competing view of mental illness in the United States in the twentieth century was conceptualized in terms of behaviorism, which involved conditioning and reactions to stimuli. Behaviorists approached treating persons with mental illnesses by trying to teach them to modify their behaviors through the use of positive and negative conditioning mechanisms. John B. Watson and B. F. Skinner were two acclaimed proponents of behaviorism for the treatment of mental illness. ANDREASEN, *THE BROKEN BRAIN*, *supra* note 148, at 17-19 and 24-26.

¹⁵⁰ Psychiatrists trained in Freudian psychoanalysis believed that nervous disturbances and serious mental illnesses could be attributed to various psychological and interpersonal factors or damaging influences, such as bad parenting or other adverse environmental factors, rather than to any biological or organic disorders of the brain. Thus, psychoanalytical practitioners were skeptical of organic therapies, like psychotropic medications, and wanted little if anything to do with them. See HALE, *THE RISE AND CRISIS OF PSYCHOANALYSIS*, *supra* note 148, at 245-247 and 257-299. See also ANDREASEN, *THE BROKEN BRAIN*, *supra* note 148, at 10-24; TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 166-169; and IRVING I. GOTTESMAN, *SCHIZOPHRENIA GENESIS THE ORIGINS OF MADNESS* 14-15 (1991) (hereinafter *GOTTESMAN, SCHIZOPHRENIA GENESIS*). In its place, these practitioners employed the use of psychoanalysis or "talk therapy" to treat patients with these disorders and to explain their irrational fears, neuroses, and psychoses. *Id.*

The practice of psychoanalysis gained widespread acceptance within the mainstream of American psychiatry following its apparent success in the treatment of combat-related neuroses during World War II.¹⁵¹ During the postwar period, psychoanalysts exerted significant influence in the development of federal mental health policy, as evidenced by the critical role they played in the establishment of the National Institute of Mental Health (NIMH)¹⁵² in 1946 and by the generous research and training grants awarded to psychoanalytical institutes during the first two

In contrast to the American thinking, Europeans in the early twentieth century accepted the view that serious mental illnesses, such as schizophrenia, were biological disorders of the brain. Dr. Emil Kraepelin (1856-1926) was an early physician and research proponent to advocate this biological view. His clinical studies regarding "*dementia praecox*", (the nineteenth century name for schizophrenia), serve as the building blocks for the modern biological view of serious mental illness. In Europe, Kraepelin is considered to be the father of psychiatry, whereas in the United States, Freud is considered to be the father of psychiatry.

ANDREASEN, *THE BROKEN BRAIN*, at 14-16, 19, and 26; GOTTESMAN, *SCHIZOPHRENIA GENESIS*, at 7-8 and 13-16.

¹⁵¹ Psychoanalysis was used to a large extent (and arguably quite successfully) to treat shell-shock or combat neuroses during and after World War I and World War II in an effort to prevent soldiers from suffering a mental breakdown. See HALE, *THE RISE AND CRISIS OF PSYCHOANALYSIS*, *supra* note 148, at 15-24, 187-210, and 245-299.

After World War II, psychoanalysis became identified with the mainstream of American psychiatry. *Id.* at 187-210 and 245-256. This is was due to the fact that a significant number of the post-World War II generation of psychiatrists in the United States received their psychiatric training in military psychoanalytical institutes. *Id.* at 187-210 and 245-256.

¹⁵² The National Institute of Mental Health was established through the enactment of the Mental Health Act of 1946. Pub. L. No. 79-487, 60 Stat. 425 (1946), 42 U.S.C. § 201, at § 232, (1994).

decades of its existence.¹⁵³ Based upon the psychiatric understanding of mental illness during this postwar period, it seemed reasonable to deny Social Security benefits to persons in IMDs while making such benefits available to (non-mentally ill and non-TB) patients in other medical institutions.

Psychoanalysis and other nonbiological approaches for the treatment of serious mental illnesses began to crumble with the discovery of organic drug therapies in the late 1950s and 1960s.¹⁵⁴

The proven effectiveness of early psychotropic medications ignited the biological revolution in psychiatry.¹⁵⁵ The biological

¹⁵³ Psychoanalytical psychiatrists, such as Karl and William Menninger, led efforts to promote the use of outpatient mental health services, primarily psychoanalytical approaches, to treat individuals suffering from various neuroses and serious mental illnesses, while deemphasizing the need for long-term institutional psychiatric care. See HALE, *THE RISE AND CRISIS OF PSYCHOANALYSIS*, *supra* note 148, at 187-210, 245-256, and 257-275. The efforts of the Menninger brothers and others culminated in the enactment of the Mental Health Act of 1946 and the establishment of the National Institute of Mental Health (NIMH). *Id.* at 209-210, 222-223, and 246-256. By 1954, a vast majority of psychiatrists described their orientation as Freudian or neo-Freudian and pursued a psychoanalytical approach to their practice. By 1962, the majority of chairmen of psychiatry departments at American medical schools were members of psychoanalytical organizations. *Id.* at 253-256; see also pages 222-230. In 1973, half of all psychiatrists in the United States specialized in psychoanalysis. *Id.* at 246.

¹⁵⁴ The advent of psychotropic medications, such as Thorazine, and other organic therapies, such as electroconvulsive therapy (ECT), in the mid to late 1950s, spurred an interest in brain research and in finding biological causes for serious mental disorders, a concern which had been kept alive by "organic" psychiatrists, mainly holdovers from the older, pre-World War II generation. *Id.* at 300-321. See also TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 167-169, 190; GOTTESMAN, *SCHIZOPHRENIA GENESIS*, *supra* note 150, at 15-16.

¹⁵⁵ Clinical research studies on new drug therapies began to

revolution in brain research slowly led to the decline and repudiation of psychoanalysis and other non-biologically-based theories for the treatment of serious mental disorders.¹⁵⁶ By the 1980s, most psychiatrists and mental health professionals accepted the notion that schizophrenia and other severe mental illnesses are biologically-based disorders of the brain.¹⁵⁷ As evidence of the repudiation of psychoanalysis within the mainstream of American psychiatry, the American Psychiatric Association (APA) released the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (the *DSM-III*) in 1980, in which it deleted all references to psychoanalytical and psychodynamic theories and explanations for serious mental disorders.¹⁵⁸ Today,

exhibit positive and scientifically verifiable results for the treatment of patients with schizophrenia and other serious mental illnesses. For their part, psychoanalytical psychiatrists were unable to match the efficacy of the new organic therapies or even demonstrate any verifiable benefits of psychoanalysis in clinical trials of patients with severe mental illnesses. *Id.*

¹⁵⁶ Sir Peter Medawar, a British medical researcher and Nobel prize winner, stated in an article, in the *NEW YORK REVIEW OF BOOKS*, in 1975 that the "doctrinaire psychoanalytical theory [was the] most stupendous intellectual confidence trick of the twentieth century." See HALE, *THE RISE AND CRISIS OF PSYCHOANALYSIS*, *supra* note 148, at 3.

¹⁵⁷ See ANDREASEN, *THE BROKEN BRAIN*, *supra* note 148, at 14-19, 27-33 and 83-247; GOTTESMAN, *SCHIZOPHRENIA GENESIS*, *supra* note 150, at 7-16 (1991); and TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 166-172.

¹⁵⁸ See HALE, *THE RISE AND CRISIS OF PSYCHOANALYSIS*, *supra* note 148, at 303.

As further evidence of the continuing controversy over Freudian theories today, the Library of Congress decided to postpone an exhibit entitled "Freud: Conflict and Culture". The Library of Congress publicly stated that it postponed the planned exhibit due to budgetary concerns. However, the Library received petitions signed by forty-two scholars from different fields, including the psychiatric community. See D. Smith, *Freud May Be Dead, But His Critics Still Kick*, *N.Y. TIMES*, December 10, 1995,

virtually all psychiatrists and mental health professionals recognize the biological nature of serious mental illnesses and the importance of organic therapies in the treatment of these conditions.¹⁵⁹

Within the past two decades, significant advances have been made in understanding the workings of the brain, which has provided further scientific evidence supporting the organic nature of these psychiatric disorders.¹⁶⁰ Even though the specific causal relationships for the onset or manifestation of severe mental illnesses have yet to be determined,¹⁶¹ recent medical research has established neurobiological components or bases for a number of psychiatric illnesses including schizophrenia, bipolar disorder, and major depression.¹⁶² Magnetic resonance imaging (MRIs) and

at D14, col. 1.

¹⁵⁹ See *supra* note 157.

Even psychoanalysts now recognize that schizophrenia and other serious mental illnesses have neurobiological underpinnings. See M. Robbins, *Psychoanalytic and Biological Approaches to Mental Illnesses: Schizophrenia*, 40 J. OF AMERICAN PSYCHOANALYTIC ASSOCIATION 425-454 (1992) and HALE, THE RISE AND CRISIS OF PSYCHOANALYSIS, *supra* note 148, at 300-379.

¹⁶⁰ Congress and the National Advisory Mental Health Council dedicated the 1990s as the "Decade of the Brain".

¹⁶¹ However, this should not preclude people suffering from these psychiatric disorders from receiving equal treatment under the Medicaid statute. Many other organic disorders, such as various types of cancer, have unknown causes and origins, and medically necessary treatments for persons suffering from these disorders are not categorically singled out or excluded from coverage under the Medicaid program.

¹⁶² See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 140-155); TORREY ET AL., SCHIZOPHRENIA AND MANIC-DEPRESSIVE DISORDER: THE BIOLOGICAL ROOTS OF MENTAL ILLNESS AS REVEALED BY THE LANDMARK STUDY OF IDENTICAL TWINS (1994)

pathologic studies have revealed structural brain abnormalities in persons with schizophrenia.¹⁶³ Abnormalities in cerebral blood flow, neurochemical transmitters (e.g., increased dopamine levels), and neuronal impulses have been found in individuals with schizophrenia.¹⁶⁴ With regard to mood disorders, abnormal fluctuations in the level of neurotransmitters called monoamines (such as norepinephrine, serotonin, and acetylcholine), have been identified in persons with bipolar disorder and major depression.¹⁶⁵ Beyond this, most medical researchers in the field

(hereinafter TORREY ET AL., SCHIZOPHRENIA AND MANIC-DEPRESSIVE DISORDER); GOTTESMAN, SCHIZOPHRENIA GENESIS, *supra* note 150, at 82-246; ANDREASEN, THE BROKEN BRAIN, *supra* note 148, at 83-247; and OTA REP. BIOLOGY OF MENTAL DISORDERS, *supra* note 11.

¹⁶³ See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 142-155 and OTA REP., THE BIOLOGY OF MENTAL DISORDERS, *supra* note 11, at 71-82. Structural abnormalities in persons with schizophrenia are most notable in the frontal cortex and in the limbic system of the brain.

¹⁶⁴ *Id.*

¹⁶⁵ Research studies have shown that patients with bipolar disorders have decreased amounts of norepinephrine (NE) metabolites during depression and increased amounts of NE during manic episodes. Some research studies have found low concentration of serotonin in autopsies of persons who have committed suicide. It has been suggested, based on available research data, that decreased activity within the NE-serotonin system is associated with depression, while increased activity of the NE-dopamine component is associated with mania. However, other neurotransmitters, such as acetylcholine, can also induce mood changes. It has been hypothesized that increased acetylcholine activity induces depression, while decreased acetylcholine activity induces mania. See OTA REP., THE BIOLOGY OF MENTAL DISORDERS, *supra* note 11, at 82-88.

Lithium is the most effective medication for controlling mood swings between depression and mania. It increases serotonin activity and decreases acetylcholine activity. Lithium also affects the activity level of both norepinephrine (NE) and dopamine. *Id.*

Also, with regard to persons with mood disorders, there appear to be alterations in normal brain activity between the

of psychiatric medicine now believe that genetics plays a role in the development of schizophrenia and other severe mental illnesses.¹⁶⁶

Congress has now recognized that serious mental illnesses are biological disorders of the brain and has recently mandated that by 1998 treatments for mental illness can no longer be subjected

right and left sides of the brain. Complicating matters pertaining to the biological causes for depression and bipolar disorders are several other variables, such as sleep, circadian rhythms, hormonal changes and alterations, and stress factors. *Id.* See also George, Ketter, Parekh, Horwitz, Herscovich, and Post, *Brain Activity During Transient Sadness and Happiness in Healthy Women*, AMERICAN JOURNAL OF PSYCHIATRY, Vol. 152, No. 3, 341-351 (March 1995).

Clinically effective antidepressant medications (e.g., tricyclic antidepressants and monoamine oxidase inhibitors) block or curb the enzymes involved in the chemical breakdown or alteration of normal monoamine neurotransmitter activity. See OTA REP., THE BIOLOGY OF MENTAL DISORDERS, *supra* note 11, at 82.

¹⁶⁶ Recent research studies have indicated that most likely there is some genetic linkage involved in the onset of schizophrenia and mood disorders. However, there is a continuing debate regarding the exact role of genetics in the development of these disorders. Irving I. Gottesman, Ph.D., a leading researcher in the area of genetics and schizophrenia, expressed in his book that genetic factors are essential as a predisposition to schizophrenia, but they are not sufficient, in and of themselves, to cause the onset or actual development of schizophrenia. Using predisposition stressors, Dr. Gottesman formulated a risk assessment chart for developing schizophrenia in one's lifetime when a first or a second degree relative manifests an onset of schizophrenia. Within his model, Dr. Gottesman also recognized the role of the psychosocial and environmental stress factors on the development of schizophrenia and other mental disorders. See GOTTESMAN, SCHIZOPHRENIA GENESIS, *supra* note 150, at 82-132. See also TORREY ET AL., SCHIZOPHRENIA AND MANIC-DEPRESSIVE DISORDER, *supra* note 162; OTA REP., THE BIOLOGY OF MENTAL DISORDERS, *supra* note 11, at 101-122; J. Egeland, *Bipolar Affective Disorders Linked To DNA Markers On Chromosome 11*, 325 NATURE 783-787 (Feb. 26, 1987), (a study of Amish families); and M. Baron, *Genetic Linkage Between CHI-Chromosomes Markers and Bipolar Affective Illness*, 326 NATURE 289-292 (Mar. 19, 1987).

to annual and lifetime caps in private health insurance policies when no such coverage limitations are imposed for treatment for other physical illnesses.¹⁶⁷ Congress should take this realization one step further and accept the fact that, in spite of the tremendous progress which has taken place in the field of psychiatric medicine within the past three decades, there continues to be a small but significant number of persons with chronic and disabling forms of schizophrenia and other serious mental illnesses who are treatment-resistant to, or fail to receive adequate benefits from, available medications and community-based treatment services and will continue to need residential treatment or institutional psychiatric care.¹⁶⁸ In addition to this population of chronic and severely disabled psychiatrically ill individuals, a number of persons with these disorders are initially treatment-resistant to standard psychotropic medications and/or experience a relapse in their

¹⁶⁷ Section 2 of the Mental Health Parity Act of 1996, S.B. 2031. This bill was signed into law by President Clinton on September 26, 1996, as part of the 1997 Veterans Administration / Department of Housing and Urban Development Appropriations Bill. Pub. L. No. 104-204, tit. 7, 110 Stat. 2874, 2944-2950 (1996).

¹⁶⁸ See the discussion of "the forgotten population", in part I of this analysis, *supra* notes 13-17 and 40-46 and accompanying text. Also, as discussed previously in part I.B, the Community Mental Health Centers Act of 1963 and the mental health provisions of the 1965 Amendments to the Social Security Act were premised on the notion that with the development of new medications and an increased number of psychiatric beds in general hospitals community mental health services would ultimately be able to replace the need for state mental institutions. See *supra* notes 27-34 and accompanying text, *citing* H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), *reprinted in* 1963 U.S.C.C.A.N. 1054, 1064-66 and S. Rep. No. 404, 89th Cong. 1st Sess., pt. 1, at 143-147 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2083-87.

condition. These individuals could greatly benefit from specialized inpatient psychiatric care and other therapeutic services provided on an outpatient, and partial hospitalization, basis through (public and private) psychiatric hospitals.¹⁶⁹

The federal medical assistance program purports to operate under a "best interest of the recipient" standard based upon a non-discriminatory policy without regard to specific diagnosis, type of illness, or condition.¹⁷⁰ Pursuant to this policy rationale underlying the federal Medicaid statute, it would seem reasonable that if a physician (i.e., a psychiatrist) determines that the most appropriate and "medically necessary" care and placement for an otherwise eligible Medicaid patient is in a state psychiatric hospital or another facility which specializes in the care and treatment of persons with psychiatric disorders that this professional medical judgment should be respected and carry the controlling weight in determining the proper care and placement for that patient. Old statutory classifications and distinctions allowing for federal medical assistance payments for some acute and long-term care of persons with some organic disorders¹⁷¹ while

¹⁶⁹ See discussion in part I and in part III.C at *infra* notes 209-213 and accompanying text.

¹⁷⁰ Section 1902(a)(19) of the Social Security Act, 42 U.S.C. § 1396a(a)(19) (1994) and 42 CFR 440.230(c) (1995).

¹⁷¹ Medicaid has no statutory exclusions for necessary medical care provided in specialized treatment facilities for persons with multiple sclerosis, Parkinson's disease, Alzheimer's disease, autism, mental retardation, and other related brain disorders. After standard certification of need and utilization review requirements have been met, federal medical assistance is allowed

denying payment for other medically necessary care for (otherwise eligible) recipients with other types of neurobiological disorders is arbitrary, irrational, and discriminatory.

Congress should mandate that Medicaid apply the "medically necessary" standard across the board for all medical neurobiological disorders.¹⁷² Using the "medical necessity" standard, the Eighth Circuit Court of Appeals, in *Pinneke v. Preisser*,¹⁷³ held that the Iowa Medicaid agency had to cover a sex reassignment surgical procedure for a transsexual Medicaid recipient. Based upon expert medical testimony, the trial court had determined that this sex conversion procedure was the only medically necessary and available treatment for this individual's transsexual condition.

for treatments of these conditions based upon what is in the best interest of the patient.

¹⁷² Congress should embrace the "medically necessary" judicial review approach articulated by Justice Stevens in his dissent in *Harris v. McRae*, 448 U.S. 297, 349-357, 100 S.Ct. 2701, 2712-2716 (1980) (Stevens, J., dissenting). The author notes that Justice Stevens joined Justice Powell's dissent in *Schweiker v. Wilson*, 450 U.S. 221, discussed in part II at *supra* notes 139-140 and accompanying text.

Justice Stevens asserted, "Individuals who satisfy two neutral criteria - financial need and medical need - are entitled to equal access to the pool [of Medicaid benefits]." 448 U.S. at 349, 100 S.Ct. at 2712. Noting that the Constitution imposes no obligation on the States to pay for medical care for indigent residents within their jurisdictions, Justice Stevens stated that, once a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations. *Id.* at 356, 100 S.Ct. 2715 *citing* *Maher v. Roe*, 432 U.S. 464, 469-470, 97 S.Ct. 2376, 2380 (1977). Justice Stevens then contended that the government must use neutral criteria in distributing the benefits, and that it has a duty to govern impartially. *Id.*

¹⁷³ 623 F. 2d 546 (8th Cir. 1980). See also the cases cited in *infra* note 175.

The district court and circuit court held that Iowa's decision to deny Medicaid payment for this procedure violated the Medicaid regulation prohibiting state agencies from arbitrarily denying or reducing the amount, duration, or scope of required services to eligible recipients based solely upon a patient's diagnosis or condition.¹⁷⁴ The appellate court cited the legislative history of the 1965 Amendments to the Social Security Act to support its assertion that Congress intended professional medical judgments to play the primary role in the determination of medically necessity.¹⁷⁵ The report from the Senate Finance Committee provided that "the physician is to be the key figure in determining the utilization of health services", and that "it is a physician who is to decide upon admission to a hospital, order

¹⁷⁴ *Id.* at 549-550, *citing* 42 CFR 440.230(c). See the discussion of this antidiscrimination regulation in part II.A, *supra* notes 73-76 and accompanying text.

¹⁷⁵ *Id.* at 549, note 3, *citing* S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147, *reprinted in* 1965 U.S.C.C.A.N., 1943, 1986.

See also Minnesota Department of Public Welfare, 257 N.W. 2d 816 (Minn. 1977) and *G.B. v. Lackner*, 145 Cal. Rptr. (Cal. App. 1978). These cases also held that sex reassignment surgery was the only "medically necessary" procedure for some patients with the condition of transsexualism and that the (Minnesota and California) state Medicaid agencies were required to cover such sex conversion procedures for Medicaid recipients with this condition. The court, in *G.B. v. Lackner*, held that this surgical procedure could not be arbitrarily denied Medicaid coverage on the grounds that this surgery was considered to be a "cosmetic procedure" (not covered under most state Medicaid plans). *But see* *Rush v. Johnson*, 565 F. Supp. 856 (N.D. Ga. 1983), which held that Georgia's Medicaid agency did not have to pay for a transsexual operation, performed in 1974, on the grounds that this surgery was found to be an experimental procedure (also not covered under most state Medicaid plans). However, even the court's holding in *Rush v. Jonson* did not dispute the notion that the "medically necessary" standard applies to sex conversion procedures for Medicaid patients with a diagnosed condition of transsexualism.

tests, drugs and treatments, and determine the length of stay."¹⁷⁶

This same "medically necessary" coverage standard should apply with regard to Medicaid payment of psychiatric health services and long-term (psychiatric) care.¹⁷⁷

b. Consequences Of The Medicaid IMD Exclusion, Viewed In Conjunction With Federal Funding Incentives Promoting The Utilization Of Community Mental Health Services

Beyond the evolution in the medical understanding of psychiatric disorders, significant societal consequences have resulted from the Medicaid IMD exclusion and other federal mental health incentives promoting the utilization of community-based mental health services. As discussed earlier,¹⁷⁸ one of the primary public policy goals of the federal mental health initiatives adopted during the 1960s was to encourage States to deinstitutionalize patients from public psychiatric hospitals and provide care for these individuals through community mental health centers.¹⁷⁹ The incorporation of the IMD exclusion into the 1965 Amendments to the Social Security Act, in particular the Medicaid

¹⁷⁶ *Id. citing* S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147, *reprinted in* 1965 U.S.C.C.A.N., 1943, 1986.

¹⁷⁷ Part III.C of this analysis, *infra* notes 214 through 225 and accompanying text, sets forth reasonable nondiscriminatory proposals to contain Medicaid costs for specialized inpatient and long-term psychiatric care, if the IMD exclusion is repealed.

¹⁷⁸ See discussion in parts I.B, *supra* notes 27-39 and accompanying text.

¹⁷⁹ *Id. citing* the legislative history to the Community Mental Health Centers Act of 1963, *published in* H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), *reprinted in* 1963 U.S.C.C.A.N. 1054, at 1064-66.

statute, was a coordinated and logical extension of this federal mental health policy.

Deinstitutionalization, with its emphasis on community mental health services, has benefitted numerous persons with serious mental illnesses who otherwise would have been institutionalized.¹⁸⁰ The humanitarian purpose underlying the deinstitutionalization movement is premised upon the notion that these individuals will be able to make a successful adjustment to life in the community and assumes that their conditions can be properly maintained on an outpatient basis with the appropriate medications.¹⁸¹ Unfortunately, however, this is not always the case.

Consequently, the Medicaid IMD exclusion, in conjunction with the overall shift in public mental health financing based on the Federal Government's mental health policy of promoting community-based treatment services, has contributed to and/or exacerbated problems for a number of individuals with severe forms of schizophrenia and other serious mental illnesses who have not been as fortunate in making a successful transition to life in the community. It is estimated that between 150,000 to 200,000 persons with a primary diagnosis of schizophrenia, bipolar

¹⁸⁰ As discussed in part I of this analysis, the majority of persons with serious mental illnesses can now be successfully treated on an outpatient basis with the appropriate medications. See discussion in *supra* notes 11-12 and accompanying text.

¹⁸¹ *Id.*

disorder, or another serious mental illness are homeless in the United States on any given day.¹⁸² Besides homelessness, deinstitutionalization has brought with it or led to an increase in the number of persons incarcerated in prisons and jails across America who suffer from severe mental illnesses.¹⁸³ A study of prisons in the United States in the mid to late 1980s concluded that ten to fifteen percent of inmates had a major thought disorder or mood disorder and needed treatment services associated

¹⁸² The National Institute of Mental Health (NIMH) and the National Center for Health Statistics (NCHS) conducted a national survey in 1989, which concluded that an estimated 200,000 mentally ill persons are homeless on any given day. See CRS, *MEDICAID SOURCE BOOK, Medicaid Services For The Mentally Ill*, *supra* note 6, at 914. Some estimates indicate that 20 to 40 percent of the homeless population suffers from a serious mental illness. *Id.* at 914-915. Other research studies have estimated that approximately 35 percent or one-third of the homeless population suffers from schizophrenia, major depression, or manic depression (bipolar disorder) and have concluded that approximately 150,000 homeless individuals in America suffer from these psychiatric disorders. See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 3 and 13-24, and TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 1-2. Closer to home, it is estimated that there are approximately 7,000 homeless persons in the District of Columbia, about a third of whom have a serious mental illness, and another third have a substance abuse disorder. A number of the District's mentally ill homeless persons were once residents of Saint Elizabeth's Hospital, who wanted to stay but were either discouraged or prohibited from doing so. See Peele, *In Pursuit of the Promise*, *supra* note 13, at 21 and 48. See also TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 249.

¹⁸³ Studies conducted prior to the start of deinstitutionalization concerning the number of former psychiatric patients arrested after being discharged from state hospitals did not find a higher arrest rate for such former patients than for the population as a whole. However, eight studies conducted between 1965 and 1978 found that the arrest and conviction rates for former psychiatric patients either equalled or exceeded that of the general population. One study conducted in California between 1972 and 1975 found that discharged patients were arrested 2.9 times more frequently than non-psychiatric patients. See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 41-42.

with a chronic and severe mental illness.¹⁸⁴ Also, a 1992 survey of the nation's jails found that 7.2 percent of inmates, or approximately 30,700 persons, suffered from a serious mental illness.¹⁸⁵ All told, it is estimated that approximately 150,000 mentally ill individuals (or more) are incarcerated in jails and prisons across the country.¹⁸⁶ Many mentally ill persons confined in jails across the country are held without charge or are incarcerated for nonviolent misdemeanor offenses, such as disorderly conduct.¹⁸⁷ Thus, the era of deinstitutionalization has

¹⁸⁴ *Id.* at 30 citing Jemelka, et al., *The Mentally Ill In Prisons*, 40 HOSPITAL AND COMMUNITY PSYCHIATRY 481-485 (1989). Other studies in various States indicated that 6.6 to 10 percent of prison inmates had schizophrenia, bipolar disorder, or major depression. TORREY, OUT OF THE SHADOWS, *supra* note 2, at 30.

¹⁸⁵ See NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAMI) & PUBLIC CITIZEN RESEARCH GROUP, CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 14-15, 28 (1992) (hereinafter CRIMINALIZING THE SERIOUSLY MENTALLY ILL). Additionally, the topic of county jails serving as "the dumping grounds" for the severely mentally ill in America was one of the subjects examined on the Cable News Network's weekly news magazine, *CNN Presents*, on Sunday, April 28, 1996. *CNN Presents: Breakdown*, (CNN television broadcast, Apr. 28, 1996). This program viewed the "breakdown" in the public mental health system as a consequence of the reduction in the amount of inpatient psychiatric care services available to treat individuals suffering from severe psychiatric disorders and the failure to furnish adequate community mental health services for these individuals. The Los Angeles County Jail is now the largest single, de-facto psychiatric institution in the country. See TORREY, OUT OF THE SHADOWS, *supra* note 1, at 42.

¹⁸⁶ This 150,000 population estimate is based upon a reasonable assessment that 10 percent of the total jail and prison population in the United States in 1995 (1,587,791) suffer from a serious mental illness. See TORREY, OUT OF THE SHADOWS, *supra* note 1, at 31.

¹⁸⁷ Twenty-nine (28.9) percent of jails responding to the 1992 jail survey stated that their facilities were sometimes used to detain or house seriously mentally ill persons without criminal charges being filed against them, (i.e., for emergency detention before commitment proceedings can be held or for other noncriminal

created a "revolving door" phenomenon for approximately 150,000 to 300,000 persons suffering from severe mental illnesses, between living on the streets, being confined in jails and prisons, and being civilly committed to hospitals for short periods of time.¹⁸⁸

Beyond the societal problems resulting from deinstitutionalization, States have found ways to circumvent the IMD exclusion by playing the financial incentive game created by Medicaid's statutory funding mechanisms. As discussed previously,¹⁸⁹ Medicaid

mental health reasons, such as hallucinating in public or "just acting strange"). Also, the third most common offense cited by the jails in the survey for arresting mentally ill individuals, after assault and/or battery and theft, was "disorderly conduct", (29.4 percent of total arrests). (Drug and alcohol related offenses were ranked fourth at 29.0 percent.) See CRIMINALIZING THE SERIOUSLY MENTALLY ILL, *supra* note 185, at 16-20 and 44-48.

¹⁸⁸ See CRIMINALIZING THE SERIOUSLY MENTALLY ILL, *supra* note 185, at 80-85, discussing an ongoing cycle faced by many seriously mentally ill persons between homelessness and repeated arrests and incarcerations for minor offenses and/or misdemeanors. The jails survey identified many individuals with schizophrenia and bipolar disorders who were jailed and/or hospitalized numerous times. One person with schizophrenia was jailed at least a hundred times, all on misdemeanor charges, and other individuals mentioned in the survey were reported to have been hospitalized at least 30 times. *Id.* at 82-83. Additionally, a study of mentally ill inmates in Los Angeles County Jail found that 37 percent of mentally ill males arrested and 42 percent of female inmates in the group had been living on the streets or in shelters at the time of their arrest. *Id.* at 82.

Other research studies have found a significant number of readmissions to state psychiatric hospitals; 30 percent in Illinois were readmitted within thirty days, and 60 percent in New York were readmitted within one year. Some individuals with schizophrenia have been hospitalized and readmitted over one hundred times. See TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 2, at 3-4, and TORREY, OUT OF THE SHADOWS, *supra* note 1, at 13-42, 61-79.

¹⁸⁹ See the discussion in part II.A, *supra* notes 68-70 and accompanying text.

covers services furnished to eligible recipients residing in general hospitals and nursing facilities with no special payment rules regarding diagnosis or the provision of psychiatric care services.¹⁹⁰ This has led States to engage in the practice of cost-shifting by discharging chronically mentally ill patients from state psychiatric hospitals and, after a relapse, admitting these former institutionalized patients to general hospitals and nursing facilities.¹⁹¹ This cost-shifting has resulted in inappropriate placements and treatment decisions for a significant number of chronically mentally ill patients, based not upon "what

¹⁹⁰ *Id. citing* 42 U.S.C. §§ 1396a(a) and 1396d(a) (1994) and 42 CFR 440.230(c) (1995). This is the case unless the facility in question is deemed to be an IMD, as in the case of *Connecticut Department of Income Maintenance v. Heckler*, 471 U.S. 524 (1985), discussed in part II.C, *supra* notes 100-110 and accompanying text.

¹⁹¹ *Id.* The placement of chronic and severely mentally ill individuals (22 to 64 years of age) in nursing facilities rather than state psychiatric hospitals or other IMDs, in order for such patients to remain eligible for Medicaid coverage and other federal entitlement programs, can best be described as "transinstitutionalization". See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 102-103.

Illustrating the significance of this cost-shifting, Dr. Torrey testified during a hearing before the Senate Finance Committee, on May 10, 1994, that federal funding incentives, such as Medicaid and other entitlement programs, have created "a gigantic fiscal carrot encouraging states to discharge patients as a means of shifting the cost of care from the state government to the federal government." Torrey asserted that "States have little fiscal incentives to ensure that discharged patients receive medication or aftercare." He further testified that "In most states today the single most important function of state departments of mental health is to find additional ways to shift the cost of psychiatric care from the state government to the federal government." See Testimony of E. Fuller Torrey, M.D., on *Deinstitutionalization*, United States Senate, Committee on Finance, FEDERAL NEWS SERVICE, (May 10, 1994). The total federal funding incentives for States to deinstitutionalize or otherwise provide care for psychiatrically ill individuals in the community has been estimated to be \$38 billion, annually. See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 91-102.

is in the patient's best interests", but upon whether federal funds are available to cover the provided treatment services.¹⁹²

Illustrating this cost-shifting phenomenon, a 1989 report of the Agency for Health Care Policy and Research estimated that of the 1.5 million nursing facility residents in the United States greater than 29 percent had a mental disorder other than or in addition to a dementia-related disorder, and 15.5 percent of the residents had a mental disorder(s), but no dementia.¹⁹³ Based upon these nursing facility population percentages, it is estimated that between 232,500 and 435,000 residents suffer from a serious mental illness other than or in addition to a dementia-related

¹⁹² See CRS, MEDICAID SOURCE BOOK, *Medicaid Services For the Mentally Ill*, *supra* note 6, at 931. See also TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 102-103.

Torrey states, in his book, that the major problem with using nursing and smaller board and care facilities to care for severely mentally ill individuals is that these facilities do not have professionally-trained staff, such as a full-time psychiatrist, to work with these patients; thus nursing facilities are primarily capable of offering only custodial care for these individuals. Torrey also mentions that the quality of care provided at state psychiatric hospitals improved during the 1970s and 1980s and that it became increasingly common to discharge patients from a relatively good hospital with active rehabilitation programs and transfer them to nursing facilities with inferior psychiatric care services and no rehabilitation programs for these patients. *Id.* See also TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 248-250.

¹⁹³ CRS, MEDICAID SOURCE BOOK, *Medicaid Services For The Mentally Ill*, *supra* note 6, at 927-928. Almost two-thirds of the residents displayed symptoms of depression, and nearly thirty percent of the residents experienced psychotic symptoms. Twenty-nine percent of the residents under sixty-five years of age, and seventeen percent of the sixty-five and older population had a primary diagnosis of a mental illness. *Id.* at 928. See also TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 91, 102-103.

disorder.¹⁹⁴ More recent research studies now estimate the total nursing facility population in the United States to be over two million¹⁹⁵ and reveal that 150,000 residents have schizophrenia, including a large percentage of individuals under sixty-five years of age.¹⁹⁶ As these numbers indicate, serious questions arise as to whether such persons in these nursing facilities are actually receiving the most appropriate and medically necessary care for their conditions.¹⁹⁷

¹⁹⁴ These nursing facility population estimates of 232,500 and 435,000 are calculated using the total 1989 nursing facility population estimate of 1,500,000, multiplied by 15.5 percent and 29 percent, respectively.

¹⁹⁵ The total nursing facility population in the United States is estimated to be 2.2 million people. See TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 10.

¹⁹⁶ *Id.* A 1988 survey of nursing facilities in four cities found that five percent of such residents had a primary diagnosis of schizophrenia, and a 1993 survey of nursing facilities in Rochester, New York revealed that 7.5 percent of such residents had a diagnosis of schizophrenia. These observations are consistent with earlier studies which indicated that approximately eight percent of nursing home residents were "chronic mental patients, formerly residents of long-term psychiatric hospitals". *Id.* Additionally, approximately 33 percent of nursing facility residents under 65 were found to have a diagnosis of schizophrenia. *Id.*

¹⁹⁷ The Federal Government has taken steps in an effort to stem the problem of inappropriate placements in nursing facilities. Congress, in the Omnibus Budget Reconciliation Act (OBRA) of 1987, Pub. L. No. 100-203, § 4215, (amended in 1990, by OBRA-90, Pub. L. No. 101-508, § 4801), mandated that States participating in Medicaid implement pre-admission screening and annual resident review (PASARR) programs to evaluate whether mentally ill and mentally retarded residents require the services furnished by the nursing facility or, in the alternative, require specialized services provided by an IMD or an intermediate care facility for mentally retarded individuals (ICF/MR). Section 1919(e)(7) of the Social Security Act, 42 U.S.C. § 1396r(e)(7) (1994) and 42 CFR 483.100 et seq. (1995).

For long-term patients, those residing in the nursing facility at least 30 months, who are determined not to require the

There is no indication in the legislative history of either the Community Mental Health Centers Act or the 1965 Amendments to the Social Security Act that Congress intended the States to engage in mental health cost-shifting to such an extent that severely mentally ill persons, who are not prepared to make the adjustment to life in the community, are discharged from state psychiatric hospitals, or that the state governments fail to uphold their traditional responsibility of furnishing necessary institutional care for (new) patients who require such services.¹⁹⁸

level of care provided by the nursing facility, but need specialized services for mental illness or mental retardation, Medicaid-participating States are obligated to offer such residents the choice between remaining in the facility or receiving the appropriate alternative care services, in either an institutional or a noninstitutional setting. 42 U.S.C. § 1396r(e)(7)(C)(i) (1994). If the resident chooses to leave the facility, the State first must explain to him or her the effect that this decision may have upon his or her Medicaid eligibility, under the state plan. Regardless of the resident's choice, the State has to provide or arrange such specialized services. A State, however, is not denied federal Medicaid reimbursement for long-term residents who choose to remain in the facility. *Id.*

The PASARR requirements mandate that for individuals residing in the facility for less than 30 continuous months, who are determined not to require the level of care provided by the nursing facility, but require specialized services for mental illness or mental retardation, the State, in consultation with the resident's family or legal representative, must arrange for the safe and orderly discharge of the patient and provide or arrange the specialized services required for the treatment of his or her mental illness or mental retardation. 42 U.S.C. § 1396r(e)(7)(C)(ii) (1994). However, in passing these PASARR requirements, Congress did not appropriate any federal funds to assist States with the costs of providing specialized psychiatric care to these former nursing facility residents. This has been a cause for concern on the part of many mental health advocates.

¹⁹⁸ See H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), *reprinted in* 1963 U.S.C.C.A.N., 1954, 2064-2066; and S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-147 (1965), *reprinted in* 1965 U.S.C.C.A.N., 1943, 2084-2087.

Nevertheless, States have either abandoned or significantly relaxed the standards of care owed to these patients in order to obtain federal Medicaid funding and other federal subsidies for these individuals.¹⁹⁹

States, in reliance upon federal funds to help pay for mental health services, have been inclined to abrogate their responsibility to provide care and maintenance services for chronic and severely mentally ill individuals who continue to require long-term psychiatric care. This abrogation of responsibility can be seen in the closures of state psychiatric hospitals nationwide (with no guarantees of adequate and/or continuous aftercare services for former patients), and in the significant reductions in state appropriations for institutional care and rehabilitative services.²⁰⁰ As a result, the most

¹⁹⁹ It is reasonably foreseeable that States would try to take advantage of these federal incentives by placing chronically mentally ill individuals in nursing facilities, rather than state psychiatric hospitals, in order to receive federal funding for their care. See the discussion in *supra* note 191 and the contentions raised in the ensuing discussion.

²⁰⁰ For example, a class-action lawsuit was filed in United States District Court, on behalf of patients (mostly long-term) in South Florida State Hospital (SFSH), who received virtually no services in the hospital designed to rehabilitate them for eventual release back into the community. In June 1993, during the pendency of this class-action, the State of Florida decided to close this state psychiatric hospital. Subsequently, in a settlement, the State agreed only to provide thirty days of supportive aftercare services for former patients. *Sanbourne v. Chiles*, Case 89-6283-CIV-NESSBITT, (S.D. Fla. 1993). However, this settlement did not provide for ongoing rehabilitative aftercare services or adequately address the needs of long-term patients who are released into the community.

Other States also have reduced the patient population at state psychiatric hospitals without recouping the savings for

vulnerable mentally ill individuals in the United States are left unprotected under both federal and state law.

Therefore, rather than furthering the positive and well-meaning purposes of deinstitutionalization, the Medicaid IMD exclusion, employed in conjunction with other federal incentives encouraging the use of community mental health services, has helped to create a system of premature release and

other state mental health programs. See Kevin Sack, *Why Politics, as Usual, Is Not Helping The Mentally Ill*, N.Y. TIMES, July 25, 1993, . 4, at 5. See also discussion in *supra* note 200, in part VI, *citing* Wyatt v. Stickney, 225 F. Supp. 781 and 334 Supp. 1341 (M.D. Ala. 1971 and 1972), and other cases and articles pertaining to state psychiatric patients' rights and the inadequacy of public mental health funding for services provided to patients at state psychiatric hospitals.

New York is trying to rectify some funding inequities in its state mental health program by designating cost savings from the closure of five state psychiatric hospitals for use for outpatient mental health and substance abuse treatment programs. See Celia W. Dugger, *Albany Accord Supports Clinics For Mentally Ill*, N.Y. TIMES, November 17, 1993, at A-1, col. 1. This agreement, however, does not ensure that most severely disabled, treatment-resistant mentally ill patients in New York will be able to receive adequate long-term psychiatric care.

Other States and municipalities have neglected to provide adequate funding for outpatient mental health programs. Thus, even today, many severely mentally ill individuals would fare better, in terms of quality of life, in a state psychiatric hospital where they could receive intensive psychiatric treatment and rehabilitative services, provided in an environment which promotes continuity of care, rather than trying to survive on their own, living in the streets. See Peter Rowe, *County mental health system is outrageous*, THE SAN DIEGO UNION-TRIBUNE, Oct. 3, 1996, at E-1. This article is based on an interview with Robert C. Coates, a San Diego Municipal Court judge and author of *A STREET IS NOT A HOME: SOLVING AMERICA'S HOMELESS DILEMMA* (1990), regarding serious shortcomings in San Diego's public mental health system, with the burden falling upon the judicial system to find and secure treatment for these individuals. See also TORREY, *SURVIVING SCHIZOPHRENIA*, *supra* note 2, at 249.

"transinstitutionalization"²⁰¹ for many mentally ill individuals who need extended psychiatric hospitalizations or residential treatment services. The Federal Government should recognize and accept the fact that these funding mechanisms are partially, or indirectly, responsible for the unintended consequences which have resulted from the States' reliance upon federal mental health policy incentives. One means by which Congress could partially rectify this situation and lessen the social problems and inappropriate placements created by States trying to take advantage of these federal funding incentives is by abolishing the exclusion of federal medical assistance for services provided to otherwise-eligible individuals (between the ages of 22 and 64) in psychiatric hospitals (i.e., IMDs).²⁰² Nonetheless, budgetary concerns have seemed to take precedence over the need to eliminate

²⁰¹ The term "transinstitutionalization" is used to describe the phenomenal increase of the number of mentally ill patients who have been admitted to nursing facilities (and other Medicaid-eligible facilities) in recent years, who would otherwise have been placed in state psychiatric hospitals or other institutions for mental diseases (IMDs), "but for" the lack of availability of federal Medicaid reimbursement. See CRS, *MEDICAID SOURCE BOOK, Medicaid Services For The Mentally Ill*, *supra* note 6, at 927.

²⁰² If there were no categorical exclusions of federal financial participation for services provided in psychiatric facilities, States would be better able to serve a larger number of persons who suffer from these severe and disabling disorders, without being predisposed to make inappropriate treatment and placement decisions for individuals strictly on the basis of whether federal reimbursement is available to help pay for such care and services.

Abolishing the IMD exclusion will not in itself eliminate the social problems discussed herein. However, the availability of federal Medicaid funds, pooled together with state and local resources, could go a long way towards providing "medically necessary" psychiatric treatment and rehabilitation services for this unprotected, and so often neglected, population.

these social problems and other inequities caused by the Medicaid IMD exclusion.²⁰³

*c. Budgetary Costs Associated With Lifting the IMD
Exclusion Versus Substitution of Benefits Argument*

Beyond the social policy arguments for lifting the IMD exclusion, the principal rationale behind allowing this discriminatory exclusion to stand is based upon budgetary concerns resulting from an extension of federal financial responsibilities if this Medicaid exclusion is repealed, especially in this era of tight budgetary constraints.

The Health Care Financing Administration (HCFA) completed a review and a report to Congress in December 1992 concerning the cost implications of abolishing the Medicaid IMD exclusion.²⁰⁴ HCFA projected in this 1992 report that eliminating the IMD

²⁰³ The ensuing discussion will examine the budgetary aspects of repealing the IMD exclusion and will set forth some nondiscriminatory proposals to contain Medicaid costs for psychiatric care, if this exclusion were to be abolished.

²⁰⁴ HEALTH CARE FINANCING ADMINISTRATION (HCFA), U.S. DEP'T OF HEALTH AND HUMAN SERVICES (HHS), HCFA PUB. NO. 03339, REPORT TO CONGRESS: MEDICAID AND INSTITUTIONS FOR MENTAL DISEASES (December 1992), (hereinafter HCFA IMD REP.).

Congress had previously directed the Secretary of H.H.S. to conduct a review of the IMD statutory policy exclusion and provide Medicaid cost estimates of federal medical assistance to cover services provided in public subacute psychiatric facilities. See Section 6408 of the Omnibus Budget Reconciliation Act (OBRA) of 1989, Pub. L. No. 101-239. Note, Section 6408 of OBRA uses the term "public subacute psychiatric facilities", but, as discussed in part II of this analysis, the Medicaid statute's definitions of covered services, set forth in Section 1905(a) of the Social Security Act, only uses the terms "institutions for mental diseases" and "inpatient psychiatric hospital services for individuals under age 21". See 42 U.S.C. § 1396d(a)(1-16) (1994).

exclusion would increase federal Medicaid expenditures for alcohol, drug abuse, and mental health (ADM) treatment services²⁰⁵ by approximately 1.73 billion dollars annually.²⁰⁶ HCFA attempted to justify the continuation of the Medicaid IMD exclusion by

²⁰⁵ Although commonly lumped together under the general category of alcohol, drug abuse, and mental health (ADM) services, serious mental illnesses, such as schizophrenia and bipolar disorders, are fundamentally different from substance abuse disorders in that these psychiatric illnesses have been determined to be neurobiological disorders of the brain. It is on this basis that this analysis contends that the Medicaid IMD exclusion should be abolished to allow otherwise-eligible recipients (of all ages) with these organic medical disorders to receive the most appropriate care and treatment for their conditions.

This analysis, however, recognizes that the Medicaid antidiscrimination provision, in 42 CFR 440.230(c) (1995) of the regulations, discussed in part II.A, *supra* notes 73-76 and accompanying text, is nonspecific in nature as to diagnosis, type of illness, or condition. Thus, this regulatory provision has been interpreted to require coverage of treatments for alcohol and substance abuse disorders on the same or similar basis as Medicaid coverage of psychiatric and mental health services for serious mental illnesses.

In spite of this, there is statutory precedent for making distinctions, under the law, as a matter of public policy, between coverage of severe mental illnesses and coverage of drug addictions or alcoholism. As evidence of such legal distinction, Congress, in the recently enacted Mental Health Parity Act of 1996, mandated that private health insurers cannot impose annual and lifetime caps for treatment of mental illness (when no such limitations are imposed for treatments of other physical illnesses). Section 2 (B)(2) of the Parity Act specifically states that this parity provision shall not be applicable to substance abuse or chemical dependency benefits. See the discussion of the Mental Health Parity Act of 1996, Pub. L. No. 104-204, tit. 7, 110 Stat. 2874, 2944-2950 (1996), in *supra* note 167. Similarly, parity bills, enacted on the state level, have also made such a distinction between these two types of health insurance benefits.

²⁰⁶ The Report estimated that the eliminating the IMD exclusion would increase total Medicaid expenditures by 3.10 billion dollars annually, 1.73 billion in federal dollars and 1.36 billion coming out of State Medicaid coffers. HCFA also viewed the lifting of the Medicaid IMD exclusion as providing an estimated annual cost savings of 870 million dollars for State and local governments. HCFA IMD REP., *supra* note 204, at ES-4, ch. VII, at 1-4.

stating that traditional inpatient or institutional psychiatric care is not as cost-effective as treatment alternatives provided through community-based programs.²⁰⁷ Therefore, the Health Care Financing Administration recommended that no major changes be made with regard to the IMD exclusion.²⁰⁸

This determination, however, ignores the fact that a small but significant number of persons with chronic and severe forms of schizophrenia and other serious mental illnesses continue to be treatment-resistant and need a structured living environment and coordinated treatment services and other activities, which are best provided through a state psychiatric hospital or another institution specializing in psychiatric care.²⁰⁹ Thus, it is fair and legitimate criticism to cite this HCFA report for failing to address issues concerning the inequitable treatment and discrimination against persons with the most severe and disabling forms of schizophrenia and other serious mental illnesses.²¹⁰

²⁰⁷ *Id.* at ch. V, pages 1-11. However, this finding ignores the fact that individuals with the most severe and chronic forms of schizophrenia and other serious mental illnesses are often treatment-resistant to common psychotropic medications and are unable to benefit from community mental health programs and outpatient psychiatric services.

²⁰⁸ *Id.* at ES-4, ch. VIII, at 1-3.

²⁰⁹ See discussion in parts I, II, and III, *supra* notes 13-19, 112-114, and 168-169, respectively, and accompanying text.

²¹⁰ See the discussion in part III.B, *supra* notes 179-197, and accompanying text.

Additionally, the introduction to this HCFA report noted that the IMD policy exclusion has been criticized as being inequitable and discriminatory against individuals with mental illness, but it specifically stated that this report would not address the

In addition to the criticisms relating to the discrimination against the most chronic and severely mentally ill individuals' need for extended and/or long-term care in a psychiatric facility, the continuation of the Medicaid IMD exclusion fails to recognize the changing nature of inpatient psychiatric care which has developed since the inception of the IMD exclusion.

Even with the many breakthroughs that have occurred in psychopharmacology since the 1960s, inpatient hospitalization is often necessary to treat and stabilize a psychiatric patient who suffers an acute episode or has an exacerbation of psychotic symptoms, before the individual can be appropriately monitored and maintained on an outpatient basis with the proper medications and rehabilitation services furnished through community mental health programs. Freestanding (or specialty) psychiatric hospitals with larger, coordinated staffs consisting of psychiatrists, psychiatric nurses, and other clinical professionals are designed to offer greater continuity of care for patients, from inpatient care and/or specialized residential treatment programs through a continuum of aftercare services (e.g., partial hospitalization

criticism that the IMD exclusion is inequitable and discriminatory. See the HCFA IMD Report, *supra* note 204, at ch. I, pages 2-3. The failure to address these issues shows an inherent bias, on the part of the Federal Government, against the need to provide inpatient or residential psychiatric care for the most severely disabled, mentally ill individuals in our society. As a result, this report is arguably fundamentally flawed, and thus the conclusions expressed therein should be appropriately discounted to reflect this prejudice on the part of the Federal Government.

programs and other outpatient psychiatric and mental health services), than are available through psychiatric units in general hospitals and separate outpatient-based community mental health service programs.²¹¹ Moreover, psychiatric hospitals are more willing to accept and care for difficult patients with very severe conditions, who are denied admission or treatment at general hospitals.²¹² Nevertheless, the continuation of the IMD exclusion precludes state Medicaid programs from taking advantage of the intensive treatment programs, greater continuity of care, and the other innovations in psychiatric care offered by psychiatric

²¹¹ Continuity of care is an important component in the provision of ongoing psychiatric care and mental health services. Trust and confidentiality are vitally important in developing and maintaining a good patient-psychiatrist (or patient-therapist) relationship, which takes time to establish. An open and honest relationship between the patient and the physician/therapist is crucial from a medical standpoint in order to allow the physician to more accurately assess and monitor the effects of medication, changes in prescriptions or dosage thereof, and other therapeutic or rehabilitative treatment options.

Consequently, a coordinated staff of psychiatrists, psychiatric nurses, and other clinical mental health professionals practicing within a specialty psychiatric hospital facility are better able to cultivate and maintain an ongoing confidential relationship with patients, providing them with a greater continuity of care than would be available through a general hospital setting and separately operated community mental health programs. This greater continuity of care, provided through a continuum of care services furnished by or under the supervision of psychiatric and mental health professionals at psychiatric hospitals, can help reduce the rate of recidivism or decompensation of mentally ill Medicaid patients requiring further inpatient hospitalization.

²¹² General hospitals typically like to admit psychiatric patients with less severe illnesses, such as depression, but are less unwilling to treat patients with more severe conditions, like schizophrenia. See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 104, *citing* two such studies finding that general hospital admissions were more easily obtained for individuals with symptoms of depression than for persons suffering from schizophrenia.

hospitals which are available to the general public and covered by private health insurance plans.²¹³

Beyond the treatment benefits offered by psychiatric hospitals, the repeal of the IMD exclusion would provide economic advantages in controlling costs of inpatient psychiatric care and related services covered under state Medicaid programs. The Medicaid IMD exclusion is anticompetitive in nature because it restricts patients' choice of provider (for otherwise eligible recipients between twenty-two and sixty-four years of age) to inpatient psychiatric care services provided at general hospitals (and crisis centers or semi-hospitals with sixteen or fewer beds).

To illustrate the anticompetitive nature of the IMD exclusion, the National Association of Psychiatric Health Systems (NAPHS) completed a nationwide study, in May 1995, of the per diem costs and average length of stays at psychiatric hospitals versus that of inpatient psychiatric care provided at general hospitals.²¹⁴ This study found that the average of cost per day in

²¹³ HCFA is beginning to recognize the value of inpatient psychiatric care provided by specialty hospitals. See the discussion in *infra* note 217, regarding HCFA using its authority, under Section 1115 of the Social Security Act, 42 U.S.C. § 1315 (1994), to grant demonstration waivers of the IMD exclusion rules to cover acute care in psychiatric hospitals for some States which have adopted managed-care Medicaid programs.

²¹⁴ Allen Dobson et al., Policy Options: Opening the Medicaid Market for Non-elderly Adult Services to Freestanding Facilities (May 1995) (unpublished manuscript, available through the National Association of Psychiatric Health Systems) (NAPHS), in Washington,

a freestanding psychiatric hospital was slightly less than the per diem costs of inpatient care in a psychiatric unit of general hospitals (\$485.67 to \$499.05).²¹⁵ The average length of stay (ALOS) at the freestanding psychiatric hospitals was 17.3 days, as compared to 13.36 days in general hospitals.²¹⁶

Therefore, with regard to acute inpatient psychiatric care, hospitalizations in specialty psychiatric hospitals function as viable and comparable substitutes for inpatient psychiatric treatment in general hospitals. This substitution lends creditability to the notion that lifting of the IMD exclusion, for acute inpatient psychiatric services, would not create a new benefit for States, under Title XIX of the Social Security Act, but rather would allow inpatient services in freestanding D.C.), (hereinafter NAPHS, IMD Policy Options).

²¹⁵ *Id.* at 18-22 and 25. This cost comparison included 464 freestanding psychiatric hospitals and 965 general hospital psychiatric units. State psychiatric hospital costs were not calculated because such cost data is not comparable to other types of inpatient psychiatric care. However, on this note, Dr. Torrey mentioned, in his book, that psychiatric care in general hospitals often costs \$200.00 or more per day than the cost of such treatment in public psychiatric hospitals. See TORREY, *OUT OF THE SHADOWS*, *supra* note 1, at 104.

²¹⁶ *Id.* at 18-22 and 24. The slightly shorter ALOS in general hospitals can, in part, be attributed to inclusion of many general hospitals with emergency rooms (particularly county hospitals) that receive large numbers of short-term admissions of patients awaiting a 72-hour hearing (for possible commitment). Also, the average length of stay in state psychiatric hospitals today is 82.83 days. Additionally, this traditional institutional psychiatric care is more analogous to residential care programs provided by some nursing facilities than to short-term inpatient hospitalizations in general and specialty hospitals to treat acute episodes. See discussion in *infra* notes 218-221 and accompanying text.

psychiatric hospitals to serve as comparable substitutes for inpatient psychiatric services in general hospitals.

Additionally, if the IMD exclusion were to be repealed, State Medicaid agencies would have greater leverage to negotiate better prices for inpatient psychiatric hospital services because more health care providers would be eligible to bid for state Medicaid contracts to provide such care.²¹⁷ More significantly, opening up the bidding process to specialty (and/or public) psychiatric hospitals to furnish acute inpatient psychiatric hospitalization services for Medicaid recipients (of all ages) could enhance the quality and continuity of care received by psychiatrically ill Medicaid patients, which could help reduce the rate or risk of

²¹⁷ Recognizing this, HCFA in recent years has granted a number of demonstration project waivers, under Section 1115 of the Social Security Act, 42 U.S.C § 1315 (1994), for States to implement managed-care Medicaid programs, in which the agency waived the IMD exclusion rules to cover acute inpatient psychiatric care in freestanding psychiatric hospitals, generally covering 30 days per episode, with a 60-day annual limit.

Massachusetts and Tennessee are two such States which have received Section 1115 waivers to implement a managed-care Medicaid program, including a waiver of the IMD exclusion for acute inpatient psychiatric care. Massachusetts contracted with six hospitals previously identified as IMDs. The State has experienced modest utilization of such IMD services; the rates of for such psychiatric services are in the same range or less than the costs of such care in general hospitals. *Id.* at 13. In 1995, the average per diem cost for inpatient hospitalization in psychiatric hospitals in Massachusetts was \$440.89, as compared to \$539.12 in general hospitals. *Id.* at 25. Likewise, in Tennessee (in 1992), prior to the implementation of Tenn-Care, the State was paying in excess of \$400.00 per day for inpatient psychiatric care; after receiving the waiver to implement Tenn-Care, the State was ability to negotiate rates for inpatient psychiatric services in the range of \$300.00 per day. *Id.* at 21, n. 31. The 1995 average per diem rates for inpatient care in psychiatric hospitals under Tennessee's Tenn-Care was \$413.38, as compared to \$489.28 in general hospital settings. *Id.* at 25.

decompensation of patients who would require further inpatient hospitalization.

Also, since a significantly greater number of chronically mentally ill persons have already been transinstitutionalized into nursing facilities²¹⁸ than remain in traditional IMDs (i.e., public psychiatric hospitals),²¹⁹ a similar compromise could be devised (after an appropriate investigation and deliberation) which would provide federal medical assistance for institutional psychiatric care or residential treatment services for (all) otherwise-eligible Medicaid recipients found to require such services, on a comparable basis to federal Medicaid reimbursements for nursing facility services.²²⁰ In so doing, this could help reduce the number of inappropriate placements of psychiatric patients in

²¹⁸ It is estimated that approximately 232,500 residents in nursing facilities suffer from serious mental illnesses (other than a dementia-related disorder), and 150,000 (over 60 percent) of such residents are estimated to have a diagnosis of schizophrenia. See the discussion in part III.B, *supra* notes 190-197 and accompanying text.

²¹⁹ A recent figure from the National Institute of Mental Health (NIMH), released in December 1994, places the total population of persons residing in public psychiatric hospitals at 71,619. See the discussion in part I.B, *supra* note 39, citing TORREY, *OUT OF THE SHADOWS*, at page 8.

²²⁰ The federal Medicaid funds saved through the elimination of inappropriate placements in nursing facilities could be applied to help cover the Federal Government's share of the assumed costs of psychiatric care services furnished in psychiatric hospitals, upon the repeal of the IMD exclusion. This would be a more sensible and efficient use of federal resources because it would provide greater access to medically necessary treatment and the most appropriate care based primarily upon the best interests of the recipient, rather than just benefitting state Medicaid coffers.

nursing facilities because States would have less incentive to play the mental health funding game, at the expense of chronically and severely mentally ill Medicaid recipients.²²¹

After acknowledging the inappropriate treatment and placement decisions and the other unintended consequences caused by the Medicaid IMD exclusion, applied in conjunction with other federal mental health incentives discouraging the use of specialized inpatient psychiatric care, policymakers would realize that there are other nondiscriminatory means by which to contain federal expenditures for inpatient and residential psychiatric care, without continuing to deny federal medical assistance for services provided to otherwise-eligible individuals between twenty-two and sixty-four years of age in psychiatric hospitals.

First, as mentioned earlier, opening up the competitive bidding process, to allow more health care entities to compete for Medicaid contracts to provide inpatient psychiatric hospital services (and specialized psychiatric nursing services or residential psychiatric care for eligible individuals), could give state Medicaid agencies greater leverage in negotiating better

²²¹ Congress previously tried to combat the problem of inappropriate placements of psychiatric patients in nursing facilities through the enactment of the pre-admission screening and annual resident review (PASARR) requirements, in OBRA-87 and OBRA-90. See discussion of the PASARR requirements in part III.B, *supra* note 197. However, Congress failed to appropriate federal funds, under the PASARR amendments, to assist States with the cost of furnishing inpatient and/or residential psychiatric care for (former) nursing facility residents who are found to be inappropriately placed in such nursing facilities.

prices for such care and services.

Beyond this, the Federal Government should require a certification of medical necessity (CMN) before reimbursing the State for such care and services. Within this CMN requirement, the Federal Government should mandate, as a prerequisite for federal payment of services provided in psychiatric hospitals and residential treatment facilities, that all feasible less intensive treatment alternatives (i.e., community mental health service programs and standard psychotropic medications) be tried and be proven unsuccessful in treating the patient.²²² Likewise, the Federal Government should require that States adopt concurrent and retrospective utilization control procedures to guard against extended and unnecessary use of inpatient psychiatric hospital services, weeding out patients who can be rightfully discharged and appropriately treated and monitored on an outpatient basis.²²³

Congress could also limit federal medical assistance payments

²²² As part of this, the Federal Government should encourage States and local communities to furnish targeted mental health programs for individuals with serious mental illnesses. This could sharply reduce the number of persons requiring intensive treatment in psychiatric facilities, due to a deterioration in their conditions resulting from the lack of adequate psychiatric and mental health services available in their communities.

²²³ The Medicaid statute requires the adoption of utilization control procedures before a hospital or a nursing facility is eligible to receive federal medical assistance. 42 U.S.C. § 1396a(a)(30) (1994). These same utilization control requirements could and should be implemented with regard to psychiatric hospital services.

to services which are considered to be primarily medical or therapeutic in nature, thereby excluding federal payment for activities deemed to be social, educational, or vocational in nature.²²⁴ As for Medicaid-eligible patients requiring extended or long-term psychiatric care in traditional state hospital settings, it should be permissible for the Federal Government to restrict federal payment to strictly cover "active treatment" services, as opposed to covering services which are determined to be "maintenance" level treatment services or "custodial care".²²⁵

IV. CONCLUSION

Although traditionally it was the responsibility of the States to care for severely mentally ill persons through institutionalization in state asylums, since the mid 1960s the Federal Government has been setting the agenda for the provision

²²⁴ Even if federal payments are restricted to cover only medical and related therapeutic services, the States would be better able to reallocate state appropriations for educational/vocational rehabilitation services and social activities to enhance the patients' quality of life in psychiatric hospitals.

²²⁵ Congress could fashion a legislative compromise concerning patients requiring extended and/or long-term care in psychiatric facilities in which States would be able to receive limited reimbursements for nursing care services, which would otherwise have been provided in a nursing facility.

Additionally, the suggestions raised herein are not intended to be an exhaustive list of cost-containment measures that Congress and HCFA may wish to utilize in restraining federal expenditures for inpatient care furnished in psychiatric hospitals, if the Medicaid IMD exclusion were to be abolished, but rather to establish that there are less drastic proposals that can be adopted, without singling out for exclusion this vulnerable group of disabled individuals in our society today.

of psychiatric and mental health services in our nation. Not only through the creation of significant financial incentives promoting the use of community-based mental health services, but also indirectly through the denial of Medicaid payment for institutional psychiatric care via the IMD exclusion, the Federal Government has been quite successful over the past thirty years in encouraging States to deinstitutionalize patients from state hospitals.

The Federal Government should now acknowledge and accept partial responsibility for the foreseeable harm and unintended consequences which have occurred as a result of such policies promoting deinstitutionalization.²²⁶ Congress could help rectify the problems caused by deinstitutionalization by abolishing the IMD exclusion under Title XIX of the Social Security Act, thereby enabling Medicaid-eligible recipients with serious mental illnesses to gain access to medically necessary and appropriate

²²⁶ The Federal Government is partly responsible for the foreseeable harm suffered by chronically and severely mentally ill Medicaid recipients (i.e., former state psychiatric patients who are now homeless and more recent severely mentally ill persons who have been denied access to medically necessary and appropriate psychiatric hospital services due to the IMD exclusion) because it usurped the States' traditional authority in setting mental health policy. The problem with the Federal Government's mental health policy lies in its overly optimistic assumptions that modern medications, community mental health services, and, if need be, short-term hospitalizations in general hospitals can successfully treat and maintain persons with serious mental illnesses. Such a policy however ignores the fact that there continues to be a small, but significant, number of individuals who are treatment-resistant and need extended and/or long-term care in a psychiatric facility. See discussion in parts I.B and III.B *supra* notes 26-46 and 179-203 and accompanying text.

psychiatric care for their conditions.

In calling for the repeal of the IMD exclusion, this analysis is not suggesting the necessity of returning to the days of warehousing psychiatrically ill persons in state mental institutions; rather the point of this analysis is that federal medical assistance should be allocated on the basis of what is medically necessary and appropriate for a given patient. At the present time, however, the appropriations of federal funds under the Medicaid program to cover services furnished to eligible individuals in need of inpatient and/or residential psychiatric care are not based upon medical considerations and the best interests of the recipients, but upon whether a particular institution or facility is eligible to receive such payments.

Thus, although the IMD exclusion may not technically violate the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, the continued application of this Medicaid exclusion discriminates against a class of (otherwise) eligible recipients (twenty-two to sixty-four years of age) with chronic and severe neurobiological brain disorders through the denial of coverage of, and access to, medically necessary and appropriate inpatient psychiatric care (and/or residential treatment services) in facilities which specialize in the care and treatment of persons with psychiatric illnesses, especially when no similar statutory exclusions are imposed for Medicaid coverage of other types of inpatient hospital and long-term care services

for recipients with other medical disorders.

In its place, this analysis advocates that the general nondiscriminatory policies underlying Title XIX of the Social Security Act and the Medicaid Regulations be applied across the board regardless of whether the prescribed treatment and care services are furnished in general hospitals, nursing facilities, or other properly licensed medical institutions or extended care facilities, including psychiatric hospital facilities. This reasonable modification would not only be consistent with an underlying principle of the Medicaid program to provide services in the "best interest of the recipient", but also this revision would help eliminate the financial incentives for States to engage in mental health cost-shifting through the inappropriate placement of chronically and severely mentally ill individuals in nursing facilities in order to obtain federal Medicaid reimbursement for such care, rather than ensuring that these recipients receive the most appropriate care for their conditions. Utilization review and control procedures could also be implemented across the board to guard against extended or unnecessary use of psychiatric hospital services and residential psychiatric care for patients who can be medically discharged and appropriately treated on an outpatient basis.

Beyond the medical and social policy arguments for abolishing the IMD exclusion, repealing this outdated federal Medicaid exclusion could yield economic benefits for the States and the

Federal Government in the long term with regard to the payment of Medicaid benefits for psychiatric and mental health services. First, abolishing the IMD exclusion today would not in actuality create a new benefit for States in terms of covering inpatient and/or long-term psychiatric hospital services, inasmuch as the vast majority of state psychiatric patients have now been deinstitutionalized or transinstitutionalized into other medical and/or long-term care facilities which are eligible to receive Medicaid payment. In addition, opening up the bidding process to allow more institutional providers to compete for Medicaid contracts would give state Medicaid agencies greater leverage in negotiating the best rates for inpatient psychiatric hospital services and appropriate long-term (nursing) care for chronically and severely psychiatrically ill Medicaid recipients. Moreover, permitting specialty and/or public psychiatric hospitals to furnish necessary psychiatric care and mental health services to Medicaid recipients could enhance the quality and continuity of care received by psychiatrically ill Medicaid patients. This, in turn, could conserve Medicaid resources in the long run by reducing the rate or risk of decompensation of patients requiring further inpatient hospitalization.

In conclusion, persons suffering from schizophrenia, bipolar disorder, and other serious mental illnesses have endured much societal stigma and discrimination based upon ignorance and misunderstandings of these disorders, especially in regards to the delivery and coverage of health care services. In addition to

coping with the various challenges and difficulties which life presents, these individuals should not also have to continue to endure the chaos and inadequacies in our present public mental health system. The present inequities in the delivery and coverage of psychiatric and mental health services evolved from outdated notions and distinctions pertaining to psychiatric illnesses that have now been rejected by modern medical science.

This is not right; America can do and deserves better. Congress, building upon the new consensus that it took to enact the Mental Health Parity Act of 1996,²²⁷ should ensure that categorically and medically needy individuals have access to the most appropriate and medically necessary psychiatric and mental health services by repealing the Medicaid IMD exclusion.

²²⁷ Pub. L. No. 104-204, tit. 7, 110 Stat. 2874, 2944-2950 (1996). See discussion of the Mental Health Parity Act in *supra* notes 167 and 205.