No. 83-2136

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR THE AMERICAN PSYCHIATRIC ASSOCIATION, THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, THE AMERICAN HEALTH CARE ASSOCIATION, AND THE NATIONAL MENTAL HEALTH ASSOCIATION AS AMICI CURIAE SUPPORTING PETITIONER

PAUL LITWAK
44 Holland Avenue
Albany, New York 12229

R. EMMETT POUNDSTONE, III
P.O. Box 3710
Montgomery, Alabama 26193

Of counsel for amicus the National Ass'n of State Mental Health Program Directors

JOEL I. KLEIN *
PAUL M. SMITH
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184

* Counsel of Record

QUESTION PRESENTED

Whether a limitation in the Medicaid law on use of federal funds to reimburse states for the care of patients in "institutions for mental diseases" should be confined to traditional mental hospitals or should be extended to cover newly developed "intermediate care facilities" that serve residents with mental conditions calling for a lesser level of care.

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INTEREST OF AMICI CURIAE

The American Psychiatric Association ("APA"), founded in 1844, is the nation's largest organization of physicians who specialize in psychiatry. More than 30,000 of the nation's 37,000 psychiatrists are members. Psychiatrists have primary responsibility for treatment of the chronically mentally ill living in state institutions, nursing homes, and other settings. As a result, the association and its members are concerned about the availability of the range of appropriate settings serving the needs of this population. In particular, they have a direct interest in forestalling the increased homelessness and inappropriate placements that could result from a cut-off of Medicaid funds for intermediate care facilities serving the mentally ill.

The National Association of State Mental Health Program Directors ("NASMHPD") is the mental health

arm of the National Governors Association. Its membership is made up of the agencies in fifty-five states and territories that are responsible for government programs serving mentally disabled persons. NASMHPD members administer or support over 12,000 public and private facilities and programs of all kinds, including state institutions, intermediate care facilities, community mental centers, and day programs. One major aspect of the responsibilities shared by NASMHPD member agencies is care for the chronically mentally ill. The issue presented in this case, involving as it does Medicaid funding for one of the major residential options for the chronically mentally ill, is a matter of critical concern to these agencies.

The American Health Care Association ("AHCA") is the nation's largest federation of licensed nursing homes and allied long term health care facilities. It is comprised of 48 affiliated state associations whose more than 8,000 member facilities provide care for over 800,000 elderly, convalescent and chronically ill residents. AHCA members provide care and services under the Medicaid program to many of the patients who stand to lose coverage if the rule at issue here is upheld. These members have a direct interest in being able to provide appropriate care to the chronically mentally ill without facing such financial consequences.

The National Mental Health Association is the nation's largest consumer advocacy organization for mental health dedicated to promoting mental health, preventing mental illness, and improving the care and treatment of mentally ill individuals. The 650 Mental Health Association local chapters and state divisions, with more than one million citizen volunteers, work toward these goals through social action, education, advocacy and public information. The NMHA is vitally concerned about the effects that this case could have on the availability of appropriate, long-term care for the chronically mentally ill.[1]

[1] The parties have agreed to filing of this brief amici curiae, and their letters of consent have been lodged with the Clerk.

STATEMENT

This case involves the eligibility for federal Medicaid reimbursement of "intermediate care facilities" that primarily serve chronically mentally ill patients. "Intermediate care facility" ("ICF") is a statutory term defined to mean a residential facility which provides "health-related care and services to individuals who do not require the degree of care and treatment which a hospital or a skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities." 42 U.S.C. § 1396d(c). The statute also requires that ICFs meet federally prescribed standards relating to quality of care and life-safety concerns. In practice, almost all ICFs are private nursing homes providing long-term care to the chronically disabled.

The dispute arises from a determination by the Department of Health and Human Services ("HHS") that most of the patients in an ICF in Connecticut, the Middletown Haven Rest Home, were ineligible for Medicaid coverage because it constituted an "institution for mental diseases" ("IMD"). This determination was based on the section of the Medicaid statute that provides coverage for ICF services "other than in an institution for tuberculosis or mental diseases." *Id.* § 1396d(a)(15). *See also id.* § 1396d(c). In a separate section, the statute also provides an exemption from the IMD exclusion for persons over age 65, who may receive ICF, skilled nursing, or hospital services in an IMD. *Id.* § 1396d(a)(14).

Middletown Haven ran afoul of the IMD requirement, as interpreted by HHS, because it primarily served mentally ill patients under age 65, many of whom had been admitted from state hospitals, and because it had staff with appropriate psychiatric training. These factors were found controlling because, in the Department's view, Medicaid coverage for the mentally ill under age 65 in ICFs is allowed only in facilities that do not themselves

become IMDs by unduly emphasizing care for patients with psychiatric disorders.[2]

Connecticut, on the other hand, maintained that the IMD exclusion was intended only to ensure that a particular group of facilities—*i.e.*, mental hospitals—not receive Medicaid funds. It argued that the exclusion was simply irrelevant to the Medicaid eligibility of a second group of facilities—ICFs. The State, therefore, sought review of the federal action before the Grant Appeals Board, which upheld the Department's position, and disallowed some $1.6 million in federal funds that had previously been paid. The district court then reversed. The Second Circuit, however, disagreed with the district court and reinstated the disallowance.[3] In the view of *amici*, this decision contravenes clear legislative intent and must be reversed.

SUMMARY OF ARGUMENT

The basic issue in this case is whether the IMD exclusion should be read broadly, to bar coverage for care in any facility that primarily serves the mentally ill (including ICFs), or more narrowly to bar coverage only in traditional mental *hospitals*. Faced with the indisputable fact that Congress intended to cover mentally ill citizens of all ages in ICFs, HHS nevertheless takes the position that when "too many" such persons are placed in the same ICF, every patient under 65 in the facility becomes ineligible for Medicaid. To reach this conclusion, HHS has borrowed a concept—the IMD—that Congress used for another purpose and has attempted to

[2] The applicable regulation defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease . . ." 42 C.F.R. § 435.1009 (1984). The Secretary has interpreted this definition to include facilities like ICFs, in addition to traditional "mental institutions." See page 23 *infra*.

[3] This created a conflict with the decision of the Eighth Circuit in *Minnesota* v. *Heckler*, 718 F.2d 852 (1983).

stretch it beyond its intended limit. In our view, this approach has little to recommend it in law or in logic.

I. The IMD exclusion was a feature of the original Medicaid statute in 1965, before there was any coverage at all for ICFs. At the time, Congress made clear that IMDs were mental hospitals and mental retardation institutions which, not surprisingly, cared exclusively for patients suffering from mental illness and mental retardation. The ICF program was enacted in 1967, and was originally not even a part of the Medicaid program. By its terms, it applied to persons needing care "because of their . . . mental condition," and contained no IMD exclusion. Its purposes were to provide an appropriate and humane alternative to state mental hospitals for the chronically mentally ill, while also providing residential coverage for the chronically physically disabled. When the ICF program was later merged into the Medicaid program in 1971, the intended purposes were not curtailed in any fashion. At no time, in short, did Congress ever suggest that an ICF would be transformed into an IMD because it reached a tipping point with respect to the number of mentally ill patients it served. See pp. 7-23 *infra*.

II. The position espoused by HHS is not only incompatible with the legislative history, it is also hard to square with any sensible policy that might be attributed to Congress. Since HHS acknowledges that Congress intended to cover the mentally and physically handicapped in ICFs irrespective of age, why would Congress want to exclude coverage for patients under age 65 only when more than half the patient's in a given ICF are mentally ill? Neither HHS nor the court below has been able to answer this basic question. On the other hand, HHS's approach would lead to two obviously unintended and manifestly undesirable effects. First, it would encourage the dispersal of the mentally ill among the larger ICF population by ruling out the option that may be much more appropriate for some patients—a specialized, psychiatrically oriented ICF. Second, by attaching the risk

of Medicaid decertification whenever a facility treats a substantial number of mentally ill people, the rule would lead to discrimination in the availability of ICF care to this group of patients whom Congress clearly intended to cover. See pp. 23-27 *infra*.

III. Finally, we think it appropriate to point out the folly of any ruling that could serve to limit the alternative forms of care available to the chronically mentally ill outside of state hospitals. In the wake of a general shift away from the use of state mental hospitals for long-term care of the chronically ill, the states are already at a budgetary breaking point in their efforts to deal with this population. A cutback in federal support would only impose greater burdens on the states' efforts to build adequate alternative care systems for such persons. See pp. 27-30 *infra*.

ARGUMENT

The question of statutory interpretation presented here, while technical, ultimately involves the availability and quality of services that are needed by many of the hundreds of thousands of chronically mentally ill in this country. Each side in this dispute offers an interpretation that is consistent with the statutory language itself. This does not mean, however, that the Court should defer to Department's preferred interpretation. Where linguistic ambiguity exists, executive agencies have an obligation to take a look at what Congress sought to accomplish in an authorizing statute. Here, that necessary attention to congressional purposes was not paid.[4] If it had been, it would have become apparent that HHS's position effectively rewrites the statute, rather than reasonably interpreting it.

[4] Deference to the agency interpretation would be doubly inappropriate here, where HHS's interpretation was contained only in informal bulletins distributed within the Department almost ten years after the initiation of coverage for ICFs and five years after the incorporation of the program in Medicaid. *See Minnesota* v. *Heckler*, 718 F.2d 852, 862 (8th Cir. 1983).

I. LEGISLATIVE HISTORY DEMONSTRATES THAT THE LIMITATION ON MEDICAID REIMBURSEMENT OF "INSTITUTIONS FOR MENTAL DISEASES" WAS AIMED ONLY AT MENTAL "HOSPITALS" AND WAS NEVER INTENDED TO LIMIT COVERAGE FOR "INTERMEDIATE CARE FACILITIES" SERVING THE MENTALLY ILL.

The key term in this dispute—IMD—is not defined in the statute. In our view, this is because the term was universally understood to refer to mental hospitals and mental retardation institutions, and not to alternative care facilities like ICFs. The legislative history fully confirms this view.

A. IMDs and the Original Medicaid Program.

The Medicaid program, enacted in 1965, represented an expansion of existing categorical "public assistance" programs for the aged, blind and disabled. As part of that expansion, Congress for the first time decided to provide coverage for persons disabled by mental illness, of all ages, in general hospitals. It did so by eliminating any exclusion based on a *diagnosis* of mental illness.[5] Except for persons 65 and over, however, it retained an exclusion based on the *facility* involved—the rule barring coverage for patients in institutions for mental diseases that had been a part of the categorical assistance programs since 1950.[6]

As the term itself suggests, the sole purpose and effect of the IMD exclusion in 1965 was to bar coverage for mental *hospitals* and mental retardation institutions.[7]

[5] *See* Pub. L. No. 89-97, § 221, 79 Stat. 356 (1965) (repealing exclusion of patients suffering from "psychosis"). Congress had already moved in this direction in 1960, by providing 42 days of coverage in general hospitals for the aged mentally ill. *See* Pub. L. No. 86-778, § 601(f), 74 Stat. 924, 991 (1960).

[6] See Pub. L. No. 81-734, §§ 303(a), 343(a), 351, 64 Stat. 477 (1950).

[7] We believe the term "institution for mental diseases" was chosen because Congress meant to include both mental hospitals and

The rule was so described repeatedly by sponsors and supporters of the bill.[8] Indeed, it probably never occurred to anyone that the IMD bar might be extended outside the hospital arena. The only other "inpatient" care covered as of 1965 was in "skilled nursing homes." And at that time nursing homes that specialized in providing care for the mentally ill or retarded simply did not exist.[9] Not surprisingly, therefore, there is no indication that Congress thought a skilled nursing home could ever be an IMD.[10] More importantly, to the extent that any less intensive, *intermediate*-level facilities existed at all, they were not covered under Medicaid in any event—for anyone of any age. As a result, it is undisputed that the

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state *institutions* for the mentally retarded. When Congress expanded Medicaid coverage in 1971 to include mental retardation institutions (but not mental hospitals) it did not change the term IMD. See p. 16, n.23 *infra*.

[8] *E.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 144 (1965) (1965 Amendments authorized payments for aged persons in "hospitals for mental diseases"); Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. 108 (1964) (testimony of Secretary Celebreeze, Dept. of H.E.W. ("these hospitals are public institutions"); 111 Cong. Rec. 15805 (1965) (remarks of Senator Ribicoff) (bill eliminates restriction on aid for "recipients . . . in mental or tuberculosis hospitals").

[9] The shift of the chronically mentally ill from hospitals to nursing homes really only began in the mid 1960's. *Toward a National Plan for the Chronically Mentally Ill*, at 2-30 to -31 (Report to the Secretary of HHS by the Steering Committee on the Chronically Mentally Ill, December 1980); Kohen & Paul, *Current Trends and Recommended Changes in Extended-Care Placement of Mental Patients: The Illinois System As a Case in Point*, 2 Schizophrenia Bull. 575, 576 (1976).

[10] The original statute generally covered "skilled nursing home services," while making clear that such services were not reimbursable if they took place "in an institution for tuberculosis or mental diseases." Pub. L. No. 89-97, § 121(a), 79 Stat. 351 (1965). As is apparent from this language, Congress was simply assuring that nursing home services provided in a mental hospital or retardation institution would not be reimbursed.

class of facilities excluded as IMDs in 1965 did not include any ICFs.

This means, of course, that HHS's present interpretation of the term IMD to include some facilities emphasizing intermediate care for the mentally ill is based, not on direct congressional intent, but on extrapolation from the terms of a provision originally aimed only at mental hospitals. One way to assess the validity of this extrapolation is to look at the underlying purpose of the original decision to exclude coverage in these hospitals.

Congress's decision to incorporate the IMD exclusion when it passed Medicaid in 1965 stemmed primarily from concerns about both the desirability and the expense of covering the thousands of chronic patients in large *state* institutions.[11] First, with the special exception of persons over 65,[12] Congress retained some residual commitment to the traditional notion, reflected in the older categorical assistance programs, that long-term care for the chronically mentally ill and retarded—then almost always in state institutions—was a state responsibility. *Schweiker* v. *Wilson*, 450 U.S. 221, 237 n.19 (1981); S. Rep. No. 404, 89th Cong., 1st Sess. 144 (1965); H. Rep. No. 213, 89th Cong., 1st Sess. 126 (1965). Second, Congress did not believe that the care typically offered by those institutions constituted appropriate treatment. It viewed these facilities as "warehouses" where inadequate custodial services were provided to patients requiring much

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[11] *See, e.g.*, Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. 108 (1964) (testimony of Secretary Celebreeze, Dept. of H.E.W.) ("The main reason for this exclusion is that most of these hospitals are public institutions . . .")

[12] Congress's decision to cover the aged in IMDs came in the context of a legislative program that, through Medicare and Medicaid, sought to provide quite comprehensive medical care to older citizens. In particular, Congress clearly had determined that it would provide long-term care to the aged who are chronically disabled, and sought to maximize the options available, including state mental institutions. *See* S. Rep. No. 404, 89th Cong., 1st Sess. 144-45 (1965).

more. *Schweiker* v. *Wilson*, *supra*, 450 U.S. at 241-42 (Powell, J., dissenting). As Senate Finance Committee Chairman Long put it in 1970, explaining the 1965 omission of IMD coverage for persons under age 65:

> [W]e had a situation, and I fear that in some cases it might still be going on, where people were not being treated; they were just being locked up the way you would lock up prisoners or animals, just to separate them from society when treatment could have restored them to society as a productive member or at least restore them to a happy life where they could find some degree of serenity between now and the time God calls them home.

Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess. 538 (1970). *See also* Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, 92d Cong., 1st & 2d Sess. 931 (1972) (additional remarks by Chairman Long).

In sum, the retention of the IMD exclusion in 1965 reflected two congressional decisions: (1) a general judgment that states should retain a significant portion of the responsibility for long-term care for the chronically mentally ill, and (2) a specific determination that Medicaid should not support the care of younger people in large state mental institutions.[13] As we shall see, the

[13] To be sure, the IMD exclusion is not *limited* to state institutions, but the legislative history confirms that they were the prime concern. It also suggests that the inclusion of the other type of IMD, private psychiatric hospitals, was a kind of afterthought, apparently motivated by a desire not to appear to discriminate against state facilities at a time when private psychiatric hospitals cared for very few long-term chronic patients. *See* Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. 108 (1964) (testimony of Secretary Celebreeze, Dept. of H.E.W.) ("The main reason for the exclusion is that most of these hospitals are public institutions and are supported by public funds. Nor did it seem reasonable to cover private but not public institutions.")

introduction of ICF coverage two years later represented a reversal of the former policy, but not of the latter.

B. The 1967 Amendments: ICFs and the Decision to Provide Long-Term Care.

In the 1967 Amendments to the Social Security Act, Congress for the first time voted to provide reimbursement for care in facilities providing services less intensive than those in hospitals or skilled nursing facilities. In that year, it chose to cover residential care for the aged, blind, and disabled residing in ICFs. It did so, not by amending Medicaid, but by adding a new section 1121 to an entirely different chapter of the Social Security Act.[14] *See* Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968).

There are several important points to understand about this original ICF program. First, unlike the original Medicaid program, it was intended to provide long-term, intermediate-level care where that was the appropriate choice. The coverage was aimed at those persons who require supervised care "because of their physical or mental condition (or both)," but who "do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home . . . is designed to provide." *Id.* As Senator Miller, one of the sponsors of the program,[15] put it:

> This provision of the bill merely recognizes the facts of life about custodial care in "extended care" facilities. These facts are that there are different levels of care now available and that not all patients need the same level of care; that those who need "skilled nursing home care" should receive it; that those who do not require such a high level of care should re-

[14] Section 1121 was part of Title XI of the Act. Medicaid is contained in Title XIX, 42 U.S.C. § 1396 *et seq.*

[15] *See* 113 Cong. Rec. 32594 (1967) (remarks of Chairman Long).

> ceive what we have designated an "intermediate level of care". . . .

113 Cong. Rec. 36321 (1967).[16]

Second, there was no intention to exclude any ICFs on the ground that they served too many mentally ill or disabled patients. Not only did the ICF statute not contain an IMD exclusion,[17] it expressly included "mental condition" as a basis for admission to an ICF, Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968) (enacting § 1121(b)(2)). And in so doing, it incorporated the decision made in the original 1965 Medicaid statute to cover the mentally ill *of all ages* as long as they were not in mental hospitals. Indeed, the "deinstitutionalization" of the mentally ill—a process that was moving at an accelerated pace by 1967—was among the primary purposes of extending coverage to ICFs. *See* S. Rep. No. 1431, 91st Cong., 2d Sess. 147 (1970) (reprinted at 117 Cong. Rec. 44721 (1971)) (Section 1121 "was intended to provide a means for appropriate placement of patients professionally determined to be in need of health-related supportive institutional care but not care at the skilled nursing home *or mental hospital* level") (emphasis supplied).

The third key point concerning the ICF program follows from the first two. In funding ICFs, Congress had

[16] *See also* S. Rep. No. 744, 90th Cong., 1st Sess. 188-89 (1967).

[17] Eligibility for ICF care under section 1121 was generally tied to eligibility for income assistance under four titles of the Social Security Act: Title I (old age assistance), Title X (aid to the blind), Title XIV (aid to the permanently and totally disabled) and Title XVI (aid to the aged, blind or disabled). Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968). These programs, in turn, did bar income assistance to residents of "public institutions" and to under-65 residents of IMDs. But section 1121 itself made it clear that these exclusions would not affect the eligibility of *ICF* residents to receive coverage under the new ICF program. Under the new program, the fact that a person was "receiving institutional services" in an ICF was to be totally disregarded in determining eligibility. *Id.* As a result, the characterization of a given ICF as a public institution or an IMD was an issue that had no relevance under section 1121.

in mind facilities that were different in kind from mental institutions. Two years after it excluded Medicaid coverage for the long-term care provided in large mental hospitals, it created this new program to provide long-term care in what were first described as "intermediate care homes." S. Rep. No. 744, 90th Cong., 1st Sess. 188 (1967). Congress thus altered its previous position on long-term coverage for the chronically mentally ill. But it still remained unwilling to fund long-term care in large state hospitals. Instead, it focused on a new kind of facility, the ICF, which is specifically viewed as a superior *alternative* to the mental institution for many people who were or had been hospitalized in such settings.[18]

In Congress's view, the essential difference between ICFs and mental hospitals turned on the scale and design of ICFs, which allowed for some guarantees that long-term, quasi-custodial care would be provided humanely and with an eye to individual needs. Above all, Congress sought to make a fresh start from the previous state efforts to provide long-term care in state hospitals. It then tied this new approach to guarantees designed to ensure appropriate placement decisions, hoping thereby to prevent a recurrence of the unfortunate "dumping" of the mentally ill that had sometimes occurred in the recent past. *See* 113 Cong. Rec. 36321 (1967) (remarks of Sen. Miller) ("Of course, we must assure that each patient is placed in the facility that meets his particular needs.")

In sum, when it came to the care of the mentally ill, the ICF was, from the beginning, specifically intended to be an alternative to the same mental institutions that were largely barred from Medicaid coverage under the

[18] Congress had previously recognized that "nursing homes" represented a useful alternative to IMDs for the aged. *See* S. Rep. No. 404, 89th Cong., 1st Sess. 145-46 (1965) (states should promote "utilization of community mental health centers, nursing homes, and other alternative forms of care").

"IMD" exclusion.[19] Having made the decision to cover care for mentally ill persons of all ages in these alternative facilities, Congress saw no reason to exclude facilities specializing in care of the mentally ill—as it had done with respect to mental *hospitals* under Medicaid. In our view, Congress never altered this fundamental policy.

C. The 1971 Amendments: ICFs are Merged into Medicaid.

The issue in this case only arose because, in 1971, Congress merged ICF coverage into Medicaid. It accomplished this transfer by amending 42 U.S.C. § 1396d to include ICF services among the categories making up "medical assistance." *Id.* § 1396d(a)(15), *added by* Pub. L. No. 92-223, § 4(a)(1)(C), 85 Stat. 809 (1971). It then supplied a lengthy definition of the term "intermediate care facility." *Id.* § 1396d(c), *added by* Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809 (1971).

Each of these new provisions incorporated the Medicaid IMD exclusion. Section 1396d(a)(15) simply provided that ICF services could not be provided in "an institution for mental diseases." Section 1396d(c) provided that for services to persons under 65, except those in specialized facilities for the retarded, the term "ICF" could not include any "public institution or distinct part thereof for mental diseases or defects." The incorporation of these exclusions, however, did not indicate any intent to bar coverage of *ICF*s that had previously been covered but were serving too many mentally ill persons. Rather, Congress's goal was to prohibit coverage of traditional mental hospitals under the guise of the ICF program.[20] The legislative history confirms this view.

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[19] For the physically disabled, ICFs were seen as an appropriate and economical alternative to "skilled" nursing homes. *See id.*

[20] We do not mean to suggest that the conversion of a former institutional building into an ICF is foreclosed in all cases. Reasonable departmental criteria arguably could allow this, consistently with congressional intent, as long as the physical plant, programs, patients, and admissions criteria in the new facility demonstrate a true adoption of the ICF approach.

First, the amendments at issue here were consistently characterized as a "transfer" to Title XIX of the *existing* ICF program—a program that, as we have noted, contained no restriction on services to the mentally ill in ICFs. *E.g.*, 117 Cong. Rec. 44721 (1971) (reprinting Senate Report) ("The amendment also provides for the transfer of the intermediate care provisions from Title XI . . . to Title XIX (Medicaid)."); S. Rep. No. 1230, 92d Cong., 2d Sess. 321 (1972).

The purposes of the transfer were twofold: (1) to bring ICFs under the Medicaid quality standards, and (2) to *expand* coverage to all "medically indigent."[21] *See id.*; 117 Cong. Rec. 44721 (1971) (reprinting Senate Report); 116 Cong. Rec. 41804 (1970) (Chairman Long describing an identical provision in a previous bill). There is not a shred of legislative history reflecting an intent to cut back on coverage for facilities commonly understood to be ICFs prior to 1971, based on the number of mentally ill people being served. On the contrary, the committee report specifically reiterated the importance of ICFs as alternatives to mental institutions:

> The committee amendment is designed to make it clear that intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home *or mental hospital.*

117 Cong. Rec. 44721 (1971) (emphasis supplied).

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[21] The original ICF program was tied to eligibility for income assistance for the aged, blind and disabled. Medicaid covers not only these "categorically needy" but also (at state option) persons in the same categories with slightly higher incomes, who are unable to pay for medical care and thus are termed the "medically needy." *See, e.g., Beltran* v. *Myers*, 451 U.S. 625, 626 n. 1 (1981).

In the process of accomplishing the transfer of the ICF program in 1971, Congress did incorporate the IMD exclusion. Its goal, however, was not to shrink the ICF program but to forestall its expansion. Immediately after the adoption of the ICF program, there were efforts by some states to use the ICF concept as a means of gaining coverage for under-65 patients in traditional state mental institutions. Those efforts centered largely on certain public facilities serving the mentally retarded, which the states had labelled ICFs. *See* Social Security Amendment of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess., 505-09, 511-15 (1970) (testimony of Dr. Kenneth Gaver representing NASMHPD). *See also id.* at 918-24 (testimony of Elizabeth Boggs, Nat'l Ass'n for Retarded Children). The validity of these efforts was controversial and the applicable regulations were ambiguous. *See* 34 Fed. Reg. 9782-84 (1969). As a result, even before the decision to transfer the ICF program to Medicaid, there had been proposals in Congress to amend Title XI to reaffirm the original conception of an ICF as something different from a large traditional institution. *See* H.R. 17550, 91st Cong., 2d Sess., § 225(b)(2) (1970).[22] By incorporating the IMD rule in the new Medicaid ICF provision, Congress simply sought to maintain the same categories of coverage for the mentally ill under age 65 that had existed since the 1967 Amendments: acute care in general hospitals and appropriate long-term care for the chronically ill in ICFs rather than traditional mental hospitals.[23]

[22] This bill, as originally reported by the House Ways and Means Committee, would have made it clear that "the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or defects." In the Senate version of the bill, this provision was replaced with the very same language that, one year later, would be used by Congress to accomplish the transfer of the ICF program to Medicaid. H.R. 17550, 91st Cong., 2d Sess. § 269 (1970) (as reported by Senate Finance Committee).

[23] At the same time, Congress heeded pleas from various groups about the need for public institutional care for the mentally retarded. It created a new category of facility, the "intermediate care facility for the mentally retarded," which was specifically authorized to be a public institution. Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809 (1971) (adding 42 U.S.C. § 1396d(d)). Thus, while continuing to deny coverage for mental hospitals, Congress shifted course with respect to state mental retardation institutions, authorizing coverage for them for the first time.

It is particularly instructive to realize in this regard that when Congress moved the ICF program into Medicaid in 1971, it elaborated for the first time on its understanding of IMDs by adding a proviso to the effect that "the term 'intermediate care facility' shall not include . . . *any public institution* . . . for mental diseases or defects," 42 U.S.C. § 1396d(c) (emphasis supplied).[24] Through this specific reference to "public institutions," Congress made plain that it was dealing with state mental hospitals, and not designing a rule that depended on whether an ICF had a particular number of mentally ill patients. The vast proportion of ICFs—including those that have a majority of mentally ill residents—are privately owned and operated, much like the facility at issue in this case. If, by transferring the ICF program in 1971, Congress had intended to exclude ICFs that primarily serve the mentally ill, it hardly would have focussed its concern on "public institutions" in the course of the very same statutory reorganization.

D. Subsequent Indicia of Congressional Intent—The 1972 Amendments.

The only subsequent indications of congressional intent concerning ICFs and IMDs came a year later, in the 1972 Amendments to the Social Security Act. Pub. L. 92-603, 86 Stat. 1329 (1972). These amendments made two changes, each of which, properly understood, makes it even clearer that ICFs are not limited by the IMD exclusion.

First, Congress again amended the definition of "medical assistance" to remedy a possible ambiguity, making it

[24] Public institutions for the retarded were exempted from this exclusion. See note 23 *supra*.

clear that the *aged* could receive ICF services not only in ICFs but in an "institution for . . . mental diseases." *Id.* § 297 (amending 42 U.S.C. § 1396d(a)(14)). It had been pointed out to Congress that the law first transferring the ICF program to Medicaid could be read as barring even the aged from receiving coverage for "intermediate" services while residing in "public hospitals for mental diseases."[25] In response, Congress sought to reaffirm its original intention of allowing the aged full coverage for all services in mental institutions.[26]

HHS relies on this provision as an indication that Congress did not want to pay for ICF services to the mentally ill under 65. But this argument simply confuses the concept of ICF *services* and the concept of an ICF *facility*. It is clear that Congress did not want to cover persons under 65 living in mental hospitals for any services, be they "intermediate" or anything else. But this hardly suggests that Congress ever declined to cover persons under 65 in *ICFs* serving a majority of mentally ill patients.

Also in the 1972 Act, Congress added coverage for "inpatient psychiatric hospital services for individuals under 21." Pub. L. No. 92-603, § 299B, 86 Stat. 1460-61 (1972) (adding 42 U.S.C. § 1396d(a)(16), (h)). This new program, which applies only to those hospitals accredited by the Joint Commission on the Accredition of Hospitals,[27] originated in Senate amendments to the House bill. The Senate amendments also included a proposal (ultimately rejected by the House) for "demonstration projects" testing the desirability of covering persons between the ages of 21 and 65—again to be limited to accredited psychiatric hospitals. H.R. 1, 92nd Cong., 2d Sess. § 299B(d) (1972).

[25] *See* Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, 92nd Cong., 1st & 2d Sess., Pt. 2, 932 (1972) (Kenneth Gaver, M.D., representing NASMHPD).

[26] In the colloquy following the suggestion that an ambiguity existed, Chairman Long confirmed that this had been the original intention. *Id.*

[27] The Commission is a private body that accredits hospitals, including state mental hospitals, to determine whether they are providing quality care and treatment.

These provisions create a problem for those who would assert that the IMD exclusion bars coverage for all under-age-65 residents of ICFs serving primarily the mentally ill. Such a theory requires one to believe that Congress intended to deny patients aged 21 and under the opportunity to receive coverage in "specialized" ICFs even as it covered them for the first time in accredited psychiatric hospitals. In addition, it requires a similar assumption about the coverage that would have been afforded to patients aged 22-64 in the Senate's proposed demonstration projects. In view of Congress's repeated assertions about the benefits of alternative, less "intensive" facilities for the chronically ill, these assumptions are simply untenable.

E. The Second Circuit's Analysis of Legislative History.

The Second Circuit, of course, ruled that ICFs could be excluded as IMDs. But its analysis of the legislative history contains two fundamental flaws. First, it wholly fails to take into account the basic policy determination to cover the mentally ill of all ages made by Congress when it created the ICF program. Then it relies on references to various hearings that do not even come close to supporting its position.

The heart of the Second Circuit's opinion is the following assertion:

> Both statutory language and the legislative history demonstrate that, with certain exceptions not at issue, Congress has explicitly declined to permit the use of Medicaid funds for custodial care and treatment of the mentally ill under age 65, *regardless of the type of facility in which that care and treatment are provided.*

731 F.2d at 1056 (emphasis added). This conclusion, to be sure, does have the virtue of clarity. But even respondents have not argued that it comes close to an accurate summary of what Congress actually intended.

Put simply, the court's analysis ignores two key facts. First, as we have discussed, there was no age criterion in the ICF program as originally passed. In other words, using the Second Circuit's language, the Congress in 1967 *did* decide to provide "custodial" care to the mentally ill, irrespective of age. Just as importantly, the ICF program as presently incorporated into Medicaid still provides coverage irrespective of age. Even the Court of Appeals was forced to acknowledge that mentally ill persons under 65 in ICFs *are* eligible for aid under present law, as long as the ICF serves enough of the physically disabled to avoid being labelled an IMD by respondents. 731 F.2d at 1056. But the Court inexplicably ignored the significance of this fact, concluding incorrectly that Congress was unwilling to cover custodial care for the mentally ill under age 65 in *any* facility.

Starting from this fundamental misconception, the Second Circuit sought to buttress its position with an incomprehensible analysis of the statutory language,[28] and several citations to legislative history that are dem-

[28] The court seems to have found some evidence of congressional intent in the fact that Congress in 1971 authorized Medicaid coverage for a special category of facilities—public institutions providing intermediate care to the mentally retarded, commonly called "ICF/MRs." 731 F.2d at 1057. See note 23 *supra*. We fail to see how this demonstrates any intent to restrict the existing coverage for the mentally ill in "ICFs," as that term was originally understood. In fact, the new coverage for ICF/MRs was, as we have noted, intended to bring in large state institutions that had previously been considered IMDs. If Congress had only been concerned with providing coverage for the mentally retarded in true ICFs, it would not have been necessary for it to create the wholly new concept of an institution called an ICF/MR. Instead, Congress could have remained comfortable with the ICF program itself, which covers both the mentally ill and the mentally retarded in true ICFs.

onstrably inapt. Most prominent among the latter references is a discussion of the Senate Report accompanying the original Medicaid bill. *Id.* at 1058 (citing S. Rep. No. 404, 89th Cong., 1st Sess. 145 (1965)). The section cited refers to the fact that the 1965 amendments removed the IMD exclusion for the aged eligible for Medicaid and income assistance. Report at 144-45. It also refers to the new requirement that state plans for assisting the aged in IMDs include provisions facilitating deinstitutionalization to "alternative" facilities where possible. Somehow, the Second Circuit derives from this discussion evidence that such alternative facilities were themselves considered IMDs. 731 F.2d at 1058. But there is no indication whatever in the language of the report that Congress was making any such assumption. In any event, as we previously explained, no ICF was covered in 1965, even if it served people over 65.

Equally specious is the Second Circuit's analysis of the 1972 hearing testimony of representatives of *amicus* NASMHPD. *Id.* at 1059 (citing Social Security Amendments of 1971: Hearings on H.R. 1 before the Senate Commission on Finance, 92nd Cong., 1st and 2d Sess. 924-29 (1972)). These officials, who testified three weeks after the transfer of the ICF program to Medicaid, were discussing the benefits that could be gained by covering patients of all ages in "mental hospitals." Hearings at 928. They pointed out that the Medicaid coverage of the aged in state hospitals had, since 1965, "transformed these hospitals from . . . human warehouses . . . into active treatment centers." *Id.* at 925. As evidence of this treatment success, they pointed to the increased deinstitutionalization of the aged into community facilities, including ICFs. *Id.* at 928. On the basis of this success, they argued for the "equity" of extending the same bene-

fits to other patients in "public institutions" and "private mental hospitals." *Id.* at 929.

Contrary to the Second Circuit's view, this testimony hardly indicates that these officials took a position on existing Medicaid coverage for ICF (as distinct from IMD) residents. 731 F.2d at 1059. They made no comments whatever on the issue. Nor can any position be inferred. In fact, the history presented entirely involved the period prior to the transfer of ICF coverage to Medicaid. Since there were no age categories in the earlier Title XI program, the witnesses' discussion of the deinstitutionalization achieved for the aged cannot have been intended as an argument for extending ICF coverage. That coverage had clearly been equal during the relevant period. The problem at issue was the unequal treatment of patients over and under 65 in psychiatric *hospitals*.

The flaws in two other references to legislative history are discussed in the margin.[29] Ultimately, it must be

[29] The court refers to the 1967 testimony of Dr. Robert Gibson representing *amicus* the American Psychiatric Ass'n and the National Association of Private Psychiatric Hospitals. 731 F.2d at 1058 (citing Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, Pt. 3, 90th Cong., 1st Sess. 1741 (1967)). Dr. Gibson was seeking an expansion of Medicaid funding for psychiatric inpatient care for persons under 65. He contrasted the existing psychiatric coverage for persons under 65—in general hospitals only—with coverage for the aged in any facility, including a psychiatric hospital and a community mental health center. *Id.* This testimony is irrelevant to the present issue. To begin with, it involved only psychiatric hospitalization, and the well-understood lines drawn in that arena by the IMD exclusion. Indeed, there was no ICF coverage for anyone when he was testifying, and none in Medicaid until 1971. Thus the comparisons drawn cannot have included intermediate care.

The Second Circuit also refers to 1970 comments by Harry Schnibbe (representing *amicus* NASMHPD) concerning a House bill that was never enacted. 731 F.2d at 1058-59 (citing Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess. 501-02 (1970)). As we have already discussed, that bill contained a provision that would have clarified the fact that the original ICF program did not cover public mental

concluded that the Second Circuit offered no substantial evidence supporting its interpretation. This might not matter if the legislative history were truly silent, or if the outcome reflected a coherent policy position. But we have already shown that the legislative record is far from silent. And the argument for reversal becomes even more compelling when one examines the policies reflected in HHS's rule.

II. HHS'S POSITION UNDERMINES ANY SENSIBLE POLICY THAT CONGRESS INTENDED BY INCLUDING THE MENTALLY ILL IN THE ICF PROGRAM.

In assessing the appropriateness of the IMD exclusion as interpreted by HHS, it is important to understand fully the peculiarities of the line that the Department has drawn. Conceding, as it must, that Medicaid does cover mentally ill patients of all ages in ICFs, HHS argues that this coverage should stop for all patients under age 65 when a given ICF becomes an "IMD." According to the Department Guidelines,[30] this can occur when a facility serves too many mental patients overall,[31] serves too many people under age 65 who are mentally ill,[32] serves too many transferees from state mental institutions,[33] or hires too many staff members who have "specialized psy-

hospitals or institutions for the retarded. The witness opposed this on the ground that it was desirable to encourage intermediate-level care in such facilities. *Id.* at 502. Strangely enough, the Second Circuit drew from this testimony evidence that the IMD exclusion covers facilities *other* than mental institutions—*i.e.*, ICFs.

[30] The current Guidelines, promulgated only as part of the *State Medicaid Manual*, are set out in the *Medicare and Medicaid Guide (CCH)* ¶ 14,601, at 6295 [hereinafter "Current Department Guidelines"]. Respondents in this case applied an older set of Guidelines that went so far as to penalize an ICF for being within 25 miles of a state mental hospital. Pet. App. at 28d-29d .

[31] Current Department Guidelines ##6, 8.

[32] Current Department Guidelines #9.

[33] Current Department Guidelines #7.

chiatric training."[34] In other words, the Department's position is that an ICF can serve the mentally ill but its care must be strictly limited, quantitatively *and* qualitatively.

Singularly missing from HHS's position is any explanation as to why Congress would adopt such a position. Application of the IMD rule to mental hospitals leads to the exclusion of a homogeneous class of persons: the under-65 patients in such facilities, all of whom, by definition, are mentally ill. While *amici* may not agree that such an exclusion is desirable, at least it was based on an intelligible set of policy judgments about mental hospitals, as we have explained above.

But when the IMD rule is extended to ICFs, as HHS would do, the situation is quite different. The rule not only produces unequal treatment of identical mentally ill persons receiving the same level of care in comparable ICFs, it also extends this irrational discrimination to the physically disabled as well. For example, if an ICF had 60 percent mentally ill and 40 percent physically ill (and the staff to serve these people properly) it would probably be classified as an IMD under the Department's guidelines and *all* of its residents under age 65 would be ineligible for Medicaid. If, however, the mix of physical and mental patients in the ICF were reversed (and the staffing changed to reflect the new mix), all residents would then be eligible for Medicaid. Can it really be that a shift of 20 percent of mentally ill patients (or less) was intended to have such a dramatic impact?

Aside from the illogical quality of HHS's position, its likely effect on the course of future events is neither difficult to trace nor heartening to contemplate. First, of course, if the mentally ill are to remain covered under Medicaid, they will have to be dispersed into the hundreds of ICF-level nursing homes primarily serving the elderly and persons with physical disabilities. While such facilities may well be appropriate for some chronically

[34] Current Department Guidelines #4.

mentally ill patients, there can be little doubt that concentration of the mentally ill in certain ICFs is often preferable from a clinical point of view and would result in economies of scale that will allow staffing better designed to meet the needs of this population.

Second, even those ICFs that have fewer than 50% mentally ill residents will be concerned about the danger of losing Medicaid coverage for all their patients under age 65 in the event they should be deemed an IMD under the regulatory criteria. The likely result is an access problem for mentally ill patients needing ICF care. Under the HHS criteria, ICFs will have a clear incentive to exclude mentally ill patients. And this problem will become especially acute when a facility's population of mentally ill persons approaches the "critical mass" that may be needed to make possible the psychiatrically oriented programs of care that many patients require.[35]

These are not idle concerns. Numerous experts have already pointed to the undesirability of attempting to care for at least certain categories of mentally ill people in nursing homes geared to the needs of the elderly. First, there are problems caused by the mixture of very different patient populations. A study by the Senate Special Committee on Aging concluded that "the effect of mixing the physically infirm patients with mentally impaired is often deleterious."[36] And HHS's own proposed plan for meeting the needs of the chronically men-

[35] Exclusion and inadequate care would, under the Department's rule, be imposed on Medicaid-eligible persons solely by virtue of the fact that their disability is caused by mental, rather than physical illness. It seems most unlikely that Congress, having chosen to provide ICF services to the mentally ill, intended to do so on terms that would predictably lead to discrimination against them. *Cf. Schweiker* v. *Wilson*, 450 U.S. 221 (1981); *Minnesota* v. *Heckler*, 718 F.2d 852, 865 (8th Cir. 1983).

[36] Staff of the Special Senate Comm. on Aging, 94th Cong., 2d Sess., *The Role of Nursing Homes in Caring for Discharged Mental Patients* at XI (Comm. Print. 1976) [hereinafter "Senate Study"].

tally ill agreed, stating in 1980 that "the need for a quiet orderly environment for extremely ill persons may not be compatible with the needs of an ambulatory, active chronically mentally ill person." [37]

The Senate study also concluded that non-specialized nursing homes are too often "poorly equipped" to meet the needs of certain mentally ill persons. "There are generally no psychiatric services available; no plans to rehabilitate patients; there are not sufficient numbers of trained staff people to care for their needs . . ." [38] And here again HHS's plan agreed, stating that the "range of the treatment and rehabilitative programs" needed by some mentally ill patients "are generally not available" in regular nursing homes. Significantly, the plan then linked this problem directly to "legislative exclusions, or regulatory interpretation of legislation," including HHS's reading of the IMD exclusion, that have created "disincentives to appropriate service." [39]

It should also be emphasized that the position we are taking does not mean that a state can simply label a facility an ICF and thereby get Medicaid coverage for its residents. There are appropriate limitations, intended by Congress, that the Department may still employ. First, hospitals and ICFs provide different levels of care. The nature and amount of medical services, including specifically active psychiatric treatment, are significantly different in the two settings. The guidelines established

[37] *Toward a National Plan for the Chronically Mentally Ill* at 2-31 (Report to the Sec'y of H.H.S. by the Steering Committee on the Chronically Mentally Ill, Dec. 1980) [hereinafter *"Toward a National Plan"*].

[38] Senate Study, *supra*, at XI.

[39] *Toward a National Plan, supra*, at 2-31. *See also* Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 90-91 (GAO Report 1977) (officials at the National Institute of Mental Health believe that application of the IMD requirement to ICFs and SNFs "hinders deinstitutionalization" and "hinders the development of appropriate programs" for the mentally ill).

by the Joint Commission on the Accreditation of Hospitals, an accrediting body formally recognized by Congress in the Medicaid statute, *e.g.*, 42 U.S.C. § 1396d(h)(1)(A), carefully distinguish between hospital-based care and long-term care such as that provided by ICFs to the mentally ill.[40] Competent professionals available to HHS can readily apply these criteria.

In addition, even when a facility is properly classified as an ICF, that does not mean that *all* of its residents are Medicaid-eligible. The Department is still authorized to determine that a particular resident is not appropriately placed in such a facility because, for example, he requires hospital-based care in an IMD.[41] These kinds of determinations, while requiring HHS to take somewhat greater care perhaps, far better satisfy congressional intent than the improper criteria that the Department now uses.

III. HHS'S RULE WOULD IMPOSE INTOLERABLE BURDENS ON STATE EFFORTS TO MEET THE NEEDS OF THE CHRONICALLY MENTALLY ILL.

It is also important, in our view, for the Court to understand the full impact that the decision in this case will have. The nation's mental health system has changed greatly since the 1960's, as the primary locus of long-term care for the chronically mentally ill has shifted from state hospitals to private facilities in the community. Understandably, this movement has placed significant pressures on community-based facilities and services that are attempting to meet the needs of the many thousands of people who have left state institutions. In the present context, it is simply indefensible for HHS to

[40] *Compare Consolidated Standards Manual for Child, Adolescent and Adult Psychiatric, Alcoholism and Drug Abuse Facilities* (JCAH 1981) *with Accreditation Manual for Long-Term Care Facilities* (JCAH 1980).

[41] See 42 U.S.C. § 1396a(a)(31) (state Medicaid plan must provide for periodic review and on site in spections geared to assessment of appropriateness of each patient's placement in an ICF).

be adopting a regulatory approach that flies in the face of this massive effort—at least without far clearer indicia of legislative intent than it is able to muster here.

The statistics documenting this process are dramatic. Between 1955 and 1980, the resident census in state and county mental hospitals shrank from 559,000 to 138,000.[42] This reduction has resulted primarily from major shortening of the average patient's length of stay in these facilities.[43] The underlying causes have included the introduction of new psychoactive medications, congressional mandates, reforms of civil commitment laws, and a general recognition of the inadequacy of traditional state institutions as places of long-term "asylum".

With most of the chronically mentally ill now living outside of the old institutions, the states have been making major efforts to meet the needs of this population for alternative residential opportunities. These efforts generally involve various "extended care facilities"—"board and care" facilities for the less disabled and nursing homes (ICFs and SNFs) for those requiring greater support and more intensive care.[44] Nursing homes alone have been called the "single largest providers of services to chronically mentally ill persons in the country."[45] And, while many of the mentally ill in nursing homes are elderly persons suffering from senility, there are also

[42] Goldman *et al., Deinstitutionalization: The Data Demythologized,* 34 Hosp. & Community Psych. 129, 131 (1983).

[43] *Id.*

[44] *See* Kohen & Paul, *Current Trends and Recommended Changes in Extended Care Placement of Mental Patients: The Illinois System as a Case in Point,* 2 Schizophrenia Bull. 575, 576 (1976); Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 10 (GAO Report 1977).

[45] *Toward a National Plan, supra,* at 2-32.

thousands of younger persons in such facilities afflicted with schizophrenia and other disorders.[46]

Because of the heavy fiscal burden involved, the process of providing community-based alternatives for the chronically mentally ill is far from complete at the present time. There is a shortage of residential options, and many of the existing facilities remain sub-standard.[47] And where sufficient alternatives do not yet exist, one common outcome is the homelessness of many who, in times past, would have been served by state mental hospitals.[48]

In view of the shift toward nursing home care for the chronically mentally ill, and the fiscal crisis now confronting states in this area, a decision upholding HHS's broad IMD exclusion would cause serious problems for states that have been providing Medicaid funds to ICFs that care largely for the mentally ill.[49] First, those states would face the prospect of disallowances of previous federal Medicaid payments—causing still further budgetary problems. In other words, there would be a financial penalty imposed on those states, and only those states that, in good faith, have been providing quality care in psychiatrically oriented ICFs.

[46] Goldman, *Long-Term Care for the Chronically Mentally Ill* 18 (Urban Inst. report 1983).

[47] *See, e.g.,* Senate Study, *supra,* at 743-52; Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 126 (GAO Report 1977).

[48] *See* Talbott & Lamb, "Summary and Recommendations," in *The Homeless Mentally Ill* 2 (Amer. Psychiatric Ass'n Task Force Report, H.R. Lamb ed., 1984) ("It is now apparent that a substantial portion of the homeless are chronically and severely mentally ill men and women who in years past would have been long-term residents of state hospitals.")

[49] A GAO study in 1977 found a substantial number of ICFs in the Medicaid program which emphasized care for the mentally disabled. Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 90-91, 178, 187 (GAO Report 1977).

Those same states (as well as others) would also face a difficult choice for the future. If they wanted to secure Medicaid funding of intermediate care for their mentally ill citizens, they would have only one option—dispersing them among the elderly in non-specialized nursing homes. If they rejected or were unable to achieve this sometimes less desirable option, and thus had to fund the care themselves, there would be strong financial pressures favoring a return to the public institutions instead of the private ICF. After all, from the state's point of view, the marginal cost of one more institutional patient is certainly less than the cost of care in private ICFs, which are invariably reimbursed on a per-patient basis.

The consequences that will inevitably flow from this unfortunate and, we believe, unintended set of options would be grave. One of the important overall effects of the ICF program, as designed by Congress, is that many former mental hospital patients are now being adequately cared for in more appropriate ICFs. These are people who, it has been shown, do not require the intensive care provided during psychiatric hospitalization. At the same time, by moving such people out of state hospitals, many states have been able to provide better care for those who properly remain in such hospitals. The current situation, while far from perfect, reflects considerable progress in the past twenty years. The position taken by HHS in this litigation would not only halt this progress, it would almost certainly begin to undo it. State hospitals would once again become a repository for those mentally ill citizens who have no place else to go. This result, in turn, would lead to improper hospital placement for many and less good hospital care for those who need it. Nothing adduced by HHS or the Court of Appeals indicates that Congress intended such perverse results.

CONCLUSION

For these reasons, the judgment below should be reversed.

Respectfully submitted,

PAUL LITWAK
44 Holland Avenue
Albany, New York 12229

R. EMMETT POUNDSTONE, III
P.O. Box 3710
Montgomery, Alabama 26193

Of counsel for amicus the National Ass'n of State Mental Health Program Directors

JOEL I. KLEIN
PAUL M. SMITH
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184

Counsel for Amici Curiae

January 2, 1985