The IMD Exclusion: A Discriminatory Denial of Medicaid Funding for Non-elderly Adults in Institutions for Mental Diseases

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NOTE

THE IMD EXCLUSION: A DISCRIMINATORY DENIAL OF MEDICAID FUNDING FOR NON-ELDERLY ADULTS IN INSTITUTIONS FOR MENTAL DISEASES†

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INTRODUCTION

Over the past few decades, the federal government has maintained the position that the care of individuals with mental illness is a burden of the states, not of the federal government. This position has been strengthened through the recent scrutiny of Institutions for

† The author is grateful to her mother, Helen Jennen, owner/administrator of Hayes Residence (a local NF/IMD), for providing valuable information and dialogue on this topic. The author would also like to acknowledge her deceased great-aunt Mildred Hayes for founding Hayes Residence and dedicating most of her life to providing shelter and care for individuals with mental and physical impairments. Finally, the author would like to thank the residents of Hayes Residence for their exuberance and continued friendship.

1. See, e.g., Legion v. Richardson, 354 F. Supp. 456, 459 (S.D.N.Y.), aff'd sub nom. Legion v. Weinberger, 414 U.S. 1058 (1973) (upholding the exclusion of state mental hospitals from Medicare and Medicaid benefits under the Social Security Act of 1935 because the "care of the mentally ill in state hospitals was the responsibility of the states . . . .").
Mental Diseases (IMDs), and the denial of funding for the services provided in IMDs under the federal Medicaid Program.

This article will examine the IMD exclusion under the Medicaid Program, which prohibits the expenditure of federal dollars for the care of non-elderly, mentally ill adults in IMDs. Emphasis will be placed on the discriminatory nature of the IMD exclusion, and on the recent impact this exclusion has had on mentally ill individuals in Minnesota. The article will also explain some of the complicated language, history, and litigation surrounding these provisions, and will outline three different arguments against the current application of the IMD classification. Finally, this article will advocate amending the Medicaid Program to repeal or, in the alternative, modify the IMD exclusion to provide equal treatment and funding for the mentally ill under the Social Security Act.

I. BACKGROUND

This section provides background information on the Medicaid Program. Additionally, this section lays the groundwork for understanding the IMD exclusion by explaining the levels of care and the types of long-term health care facilities that are covered under the Medicaid Program.

A. Medicaid Program

The Medicaid Program (which is often referred to at the state level as Medical Assistance) under the Social Security Act is a federal assistance program for "aged, blind, and disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical, . . . rehabilitative, and other [services]." This program provides grants to participating states to help cover medical expenses for qualifying individuals. By setting out a "state plan," par-

2. See infra notes 47-51 and accompanying text (discussion of a recent federal audit of IMDs).

3. See infra note 33.

4. Id.

5. 42 U.S.C. § 1396 (1988). For a simplified explanation of the Medicaid Program, see Medicaid in Minnesota: How It Stacks Up, Saint Paul Pioneer Press, July 15, 1990, at 1G, col. 3 [hereinafter Medicaid in Minnesota]. Medicaid is the main government health care program "for the poor and disabled," and should not be confused with the Medicare Program. Medicare is a federal insurance program to cover hospitalization and doctors' charges, supplemented by monthly premiums paid by the beneficiaries who desire coverage. Id. For a more detailed comparison of Medicaid and Medicare, see Legion, 354 F. Supp. at 458.

6. 42 U.S.C. § 1396b (1988). See also Medicaid in Minnesota, supra note 5, at 1G, col. 2. The percentage of state contributions changes from year to year. In Minnesota in 1990, the federal government share was 54%, the state share was 41.4%, and the county share was 4.6%. Id.
Participating states are allowed to determine, to a certain degree, eligibility requirements and services to be provided. While the Medicaid Program broadly covers many medical services, this article will focus on Medicaid coverage of institutional long-term care for disabled individuals.

A "disabled individual," under the Medicaid Program, is defined as an individual who is "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." The statute further defines a "physical or mental impairment" as "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."

The following section explains the various levels of institutional long-term care and the types of facilities that provide such care as defined under the Program. A brief history will be provided to show how the levels of institutional long-term care have changed over the past twenty-five years, as several of the cases discussed later in the article will refer to classifications that are no longer used.

B. Long-Term Care Under the Medicaid Program

As originally enacted in 1965, the Medicaid Program only authorized reimbursement for a single level of institutional long-term care. This level of care was called "skilled nursing home care," and was created to provide a lower level of care than that provided in hospitals.

---

7. See 42 U.S.C. § 1396a (1988). A state plan is a contract with the federal government explaining how the state will administer the federal funds. Although the state plan must comport with federal requirements, the statute allows for variations from state to state. For example, each state may determine income and resource limitations for its state plan. Id.

8. The term "institutional long-term care" is used in this article as a general term to refer to the care provided in the long-term care facilities as provided in 42 U.S.C. § 1396d (1988) (definition of long-term care coverage under the Medicaid Program).


In 1971, Congress created a second level of care under the Medicaid Program, called "intermediate care." This level of care fell below skilled nursing home care, but above the level of care provided in boarding homes. 14 This intermediate level of care was intended to enable states "to use lower cost facilities more appropriate to the needs of thousands of persons, thus avoiding the higher charges for skilled nursing homes when care of that kind [was] not needed." 15 Facilities under the Medicaid Program that provided the intermediate level of care were called "Intermediate Care Facilities" (ICFs). 16

The most recent statutory definition of an ICF (prior to the changes effective October 1, 1990) was

an institution which . . . is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or 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 . . . . 17

Federal regulations defined a resident of an intermediate care facility as "an individual who is . . . [i]n need of and receiving professional services to maintain, improve, or protect health or lessen disability or pain under the direction of a practitioner of the healing arts [and] . . . [u]nder care and supervision 24 hours a day." 18

Facilities which provide nursing home care were called "Skilled Nursing Facilities" (SNFs). An SNF was also defined (prior to October 1, 1990) under the Medicaid Program as a facility that provides

14. See Level of Care, supra note 12, at 960 (In creating intermediate level of care, the intent of Congress was to reduce the number of qualified Medicaid recipients relying on the more costly SNF care.).


Resident of an intermediate care facility is an individual who is—

(a) In need of and receiving professional services to maintain, improve, or protect health or lessen disability or pain under the direction of a practitioner of the healing arts;

(b) Admitted to an intermediate care facility in accordance with §§ 450.370 through 450.381 of this subchapter, or receiving ICF services in a hospital with a swing-bed approval in accordance with § 447.280 of this chapter;

(c) Under care and supervision 24 hours a day; and

(d) If he or she is in an institution for the mentally retarded, receiving active treatment as defined in this section.

Id.
inpatient, skilled nursing or rehabilitative services\textsuperscript{19} on a higher level than an ICF.\textsuperscript{20}

Effective October 1, 1990, the Medicaid Program was amended to create a single classification, "Nursing Facility" (NF), to provide both ICF and SNF services.\textsuperscript{21} Additionally, the ICF and SNF classifications were eliminated.\textsuperscript{22} The new NF classification combines the levels of care previously provided under both the old SNF classification\textsuperscript{23} and the old ICF classification.\textsuperscript{24} Since the new NF classification requires facilities to provide both levels of care to participate in the Medicaid Program, the old ICFs must now meet the new, higher requirements to operate as an NF.\textsuperscript{25}

The October 1990 amendment, creating a single level of care (NF), resulted from a perceived ineffectiveness of the prior two levels of care (ICF and SNF), and has been both criticized and supported. Supporters of the amendment criticize the old system because of its

\footnotesize

\begin{itemize}
\item \textsuperscript{19} 42 U.S.C. § 1395i-3(a) (1988).
\item In this subchapter, the term “skilled nursing facility” means an institution (or a distinct part of an institution) which—
\begin{itemize}
\item (1) is primarily engaged in providing to residents—
\begin{itemize}
\item (A) skilled nursing care and related services for residents who require medical or nursing care, or
\item (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,
\end{itemize}
\item and is not primarily for the care and treatment of mental diseases . . . .
\end{itemize}
\end{itemize}

Id.

\item \textsuperscript{20} See 42 U.S.C. § 1396d(c) (Supp. V 1981).

\item \textsuperscript{21} A Nursing Facility is defined as

an institution . . . which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,
(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
(C) on a regular basis, health-related care and services to individuals 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,

and is not primarily for the care and treatment of mental diseases . . . .

42 U.S.C. § 1396r(a) (1988); see also Level of Care, supra note 12, at 959.

\item \textsuperscript{22} See, e.g., 42 U.S.C. § 1396d(c), (i) (1988) (no longer containing definitions for ICF or SNF); see also Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4211(e), 1987 U.S. CODE CONG. & ADMIN. NEWS (101 Stat.) 1330, 1330-204, 1330-205 (striking the ICF and SNF definitions).

\item \textsuperscript{23} Compare 42 U.S.C. § 1396r(a) (1988) with 42 U.S.C. § 1395i-3(a) (1988); see also supra notes 19 and 21.


\item The requirements do, however, allow for some flexibility. Facilities may obtain a specific "waiver" to waive additional nurse staffing requirements. See 42 U.S.C. § 1396r(b)(4)(C) (1988) (as amended). This waiver was made available after Congress recognized that some facilities may have trouble finding sufficient numbers of licensed nurses (RNs and LPNs). See Level of Care, supra note 12, at 963.

\end{itemize}
claimed "’inability . . . to properly match resources with patient care needs.’" The old system was also criticized because the United States Department of Health and Human Services (HHS) had trouble controlling how the different states assigned the ICF and SNF classifications to the long-term care facilities in the state. Varied interpretations on the state level of the ICF and SNF classifications resulted in a vast difference in the numbers of ICFs and SNFs from state to state. Additionally, supporters of the amendment believe that the new system will provide more flexibility, and that an individual's choice of facilities will not be restricted by the ICF and SNF levels of care because NF facilities will satisfy both levels of needs.

Those who criticize the amendment anticipate an increase in some states' Medicaid budgets. States with a large number of ICFs will see an increase in their Medicaid budgets because the old ICF facilities will now bill at the higher NF rates to account for the stepped-up level of care requirements.

II. THE IMD EXCLUSION

A. Definition and Application of the IMD Exclusion

In addition to the above-mentioned classifications for long-term care facilities, i.e., ICF, SNF, and the new NF classification, the Medicaid Program also created a classification for Institutions for Mental Diseases (IMD). This article's primary focus is on the IMD classification and how the classification relates to the previously-mentioned level of care classifications.

Unlike the other classifications, IMD is used only for the purposes

26. Id. at 962 (quoting Fries, A Patient Classification System for Long-Term Care: Executive Summary, Health Care Financing Administration, Grants and Contracts Rep. 3 (Aug. 1984)).

27. In 1985, Texas had 770 ICFs, while Arizona had none. The District of Columbia had three SNFs, while California had 1,148. See id. at 961.

28. See, e.g., id. at 962-63 (explaining the change in the respective levels of care and the effect of the change in forcing facilities to retrofit to meet the higher standard).

29. See id. at 963. One such group is the Institute of Medicine. Id.

30. Id. at 964. The billing rates are controlled in some states by reimbursement systems that pay different amounts for different patients, depending upon the individuals' care needs. For more information on Medicaid reimbursement systems, see generally id.

of excluding certain individuals from Medicaid eligibility. The IMD exclusion specifically prohibits an otherwise eligible person from receiving Medicaid if that individual is between the ages of twenty-one and sixty-four years old and resides in a long-term care facility that is classified as an IMD.

Due to the exclusionary nature of the IMD provisions, the IMD exclusion stands apart from all other Medicaid provisions. The only similar provision within the Medicaid Program is the repealed provision that similarly targeted and excluded individuals within institutions for tuberculosis.

32. See generally 42 U.S.C. § 1396d(a) (1988) (clauses which limit application of Medical Assistance to IMDs are found in subsections 1, 4(A), 14, 15, 16).

33. The statutory Medicaid provisions include the following coverage:

- payment of part or all of the cost of the following care and services . . . for individuals . . . who are—
  - (i) under the age of 21, . . .
  - (iii) 65 years of age or older, . . .
  - (v) 18 years of age or older and permanently and totally disabled, . . .
  - (vii) blind or disabled as defined in section 1382c of this title, . . . but whose income and resources are insufficient to meet all of such cost [of]—

  - (1) inpatient hospital services (other than services in an institution for mental diseases);
  - (4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older . . . ;
  - (13) other diagnostic, screening, preventive, and rehabilitative services;
  - (14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;
  - (15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care;
  - (21) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

- (A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or
- (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

42 U.S.C. § 1396d(a) (1988) (emphasis added). These repeated exclusions for individuals in IMDs are referred to in this article as the "IMD exclusion."

34. Id.

Examples may assist in understanding the unusual results of the IMD exclusion. If an individual twenty-one through sixty-four years of age resides in an IMD, that individual is excluded from benefits under the Medicaid Program. If that same individual moves from the IMD to a non-IMD facility, that person would no longer be excluded from the Medicaid Program. At the same time, an individual under twenty-one or over sixty-four years of age, residing in an IMD, is not excluded from Medicaid Program benefits.

One major problem with the IMD exclusion is the definition of Institutions for Mental Diseases. Even though the IMD exclusion dates back to 1965, the term “IMD” was not statutorily defined until 1988. After many years of controversy, Congress finally defined the term to mean “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”

Even though “IMD” was not statutorily defined until 1988, it has been loosely defined through federal regulations and other internal, unpublished guidelines of HHS since 1965. The current regulatory definition states that an IMD is “determined by its overall character.” If the facility is “established and maintained primarily for the care and treatment of individuals with mental diseases,” that facility is considered an IMD.

Additionally, HHS uses ten internal and unpublished interpretive guidelines to determine whether or not a facility has the “overall character” of an IMD. These criteria focus upon two general ar-

37. Id.
38. Id. § 1396d(i).
39. Id. Prior to the enactment of the statutory definition, the term “IMD” was defined in federal regulations promulgated by the Secretary of Health and Human Services.

"Whether an institution is one for... mental diseases will be determined by whether its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with... mental diseases (whether licensed or not)... . "Institution for mental diseases' means 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."

Connecticut Dep't of Income Maintenance v. Heckler, 471 U.S. 524, 531 (1985) (quoting 45 C.F.R. § 248.60(a)(3)(ii) and (b)(7) (1972)).
41. Id. Under the regulatory definition, an institution for the mentally retarded is not considered an institution for mental diseases. Id.
42. The internal guidelines are as follows:

1. The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;
2. The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;
eas: the characteristics of a facility's resident population, and the type of services provided by the facility. 43 Considered "useful in identifying IMDS," no single guideline is determinative in any given case. 44 These guidelines have been highly criticized, and will be more thoroughly discussed in a subsequent section of this article.

B. The IMD Controversy

Although the IMD exclusion has been in existence since 1965, the controversy over the correct application of the IMD classification intensified during the late 1970s and early 1980s, reaching a peak in 1989. 45 In 1979, HHS conducted an investigation "to determine whether certain states were discharging patients from mental hosp-

3. The facility is accredited as a psychiatric facility by the JCAH [Joint Commission on Accreditation of Hospitals];
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or by the fact that a large proportion of the patients are receiving psychopharmacological drugs;
5. The facility is under the jurisdiction of the State's mental health authority;
6. More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patients' medical records;
7. A large proportion of the patients in the facility have been transferred from a State mental institution for continuing treatment of their mental disorders;
8. Independent Professional Review teams report a preponderance of mental illness in the diagnoses of the patients in the facility (42 C.F.R. 456.1);
9. The average patient age is significantly lower than that of a typical nursing home;
10. Part or all of the facility consists of locked wards.


43. For a more extensive discussion of the guidelines see, infra notes 137-57 and accompanying text.
44. TITLE XIX FINANCIAL MANAGEMENT REVIEW GUIDE, supra note 42, at 7.
45. The controversy began over the HHS definition and application of the term "IMD." For example, in Connecticut Dep't of Income Maintenance v. Heckler, 471 U.S. 524, 527 n.5 (1985), the HHS applied unpublished guidelines to determine that a facility in Connecticut was an IMD. The HHS had developed these guidelines to determine what constitutes "primarily engaged" and "overall character." Although these guidelines had never before surfaced in departmental audits, the HHS used these guidelines to disallow funding for a facility that had admitted a number of individuals that had been former residents of Connecticut's state mental hospitals. Id. at 526-27, 527 n.5.
tals and arranging their placement in ICFs in order to circumvent the Medicaid exclusion for patients under age 65 in IMDs."

In 1988, the Inspector General's Office notified the Minnesota Department of Human Services of an audit, to be conducted after January 1, 1989, to identify IMDs. The Department of Human Services responded by conducting its own investigation, prior to the federal audit, to determine which facilities would most likely qualify as IMDs under the federal guidelines.

The state's investigation first identified "a number of certified nursing and boarding care homes with more than 16 beds . . . as having at least 50 percent of their residents with physical and MI [Mental Illness], or MI only, diagnoses." Thereafter, sixteen of these facilities (eleven in Hennepin County alone) were declared IMDs by the Minnesota Department of Human Services, effective January 1, 1989.

Three hundred and twenty-five residents were left without a source of funding after the state's declaration of the sixteen new

46. Connecticut Dep't of Income Maintenance v. Heckler, 731 F.2d 1052, 1054 (2d Cir. 1984), aff'd, 471 U.S. 524 (1985). The court of appeals reversed the district court's ruling that an ICF cannot also be labeled an IMD, holding instead that the IMD definition adopted by the HHS furthered congressional intent. See id. at 1060. The Supreme Court affirmed the court of appeals, holding that the terms ICF and IMD were not mutually exclusive. See Connecticut Dep't of Income Maintenance, 471 U.S. at 537. See also infra notes 106-36 and accompanying text (discussing further the issue of mutual exclusivity).

47. See REVIEW OF NURSING FACILITIES, supra note 42, at 16.

48. Id.

49. Id. at 17. Subsequent to the January 1, 1989, effective date, four of these new IMDs were "undeclared." Thus, the March 1990 study focused upon twelve facilities rather than the original sixteen. Id. at 3. As of the date of the study, there are thirteen declared IMDs: the twelve declared as such on January 1, 1989, and one which was declared an IMD prior to that date. Id.

The following list shows the NFs in Minnesota that have been classified as IMDs and the number of residents affected by the classification (current as of March 1990).

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>No. Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bannochie Nursing Home</td>
<td>21</td>
</tr>
<tr>
<td>Birchwood Care Home</td>
<td>30</td>
</tr>
<tr>
<td>Franklin Place East</td>
<td>19</td>
</tr>
<tr>
<td>Grand Avenue Rest Home</td>
<td>6</td>
</tr>
<tr>
<td>Hayes Residence</td>
<td>16</td>
</tr>
<tr>
<td>Horizon West Health Care Center</td>
<td>56</td>
</tr>
<tr>
<td>Minnetonka Health Care Center</td>
<td>12</td>
</tr>
<tr>
<td>Queen Care Center</td>
<td>27</td>
</tr>
<tr>
<td>Pillsbury Board and Care</td>
<td>16</td>
</tr>
<tr>
<td>Southside Care Center</td>
<td>14</td>
</tr>
<tr>
<td>Stillwater Residence</td>
<td>15</td>
</tr>
<tr>
<td>Northside Residence</td>
<td>17</td>
</tr>
<tr>
<td>Andrew Care Home</td>
<td>184</td>
</tr>
</tbody>
</table>

Id. at Appendix I.
IMDs.\(^{50}\) Certain state programs were modified or amended, however, to ensure adequate coverage of costs. For example, the Minnesota General Assistance Program was amended to provide funding for medical care "for any person . . . over age 18 and who would be eligible for medical assistance except that the person resides in a facility that is . . . an institution for mental diseases."\(^{51}\)

Additional funding was provided through the Minnesota Supplemental Aid Program. Because the statutory rate cap under the program was too low to provide for full payment to the newly declared IMD facilities,\(^{52}\) an amendment was enacted that exempted the IMD facilities from the rate cap.\(^{53}\) This exemption is temporary, however, and expires July 1, 1991.\(^{54}\)

C. Arguments Against the IMD Exclusion

Both in its conception and application, the IMD exclusion is a discriminatory and poorly executed provision. As such, three arguments against the IMD exclusion can be raised. First, the IMD exclusion violates the equal protection clause of the Constitution, and thus should be stricken. Second, the IMD classification is mutually exclusive, and should not be applied to Nursing Facilities (NFs). And third, the IMD interpretive guidelines are improper and should be changed to only apply to facilities that provide a specialized degree of mental health services. These arguments will be examined in greater depth in the sections that follow.

1. Unconstitutionality Under the Equal Protection Clause

   a. Rational Basis Test

The court decisions that address the constitutionality of the IMD exclusion under the equal protection clause have all upheld the exclusion by using the "rational basis" test.\(^{55}\) This well-known test re-

\(^{50}\) Id. at 3, 17.
\(^{51}\) Minn. Stat. § 256D.03, subd. 3(3) (1990).
\(^{52}\) In 1989, the rate paid for long-term care was not to exceed $919.80 per month. Id. § 2561.05, subd. 1. The maximum rate is increased annually by the lesser of the percentage of change in the consumer price index, as published by the Bureau of Labor Statistics, or 2.5%. Id. § 2561.05, subd. 7.
\(^{53}\) The amendment provides:

   (c) The following residences are exempt from the limit on negotiated rates and must be reimbursed for documented actual costs, until an alternative reimbursement system . . . is developed by the commissioner:

   (2) a residence certified to participate in the medical assistance program [Medicaid], licensed as a boarding care facility or a nursing home, and declared to be an institution for mental disease by January 1, 1989.

Id. § 2561.05, subd. 2(c).

\(^{54}\) Id. § 2561.05, subd. 2(c)(2).

\(^{55}\) Schweiker v. Wilson, 450 U.S. 221 (1981) (addressed the constitutionality of
quires the party attacking the statutory classification to prove that the classification is not rationally related to a legitimate governmental objective.\textsuperscript{56} It grants a heavy presumption of constitutionality to the defending government body.\textsuperscript{57} Statutory classifications are rarely struck down as unconstitutional under this standard of review.\textsuperscript{58}

In \textit{Legion v. Richardson},\textsuperscript{59} the District Court for the Southern District of New York found the IMD exclusion constitutional under the rational basis test. On appeal, the Supreme Court summarily affirmed this decision. This 1973 case involved a class action suit brought on behalf of mentally ill individuals in public mental institutions. The decision was based on a very narrow definition of IMD that only included state mental hospitals.\textsuperscript{60} The court's assumption, that the IMD exclusion only included state mental hospitals, is clear from both the facts of the case and the statements made by the court.\textsuperscript{61}

The reasons advanced by the court to uphold the IMD exclusion

\begin{flushleft}
the IMD exclusion with respect to the Supplemental Security Income provisions within the Social Security Act); \textit{Legion v. Richardson}, 354 F. Supp. 456 (S.D.N.Y.), \textit{aff'd sub nom.} \textit{Legion v. Weinberger}, 414 U.S. 1058 (1973) (class action to enjoin the state defendants from refusing to apply for Medicaid funds to provide care and treatment for individuals aged twenty-two through sixty-four in state mental hospitals); \textit{see also} \textit{Cospito v. Heckler}, 742 F.2d 72, 83 (3d Cir. 1984) (upholding termination of Medicare, Medicaid, and Supplemental Social Security Income benefits of patients in a psychiatric hospital which had lost accreditation and certification); \textit{Kantrowitz v. Weinberger}, 530 F.2d 1034 (D.C. Cir. 1976) (statute denying payment for care or services to persons aged twenty-one through sixty-four, who were patients in institutions for mental disease, not irrational or unconstitutional).
\end{flushleft}
show the court only considered state mental hospitals in its decision. Thus, the reasoning of the court addressed the IMD exclusion only as the exclusion applied to state mental hospitals. No justification was shown for applying the IMD exclusion to private long-term care facilities.

The first reason given by the court was that “[a]t the time of the passage of . . . Medicaid, Congress had determined that advances made in treating mental patients were sufficient to indicate that many would soon be treated in facilities where more remedial benefits were available.” In other words, it was not necessary for the Medicaid Program to extend to individuals in state hospitals. These individuals would soon be treated in facilities that provided more advanced treatment and also qualified for benefits under the Medicaid Program or similar non-state funded programs.

Second, the court referred to “the belief by Congress that care of the mentally ill in state hospitals was the responsibility of the states.” Here, again, the court found justification for the IMD exclusion based on a consideration of state mental hospitals only. Since state mental hospitals are operated, governed, and financed by the state, it is easy to find justification for the states to retain responsibility for individuals within state facilities.

Later, in a 5-4 decision in Schweiker v. Wilson, the Supreme Court upheld the IMD exclusion under the rational basis test. The Schweiker Court overturned the lower court’s determination that the exclusion was unconstitutional. To support the IMD exclusion, the Court found an identifiable governmental objective in Congress’ need to limit federal spending under the Social Security Act. The Court also found that states have a “‘traditional’ responsibility to care for those institutionalized in public mental institutions.” The Court added that statutory classifications “[do] not offend the Constitution simply because the classification “is not made with mathematical nicety or because in practice it results in some inequity.”

On the surface, the Schweiker decision appears to strengthen and broaden Legion, and put an end to the issue of whether the IMD exclusions characterize America’s public mental institutions—America’s Willowbrooks.” Id. at 459 (emphasis added).

62. Id.
66. Id. at 238-39.
67. Id. at 256-37.
68. Id. at 234 (quoting Dandridge v. Williams, 397 U.S. 471, 485 (1972), quoting Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78 (1911)).
clusion is constitutional. There are, however, two reasons why the Schweiker ruling should not be the last word on the constitutionality of the IMD exclusion.

First, like the Legion court, the Schweiker Court did not focus on the current application of the IMD exclusion. Instead, like Legion, the Schweiker opinion focuses on public mental institutions. As stated by Justice Blackmun, "[T]he issue in this case is whether Congress constitutionally may decline to grant . . . benefits to a class of otherwise eligible individuals . . . in public mental institutions that do not receive Medicaid funds for their care."70

But even more significantly, the Schweiker Court analyzed the constitutionality of the IMD exclusion as the exclusion relates to Supplemental Security Income (SSI) Program benefits, rather than as the exclusion relates to Medicaid benefits.71 The SSI Program is an independent program under the Social Security Act which, in addition to other benefits, provides a small stipend to individuals in long-term care facilities who are eligible for the Medicaid Program.72 Consequently, individuals who were barred by the IMD exclusion from Medicaid eligibility were also barred from receiving the small stipend under the SSI Program.

The appellees in Schweiker were residents in a public mental institution who were denied benefits under the Medicaid Program because of the IMD exclusion.73 But, the appellees' challenge of the IMD exclusion was not focused on Medicaid benefits directly.74 Rather, the appellees challenged the IMD exclusion because the exclusion prevented them from receiving the stipend they would otherwise be entitled to under the SSI Program.75

Many of the issues and arguments regarding the IMD exclusion

69. The terms "public mental institution" and "state mental hospital" appear to be used interchangeably in Schweiker and Legion.
71. Id.
72. Id. at 224. The main benefit provided under the SSI Program is "a subsistence allowance . . . to the Nation's needy aged, blind, and disabled." Id. at 223 (quoting 42 U.S.C. § 1382c (1988)). In this case, however, only a small stipend, not to exceed $300 per month, was denied, not the subsistence allowance. Id. at 224.
73. Id. at 228 n.9 (defining the class in a previous class action of which the current plaintiffs were a part).
74. The Schweiker appellees most likely avoided a direct challenge to the IMD exclusion because of the recent decision in Legion v. Weinberger upholding the exclusion. See supra notes 59-64 and accompanying text.
75. Schweiker v. Wilson, 450 U.S. 221, 225 (1981). The Court, characterizing the appellees' position, said:

Appellees brought this suit to challenge . . . Congress' having conditioned the limited assistance grant on eligibility for Medicaid: a person between the ages of 21 through 64 who resides in a public mental institution is not eligible to receive this small stipend, even though that person meets the other eligibility requirements for SSI benefits, because treatment in a public
are the same under either the Medicaid or the SSI Programs. In fact, in the absence of any significant legislative history behind the SSI Program, the Schweiker Court even borrowed legislative history from the Medicaid Program to show the IMD classification was rationally related to a legitimate governmental objective under the SSI Program. The Court justified borrowing of the legislative history by finding that Congress intentionally piggy-backed the SSI Program eligibility requirements on those of the Medicaid Program.

Despite the similar application of the IMD exclusion in both the Medicaid and SSI Programs, the decision in Schweiker should not carry back to the IMD exclusion as it applies to Medicaid benefits. Even though the Court borrowed the Medicaid legislative history, and worked through an analytical framework that would also apply to the IMD exclusion under the Medicaid Program, the effects of the exclusion under the two programs are vastly different.

The effects the IMD exclusion has on individuals under the Medicaid Program are significantly more severe than the effects of the exclusion under the SSI Program. Under the Medicaid Program, the IMD exclusion bars individuals from receiving federal funds for medical and long-term care. Under the SSI Program, the IMD exclusion only bars individuals from receiving a small stipend. In the Schweiker opinion, Justice Blackmun supported the Court’s holding that the application of the IMD exclusion to the SSI Program is constitutional by stating that “[a]t the most, this legislation incidentally denies a small

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mental institution for a person in this age bracket is not funded under Medicaid.

Id. (footnote omitted).

76. See id. at 236-37. The Court noted that “[t]he Medicaid limitation was based on Congress’ assumption that the care of persons in public mental institutions was properly a responsibility of the States.” Id. at 237 n.19, (quoting H.R. Rep. No. 1300, 81st Cong., 1st Sess. 42 (1949)); S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, at 144-47 (1965).

77. See Schweiker, 450 U.S. at 235-37.

The limited nature of Medicaid eligibility did not pass unnoticed by the enacting Congress. In the same bill that established the SSI program, Congress considered, and passed, an amendment to Medicaid, providing coverage of inpatient services to a large number of the juvenile needy in public mental institutions. . . . This legislative history shows that Congress was aware . . . of the limitations in the Medicaid program that would restrict eligibility for the reduced SSI benefits; we decline to regard such deliberate action as the result of inadvertence or ignorance.

Id. at 235-36 (citations and footnote omitted). The provision which provides Medicaid coverage for minors is found at 42 U.S.C. § 1396a(a)(16) (1988). Coverage is provided for certain inpatient psychiatric hospital services rendered to persons under twenty-one years of age. Id. § 1396d(h)(1). “To be eligible . . . [such persons] must be receiving ‘active treatment’ that meets standards prescribed by the Secretary and that ‘can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary.’” Schweiker, 450 U.S. at 236 n.18 (quoting 42 U.S.C. § 1396d(h)(1)(B)).
monthly comfort benefit to a certain number of persons suffering from mental illness . . . .”

This variance of effect is a compelling reason to re-examine the constitutionality of the IMD exclusion with respect to the denial of Medicaid benefits.

b. Heightened Standard of Review

The appellees in Schweiker argued that the mentally ill should be considered a “suspect” or “quasi-suspect” class, entitled to a heightened standard of review. This standard of review would require the governmental body defending the legislative classification to prove that the classification is necessary to serve a compelling governmental interest. Under this standard of review, legislative classifications are rarely upheld.

The appellees in Schweiker argued that the review of the IMD exclusion should “be subjected to a heightened standard of review” because the mentally ill “historically have been subjected to purposeful unequal treatment; [because] they have been relegated to a position of political powerlessness; [because] prejudice against them curtails their participation in the pluralist political system and strips them of political protection against discriminatory legislation.” The Court in Schweiker, however, found “no occasion to reach this issue” because the express language of the statutory exclusion showed no direct impact based on the mental health classification. The Court found that the exclusion did not just single out mentally ill individuals. Rather, the Court found that the IMD exclusion imposes

78. Schweiker, 450 U.S. at 231 (emphasis added).
79. Id. at 230.
80. See, e.g., City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 440 (1985) (When statutes are written in a manner which classifies by race, alienage, or national origin, “these laws are subjected to strict scrutiny and will be sustained only if they are suitably tailored to serve a compelling state interest.”).
81. Schweiker, 450 U.S. at 230 (citation omitted).
82. Id. at 231. Specifically, the Court stated:

We have no occasion to reach this issue because we conclude that this statute does not classify directly on the basis of mental health. The SSI program distinguishes among three groups of persons, all of whom meet the basic eligibility requirements: persons not in a “public institution” may receive full benefits; persons in a “public institution” of a certain nature (“hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) . . . under [Medicaid]”) (emphasis added), may receive reduced benefits; and persons in any other “public institution” may not receive any benefits.

Id. (footnote and citation omitted).
equivalent deprivation to a group that only partially consists of mentally ill individuals, while at the same time, provides benefits to substantial numbers of mentally ill individuals outside the identified group.83

The Court's conclusion cannot be disputed. Under the current application of the IMD exclusion, all individuals between twenty-one and sixty-four years of age in IMDs fall within the exclusion, whether or not they are mentally ill. And some individuals with mental illness who have found placement in non-IMD Nursing Facilities (NFs) are receiving Medicaid benefits.

Although the IMD exclusion does not specifically and precisely target and affect only the mentally ill, this group is predominantly affected. Many facilities have been declared IMDs because fifty percent or more of their resident population consisted of individuals with mental illness. Thus, the group that is subsequently denied Medicaid benefits predominantly consists of individuals with mental illness.

This underinclusiveness appears to be intentional. By not including all individuals with mental illness, the exclusion has escaped the harsh scrutiny that would accompany a perfectly inclusive classification of all mentally ill. Instead the IMD exclusion targets a specific type of facility (IMDs), and allows federal funding for those mentally ill individuals who have found placement in non-IMD NFs. By setting forth the current IMD exclusion in this way, the HHS has avoided the long-term care expense of vast numbers of individuals with mental illness who live in IMDs.

The Court in Schweiker suggested that the heightened scrutiny issue could be further examined if there was evidence that the IMD classification imposed a disproportionate, direct impact on the class of mentally ill. This issue was dismissed, however, because the record did not present any statistical support.84 If the current application of the IMD exclusion had been brought before the Schweiker Court, and the constitutionality issue had been analyzed with respect

83. Id. "The group thus singled out for special treatment . . . does not entirely exclude the mentally ill. In fact, it includes, in a sizable proportion to the total population receiving SSI benefits, large numbers of mentally ill people." Id. (footnote omitted).

84. Schweiker, 450 U.S. at 234. The Court noted that appellees have failed to produce any evidence that the intent of Congress was to classify on the basis of mental health. Appellees admit that no such evidence exists; indeed, they rely on the absence of explicit intent as proof of Congress' "inattention" to their needs and, therefore, its prejudice against them. As in Jefferson v. Hackney, 406 U.S. 535 (1972), the indirect deprivation worked by this legislation upon appellees' class, whether or not the class is considered "suspect," does not without more move us to regard it with a heightened scrutiny. Id. at 233-34 (citation omitted).
to the denial of Medicaid benefits rather than SSI benefits, the outcome would surely have been different. Today, the record could easily be filled with enough statistical support for the Court to find a disproportionate and direct impact on the mentally ill.85

A later decision by the Supreme Court in City of Cleburne v. Cleburne Living Center86 appears to have closed the door that was left partially open in Schweiker, that the mentally ill could possibly be considered a “suspect” or “quasi-suspect” class. The Court in Cleburne advanced several reasons for overturning a lower court decision that declared the class of the mentally retarded as a suspect class.87 Explaining

85. See supra notes 47-51 and accompanying text (current statistics showing the impact the IMD exclusion currently has on the mentally ill).

86. City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985). In July 1980, co-respondent Jan Hannah purchased a building in Cleburne, Texas. Cleburne Living Center, Inc. (CLC) intended to lease this building from Hannah and use it as a group home for the mentally retarded. The home was to provide housing for thirteen mentally retarded men and women, with CLC staff members providing constant supervision. Id. at 435.

The city of Cleburne informed CLC that the home was classified as a hospital for the feeble-minded and that under the zoning regulations applicable to the desired site, a special use permit was required to run the home. CLC applied for the permit. Following a public hearing, the city council voted down CLC’s application by a three-to-one vote. Id. at 436-37.

CLC filed a suit in federal district court against the city and a number of its officials, claiming that the zoning ordinance discriminated against the mentally retarded in violation of the equal protection rights of CLC and its residents, and that the ordinance was invalid on its face and as applied. The district court, employing the minimum level of judicial scrutiny, held the ordinance and its application constitutional. The court concluded that no fundamental right was implicated and that mental retardation was neither a suspect nor a quasi-suspect classification. Id. at 437.

CLC appealed and the Court of Appeals for the Fifth Circuit reversed, finding the city ordinance invalid as applied. The court, applying an intermediate level of scrutiny test, held that the ordinance was invalid on its face because it did not substantially further any important governmental interest. Id. at 437-38. See also City of Cleburne v. Cleburne Living Center, Inc., 726 F.2d 191 (5th Cir. 1984).

87. One point which must be emphasized is that the “mentally retarded” are considered separate from “other groups,” such as the “mentally ill.” See Cleburne, 473 U.S. at 445-46.

Generally, where a group of individuals affected by a law have distinguishing characteristics relevant to the interests of the state, courts have been reluctant to closely scrutinize legislative action. Legislatures at the national and state level should be free to decide whether, how, and to what extent those interests should be pursued. Id. at 441-42.

Specific reasons given by the Court were:

(1) Those who are mentally retarded have a reduced ability to cope with the daily requirements of life. The state interest in dealing with and providing for these individuals is a legitimate one. Id. at 442.

(2) There has been significant legislative response to the problems of the mentally retarded. Therefore, there is no apparent need to classify the mentally retarded as a suspect class, requiring intrusive oversight by the judiciary. Id. at 443-45.
that the treatment of the mentally retarded is a difficult and technical matter that must be left to the legislature, the Court concluded:

[I]f the large and amorphous class of the mentally retarded were deemed quasi-suspect . . . , it would be difficult to find a principled way to distinguish a variety of other groups who have perhaps immutable disabilities setting them off from others, who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large. One need mention in this respect only the aging, the disabled, the mentally ill, and the infirm. We are reluctant to set out on that course, and we decline to do so.88

After refusing to acknowledge the mentally retarded (and the mentally ill) as even a quasi-suspect class subject to a “middle level scrutiny,” the Court in Cleburne stated that the class is not left “unprotected from invidious discrimination.”89 The Court stressed that “[t]o withstand equal protection review, legislation that distinguishes between the mentally retarded and others must be rationally related to a legitimate governmental purpose.”90 The Court subsequently returned a rare decision under the rational basis test, striking down the zoning ordinance at issue as unconstitutional.91

There has been much discussion over whether the Court in Cleburne applied the rational basis test or a heightened standard of review.92 Although the Court examined four different reasons provided by the Council to uphold the ordinance,93 the majority did not

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88. Id. at 445-46 (emphasis added).
89. Id. at 446.
90. Id.
91. In striking down the ordinance, the Court noted that the city did not require special use permits for apartments, multiple dwellings, hospitals, sanitariums, or nursing homes in the same or similarly classified zones. By requiring CLC to obtain a special use permit, the city of Cleburne was depriving CLC of equal protection of the laws. For that reason the Court did not decide whether Cleburne “may never insist on a special use permit for a home for the mentally retarded” in the zone types in question; that is, the Court did not decide whether the ordinance was facially invalid when mentally retarded individuals are involved. Id. at 447-48.
92. Justice Marshall disagreed with the majority’s as-applied method of reaching its conclusion. He found that, in spite of the invalidation of the ordinance on rational basis grounds, the ordinance should be subject to “the sort of probing inquiry associated with heightened scrutiny.” Id. at 458. See also infra note 96.
93. The four reasons given by the council were:

(1) The majority of property owners within 200 feet of the home had a negative
find any of these reasons to be rationally related to a legitimate governmental purpose. According to the dissent in Cleburne, the majority applied a heightened level of review under the rational basis test. The dissent explained that "Cleburne's ordinance surely would be valid under the traditional rational basis test applicable to economic and commercial regulation."

In a concurring opinion, Justice Stevens also addressed problems with the manner in which the Court defined the two standards of review in equal protection cases. He suggested that the "rational basis" test and the "strict scrutiny" test are extremes that do not adequately explain the decisional process.

In my own approach to these cases, I have always asked myself whether I could find a "rational basis" for the classification at issue. . . . In every equal protection case, we have to ask certain basic questions. What class is harmed by the legislation, and has it been subjected to a "tradition of disfavor" by our laws? What is the public purpose that is being served by the law? What is the characteristic of the disadvantaged class that justifies the disparate treatment?

Perhaps if the constitutionality of the IMD exclusion was brought before the Court today (in the heat of the IMD controversy, as more and more facilities are being classified as IMDS), the Court would consider some of the questions posed in Justice Stevens' concurrence. Like the decision in Cleburne, the governmental objectives behind the IMD exclusion perhaps would not be considered legitimate enough to allow such adverse effects on the mentally ill.

In summary, the constitutionality of the current IMD exclusion is

attitude about the home. In addition, elderly residents in the area were afraid to have mentally retarded people living in their neighborhood. Id. at 448.
(2) The facility was located across the street from a junior high school and students of that school might harass residents of the home. Id. at 449.
(3) The house was located on a flood plain. Id.
(4) The house was too small to accommodate the proposed number of residents. Id. at 449-50.

94. Id. at 448.
95. Id. at 455 (Marshall, J., concurring in part, dissenting in part).
96. Justice Marshall explained that a "heightened scrutiny or 'second order' rational basis review, is a method of approaching certain classifications skeptically, with judgment suspended until the facts are in and the evidence considered." Id. at 471-72. Under this level of scrutiny, courts will not intrude on the legislative process. But, where there has been prejudice in the past and the threat remains, heightened scrutiny is appropriate. Id. at 472. According to Justice Marshall, the as-applied method used by the majority left the city of Cleburne without sufficient guidance to decide to whom the ordinance should be applied. Id. at 474.
97. Id. at 456.
98. Id. at 451 (Stevens, J., concurring).
99. Id.
100. Id. at 452-53.
unresolved. Although the Supreme Court upheld the classification under the rational basis test,\textsuperscript{101} the \textit{Schweiker} Court did not examine the exclusion in its current context. Instead, the holding focused on the IMD exclusion as it relates to public/state mental hospitals and nominal SSI benefits. The Supreme Court has not addressed the constitutionality of the IMD exclusion in its current context as it affects the residents of many private long-term care facilities.

Additionally, \textit{Schweiker} analyzed the constitutionality issue with respect to the effects on beneficiaries of the SSI Program. The reasons and statistics given to support the exclusion were directly related to nominal benefits under the SSI Program, rather than the substantial long-term care benefits provided under the Medicaid Program. Finally, even though the IMD exclusion has been upheld in these cases, each court expressed support for the opposing view. The Court in \textit{Schweiker} expressed disapproval of Congress' IMD exclusion. In reference to the rational basis test, the Court stated that the test "does not allow us to substitute our personal notions of good public policy for those of Congress."\textsuperscript{102} The Court went on to say that "we must disregard the existence of other methods of allocation that we, as individuals, perhaps would have preferred."\textsuperscript{103}

The district court in \textit{Legion v. Richardson} also explained:

In holding as we do, we are not unsympathetic to plaintiffs' allegations that the mentally ill have not received adequate care, nor are we blind to the deplorable conditions that characterize America's public mental institutions. . . . But confronted with a naked constitutional issue we are unable to afford plaintiffs the only remedy available—a declaration that the challenged legislation is unconstitutional.\textsuperscript{104}

The court concluded with a rare expression of appreciation to the attorney for the mentally ill in this case "for his devoted efforts to attempt to benefit a class of individuals who seem clearly to be in need of assistance."\textsuperscript{105}

2. Mutually Exclusive Classifications

An alternative position adopted in opposition to the IMD exclusion...
sion is that the IMD classification and the other Medicaid facility classifications are mutually exclusive. This means that a private facility that is already licensed as a Nursing Facility (NF) (previously, Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF)) should not also be classified as an IMD.106

In 1985, the Supreme Court in Connecticut Department of Income Maintenance v. Heckler reviewed the mutual exclusivity issue to resolve “[t]he square conflict on an important question of statutory construction” between the Eighth and Second Circuit Courts of Appeals.107 The Court supported the Second Circuit decision, and held that the two terms “IMD” and “ICF” in the Medicaid Program were not mutually exclusive, and therefore, an ICF might also be classified as an IMD.108 The Court supported this conclusion by stating that “[t]he thrice-repeated [IMD] exclusion demonstrates that Congress did not intend the ICF and IMD categories to be mutually exclusive; if Congress had intended separate categories, the IMD exclusion from services in other types of facilities would be unnecessary and illogical.”109

The Court’s mutual exclusivity analysis was, however, incomplete. In determining the scope and definition of the term “IMD,” the

106. Prior to the introduction of the NF classification in October 1990, the IMD exclusion was entirely separate from the ICF and SNF statutory definitions. An IMD was defined in 42 U.S.C. § 1396d(i) (1988) and set out as exclusionary at 42 U.S.C. § 1396d(a) (1988). For specific statutory language, see supra notes 31 and 33. The NF definition, however, includes one phrase that brings a portion of the IMD definition within the NF definition with an exclusionary effect. The definition limits qualifying NF facilities to those which are “not primarily for the care and treatment of mental diseases.” 42 U.S.C. § 1396r(a)(1) (1988). This language is similar to language contained in the definition of an IMD. See id. § 1396d(i). Although the mutually exclusive argument may be somewhat weakened by the inclusion of the IMD language in the NF definition, the argument is nevertheless relevant because the NF definition also includes the ICF and SNF definitions. For the definition of NF, see supra note 21.

107. Connecticut Dep’t of Income Maintenance v. Heckler, 471 U.S. 524, 528 (1985). The state of Connecticut maintained that Medicaid should be available to mentally ill persons in ICFs since the intent of the statute was to exclude only public mental hospitals. The state supported its position by stating that the distinction was “designed to encourage the placement of mental patients in ICF’s, an alternative and favored type of facility.” Connecticut Dep’t of Income Maintenance v. Heckler, 731 F.2d 1052, 1056 (2d Cir. 1984), aff’d, 471 U.S. 524 (1985). Connecticut argued that Congress was concerned about funding certain types of facilities, and was not concerned about limiting funding based on the individual’s diagnosis. Id.

108. Connecticut Dep’t of Income Maintenance, 471 U.S. at 537, 538.

109. Id. at 529. The Court further noted that other provisions of the Act clearly establish that services performed for the mentally ill may be covered if performed in a hospital, SNF, or an ICF that is not an IMD. Id.

While the Court did not explicitly address the mutual exclusivity issue in relation to SNFs, its analysis would appear to also extend to the old SNF classification. See, e.g., 42 U.S.C. § 1396d(a)(4)(A) (Supp. V 1975).
Court incorrectly restricted its analysis to the statutory and regulatory provisions surrounding the IMD exclusion, without examining the U.S. Department of Health and Human Services (HHS) interpretive IMD guidelines.\textsuperscript{110}

The IMD guidelines are the very life of the IMD exclusion and provide the most specific definition. These guidelines provide the only detailed and practical definition of an IMD, and are the basis for IMD classifications. Therefore, the Court's analysis of the IMD exclusion was incomplete without examining the HHS interpretive IMD guidelines.

In contrast, the Eighth Circuit Court of Appeals, in \textit{Minnesota v. Heckler},\textsuperscript{111} did include the interpretive IMD guidelines as part of its analysis of the proper use of the IMD classification and arrived at the conclusion that the ICF and IMD classifications were mutually exclusive.\textsuperscript{112} Although the court refrained from specifically stating that an ICF could never be classified as an IMD, the court's analysis and conclusions support the position that the two classifications were intended to be mutually exclusive.

\textsuperscript{110} The HHS guidelines were recently amended. At the time of \textit{Minnesota v. Heckler}, \textit{718 F.2d 852} (8th Cir. 1983), however, the guidelines were as follows:

1. A facility is licensed as a mental institution;
2. It advertises as a mental institution;
3. More than 50 percent of the patients have a disability in mental functioning [as defined in the \textit{International Classification of Diseases}];
4. It concentrates on managing patients with behavior or functional disorders and is used largely by mental hospitals for alternative care;
5. It is under the jurisdiction of the mental health authority;
6. It is frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them;
7. The facility is in proximity to a State Mental Institution (for example, within a 25-mile radius);
8. The age distribution is uncharacteristic of nursing home patients;
and
9. The basis of Medicaid eligibility for patients under 65 is a mental disability.

\textit{Id.} at 862 (citing a Departmental "intra-office instructional bulletin[] to assist federal field office personnel in their determinations as to the 'overall character' of a facility"). For the text of the new guidelines, see \textit{supra} note 42.

\textsuperscript{111} \textit{Id.} at 852 (8th Cir. 1983). There, the State of Minnesota brought suit against Margaret M. Heckler, Secretary of the HHS, contesting Heckler's decision to disallow federal financial participation to three Minnesota community residential facilities under the Medicaid Program. Heckler had decided that the facilities were IMDs and thus did not qualify for partial reimbursement by Medicaid. \textit{Id.} at 855.

The court concluded that the HHS acted contrary to statutory provisions by classifying the three facilities as IMDs. The court held that an IMD is distinguished from an ICF by the degree of care and treatment required by the mental and physical conditions of the patients in the facility, not the mere presence of patients diagnosed with a mental disability. \textit{Id.} at 866.

\textsuperscript{112} \textit{Id.} at 861-62; see also \textit{supra} note 110 and accompanying text.
First, the Eighth Circuit found that the statutory definition of an ICF supplies manifest clarification not only of what an ICF is, but more importantly . . . , how an IMD is and is not to be exclusively characterized. The ICF definition expressly authorizes care of patients in an ICF with diagnoses of either ‘mental or physical condition[s]’ as long as the illnesses involved ‘require’ a lesser ‘degree of care and treatment’ than a hospital or SNF provides.\(^{113}\)

This definition alone rebuts the contention of HHS that an ICF can be labeled an IMD merely because mentally ill individuals are present in the facility.

Further, the Eighth Circuit examined the legislative history behind ICF coverage under the Medicaid Program. The court found that ICF coverage was added in 1971 for individuals who would otherwise require placement in a mental hospital or skilled nursing facility.\(^{114}\) Therefore, applying the IMD exclusion to ICFs, “negates a portion of the statute by encroaching upon the intended role Congress determined intermediate care facilities were designed to serve.” \(^{115}\)

In the absence of a statutory definition of an IMD, the Eighth Cir-

\(^{113}\) Minnesota v. Heckler, 718 F.2d at 863. The court noted that “many persons within an ICF may be deaf or blind or have other physical ailments in conjunction with associated mental problems.” \(Id.\) at 863 n.20. In comparison, the court cited an earlier Eighth Circuit opinion suggesting that statutory limitations for IMDs “do not apply to mental health problems in general.” \(Id.\) (quoting Pinneke v. Preisser, 625 F.2d 546, 550 (8th Cir. 1980)). This ICF definition has been incorporated, almost verbatim, into the NF statutory definition, and thus remains an issue today. The exact language of the NF definition includes:

[T]he term “nursing facility” means an institution . . . which . . . is primarily engaged in providing to residents . . . on a regular basis, health-related care and services to individuals 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. § 1396r(a)(1) (1988). The NF definition, however, also includes the IMD exclusion, by adding language excluding facilities which are “primarily for the care and treatment of mental diseases.” \(Id.\)

\(^{114}\) Minnesota v. Heckler, 718 F.2d at 864. See also 117 CONG. REC. 44,721 (1971) (Statement of Senator Long citing Report of Senate Finance Committee). The committee report indicated that the intent of the statute was to assure that each category of patient was properly placed. In addition, Congress intended to “provide a less costly institutional alternative” than “skilled nursing home care” for those who did not need the services provided thereunder. \(Id.\)

\(^{115}\) Minnesota v. Heckler, 718 F.2d at 865. The court also noted the flaws inherent in the HHS guidelines. Basically, the criteria do not indicate the nature of services being furnished by the facility. In addition, “enforcement [of the guidelines] may provide an undesirable incentive for substitution of nonpsychiatric diagnoses and transfer of patients to avoid reaching guideline percentile.” \(Id.\) at 865 n.25 (quoting discussion paper titled “Redefinition on Institution of Mental Diseases”).
cuit continued its analysis by examining the regulatory definition. At that time, the federal regulations defined an IMD as an institution primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Unless the “overall character” test in the federal regulation refers only to a heightened degree of mental health care and services not ordinarily provided in an ICF, this regulatory definition encroached upon the statutory definition of an ICF. Since the statutory definition of an ICF at that time allowed Medicaid payment for individuals “who because of their mental or physical condition require care and services which can be made available to them only through institutional facilities,” federal regulations which render a facility an IMD merely because it provides such allowable services would undercut the statutory definition of an ICF.

Next, the court examined the IMD guidelines employed by the HHS to determine whether a facility’s overall character is that of an IMD. The court found that the HHS “acted contrary to statutory provisions and congressional intent when . . . it employed criteria chiefly focusing on the mere presence in each facility of patients with diagnoses of a mental disability.” The court held that the “cardinal gauge by which to distinguish IMDs and ICFs must be the degree of care and treatment required by the mental or physical conditions of patients at any given facility.” The court also suggested that the ICF, SNF, and IMD categories should designate the degree of care and treatment available within facilities, and that the HHS should be able to use patient admission and review standards to ensure proper patient placement within facilities.

Finally, the court examined the legislative history behind the enactment of the IMD exclusion. The initial reason for the IMD exclu-

117. The regulations do not specifically define an ICF. See supra note 18 for the definition of a resident of an ICF prior to the changes effective October 1990.
119. Id.
120. See Minnesota v. Heckler, 718 F.2d 852, 862 (8th Cir. 1983).
121. Id. at 866.
122. Id.
123. The emphasis on the degree of care, in theory, would eliminate the concern of the HHS that Medicaid benefits not be provided to IMD facilities that do not provide the level of care required by a patient’s mental diagnosis. See id. at 866 n.27.
sion was that "‘long-term care in such hospitals had traditionally been accepted as a responsibility of the States.’"124 This language indicates that the IMD exclusion was intended to only exclude state mental hospitals.

Unfortunately, the Supreme Court in Connecticut Department of Income Maintenance125 never reached the critical issues that were drawn out by the Eighth Circuit Court in Minnesota v. Heckler.126 While the Supreme Court employed an independent standard of review during its statutory analysis of the IMD exclusion, the Court changed its scope of review when it analyzed the HHS regulations and guidelines.127 The Court stated that "the agency's construction need not be the only reasonable one in order to gain judicial approval," and approved the HHS regulations without analysis.128

The Court also cited the Social Security Act as support for this decision, stating, "The Act expressly provides the Secretary with authority to ‘make and publish such rules and regulations, not inconsistent with’ the Act ‘as may be necessary [for the Act’s] efficient administration.’"129 The Court concluded, without analysis, that "the Secretary’s interpretation of ‘institution for mental diseases’ comports with the plain language of the statute," and upheld the de-

124. Id. at 863 (quoting Schweiker v. Wilson, 450 U.S. 221, 237 n.19 (1981)) (emphasis added).
127. Connecticut Dep’t of Income Maintenance, 471 U.S. at 532.
128. Id.

The Supreme Court did, however, briefly discuss the state’s second contention, but found such contention without merit. The state argued that disallowance undermined the cooperative federalism concept on which public assistance programs are based. The Court agreed that the general policy of federal-state cooperation favors a liberal interpretation of the eligibility provisions of the Act. Nevertheless, the Court felt that disallowance was necessary to "respect the apparent limits that Congress ha[d] placed on its own decision to fund the implementation of sound policy." Id. at 532 n.22.

129. Id. at 530 n.16 (quoting 42 U.S.C. § 1302).

In Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), the Supreme Court upheld the Environmental Protection Agency's interpretation of the phrase "stationary source" within the Clean Air Act Amendments of 1970. In doing so, the Court stated that the Court had long recognized that considerable weight should be given to an executive department's construction of a statute. The Court went on to state that

the principle of deference to administrative interpretations "has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations."

Id. at 844 (quoting United States v. Shimer, 367 U.S. 374, 382 (1961)).
cision of the Second Circuit.\textsuperscript{130}

The Supreme Court also incorrectly concluded that "it is perfectly clear that hospitals, skilled nursing facilities, and intermediate care facilities are not ineligible [under Medicaid] simply because they provide care and treatment for mentally ill patients."\textsuperscript{131} A simple reading of the guidelines shows that this conclusion is unfounded. The guidelines expressly exclude facilities from the Medicaid Program that provide care and treatment for mentally ill patients if fifty percent of the resident population consists of mentally ill individuals.\textsuperscript{132} If the Court would have followed the Eighth Circuit in employing an independent standard of review of the HHS guidelines, and would have examined the guidelines, rather than giving deference to the HHS, the Court could not have reached this conclusion.

The Supreme Court's decision in \textit{Connecticut Department of Income Maintenance} also conflicts with prior reasoning relied upon in \textit{Schweiker} to render the IMD exclusion constitutional. In \textit{Schweiker},\textsuperscript{133} the Court relied on the premise that the statutory IMD exclusion "does not classify directly on the basis of mental health."\textsuperscript{134} On the

\textsuperscript{130.} \textit{Connecticut Dep't of Income Maintenance}, 471 U.S. at 538. The Court only referenced the regulations by stating that "there was ample evidence for the review team's conclusion that Middletown was 'primarily engaged' in providing diagnostic treatment and care for persons with mental diseases within the meaning of the applicable regulations." \textit{Id.} at 526-27. The Court set forth the HHS criteria:

The Secretary has developed criteria designed to focus on what constitutes "primarily engaged" and "overall character." The review team utilized the following criteria when evaluating Middletown Haven:

1. That a facility is licensed as a mental institution;
2. That it advertises or holds itself out as a mental institution;
3. That more than 50\% of the patients have a disability in mental functioning;
4. That it is used by mental hospitals for alternative care;
5. That patients who may have entered a mental hospital are accepted directly from the community;
6. That the facility is in proximity to a state mental institution (within a 25-mile radius);
7. That the age distribution is uncharacteristic of nursing home patients;
8. That the basis of Medicaid eligibility for patients under 65 is due to a mental disability, exclusive of services in an institution for mental disease;
9. That the facility hires staff specialized in the care of the mentally ill; and
10. That independent professional reviews conducted by state teams report a preponderance of mental patients in the facility.

\textit{Id.} at 527 n.5; \textit{see also Review of Nursing Facilities, supra} note 42, at 7-8 (guidelines used by the Minnesota Department of Human Services).

\textsuperscript{131.} \textit{Connecticut Dep't of Income Maintenance}, 471 U.S. at 536. This conclusion was based upon the Court's interpretation of the legislative history of the IMD exclusion. \textit{Id.}

\textsuperscript{132.} \textit{See supra} note 130.

\textsuperscript{133.} Schweiker v. Wilson, 450 U.S. 221, 231 (1980).

\textsuperscript{134.} \textit{Id.} at 231. The conclusion here was based upon the Court's reasoning that the statute did not isolate the mentally ill, or subject the mentally ill to special or subordinate treatment. At the most, the Court stated, the statute denied "a small
contrary, the holding of the Second Circuit specifically states that "the IMD exclusion virtually compels [the HHS to employ guidelines which] focus on the nature of the illnesses treated rather than the care furnished." 135

In conclusion, the Court's avoidance of the underlying issues in Connecticut Department of Income Maintenance resulted in a decision that was very unfavorable for the mentally ill. By avoiding an analysis of the interpretive IMD guidelines, the Court conveniently avoided criticism from both the legislative and executive branches of government that would result from a decision finding the IMD classification and the other Medicaid facility classifications mutually exclusive. By the Court's own admission, the state, representing the mentally ill, "persuasively argued that its position represent[ed] sound and enlightened policy." 136 A more in depth analysis of the interpretive IMD guidelines would most likely have caused the Court to overturn Congress' and the HHS longstanding position that the IMD exclusion may apply to ICFs and SNFs.

3. Improper Guidelines

A third, alternative argument against the IMD exclusion is that the HHS internal interpretive IMD guidelines, used to determine whether a facility should be classified as an IMD, are excessively broad. Consequently, the guidelines should be changed so that facilities are classified as IMDs only if they provide a specialized degree of mental health services. While this argument recognizes that such a revision may still bar some Nursing Facility (NF) residents from receiving Medicaid, these changes would reduce the number of facilities that fall within the IMD exclusion.

The current guidelines consist of ten criteria 137 to determine whether a facility should be declared an IMD. Auditors use these guidelines to determine whether the "overall character" of a facility is "established and maintained primarily for the care and treatment of individuals with mental diseases." 138 While it has been determined that the satisfaction of a single criterion is not enough to de-


136. Connecticut Dep't of Income Maintenance v. Heckler, 471 U.S. 524, 537 (1985). The Court went on to say that the state had not, however, "established that Congress ha[d] only excluded 'hospitals' in which a mental illness [was] treated instead of 'institutions for mental diseases.' " Id. at 537-38.

137. See supra notes 42 and 130 (current Minnesota Department of Human Services and HHS guidelines).

clare a facility an IMD, neither the HHS nor the courts have specified how many of the criteria are required.

An audit team review guide was prepared by the Health Care Financing Administration in April 1987 to advise auditors how to collect data to meet the "overall character" test. To ensure that the overall character test is met, this review guide instructs auditors that "[i]t is essential that you evaluate the applicability of each criterion for each facility reviewed. You must support as many of these criteria as possible with as much supporting documentation as possible." The ten IMD guidelines can be split into two main categories: one that focuses on the profile of the resident population within a facility, and one that focuses on the type of services provided within a facility. The category of guidelines that focuses on the profile of the patient population within a facility has received the most scrutiny. Guideline number eight focuses on a "preponderance of mental illness in the diagnoses of the patients in the facility," guideline number four focuses on the "proportion of the patients [that] are receiving psychopharmacological drugs," and guideline number

139. Granville House, Inc. v. Department of Health & Human Servs., 715 F.2d 1292 (8th Cir. 1983). The circuit court held that satisfaction of one criterion would not necessarily be enough to declare a facility an IMD and remanded the case to the district court. Id. at 1304.

140. See Title XIX Financial Management Review Guide, supra note 42. The agency set out in the introduction that the guide is designed to provide specific instructions on performing a financial management review of facilities which may be institutions for mental diseases (IMDs). As such, this guide reflects current law, legislations, policy, Grant Appeals Board (GAB) decisions, and various court decisions on this subject as referenced in Section II. The methods and procedures detailed in this guide are a compilation of those that have been successfully employed in the past in various regional office financial management reviews and Office of the Inspector General Audit Agency audits of IMDs.

Id. at 1.

141. Id. at 8 (emphasis in original). The purpose behind the supporting documentation requirement is that no one criterion is sufficient by itself to classify an institution. Consistent with this idea, recent decisions have evaluated IMD determinations on the basis of the variety and sufficiency of the evidence presented to support the determination. Id. at 7-8; see also supra note 139 and accompanying text.

In general, the methodologies used to support certain criteria have been and likely will continue to be closely scrutinized by the states. Title XIX Financial Management Review Guide, supra note 42, at 8.

142. Id.

143. Id. at 11. The eighth guideline requires that an auditor carefully review the appropriate Independent Professional Review reports to determine if there is an indication of a preponderance of mentally ill patients in the facility under review. If this criterion is carefully and adequately supported, it may carry great weight by providing an unbiased corroboration of patient statistics. Id.; see also Review of Nursing Facilities, supra note 42, at 8 (guideline number eight) and note 130 (guideline number ten).

144. Title XIX Financial Management Review Guide, supra note 42, at 12. The
six focuses on whether "more than 50% of all the patients in the facility have mental diseases which require inpatient treatment according to the patients' medical records" (commonly known as the 51% rule).145

While the Supreme Court has never directly analyzed any of these criteria, the 51% rule was under close scrutiny in Minnesota v. Heckler.146 The court in Minnesota v. Heckler held that the "cardinal gauge by which to distinguish IMDs and ICFs must be the degree of care and treatment required by the mental or physical conditions of patients residing at any given facility," as opposed to the "mere presence" of mentally ill patients.147

The court in Minnesota v. Heckler found the 51% rule to be in direct conflict with the statutory definition of an ICF.148 The court stated that the statute "expressly authorizes care of patients in an ICF with diagnoses of either 'mental or physical condition[s]' as long as the illnesses involved 'require' a lesser 'degree of care and treatment' than a hospital or SNF provides."149 Therefore, the 51% rule conflicted with the ICF definition that authorized care for patients with mental conditions.

Additionally, the 51% rule conflicts with the Supreme Court's holding in Schweiker. The Court in Schweiker upheld the constitutionality of the IMD exclusion by relying on the premise that the IMD exclusion does not directly target individuals with mental illness, but focuses on the type of institution providing the care.150

The obvious problem with these guidelines is that they "seek out" mentally ill individuals who have already met a facility's admission requirements. These guidelines show that the IMD exclusion applies directly to mentally ill individuals. If, as these guidelines indicate, the IMD exclusion hinges on the mere presence of large numbers of mentally ill individuals, then the IMD exclusion does, in fact, discriminate directly against the class of the mentally ill.

Another problem with the 51% rule is that the rule does not re-

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fourth guideline requires the auditor to evaluate the patient's treatment process in order to determine if that treatment is focused on a mental or physical illness and thus, in turn, establish whether a facility provides psychiatric/psychological treatment. Id.; see also REVIEW OF NURSING FACILITIES, supra note 42, at 7 (guideline number four).

145. TITLE XIX FINANCIAL MANAGEMENT Review Guide, supra note 42, at 14. In applying the sixth guideline, the reviewers must determine whether the patient's current need for institutionalization results from a mental disease. Id.; see also REVIEW OF NURSING FACILITIES, supra note 42, at 8 (guideline number six).

146. 718 F.2d 852 (8th Cir. 1982).
147. Id. at 866.
148. Id. at 862.
149. Id. at 863.
quire a patient to have a primary diagnosis of mental illness to be included in the fifty-one percent.151 The rule only requires a secondary diagnosis or a history of mental illness in any patient. This means that patients admitted for physical problems will be counted toward the fifty-one percent if they have either a prior history of mental illness or a secondary diagnosis of mental illness.152

A change in the HHS internal interpretive guidelines to eliminate the criteria that focus on the presence of mentally ill within long-term care facilities would accomplish three things. First, such a change would extinguish the valid argument, that was presented by the Eighth Circuit in Minnesota v. Heckler and ignored by the Supreme Court, that the IMD exclusion cuts across the statutory definitions of the ICF and SNF classifications (now NF). Second, this change would reduce the number of facilities that are classified as IMDs, and finally, it would reduce the impact of the IMD exclusion on the class of mentally ill.

But even if the guidelines were changed to eliminate the criteria that focus on the presence of mentally ill individuals, the remaining criteria that focus on the type of services provided would continue to reduce the quality of life for all residents who live in NFs.153 For example, guideline number four that focuses on whether a facility’s "staff has specialized psychiatric/psychological training"154 and whether "a large portion of the patients are receiving psychopharmacological drugs,"155 flies in the face of the statutory requirement that NFs "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ."156

If facilities are so penalized for hiring staff with such training, or for administering the proper psychopharmacological drugs, the obvious effect will be to discourage facilities from providing these services. In discontinuing mental health services and appropriate drug treatment to avoid the IMD exclusion, the quality of life of all NF residents will necessarily be diminished.

151. Id. See also Review of Nursing Facilities supra note 42, at 8 (guideline number six).
152. Minnesota v. Heckler, 718 F.2d at 863.
153. Nursing Facilities are required by statute to "care for . . . residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." 42 U.S.C. § 1396r(b)(1)(A) (1988).
154. See Review of Nursing Facilities, supra note 42, at 7 (guideline number four).
155. Id.
156. 42 U.S.C. § 1396r(b)(2) (1988) (requirements relating to "quality of life" which NFs must promote).
III. THE RESPONSE OF THE STATE OF MINNESOTA

In response to the current federal IMD policies, the Minnesota Department of Human Services has set out recommendations for IMD facilities. These recommendations, intended to "alleviate the adverse financial and service ramifications of the federal government's IMD policies," directly affect alternatives for individuals with mental illness with respect to placement and services.

Many of the state's recommendations encourage facilities to change the characteristics and/or resident populations of the facility to avoid the IMD classification. These recommendations, together with the uncertainty of state funds, provide a great incentive for private facilities to make the changes necessary to avoid the IMD classification, and ensure payment under Medicaid. As facilities work to avoid the IMD classification, there will be fewer alternatives for the mentally ill.

IV. PROPOSAL

The IMD exclusion within the Medicaid Program is currently under review by the United States Health Care Financing Administration (HCFA). This review, mandated by Congress, requires the Secretary of Health and Human Services to conduct a study of the IMD exclusion, and to release that study to Congress on October 1, 1990. The report has been delayed, however, and is not expected

157. These recommendations include the following:
- Require all NF/IMDs to maintain current diagnostic assessments on file for all residents.
- Encourage downsizing to non-IMD status where feasible [16 beds or less].
- Encourage movement toward serving a more physically disabled population where feasible.
- Provide continuing information to facilities and counties on the types of individuals who can and cannot be served in NF/IMDs and on the resources available to assist facilities in meeting resident needs.
- Re-evaluate the IMD status of the NF/IMDs at logical points and "undeclare" facilities as IMDs if appropriate.
- Revise the state's NF level-of-care criteria to further prevent admission or retention of individuals who have primary MI [Mental Illness] disabilities.
- Advocate at the federal level for changes in IMD policy.

ReVIEW OF NURSING FACILITIES, supra note 42, at 65-71 (emphasis added).

158. Id. at vii.

159. For recommendations from REVIEW OF NURSING FACILITIES, see supra note 157.

160. Minnesota county representatives have observed that few service alternatives exist for mentally ill residents at this time. See REVIEW OF NURSING FACILITIES, supra note 42, at 58.

If the current IMDs are able to avoid the classification in the future, there will be a much higher demand for other types of community living arrangements and psychiatric hospitals/facilities not certified under the Medicaid Program (state funded).

161. Congress provided the following:
to be completed until much later, in spring of 1991.\footnote{Telephone interview with Jeff Buck, Analyst in the Office of Research and Demonstrations, Health Care Financing Agency (Nov. 4, 1990). The report on IMDs was not completed by the October 1, 1990, date mandated by Congress. HCFA is currently working on the report, and expects the report to be completed by early- to mid-1991. Because the IMD exclusion has been in the Medicaid provisions since 1965, and because repeal of the exclusion would cost the federal government billions of dollars, the study is not likely to recommend repeal of the IMD exclusion. \textit{Id.; see also supra note 161} (statute mandating report).} Given the longstanding congressional support of the IMD exclusion, and the additional costs the federal government would incur if the IMD exclusion were repealed, the conclusions of the study are likely to support continued retention of the IMD exclusion.\footnote{See supra note 162.}

To counter these unfavorable conclusions, strong arguments must be made to Congress for the elimination or modification of the IMD exclusion. Legislation should be drafted in response to the study to support the three alternative arguments stated previously in this article:

(1) the IMD exclusion should be repealed;
(2) the Medicaid classifications should be mutually exclusive; and,
(3) the IMD interpretive guidelines are improper and should be changed to focus only on facilities that provide a specialized level of mental health services.

The congressional mandate provides a unique opportunity to argue for the repeal or modification of the IMD exclusion. Such an opportunity may not surface again. If the opportunity is allowed to pass without the repeal or modification of the IMD exclusion, the
IMD issues may be buried with little chance of being repealed in the future.

Conclusion

If the IMD exclusion is not repealed, each state will be prompted to propose or adopt plans to address or avoid the financial burden of caring for the mentally ill that had been covered in NFs (previously SNFs and ICFs) under the Medicaid Program. Thus, the mentally ill will be subjected to inconsistent levels of treatment across the United States.

The time has come for Congress to enact fair and responsible changes to the Medicaid Program to ensure that the mentally ill receive the same quality of care and treatment throughout the country. All disabled individuals, whether or not they have a history of mental illness, deserve an equal opportunity to obtain long-term care services.

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