Essay

A New Interpretation, an Absurd Result: How HHS Is Short-Changing Children with Severe Mental Illness

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In a 2002 speech that would soon be forgotten amid the excitement and controversy of the Iraq War, President George W. Bush made a compassionate plea on behalf of the millions of Americans who suffer from mental illness.[1] Announcing the creation of the President's New Freedom Commission on Mental Health, President Bush noted the substantial challenges confronting the care and treatment of the mentally ill: "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. They deserve a health care system that treats their illness with the same urgency as a physical illness."[2] He identified three obstacles in particular that required the attention not only of the Commission but also of the nation at large[3]:

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1 Press Release, The White House, President Says U.S. Must Make Commitment to Mental Health Care (Apr. 29, 2002), *available at* http://govinfo.library.unt.edu/mentalhealthcommission/20020429-1.htm.

2 *Id.*

3 *Id.*; *see also* President's New Freedom Commission on Mental Health, http://www.mentalhealthcommission.gov (last visited Feb. 4, 2009) (announcing establishment of Commission and preparation of final report of policy identification).

> The first obstacle is the stigma, the stigma that often surrounds mental illness—a stigma caused by a history of misunderstanding, fear, and embarrassment.
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> Stigma leads to isolation, and discourages people from seeking the treatment they need. Political leaders, health care professionals, and all Americans must understand and send this message: mental disability is not a scandal—it is an illness. And like physical illness, it is treatable, especially when the treatment comes early.
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> The second obstacle to quality mental health care is our fragmented mental health service delivery system. Mental health centers and hospitals, homeless shelters, the justice system, and our schools all have contact with individuals suffering from mental disorders. Yet many of these disorders are difficult to diagnose. This makes it even harder to provide the mentally ill with the care they need.
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> Many Americans fall through the cracks of the current system. Many years and lives are lost before help, if it is given at all, is given. . . .
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> The third major obstacle to effective mental health care is the often unfair treatment limitations placed on mental health in insurance coverage. Many private health insurance plans have developed effective programs to identify patients with mental illnesses, and they help them get the treatment they need to regain their health.
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> But insurance plans too often place greater restrictions on the treatment of mental illness than on the treatment of other medical illnesses. As a result, some Americans are unable to get effective medical treatments that would allow them to function well in their daily lives.[4]

President Bush went on to tell the story of one mentally disabled person who had been allowed to "fall through the cracks" of the current healthcare system; a person who, if he had received early and appropriate treatment, might have been spared a great deal of suffering.[5] The story was about a fourteen year-old honors student who had

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4 *See* Press Release, The White House, *supra* note 1.

5 *Id.*

turned to hard drugs in order to ease his severe depression.[6] He became addicted, and over the next sixteen years was incarcerated six times.[7] At thirty, the boy, now a man, was diagnosed with bipolar disorder.[8] And after receiving the long-term care he required, he was able to regain something of the life he had lost during his years of struggles with the devastating disease.[9]

As persons with mental illness emerge from "out of the shadows,"[10] stories like the one President Bush recounted are increasingly common.[11] So too are the recommendations that invariably accompany these anecdotes. The obstacles President Bush identified, and which the New Freedom Commission discussed at length in its final report, are clear: successfully confronting the challenges posed by mental illness will require (1) the elimination of the stigma attached to the illness, (2) an integration of the mental health care delivery system, and (3) an end to unfair limitations placed on the treatment of mental illness as compared with other illnesses.[12]

Yet even as President Bush demonstrated his grasp of the problems facing the successful treatment of the mentally ill, the Bush Administration was taking action that made even more daunting each of the three obstacles the President identified in his 2002 speech. Even as President Bush made his impassioned plea, the agency that describes itself as "the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves,"[13]—the Department of Health and Human Services ("HHS")—was taking action that makes more difficult the lives of some of society's most vulnerable members: poor children who reside in mental institutions. Pursuant to a new and misguided interpretation of the statute governing Medicaid, the nation's public health insurance program for low-income families, the agency within HHS that administers the program was drastically diminishing federal support

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6 *Id.*

7 *Id.*

8 *Id.*

9 *Id.*

10 *See generally* E. Fuller Torrey, Out of the Shadows: Confronting America's Mental Illness Crisis (1997).

11 *See, e.g*, Series, *Troubled Children*, N.Y. Times, Oct. 22–Dec. 22, 2006.

12 *See* The President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Healthcare in America 19–26 (2003).

13 U.S. Dep't of Health & Human Servs., *HHS: What We Do*, http://www.hhs.gov/about/whatwedo.html (last visited Feb. 4, 2009).

for institutionalized children who qualify for Medicaid. As this Essay will show, this agency action, far from advancing the Bush Administration's avowed goals for improving healthcare for the mentally ill, ironically tends (1) to further stigmatize those affected by the action (i.e. institutionalized children), (2) to further fragment the mental health care delivery system, and (3) to impose additional discriminatory restraints on the treatment of the mentally ill.

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In 2001, the Department of Health and Human Services' Office of the Inspector General ("OIG") began a series of audits of states' claims for federal assistance under the Medicaid program.[14] These claims for "federal financial participation" ("FFP") were essentially states' requests for federal matching contributions toward the cost of providing healthcare to low-income children under twenty-one who reside in so-called "institutions for mental diseases" ("IMDs").[15] Although the federal government had previously provided the states with such matching funds to help meet the medical needs of these children to the same extent it provided such funds for all other Medicaid-eligible children,[16] the Centers for Medicare and Medicaid Services ("CMS"), had adopted the new position that the Medicaid statute only required FFP for a narrow subset of services provided to children living in IMDs, namely "inpatient psychiatric services."[17] Thus, while the federal government would continue to provide FFP for treatment in the form of psychotropic drug regimens and psychotherapy, the OIG announced that under CMS's interpretation of the Medicaid statute, states were required to foot the bill for all other

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14 Appellant's Opening Brief at 2, Virginia Dep't of Med. Assistance Servs., DAB No. A-08-73 (Dep't of Health & Human Servs. June 27, 2008).

15 *See id.* at 1; *see also* Letter from Rep. Henry A. Waxman to Mark B. McClellan, Adm'r, Ctr. for Medicare & Medicaid Servs., & Dan Levinson, Acting Inspector Gen., Dep't of Health & Human Servs. (Mar. 8, 2005) [hereinafter Waxman Letter], *available at* http://oversight.house.gov/documents/20050308110415-98765.pdf.

16 *See* Waxman Letter, *supra* note 15, at 2 ("There is no precedent for the [agency's new interpretation]. For more than 30 years, the federal government, the states, and the courts have never doubted that federal funds can support the comprehensive care of children in mental institutions.").

17 *See* New York State Dep't of Health, DAB No. 2066, at 7–8 (Dep't of Health & Human Servs. Feb. 8, 2007); *see also, e.g.*, Office of Inspector Gen., Dep't of Health & Human Servs., Audit of Medicaid Payments for Under 21 Year Old residents of Private Psychiatric Hospitals That Are Institutions for Mental Diseases in Florida 2, Rep. no. A-04-02-02014 (Feb. 2003) [hereinafter Florida Audit Report].

medical care and services that IMD residents required (e.g., acute care hospital services).[18]

This new position resulted in the OIG's requirement that states that had previously applied FFP to now-excluded services for children in IMDs reimburse the federal government for these costs.[19] Facing millions of dollars in "disallowances," several states challenged CMS's new policy before the HHS Departmental Appeals Board ("the Board"). The Board's response to the first of these challenges, in *New York State Department of Health*,[20] agreed with CMS's new, narrow interpretation of the Medicaid statute and upheld the disallowance of FFP against the State of New York.[21] As this Essay will show, the Board's decision, while perhaps consistent with the plain language of the statute, is radically at odds with the purpose of the Medicaid statute as a whole and with that of the particular provision in dispute.

Fortunately, CMS and the Board do not have the final say as to what the Medicaid statute means: Congress and the federal courts can also correct this misguided interpretation and right the ship that President Bush appeared to launch in his 2002 speech about the nation's goals with respect to the treatment of the mentally ill. Accordingly, the Essay concludes that CMS's interpretation should be reexamined and revised in light of the purpose of the Medicaid statute.

Part I of this Essay briefly describes the workings of the immensely complex Medicaid program and the statute and regulations that govern it. This Part includes a discussion of the so-called "IMD exclusion" in the Medicaid statute that prohibits federal funding for the care and treatment of certain persons living in IMDs. Part II describes the two exceptions to the IMD exclusion—namely those for children under 21 and adults over 65—and pays particularly close attention to the latter exception. Part III explains the Bush Administration's new, narrow interpretation of the "under-21 exception" that has resulted in the almost-complete repeal of this important provision of the Medicaid statute. This Part examines the Board's interpretation of the statute in *New York*, and concludes with some recommendations for Congress as well as for the courts that will be asked to confront the statute in the near future.

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18 *See generally* Waxman Letter, *supra* note 15; FLORIDA AUDIT REPORT, *supra* note 17.

19 *See e.g.*, *New York*, DAB No. 2066, at 1; Appellant's Opening Brief, *supra* note 14, at 1.

20 New York State Dep't of Health, DAB No. 2066 (Dep't of Health & Human Servs. Feb. 8, 2007).

21 *See id.* at 2–4.

I. Medicaid and the "IMD Exclusion"

The Grants to States for Medical Assistance Programs, better known as Medicaid, was enacted as part of the Social Security Amendments of 1965.[22] The goal of Medicaid was—and is—to improve healthcare for certain needy groups, including "families with dependent children . . . whose income and resources are insufficient to meet the costs of necessary medical services."[23] As of the year 2000, 44.3 million people were enrolled in the program.[24] In fiscal year 2002, federal and state spending on Medicaid reached 258.2 billion dollars;[25] of all federally funded social programs, only Social Security costs more.[26]

Medicaid is essentially a partnership between the federal government and the states; the states are charged with administering the provision of medical assistance, while the federal government provides the states with matching funds for certain covered medical services.[27] Medicaid's basic rules require all states to provide certain medical services for certain population groups; these groups and services are outlined in the Medicaid statute.[28] But apart from these constraints, states have a great degree of discretion in defining the specific features of their programs or "plans."[29] For example, the Medicaid statute lists certain services that are "optional."[30] These are services for which federal funding is available if a state decides to include one of these services as part of its state plan, but the state can pick and choose among these or, indeed, chose to include none of them at all.[31]

Beyond these basic features of the program, "[t]he complexity of Medicaid," as the House Ways and Means Committee remarked in its guide to the program ("The Green Book"), "presents an enormous

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22 Grants to States for Medical Assistance Programs, Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified at 42 U.S.C. § 1396 (2006)). This Essay follows the common practice of referring to the provisions of the Medicaid statute by their section numbers in the Social Security Act (§§ 1901–1941), of which Medicaid is a part, while providing citations to the corresponding sections of the United States Code in the footnotes.

23 42 U.S.C. § 1396 (2006).

24 H.R. COMM. ON WAYS AND MEANS, THE 2004 GREEN BOOK § 15, at 15-41 (2004) [hereinafter 2004 GREEN BOOK].

25 *Id.* at 15-26.

26 *Id*. at 15-31.

27 *See* Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1, 4 (1983).

28 *See* 2004 GREEN BOOK, *supra* note 24, § 15 at 15-32 to -41.

29 *Id*. at 15-49 to -51.

30 *Id.* at 15-49.

31 *See id.*

challenge for anyone attempting to make generalizations about [it]."[32] Although the fundamental contours of Medicaid are clear—the federal government provides matching funds to assist the states in improving healthcare for the needy—defining (1) who is eligible and (2) what kinds of medical assistance are covered is extraordinarily complex. What follows is an admittedly simplified attempt to address both these questions.

A. Eligibility

Under the Medicaid statute, over fifty population groups are potentially eligible for state medical assistance programs, for which the federal government provides funding.[33] Some of these groups must be covered by any state participating in Medicaid; others may be covered at the option of the state.[34] As the *Green Book* puts it, "Medicaid is a means-tested program"; to be eligible, an applicant's income and resources must fall within certain limits.[35] Low income and limited resources, however, are not sufficient to qualify for Medicaid.[36] Not even families who are eligible for Temporary Assistance for Needy Families (commonly known as "welfare"[37]) are automatically eligible for Medicaid.[38] Instead, under a common pathway to coverage, § 1931 of the Medicaid Statute (titled "Assuring Coverage for Certain Low-Income Families"), most applicants must meet the requirements of the state where they reside, and those requirements vary widely.[39]

In addition to § 1931's pathway for low-income families, several other provisions require coverage for certain groups Congress has judged to be particularly needy. These include pregnant women and children under the age of six with family incomes below 133 percent of the federal poverty level;[40] children over age five and under nineteen whose families earn less than 100 percent of the federal poverty

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32 *Id*. at 15-32.

33 *Id*.

34 *Id.*

35 *Id.*

36 *Id.* at 15-31.

37 *See* U.S. Dep't of Health and Human Servs., Admin. for Children & Families, About TANF (2008), http://www.acf.hhs.gov/programs/ofa/tanf/about.html.

38 2004 Green Book, *supra* note 24, at 15-33.

39 *Id*.

40 *Id.*

level;[41] and, with one exception, persons receiving Supplemental Security Income (SSI) under Title XVI of the SSA.[42]

Although Medicaid's eligibility requirements defy easy generalization, this brief survey suggests that they essentially conform to Medicaid's stated purpose, namely to assist those groups that, when faced with limited income and resources, are especially vulnerable: (1) families with children, (2) the elderly, and (3) the disabled.[43] As the next Section will show, the services Medicaid covers are also largely in line with this purpose—with one significant exception: the exclusion of assistance for patients in IMDs.

B. Covered Services

Section 1902 of the Medicaid statute provides that a "State plan for medical assistance must . . . provide for making medical assistance available, including at least the care and services listed in [certain paragraphs of section 1905(a)]" to individuals for whom the statute requires coverage.[44] The remaining types of medical assistance listed in the section may, but need not, be included in the state's plan.[45] The required services include those kinds of services Congress has deemed essential to fulfilling the goal of Medicaid: to provide program recipients medical care and services which are typically available to members of the public with private health insurance plans.[46] These include outpatient hospital services,[47] laboratory and x-ray services,[48] physician and dentist services,[49] as well as services provided by nurse-midwives,[50] pediatric nurses,[51] and nurse practitioners.[52] Two other required services bear deeper discussion because of their importance to this Essay.

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41 *Id.* at 15-34.

42 *Id.* at 15-35. SSI is a cash assistance program for aged, blind, and disabled persons whose income falls below a certain level and whose resources are limited. *Id.*

43 *See supra* note 23 and accompanying text.

44 42 U.S.C. §§ 1396a(a)(10), 1396d(a) (2006). See Part I.A for a discussion of eligibility.

45 *See id.* §§ 1396a(a)(10)(ii), 1396d(a).

46 *See* 42 C.F.R. § 447.204 (2008) ("The agency's payments must be sufficient to enlist enough providers so that services . . . are available to recipients at least to the extent that these services are available to the general population.").

47 42 U.S.C. § 1396d(a)(2)(A).

48 *Id.* § 1396d(a)(3).

49 *Id.* § 1396d(a)(5)(A)–(B).

50 *Id.* § 1396d(a)(17).

51 *Id.* § 1396d(a)(21).

52 *Id.*

First, under § 1905(a)(4)(B), state plans are required to provide assistance in the form of "early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21."[53] Early and Periodic Screening, Diagnostic, and Treatment Services ("EPSDT") include a wide range of medical services, including vision, hearing, and dental services,[54] that must be provided to qualified children and adolescents.[55] This requirement bears noting because it is in keeping with Medicaid's heightened concern for the health of children.

Second, under paragraph (1) of the same section, "inpatient hospital services" must be included in a state's plan, but this term excludes "services in an institution for mental diseases."[56] Lest the reader be confused by this provision, which might be read as simply not *requiring* states to include coverage for services in an institution for mental diseases ("IMD"), Congress included other language in paragraph (28) of the same section that makes it clear that FFP for services provided in IMDs is, with two exceptions (discussed below), *not permitted* in a state's Medicaid plan.[57] The paragraph makes this clear by excluding from the definition of "medical assistance" (i.e., care and services for which FFP is available) "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."[58] This is Medicaid's so-called "IMD exclusion," which, as the remainder of this Essay will show, has engendered a great deal of controversy since its enactment as part of the original 1965 legislation that created Medicaid.

C. The IMD Exclusion

The policy of denying federal funding for services in IMDs has its origin in legislation passed long before Medicaid. The Social Security Amendments of 1950 created, *inter alia*, Title XIV to the Social Security Act, "Grants to States for Aid to the Permanently and Totally Dis-

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53 *Id.* § 1396d(a)(4)(B).

54 *See id.* § 1396d(r) (defining "early and periodic screening, diagnostic, and treatment services").

55 *See id.* § 1396d(a)(4)(A).

56 *Id.* § 1396d(a)(1).

57 *Id.* § 1396d(a)(28).

58 *Id.* § 1396d(a)(28)(B).

abled."[59] Although the Act provided federal funds for the care of "needy individuals eighteen years of age or older who are permanently and totally disabled," it specifically excluded from its purview "any individual who is a patient in an institution for . . . mental diseases."[60] This policy was continued in Medicaid's forerunner, the Kerr-Mills Medical Assistance Program, enacted in 1960, and eventually found its way (at least partially) into the Medicaid statute itself.[61]

The legislative history relating to the IMD exclusion and contemporaneous mental health legislation reveals two justifications for the policy. First, in what would become a constant refrain justifying the exclusion, the House report accompanying the Social Security Amendments of 1950 explained that federal funding would not be available for IMD residents because "*States* have generally provided for medical care of such cases."[62] Professor Joanmarie Davoli has described the origin of this often mentioned but seldom explained rationale:

> Historically, care for mentally ill individuals was considered a family, locality or state responsibility. In the early colonial United States . . . . mentally ill individuals were cared for at home, or confined in individual, cell-like buildings . . . .
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> When a family could not provide for or control a mentally ill member, the individual became the concern of the community. At times, the town officials provided funds directly to families to assist them in caring for their mentally ill member. Another option involved having the stricken individual "boarded out," with funds paid by the officials for a private citizen to take over his care.[63]

Eventually, as Professor Davoli further explains, the mentally ill whose families did not have the resources to care for them were placed in state-run institutions, a practice which continued through the nineteenth and twentieth centuries.[64] "By the middle of the 20th

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59 Pub. L. No. 81-64, 64 Stat. 555 (1950). This was later replaced by the SSI program, which is now Title XVI of the SSA.

60 Pub. L. No. 81-64, § 1405, 64 Stat. 555, 557–58 (1950) (codified at 42 U.S.C. § 1351 (2006)).

61 Kerr-Mills Act, Pub. L. No. 86-778, 74 Stat. 924 (1960).

62 H.R. REP. NO. 81-1300, at 42 (1949) (emphasis added).

63 Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J.L. & MED. 159, 165–66 (2003).

64 *Id.* at 167–68.

century, most states had a lengthy history of providing psychiatric care, particularly hospitalization, to the indigent mentally ill."[65] Hence the notion that care for residents in IMDs was the responsibility of the states.

A second explanation for the IMD exclusion—the federal government's dim view of the therapeutic value of long-term care in an IMD—was just emerging at the time of the enactment of the 1950s Amendments. By the time Medicaid was enacted, however, this rationale was predominant in justifying the continuation of the IMD exclusion.[66] The decade following the Amendments' enactment witnessed an increasing concern—both in Congress and in America at large—for life inside mental health institutions.[67] A number of journalistic exposés in the late 1940s revealed deplorable conditions inside state-run mental hospitals, conditions which one journalist likened to those inside Nazi concentration camps.[68] These depictions culminated in works like Ken Kesey's condemnation of institutionalization in the 1962 novel, *One Flew Over the Cuckoo's Nest* and Frederick Wiseman's 1967 documentary *Titicut Follies*, which was banned worldwide until 1992 for its shocking footage of a Massachusetts mental institution.

Congress's interest in the conditions inside IMDs began in earnest in 1955, when it passed the Mental Health Study Act,[69] pursuant to which the Joint Commission on Mental Illness and Health conducted a six-year study for the purpose of producing recommendations for a national mental health program.[70] The study's findings regarding state mental institutions, as discussed in a 1963 House report, were particularly bleak. The House report explained that "[a]t the present time . . . the treatment of mental illness takes two major forms. For those few who can afford it, there is private psychiatry, and for the great masses there is the State mental hospital."[71] The latter form, the report found, presented a "dismal picture."[72] In addition to many state institutions being "fire and health hazards by the

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65 *Id*. at 168.

66 *See id.* at 169 & n.58.

67 *See id.* at 168.

68 *See* ALBERT DEUTSCH, THE SHAME OF THE STATES 41–42 (Arno Press 1973) (1948) ("As I passed through [the wards of an institution], I was reminded of the pictures of the Nazi concentration camps at Belsen and Buchenwald.").

69 Mental Health Study Act of 1955, Pub. L. No. 84-182, 69 Stat. 381.

70 H.R. REP. NO. 88-694, at 10 (1963), *reprinted in* 1963 U.S.C.C.A.N. 1054, 1063.

71 *Id.* at 11, 1963 U.S.C.C.A.N. at 1064.

72 *Id.* at 12, 1963 U.S.C.C.A.N. at 1065.

standards of their own States," the report found that because of inadequate staffing and funding, "[o]nly a small percentage of the institutions can be said to be therapeutic and not merely custodial."[73] These inadequacies led to longer patient stays in the state institutions, which further exacerbated the problems the report identified.[74] Somewhat surprisingly given the source of the problems (poor funding and understaffing), the course of action Congress took on this occasion was to support the establishment of alternative institutions for the treatment of the mentally ill, so-called Community Health Centers, rather than provide more funding for IMDs.[75]

II. The Exceptions to the IMD Exclusion

A. The Over-65 Exception

Congress revisited the problem of caring for the mentally ill two years later, as it put together the legislation that would become Medicaid. Although Congress ultimately decided to include an IMD exclusion similar to the one provided in the 1950 Amendments and the Kerr-Mills Act, this IMD exclusion applied only "to care or services for any individual who ha[d] not attained 65 years of age."[76] In other words, Congress created an exception to its traditional practice of deferring entirely to the states in the area of the long-term mental healthcare: Congress would provide FFP for the care of IMD residents 65 and older.

The reason for this partial change of heart regarding IMDs is discussed in Medicaid's legislative history. In contrast to the dismal picture of mental institutions noted in 1963 House report,[77] the Senate report accompanying the Medicaid bill noted that "[t]here have been many encouraging developments . . . in the care and treatment of the mentally ill."[78] Nevertheless, Congress was still apparently concerned about IMDs being "merely custodial" rather than therapeutic, and thus enacted "safeguards"[79] to ensure that its funding for IMD residents would be used for therapeutic purposes. Specifically, Congress required that states seeking FFP for services provided to elderly pa-

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73 *Id.* at 11, 1963 U.S.C.C.A.N. at 1064.

74 *Id.* at 12, 1963 U.S.C.C.A.N. at 1064–65.

75 Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, §§ 200–207, 77 Stat. 282, 290–94 (codified at 42 U.S.C. §§ 2681–2688d (1970)).

76 42 U.S.C.§ 1396d(a)(28) (2006).

77 *See supra* text accompanying note 72.

78 S. REP. NO. 89-404, at 144 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2084.

79 *Id.* at 145, 1965 U.S.C.C.A.N. at 2085.

tients in IMDs comply with therapeutic standards defined in § 1905(a)(20) and (21) of the Medicaid statute.[80] These provisions demonstrate Congress's belief (discussed at length in the Senate report[81]) that in order to be effective, psychiatric treatment in an IMD had to be accompanied by comprehensive treatment of all medical needs.[82] Thus, § 1902 (a)(20) required states seeking FFP for elderly IMD patients to

> provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, [and] that he will be given appropriate medical treatment within the institution.[83]

In other words, Congress sought to ensure that the IMD services for which FFP would be available were geared toward *rehabilitation*. Whereas the report produced pursuant to the Mental Health Study Act had found that IMDs were largely "custodial" (i.e., essentially devoted to incapacitation of the patients), the thinking that informed the Medicaid statute's treatment of IMDs apparently believed in the ability of the IMD to advance the ultimate goal of mental healthcare at that time: the reintegration into the community of the mentally ill. Importantly, both the statue and the legislative history explain that this goal can only be met through the holistic treatment of the patient. Not only must the patient receive psychiatric services, she must also have her other medical needs met in order to become again a functioning member of society.

B. The Under-21 Exception

The goal of reintegrating into the community the mentally ill who required long-term institutional care was the principal purpose for enactment of the second exception to the IMD exclusion, which applies to IMD residents who are under age 21. Congress enacted this exception as part of the Social Security Amendments of 1972.[84] As the Senate report explained the addition of this exception, "the nation cannot make a more compassionate or better investment in medicaid [sic]

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80 *Id.* at 144, 1965 U.S.C.C.A.N. at 2084.

81 *Id.* at 144–45, 1965 U.S.C.C.A.N. at 2084–85.

82 This is one of the central arguments made in the most recent challenge to a disallowance pursuant to the new CMS interpretation, brought by the Commonwealth of Virginia. *See* Appellant's Opening Brief, *supra* note 14, at 7.

83 42 U.S.C. § 1396a(a)(20)(B) (2006).

84 Pub. L. No. 92-603, 86 Stat. 1460 (1972).

than this effort to restore mentally ill children to a point where they may very well be capable of rejoining and contributing to society as active and constructive citizens."[85] As with the over-65 exception, FFP made available pursuant to this exception came with conditions meant to ensure active treatment carried out with an eye toward the rehabilitation of the patient. Accordingly, the new provisions required that the services provided "involve active treatment" and that "a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined [that services] are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary."[86]

Yet despite the similarity in purpose between the over-65 and under-21 exceptions to the IMD exclusion, the structure and language of the two differ. Although the over-65 exception is built into the IMD exclusion itself (§ 1905(a)(28) excludes FFP for IMD residents who have "not attained 65 years of age"), the under-21 exception is expressed as a service (like, for example, dental services and physical therapy) for which FFP is available at the option of the state. In other words, the statute includes "inpatient psychiatric hospital services" provided to children in IMDs within the definition of "medical assistance" under § 1905.

More importantly given recent developments,[87] the language in which the exceptions are expressed differs slightly. The under-21 exception states that FFP will be available for "inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h)."[88] Subsection (h) explains that such services include only "inpatient services which are provided in an institution . . . which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified."[89] As explained above, these services involve active treatment that a team of

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85 S. REP. NO. 92-1230, at 281 (1972).

86 42 U.S.C. § 1396d(h)(1)(B) (2006); s*ee also* H.R. REP. NO. 92-1605, at 65 (1972) (Conf. Rep.), *reprinted in* 1972 U.S.C.C.A.N. 5370, 5398.

87 *See infra* Part III.

88 42 U.S.C. § 1396d(a)(16) (2006).

89 *Id.* § 1396d (h)(1)(A). The definition of "psychiatric hospital" is the same as IMD. *Compare* 42 U.S.C.§ 1395x(f) ("The term 'psychiatric hospital' means an institution which is primarily engaged in providing, by or under the treatment of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons . . . ."), *with* 42 U.S.C. § 1395d(i) ("The term 'institution for mental diseases' means 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.").

physicians determines can be reasonably expected to improve the patient's condition.[90] In contrast, the over-65 exception explicitly states that FFP is available for "inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases."[91]

Despite these facial differences between the two exceptions, they were, until recently, treated similarly by the agencies administering Medicaid; that is, assuming children and seniors living in IMDs otherwise met income and resource requirements, states could receive FFP for the medical care of these IMD residents to the same extent as they could for nonresidents.[92] Thus, children and seniors in IMDs could receive all the services provided in the State's plan, and the State would receive federal reimbursement for this coverage.[93] As the next Part discusses, however, this approach to Medicaid coverage was radically altered, as the Bush Administration seized upon the facial differences between the exceptions and substantially narrowed the coverage of the under-21 exception.

III. The OIG Audits and the Reinterpretation of the Under-21 Exception

As discussed in Part I of this Essay, the Department of Health and Human Services' Office of the Inspector General began a series of audits of state Medicaid programs in 2001.[94] These audits were premised upon the notion that states were precluded from claiming FFP for medical services provided to children in IMDs unless those services were "inpatient psychiatric services."[95] In other words, under this reading of the statute, FFP was available for psychiatric treatment (e.g., psychotropic drug regimens and psychotherapy), but not for any other medical care the IMD patient might require (e.g., treatment for common physical illness, for broken bones, etc.). The audits were specifically aimed at determining whether the states had "adequate controls in place" to prevent a state from claiming FFP for nonpsychiatric medical care of this kind.[96]

Not surprisingly, given the longstanding interpretation of the under-21 exception providing FFP for coverage of children in IMDs to

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90 *See supra* text accompanying note 86.

91 42 U.S.C. § 1396d(a)(14) (2006).

92 *See* Waxman Letter, *supra* note 15, at 4–5.

93 *See id.*

94 *See, e.g.*, FLORIDA AUDIT REPORT, *supra* note 17.

95 *See id.*

96 *Id.*

the same extent as that provided to other children, the OIG audit revealed that many states had been claiming FFP for nonpsychiatric medical care of children in IMDs.[97] Accordingly, the OIG demanded that the states repay millions of dollars spent on the medical care of institutionalized children.[98] Several states have challenged these "disallowances" before the adjudicatory body within HHS, the Departmental Appeals Board ("the Board"). The next section discusses the Board's decision in one of these cases, *New York State Department of Health*.

A. New York State Department of Health

Following the OIG's audit of the New York State Department of Health, New York was "disallowed" (essentially billed for) $7,642,194 that the state's Department of Health had requested FFP for "medical assistance" under Medicaid for certain medical services provided to institutionalized children.[99] The audit report concluded that New York had improperly claimed FFP for, among other things, inpatient acute hospital care, as well as physician and dental care.[100] The auditors' decision to disallow these claims was based on the position that these services did not meet the definition of "inpatient psychiatric hospital services for individuals under age 21" as provided in the "under-21" exception of the IMD exclusion.[101]

New York challenged the disallowance before the Board on several grounds, all of which suggested that institutionalized children were eligible for the full range of Medicaid services. First, New York argued that because the term "inpatient psychiatric hospital services" was included in the statute's list of optional services, it should be treated as a service for which FFP is available *in addition* to the other services enumerated in the list (e.g., dental services, laboratory services, etc.).[102] The Board quickly dispensed with this argument by explaining that provision 1905(a)(16) should be read as a narrow exception to the broad IMD exclusion in paragraph (a)(28),[103] which provides that "except as otherwise provided in paragraph (16), [medical assistance] does not include . . . any such payments with respect to

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97 Waxman Letter, *supra* note 15, at 6–7.

98 *Id.*

99 New York State Dep't of Health, DAB No. 2066, at 1 (Dep't of Health & Human Servs. Feb. 8, 2007).

100 *Id.*

101 *Id.* at 3–4.

102 *Id.* at 9.

103 *Id.*

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."[104] The Board agreed with the CMS's framing of the issue: the validity of the disallowances turned on the definition of "inpatient psychiatric hospital services for individuals under age 21."[105] States could obtain FFP for these services, but nothing more.

Perhaps anticipating this conclusion, New York next argued for a broad definition of "inpatient psychiatric hospital services," a definition that would include the kind of medical and dental services for which the OIG had decided FFP was unavailable.[106] To do so, New York pointed to the legislative history, which, as discussed above, suggests that the exception was meant to apply to the range of medical services necessary to the rehabilitation of the child, and not simply psychiatric treatment.[107] In response, the Board focused on § 1905(h)(1),[108] which defines "inpatient psychiatric hospital services" (somewhat tautologically) as "inpatient services which are provided in an institution . . . which is a psychiatric hospital . . . or in another inpatient setting that the Secretary has specified in regulations."[109] Because the Secretary has not issued any regulations further defining "inpatient psychiatric hospital services," the Board focused solely on the first part of the paragraph, paying particular attention to the requirement that the inpatient services be provided "in" a psychiatric hospital.[110] Given that most of the services for which FFP was disallowed were actually performed outside IMDs (e.g., in general hospitals, clinics, and dentists' offices), the Board concluded that the services did not fall within the definition, and thus ultimately upheld the disallowances against New York.[111]

B. Criticism of the New York Decision and a Call for Change

It must be conceded that the plain language of the Medicaid statute's definition appears to support CMS's interpretation of the statute. But such a narrow interpretation of the statute is flatly at odds with the purpose of the exception, which, as discussed above, is the

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104 42 U.S.C. § 1396d(a)(28) (2006).

105 *Id.* § 1396d(a)(16); *New York*, DAB No. 2066, at 9–10.

106 *New York*, DAB No. 2066, at 10.

107 *Id.* at 10–11.

108 *Id.*

109 42 U.S.C. § 1396d(h).

110 *New York*, DAB No. 2066, at 21–23.

111 *Id.* at 27–28. New York raised several other, less persuasive arguments, which the Board dismissed in turn. Because they are less relevant, I do not discuss them here.

rehabilitation of institutionalized children. As Congress recognized in previous discussions of long-term treatment of mental illness in IMDs, such rehabilitation requires holistic treatment of the patient, not just psychotherapy and psychotropic drug regimens.

When faced with the conflict between purpose and text of the kind seen here, courts have often chosen to honor the purpose of the law even if this meant deemphasizing the apparent plain meaning of the statute.[112] Even Justice Scalia, the supreme exponent of the textualist theory of statutory interpretation, has recognized that sometimes Congress does not mean what it appears to say, and that the courts must look past the ordinary meaning of a statute if such meaning would produce an absurd result.[113]

Interpreting the under-21 exception to the IMD exclusion to allow FFP for only psychiatric treatment produces such a result. Although the legislative history shows that Congress believed it was providing a second exception to the IMD exclusion that would work similarly to the one provided for IMD patients over 65, the unfortunately ambiguous language of the under-21 provision has allowed CMS to cut funding for some of society's most vulnerable members. If Congress had intended such a dramatic difference between the two exceptions, surely the legislative history would reflect this.[114] But the only mention of the exception describes its intended operation in terms similar to those used to describe the over-65 exception enacted seven years before: "the nation cannot make a more compassionate or better investment in medicaid [sic] than this effort to restore mentally ill children to a point where they may very well be capable of rejoining and contributing to society as active and constructive citizens."[115]

The argument that the different forms in which the two exceptions appear in the text establishes that they are meant to operate differently comes up short in this context. The so-called "whole act

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112 *See, e.g.*, United Steelworkers v. Weber, 443 U.S. 193, 201 (1979) ("The prohibition against racial discrimination . . . must therefore be read against the background of the legislative history of Title VII and the historical context from which the Act arose."); Holy Trinity Church v. United States, 143 U.S. 457, 459 (1892) ("It is a familiar rule, that a thing may be within the letter of the statute and yet not within the statute, because not within its spirit, nor within the intention of its makers.").

113 *See* Green v. Bock Laundry Machine Co., 490 U.S. 504, 527 (1989) (Scalia, J., concurring in the judgment).

114 Courts have often found silence in the legislative history where one would expect to hear commentary to be significant in deciding whether to give a statute its literal meaning. *See, e.g.*, Gustafson v. Alloyd Co., 513 U.S. 561, 578 (1995); Griffin v. Oceanic Contractors, 458 U.S. 564, 573–74 (1982).

115 S. REP. NO. 92-1230, at 281 (1972).

rule," on which this argument relies, has been persuasively criticized, especially in the context of large, multifarious pieces of legislation like the Social Security Amendments of 1972, in which the under-21 exception was a veritable needle in the haystack.[116]

Finally, the fact that the agency had until very recently treated the exceptions similarly—and that Congress took no action—suggests that Congress had implicitly ratified the agency's approach.[117] The stern letter sent from Congressman Henry Waxman to the OIG, chiding the agency's change in policy, lends further support to the notion that Congress had given its sanction to the agency's former approach.[118]

Fortunately, the Board does not have the final say as to what the statute means: the federal district courts can hear appeals of the Board's decisions and, of course, Congress could simply revise the provision in such a way as to make its language conform to the purpose underlying the exception. Perhaps the strongest argument a state challenger could make in federal court would be based on the *Chevron* doctrine, which requires deference to an agency's interpretation of an ambiguous statute only if that interpretation is reasonable.[119] Given that CMS's interpretation is clearly at odds with the exception's purpose, and that the application of this interpretation has produced the absurd result of covering only psychiatric services (the very services that the IMD exclusion was always most concerned with excluding), a state would have a strong argument that (1) Congress did not speak to the precise issue at hand (and consequently that the statute is "ambiguous" under *Chevron*), and (2) that the interpretation is unreasonable.

Alternatively, of course, Congress could rewrite the exception by striking the paragraph in § 1905(a)(16) (42 U.S.C. § 1396d(a)(16)) and

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116 *See, e.g.*, Del. Tribal Bus. Comm. v. Weeks, 430 U.S. 73, 97 (1977) (Stevens, J., dissenting) (recognizing that the phraseology of different statutory provisions is often "the consequence of a legislative *accident*, perhaps caused by nothing more than the unfortunate fact that Congress is too busy to do all of its work as carefully as it should"); RICHARD A. POSNER, THE FEDERAL COURTS: CRISIS AND REFORM 281 (1985) ("The conditions under which legislators work are not conducive to careful, farsighted, and parsimonious drafting."); *see also* Sorenson v. Sec'y of the Treasury, 475 U.S. 851, 867 (1986) (Stevens, J., dissenting); Mountain States Tel. & Tel. Co. v. Pueblo of Santa Ana, 472 U.S. 237, 255–56 (1985) (Brennan, J., dissenting).

117 For examples of courts that have taken congressional acquiescence as implicit ratification of an agency's interpretation of a statute, see *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132–33 (2000) and *Johnson v. Transportation Agency*, 480 U.S. 616, 642 (1987).

118 *See* Waxman Letter, *supra* note 15, at 7–8.

119 *See* Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843–44 (1984).

the definitions provided in subsection (h), while rewriting the paragraph in § 1905 (a)(28) to read as follows:

> such term ["medical assistance"] does not include—
>
> . . . .
>
> (B) any such payments with respect to care or services for any individual who between the ages of 22 and 64 who is a patient in an institution for mental diseases.

Redrafting the provision is obviously the optimal course of action if one thinks solely in terms of results: the proposed language would force CMS to resume its longstanding practice of providing FFP for all Medicaid-covered services for institutionalized children. But such is always the case with calls to redraft statutory language. The problem with most such proposals is that they do not consider the problem of the process of implementation, and thus are frequently impractical given the way business is carried out on Capitol Hill, where interest groups—rather than the public's interest—too often dominate and very few things are done quickly.

This proposal is different. Congress has recently expressed its support for so-called "mental health parity" (similar treatment of mental illness and physical illness by private insurers) in a piece of legislation that accompanied the recent Bailout Act.[120] When we remember that Medicaid is the nation's public insurer for low-income families, the issue discussed in this Essay reveals itself as one of parity in insurance: indigent persons living in IMDs are being treated differently from persons not living in IMDs.[121] In other words, concerns like these are presently on Congress's radar. Furthermore, when one considers the beneficiaries of the proposal, poor children with serious mental illness, it seems unimaginable that the proposal would be met with serious resistance. Indeed, a member of Congress who came forward with such a proposal would surely be lauded for suggesting that the government serve the purpose it is supposed to serve: to help those who cannot help themselves.

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120 *See* Fred Frommer, *After Twelve Years, Wellstone Mental Health Parity Act is Law*, MPR.ORG, Oct. 3, 2008, http://minnesota.publicradio.org/display/web/2008/10/03/parity_finalpassage.

121 The Supreme Court has previously rejected a challenge to the IMD exclusion under the Equal Protection Clause. *See generally* Schweiker v. Wilson, 450 U.S. 221 (1981).