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CODIFIED DISPARITY: THE MEDICAID IMD EXCLUSION, MENTAL HEALTH PARITY, AND CONGRESSIONAL INTENT

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I. INTRODUCTION

Wilbur Mills had a problem. He was a southern Democrat in a time when Democrats spearheaded fiscal conservatism in the United States House of Representatives, and a president from Mills' own party was flipping the narrative by which parties, regions, and ideologies drove federal spending on social benefits for low-income Americans.¹ President Lyndon Johnson was hell-

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1. See Julian E. Zelizer, *How Medicare Was Made*, THE NEW YORKER (Feb. 15, 2015), <https://www.newyorker.com/news/news-desk/medicare-made> [<https://perma.cc/JC9E-9VVM>].

bent on passing some form of publicly funded healthcare in the wake of his landslide 1964 reelection victory.² Mills was chair of the powerful House Ways and Means Committee. He opposed the public healthcare funding mechanism accompanying Johnson's legislation—increases in Social Security taxes—and had spent the better part of two decades blocking any substantive bills on the topic from coming to a vote in his committee.³ Mills may have believed that he staved off momentum from his more progressive colleagues by passing the Kerr-Mills Act in 1960—a watered down approach that allowed states to opt in to limited health coverage for low income seniors. Kerr-Mills used matching state funds based on a given state's per capita income.⁴ His plan failed to effectively provide coverage for vulnerable Americans due to its shaky funding scheme and lack of a nationwide mandate.⁵ It also failed to placate progressives on Capitol Hill and the White House because it did not adequately provide healthcare services.⁶

Mills was a physically unassuming man but a shrewd political operator with a mind suited for solving the complex fiscal issues facing Congress in a complicated political environment. He may have switched in and out of his native southern accent depending on whether he was speaking to constituents in central Arkansas or Washington's elite, and some contemporaries believed that he read the federal tax code in his leisure time.⁷ His principle concern with the program that became Medicare was that it would raise Social Security taxes to an unconscionably high rate,⁸ but he was losing fiscal conservative allies in the House and on his committee. A slew of new, more liberal members of Congress

2. Johnson defeated arch conservative Senator Barry Goldwater of Arizona in 1964 by an electoral margin of 486-52. Johnson had more legislative experience than any president of the twentieth century up to that point; he instinctively knew he had a short window to pass controversial and expensive legislation. *See generally* IRWIN UNGER, *THE BEST OF INTENTIONS: THE TRIUMPH AND FAILURE OF THE GREAT SOCIETY UNDER KENNEDY, JOHNSON, AND NIXON* (1996); JULIAN E. ZELIZER, *THE FIERCE URGENCY OF NOW: LYNDON JOHNSON, CONGRESS, AND THE BATTLE FOR THE GREAT SOCIETY* (2015).

3. Congressional committee chairs control the agenda for their committees, and therefore control which bills reach the House and Senate floors. *See generally* *The Committee System in the U.S. Congress*, CONG. RSCH. SERV. 2 (Oct. 14, 2009), https://www.everycrsreport.com/files/20091014_RS20794_64d74bfc8f8aa83aafb5b05ee700eda5db27eb2d.pdf [<https://perma.cc/TT5B-D7NW>].

4. Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924, 924 (1960).

5. *See* *MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE* (Alan B. Cohen et al., Oxford Univ. Press 2015); Judith D. Moore & David G. Smith, *Legislative Medicaid: Considering Medicaid and Its Origins*, 27 *HEALTH CARE FIN. REV.* 45 (2005).

6. *Id.*

7. *MEDICARE AND MEDICAID AT 50*, *supra* note 5, at 13 (Mills' intermittent southern accent); Zelizer, *supra* note 1.

8. Moore & Smith, *supra* note 5, at 50; *MEDICARE AND MEDICAID AT 50*, *supra* note 5, at 9-13.

adroitly rode Johnson's coattails into power in January 1965.⁹ Mills worked with a closeknit group of fiscal and healthcare policy experts in the executive and legislative branches and concocted a compromise: two tiers of Medicare would pay for hospital treatment and doctor visits (Medicare Part A and B, respectively), and a third piece would build upon the shared state/federal funding model of Kerr-Mills to offer health coverage to low-income individuals.¹⁰ This would be enough for progressives looking to help less fortunate Americans but might still be just barely too expensive for the collective conscience of fiscally conservative southern Democrats. One more compromise made it into Medicare and Medicaid's enabling legislation: denying coverage for two subcategories of people living below the poverty line—people with psychiatric conditions and people who are incarcerated—two broad groups of people whose healthcare was apparently expendable for the 89th Congress.¹¹

Since the earliest days of what is now the United States, justice-involved persons (particularly incarcerated individuals) and people living with the more severe cases of mental illness have occupied an egregiously low level of society. Congress chose to cut them out of Medicaid coverage via two distinct subsections within the Social Security Amendments of 1965.¹² The two exclusions were drafted hastily, almost as afterthoughts,¹³ and likely also to push the budget math back into the black, but it cannot be a coincidence that two populations already relegated to the margins of American society did not earn health coverage in the twentieth century's preeminent healthcare legislation. Congress did not think they mattered enough to be included.

Congressional intent, however, is not static. The legislative body meant to represent the nation's citizenry and make incarnate its collective will change its mind regularly. It grows; it evolves. Congress has even blatantly countermanded its own policies, usually after shifts in public opinion.¹⁴ When Congress created

9. Benjamin J. Guthrie, *Statistics of the Presidential & Congressional Election of No. 3, 1964*, U.S. GOV'T PRINTING OFFICE (1965), https://clerk.house.gov/member_info/electionInfo/1964election.pdf (showing a net Democrat gain of 36 seats from the 1964 U.S. House elections).

10. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in 42 U.S.C. §§ 301 et seq.).

11. 42 U.S.C. § 1396d(a)(31)(A) (2018) (barring Medicaid funds from covering healthcare services for "any individual who is an inmate of a public institution"); 42 U.S.C. § 1396d(a)(31)(B) (2018) (barring Medicaid funds from covering "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").

12. *Id.*

13. See J. Michael E. Gray & Madeline Easdale, *Blatant Discrimination within Federal Law: A 14th Amendment Analysis of Medicaid's IMD Exclusion*, 18 U. MASS. L. REV. 165, 171 (2023).

14. The greatest public policy shift in the history of the United States that led to a reversal in the will of Congress was the shift from institutional support of slavery and slave owners to abolition. See generally ERIC FONER, *RECONSTRUCTION: AMERICA'S UNFINISHED REVOLUTION, 1863–1877* (1988) (a broad discussion of the legal end of slavery and congressional struggles to

Medicaid in 1965, it acted somewhat hastily while focusing mainly on Medicare.¹⁵ Although Medicaid was and is badly needed to provide health coverage for millions of Americans, certain pieces fell on the proverbial cutting room floor and their absence is having dire consequences nearly six decades later. Medicaid's enabling legislation included two discriminatory provisions that prevent people who are incarcerated, as well as people with illnesses requiring inpatient psychiatric care from receiving the full extent of services needed to treat their ailments. In addition to violating the 14th Amendment's Equal Protection Clause,¹⁶ this latter provision, known as the IMD exclusion, directly contradicts more recent congressional intent to treat mental and physical conditions equally under the law.¹⁷ This article examines the history and impact of the IMD exclusion, including its questionable origins, its impact on healthcare systems generally, and the resulting deprivations of medically necessary care.¹⁸ Next, the article discusses the discriminatory effect of the IMD exclusion; it denies federal and state funded health coverage for a specific class of individuals while allowing it for everyone else.¹⁹ After quickly codifying that discriminatory rule, Congress established a pattern of passing landmark legislation that was more fair and reasonable, intentionally promoting equal and equitable treatment of the very people denied equality under the IMD exclusion.²⁰ The final sections herein provide a chronological description of three pieces of landmark legislation from the decades following Medicaid. Those subsequent congressional actions were inconsistent with the perpetuance of the IMD exclusion, and this article concludes with an argument that congressional intent has evolved enough that the courts can and should act, if Congress will not, and end this disparity of healthcare coverage.²¹

II. THE MEDICAID IMD EXCLUSION

The mid-1960s saw many social movements intersect with political will and result in legislation. The administrations of presidents John Kennedy, and to a much greater degree, Lyndon Johnson, brought social inequity and the federal

enforce the mid-nineteenth century sea change in public opinion). Abolition and Reconstruction remain the most far-reaching change of Congressional intent and the most dramatic; it came on the heels of the nation's deadliest war to date.

15. See *infra* Section II. (unpacking more of the multilayered compromises that resulted in Medicaid).

16. For an analysis of the IMD exclusion with respect to the Equal Protection Clause, see Gray & Easdale, *supra* note 12, at 175-76.

17. See *infra* Section III.

18. See *infra* Section II.

19. See *infra* Section II.B.

20. See *infra* Section III.

21. See *infra* Section IV.

government's constitutional ability to counteract it to the fore.²² Voter rights,²³ civil rights,²⁴ and fair housing access²⁵ all made it into federal code and became perpetually enshrined in the federal budget. The single largest, most impactful, and most expensive²⁶ piece of legislation from the era was arguably the lowest profile piece of the Johnson Administration's Great Society platform—the Social Security Amendments of 1965.²⁷ The amendments created two publicly funded healthcare coverage plans. Medicare would cover people who had reached the age of retirement and Medicaid would cover low-income individuals.²⁸ Understanding the present state of the two programs requires an understanding of their political origins.

Both Medicare and Medicaid were a continuation of broad New Deal priorities stemming from the social unrest and political upheaval of the 1930s. The Franklin Roosevelt administration's New Deal promised federal resources to provide for seniors and to lift people living in poverty up to a higher economic standard of living.²⁹ After passage of those social programs, healthcare costs rose rapidly in the ensuing decades, and people without employer provided health insurance were largely underinsured.³⁰ The Johnson administration saw those rising costs as a threat to both short term economic stability and long term

22. The Kennedy administration had good intentions and played a leading role in advancing the dialogue around equality for marginalized people, particularly Black people living under the long-lasting effects of slavery and Jim Crow. However, the Kennedy administration may have lacked the boldness necessary to engage with Congress on these initiatives. To be fair, President Kennedy had less than three years in office and may well have acted on his more progressive inclinations had he had one or even two full terms. The preceding administration of President Lyndon Johnson did not lack boldness and the president had ample experience with the inner workings of Congress. Almost immediately upon taking office, President Johnson began passing legislation to address societal inequities. For a general discussion of the time-period and the legislation it produced. *See generally* ZELIZER, *supra* note 2; ROBERT A. CARO, *THE YEARS OF LYNDON JOHNSON: THE PASSAGE OF POWER* (2012).

23. Voting Rights Act of 1965, Pub. L. No. 89-110, 79 Stat. 437 (1965) (codified as amended in 52 U.S.C. §§ 10101-10702).

24. Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964) (codified as amended in sections of 42 U.S.C. §§ 2000 et seq.).

25. Fair Housing Act of 1968, Pub. L. No. 90-284, 82 Stat. 73 (1968) (codified as amended in 42 U.S.C. §§ 3601-3631).

26. Already expensive upon its initial implementation, the cost of publicly funded healthcare has grown substantially in the decades since 1965. Medicare alone is over twice the size of any single private insurer with 2021 expenditures of over \$900 billion. *See NHE Factsheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> [<https://perma.cc/54VQ-N3V6>] (last modified Dec. 14, 2022).

27. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in 42 U.S.C. §§ 301 et seq.).

28. *Id.* at 42 U.S.C. §§ 1396 et seq.

29. *See generally* ARTHUR M. SCHLESINGER, JR., *THE AGE OF ROOSEVELT VOL. 2: THE COMING OF THE NEW DEAL* (1958).

30. *See* Rosemary A. Stevens, *Health Care in the Early 1960s*, 18 HEALTH CARE FIN. REV. 11 (1996).

economic prosperity for millions of people.³¹ Congressional liberals wanted what would today be called a single-payor health plan, financed by direct taxation and administered by the federal government.³² More conservative policymakers believed that such a system would be too costly and would fail to see the results promised by leading Democrats in Congress and the White House.³³

Congress struck a series of compromises to provide some healthcare for the most vulnerable members of American society without overextending the federal budget.³⁴ Medicare would not cover everyone; it would only cover individuals who had reached the approximate age of retirement.³⁵ This alone would not have satisfied congressional liberals because the elderly were not the

31. When President Johnson signed the enabling legislation, he spoke about the “injustice” of denying “the miracle of healing to the old and to the poor.” See Lyndon B. Johnson, *Remarks with President Truman at the Signing in Independence of the Medicare Bill*, THE AMERICAN PRESIDENCY PROJECT (July 30, 1965) <https://www.presidency.ucsb.edu/node/241296> [<https://perma.cc/3ZT2-AEC2>]. The New Deal had a lasting impact on both the ideologies and career trajectory of President Johnson. He saw his Great Society initiatives as the continuation of progressive policies began under the Franklin Roosevelt administration, continued at least in spirit by President Truman, but never completed. Johnson saw many reforms as ripe for completion by the time he became president in 1963. It was a typically grand Johnsonian gesture that he signed Medicare and Medicaid’s enabling legislation alongside former President Truman at the Truman Presidential Library in Independence, Missouri. *Id.*; see also ROBERT A. CARO, *THE YEARS OF LYNDON JOHNSON: THE PATH TO POWER* 526-81 (Vintage Ed., 1990) (examples of Johnson’s work with Roosevelt and his role in New Deal legislation); Zelizer, *supra* note 1, at 73-74 (describing Johnson’s conflicted personal politics on civil rights but his longstanding commitment to the New Deal).

32. The movement towards single-payor healthcare in the United States dates at least to the very early twentieth century with roots in the labor movement and workers’ rights. By the 1930s, Roosevelt wanted to include healthcare in the Social Security Act but had to push it aside to pay for the statute’s primary goal of income for seniors. See Abigail Abrams, *The Surprising Origins of ‘Medicare for All’*, TIME (May 30, 2019, 2:05 PM), <https://time.com/5586744/medicare-for-all-history/> [<https://perma.cc/J6K4-TVT5>]. The first president to call for government funded healthcare was Harry Truman in his 1949 State of the Union address. See Harry S. Truman, *Annual Message to the Congress on the State of the Union*, THE AMERICAN PRESIDENCY PROJECT (Jan. 5, 1949) <https://www.presidency.ucsb.edu/documents/annual-message-the-congress-the-state-the-union-21>.

33. See Julian E. Zelizer, *The Contentious Origins of Medicare and Medicaid*, in *MEDICARE AND MEDICAID AT 50: AMERICA’S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE* (Alan B. Cohen et al. ed., Oxford Univ. Press 2015); see also Jonathan Oberlander & Theodore R. Marmor, *The Road Not Taken: What Happened to Medicare for All?*, in *MEDICARE AND MEDICAID AT 50: AMERICA’S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE* (Alan B. Cohen et al., Oxford Univ. Press 2015); see also discussion of Chairman Wilbur Mills’ political dilemma *supra*, Introduction.

34. See ZELIZER, *supra* note 2, at 226 (discussing the rapidly increasing strain of the Vietnam War on the federal budget as Johnson needed increased spending to cover Great Society programs).

35. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in 42 U.S.C. §§ 301 et seq.).

only population unable to cover healthcare expenses.³⁶ Children and adults under retirement age who lived below the poverty line would need coverage as well, but the federal budget could not withstand that level of spending.³⁷ Chairman Mills brokered a compromise that would permanently and radically alter the healthcare delivery system in the United States, as well as extend limited but vital healthcare to low-income Americans. States would have the option to take part in a program funded jointly by the federal and individual state governments, administered by the state governments through the restrictions of federal guidelines, and it would be incumbent upon the states to enroll and oversee the cases of individuals who qualified.³⁸ This was Medicaid.

Even with a cost-sharing approach, Medicaid had the potential to become untenably expensive. Poverty was rising in the 1960s and with it rose the number of potential Medicaid enrollees.³⁹ Congress sacrificed two subsets of that population, both inherently likely to live below the poverty line. People who are incarcerated and people in need of inpatient psychiatric care have never received full benefits under Medicaid due to the resulting inmate exclusion⁴⁰ and the institutions for mental diseases (IMD) exclusion.⁴¹ Likely meant as a politically acceptable means to an end of paying for the majority of Medicaid eligible individuals, some of the most marginalized people in the United States have been living and dying without medically necessary care due solely to the involuntary status of having a severe mental illness (SMI).

In 1965, people with SMI and other behavioral health diagnoses had long been relegated to the margins of society.⁴² Psychiatric hospitals or “asylums” varied greatly in standard of care and carried a public perception, somewhat

36. *Id.*; Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (although the 1965 amendments created Medicare to extend coverage to the elderly, a second round of amendments in 1972 extended Medicare to people ages twenty-one to sixty-four who have been considered disabled by the federal government for at least two years).

37. The total costs of any health plan, whether private insurance or publicly funded programs, include both reimbursements (paying healthcare providers for services) and administrative expenses. Medicaid administrative costs are relatively low, about five percent, which is consistent with federal programs supporting low-income individuals. See *MACStats: Medicaid and CHIP Data Book*, MEDICAID & CHIP PAYMENT & ACCESS COMM’N. 37-74 (Dec. 2022), https://www.macpac.gov/wp-content/uploads/2022/12/MACSTATS_Dec2022_WEB-508.pdf [<https://perma.cc/Q7PV-FWP6>].

38. 42 U.S.C. §§ 1396 et seq.

39. For an in-depth discussion of the causes of income inequality in the twentieth century, see Robert D. Plotnick et al., *The Twentieth Century Record of Inequality and Poverty in the United States*, INST. FOR RSCH. ON POVERTY (1998), <https://www.irp.wisc.edu/publications/dps/pdfs/dp116698.pdf> [<https://perma.cc/XM5N-WR6G>].

40. 42 U.S.C. §1396d(a)(31)(A) (barring Medicaid funds from covering healthcare services for, “any individual who is an inmate of a public institution).

41. 42 U.S.C. §1396d(a)(31)(B) (barring Medicaid funds from covering, “care or services for any individual who has not attained sixty-five years of age and who is a patient in an institution for mental diseases”).

42. See E. FULLER TORREY, *AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL HEALTH TREATMENT SYSTEM* 44-45 (2014) (hereinafter *AMERICAN PSYCHOSIS*); see Zelizer, *supra* note 2, at 181.

accurately, of not being places for efficacious medical treatment.⁴³ Exposés on the abhorrent conditions within some individual psychiatric institutions throughout the twentieth century contributed to a movement towards deinstitutionalization.⁴⁴ The noble intentions of that movement likely contributed to the creation of the IMD exclusion, or at least to the acceptance of the exclusion by the psychiatric community, members of Congress, and the general public.⁴⁵ Its results have been far from beneficial for people with SMI.

A. Impact of the IMD Exclusion

The IMD exclusion bars federal fund participation (FFP) from reimbursing treatment in a facility that specializes in inpatient psychiatric care and has more than sixteen beds.⁴⁶ The effect of federal funds flowing towards every other type of healthcare services but not to psychiatric care has been a devastating reduction in the number of available psychiatric beds.⁴⁷ Available psychiatric beds, particularly in state hospitals, have declined gradually but dramatically over the last sixty years.⁴⁸ Fewer psychiatric beds means less access to mental healthcare for people who have the most serious mental health conditions. Some common SMI symptoms necessitate inpatient care far more than other, less severe mental health conditions.

People with SMI live under the constant specter of experiencing psychosis, the condition that leaves a person out of touch with reality and believing that

43. See AMERICAN PSYCHOSIS, *supra* note 41, at 61-92; Sabah H. Muhammad & J. Michael E. Gray, *An Untenable Space: The Dilemma of Black Families Caring for a Loved One with Severe Mental Illness and an Argument for a Legislative Solution*, 53 Tex. Tech L. Rev. 575, 577-81 (2021).

44. See AMERICAN PSYCHOSIS, *supra* note 41, at 44-45; Community Mental Health Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (1963) (codified as amended in 42 U.S.C. §§ 2661-2698(b)) (the movement reached its legislative apex with the last major legislation signed by President Kennedy before his death).

45. It is worth noting that the IMD exclusion received negligible attention from Congress, the Johnson administration, and the public at the time of its passage. In fact, Medicare completely overshadowed Medicaid at that time. Considering the impact Medicaid has had on the federal budget and the treatment of mental illness, it is shocking how little discussion occurred in 1965. See AMERICAN PSYCHOSIS, *supra* note 41, at 72-73 (citing interviews and testimony of individuals who worked on the Social Security Amendments).

46. See 42 U.S.C. § 1396d(a)(31)(B) (text of the IMD exclusion); see also 42 U.S.C. § 1396d(i) (defining IMDs as, “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.”).

47. See generally Doris A. Fuller et al., *Going, Going, Gone*, TREATMENT ADVOC. CTR. 1-5 (June 2016), https://www.treatmentadvocacycenter.org/reports_publications/going-going-gone-trends-and-consequences-of-eliminating-state-psychiatric-beds/ [https://perma.cc/8EGQ-5MRZ].

48. *Id.*

irrational and objectively untrue delusions are authentic.⁴⁹ SMI is generally treatable through medication and other services, but each case is unique, and some people experience SMI that is treatment resistant.⁵⁰ SMI is not like other less debilitating forms of mental illness in that it, almost without exception, completely disrupts the life of the person with the diagnosis and can be extremely difficult to treat for long periods of time.⁵¹ The IMD exclusion keeps those who require periodic inpatient psychiatric care from accessing it. In some states, that means they can access a hospital bed for limited amounts of time.⁵² In other states, it is nearly impossible for them to access inpatient psychiatric care at all.

49. See NAT'L INST. MENTAL HEALTH, U.S. DEP'T HEALTH & HUM. SERV., PUB. NO. 20-MH-810, UNDERSTANDING PSYCHOSIS 1-3 (Dec. 2019), <https://www.nimh.nih.gov/sites/default/files/documents/health/publications/understanding-psychosis/understanding-psychosis.pdf> [<https://perma.cc/Y4QF-SR5Q>].

50. See E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 100 (7th ed. 2019) (hereinafter SURVIVING SCHIZOPHRENIA).

51. See *id.* at 70-83 (quoting Justice Ginsburg “placement outside the institution may never be appropriate,” and acknowledging the severity of some mental health cases); see also *Olmstead v. L. C. by Zimring*, 527 U.S. 581, 605 (1999) (citing Brief for American Psychiatric Association et al. as Amicus Curiae Supporting Respondents, *Olmstead v. L. C. by Zimring*, 527 U.S. 58 (1999), 1999 WL 134004).

52. States have two options for accessing FFP for inpatient SMI treatment in IMDs and both are limited in scope. The first is a 2016 rule that allows one stay of up to fifteen days within a monthly payment period. See Special Contract Provisions Related to Payment, 42 C.F.R. § 438.6(e) (2020), <https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-sec438-6.pdf>. The other is via Sec. 1115 of the Social Security Act, through which states may apply for demonstration waivers. See 42 U.S.C. § 1315a. Through a “demonstration project,” CMS has the authority to waive specific provisions of Medicaid law. *Id.* at § 1315a(d). As the name implies, the waivers are an opportunity for states to demonstrate an alternative way to provide services to Medicaid enrollees that is more efficient and/or furthers the legislative intent of the enabling legislation. This process is not generally an organic one, in which states may envision a new method of reimbursing for services and apply to CMS. Rather, it is a top-down process, in which CMS creates waiver opportunities and then notifies state Medicaid departments. See e.g. Letter from Daniel Tsai, Deputy Adm'r & Dir., Ctr. for Medicare & Medicaid Serv., to State Medicaid Dir. (Apr. 17, 2023), <https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf>. CMS began accepting applications to partially waive the IMD exclusion with respect to substance use disorder (SUD) in 2015 and with respect to SMI in 2018. See Letter from Vikki Wachino, Deputy Dir., Ctr. for Medicare & Medicaid Ser., to State Medicaid Dir. (July 27, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf> (announcing SUD waiver opportunity); see also Letter from Mary C. Mayhew, Deputy Adm'r & Dir., Ctr. for Medicare & Medicaid Ser., to State Medicaid Dir. (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf> (announcing SMI waiver opportunity). Sec. 1115 SMI demonstration waivers allow individual stays in an IMD of up to sixty days so long as the statewide average length of stay does not exceed thirty days. The fifteen-day rule dates from 2016 and the first states to obtain waivers did so beginning in 2019. Both provisions are better than having no method of accessing FFP but they both ignore the needs of people with chronic conditions like SMI who sometimes need longer hospital stays. The fifteen-day rule is only available to states with Medicaid managed care, and most states do. See *infra* Section III C. However, the waivers require significantly more effort from state Medicaid departments and only ten states and the District of Columbia have taken advantage of the SMI opportunity as of December 1, 2023.

The lack of access to inpatient beds is not just about acute care and stabilizing the symptoms of a person with SMI; it is also about achieving long term stability in the life of that person. SMI advocates, the individuals and organizations who seek better access to care for people living with SMI, describe a “revolving door”—the endless cycle from hospital, to incarceration, experiencing homelessness, and back again. SMI advocates also advocate for a “continuum of care,” meaning “a variety of services including but limited to inpatient psychiatric facilities, outpatient services, housing support, integration of behavioral health and criminal justice solutions, and other services.”⁵³ Quality inpatient services are the cornerstone of that continuum and, although part of the revolving door cycle, inpatient care is also necessary to ending that cycle and achieving long term stability.⁵⁴ When a person is experiencing psychosis and lacks insight into their own condition,⁵⁵ inpatient psychiatric treatment can be medically necessary and is the most likely way to prevent them from further deterioration.⁵⁶ Denying a person that treatment is not a furtherance of the deinstitutionalization movement; it is an inhumane insistence that they languish on the streets, in jails, and in prisons because they could not access a treatment bed when they needed it.

B. Inherent Discrimination of the IMD Exclusion

The IMD exclusion’s denial of inpatient psychiatric services to people with SMI is not only ethically unconscionable but also unconstitutional. People with SMI are a quasi-suspect class and are entitled to intermediate scrutiny under the Fourteenth Amendment’s Equal Protection Clause.⁵⁷

53. See J. Michael E. Gray, *HIPAA, Telehealth, and the Treatment of Mental Illness in a post-COVID World*, 46 OKLA. CITY U. L. REV. 1, at note 43 (2021); accord Debra A. Pinals & Doris A. Fuller, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, TREATMENT ADVOC. CTR. 3 (Oct. 2017).

54. See generally Pinals & Fuller, *supra* note 52.

55. See AMERICAN PSYCHOSIS, *supra* note 41, at 95.

56. Psychiatric deterioration is a term used in the statutory language of twenty-five states to describe the impact of SMI on a person’s brain functioning. Psychiatric deterioration is a form of harm to self that can be prevented through medical treatment in an appropriate facility. There are both physical manifestations in the brain matter and behavioral symptoms of a patient that result from lack of treating SMI. See Dailey et al., *Grading the States: An Analysis of U.S. Psychiatric Treatment Laws*, TREATMENT ADVOC. CTR. 18-20 (Sept. 2020). The latest state to include psychiatric deterioration as a criterion for inpatient commitment is Louisiana, and that state defines it as, “a decline in mental functioning, which diminishes the person’s capacity to reason or exercise judgment.” LA. STAT. ANN. § 28:2(28) (2022).

57. The relevant text of the Fourteenth Amendment reads:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; *nor deny to any person within its jurisdiction the equal protection of the laws.*

U.S. CONST. amend. XIV, § 1 (emphasis added).

The federal courts apply intermediate scrutiny, also known as heightened scrutiny, to determine whether a legal provision unconstitutionally discriminates against a class of quasi-suspect individuals. Once the court determines that individuals fall within a quasi-suspect class, then it examines the nature of a policy that discriminates against the members of that class to see if it can identify a state interest. If the discriminatory act has such a government interest, then it may pass the intermediate scrutiny test and the discrimination may persist.⁵⁸

People with SMI constitute a quasi-suspect class by passing jurisprudential muster of 1) being subjected to “a history of purposeful unequal treatment;”⁵⁹ 2) possessing a characteristic that “bears no relation to ability to perform or contribute to society;”⁶⁰ are a “discrete group;”⁶¹ and have been “relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process.”⁶²

People living with SMI experienced purposeful unequal treatment prior to

Courts apply either strict scrutiny, intermediate (also known as heightened) scrutiny, or rational basis to determine if a public law or program violates the Equal Protection Clause. For a full analysis of Equal Protection Clause violation with relation to mental illness, *see* Gray & Easdale, *supra* note 12, at 182-6.

58. *See e.g.*, *Wengler v. Druggists Mutual Ins. Co.*, 446 U.S. 142 (1980). Wengler was part of a late-twentieth century slew of cases that came to define the middle tier of judicial discrimination analysis. *See also* *Craig v. Boren*, 429 U.S. 190 (1976); *Califano v. Goldfarb*, 430 U.S. 199 (1976); *Califano v. Westcott*, 443 U.S. 76 (1979). These cases leading up to Wengler synthesized rules related to scrutiny in questions of gender discrimination. The concept of intermediate scrutiny in this context has both troubled and confounded this article’s author since his first year of law school. The idea that classes of individuals may face discrimination if there is a government interest in oppressing them seems counterintuitive to the nature of twentieth century and contemporary movements towards equality, even if it is consistent with most of American history. A human-made legal framework justifying the unequal treatment of classes of people who have not been adjudicated as wrongdoers encapsulates the nation’s pre-Civil Rights Era institutionalized bigotry more than it achieves equality or equity.

59. *See* *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312-13 (1976) (summarizing and reapplying the element of historical purposeful unequal treatment. “[E]qual protection analysis requires strict scrutiny of a legislative classification only when the classification impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class”).

60. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440-41 (1985) (quoting *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973)). *Frontiero* involved gender and historical discrimination, which is a different subject matter from mental illness, but the court’s analytical framework is still useful here.

61. *See* *United States v. Carolene Products Co.*, 304 U. S. 144, 152-153, n.4 (1938) (origin of the terminology, considering an alleged violation of the Fifth Amendment’s interstate commerce clause); *Massachusetts Board of Retirement v. Murgia*, 427 U. S. 307, 313-14 (1976) (application of the term to a Fourteenth Amendment’s equal protection clause regarding age discrimination); *Brown v. Gilliard*, 483 U.S. 587, 602 (1987). *Brown* is another Fifth Amendment challenge but has a related and useful line of reasoning. *See also* *Lyng v. Castillo*, 477 U.S. 635, 638 (1986). *Carolene Products Co.*, 304 U.S. at 153, n. 4. In the case of codified discrimination due to mental illness, the level of injustice does indeed call for a more searching inquiry.

62. *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 30 (1973).

1965, and the IMD exclusion only exacerbates their unjustly unequal place in American society. They also “contribute to society” in countless ways.⁶³ The *Frontiero* court discussed “immutable characteristic[s] determined solely by the accident of birth” and the constitutionality of allowing discrimination based on such characteristics.⁶⁴ The *Cleburne* court then analyzed the involuntary nature of some conditions, *i.e.*, *Frontiero*’s “accident of birth,” and whether they bear any relationship to one’s ability to contribute to society.⁶⁵ The status of living with mental illness is an “accident of birth,” or more accurately, the result of many factors outside the control of a person living with the condition, and does not bar them from having a positive impact on society.⁶⁶

For the question of whether a number of people constitute a discrete group, several cases apply some version of the phrase “discrete and insular” and then ask whether being such a minority group creates a “special condition” hampering the political processes which should be protecting a class of people.⁶⁷ In *Lyng*, Justice Stevens considered whether members of a “disadvantaged class” have been “subjected to discrimination,” have “exhibit[ed] obvious, immutable, or distinguishing characteristics that define them as a discrete group,” and are a “minority or politically powerless.”⁶⁸ In several other cases examining this issue, courts asked if people who are different from the majority in some way have been subjected to injustices by state or federal law and if that discrimination, in the phrasing of the Court in *Carolene Products Co.*, “may call for a correspondingly more searching judicial inquiry.”⁶⁹ In the case of codified discrimination due to mental illness, the level of injustice does indeed call for a more searching inquiry.

The last criterion, concerning political powerlessness, has some overlap with the question of discrete and insular groups. The political powerlessness of people with SMI is due in large part to the lack of available treatment to get patients stable enough to take part in the political system. While it is not impossible for a person who is experiencing homelessness due to mental illness, for example, to be informed and vote in public elections, it is more difficult for them to do so than someone who is not living with those symptoms and in those conditions. Furthermore, political power is much more than voting. The more

63. See Gray & Easdale, *supra* note 12.

64. *Frontiero* 411 U.S. at 686.

65. *City of Cleburne*, 473 U.S. at 441-42.

66. See *e.g.*, Radhika Chalasani, Famous People Living with Bipolar Disorder (April 11, 2018, 9:37AM), <https://www.cbsnews.com/pictures/famous-people-celebrities-bipolar/> (discussing a few of the many people living with bipolar disorder who have found success in the entertainment industry).

67. *Carolene Products Co.*, 304 U. S. 144, 152-53 n.4; *Massachusetts Board of Retirement v. Murgia*, 427 U. S. 307, 313-14 (1976) (application of the term to a Fourteenth Amendment’s equal protection clause regarding age discrimination); *Brown v. Gilliard*, 483 U.S. 587, 602 (1987). *Brown* is another Fifth Amendment challenge but has a related and useful line of reasoning. See also *Lyng v. Castillo*, 477 U.S. 635, 638 (1986).

68. *Lyng*, 477 U.S. at 638.

69. *Carolene Products Co.*, 304 U.S. at 153 n.4.

nuanced aspects of influencing political systems require levels of experience, knowledge, social status, financial resources, and other attributes that are difficult for people with untreated SMI to possess.

People living with SMI meet all criteria as a quasi-suspect class, and as members of a constitutionally protected class, there is no government interest in discriminating against them by denying them the same level of care as people without SMI.⁷⁰ Treating different classes of people unequally under the law is the anthesis of the Equal Protection Clause. Treating one group of people differently than others on the basis of a psychiatric condition violates yet another framework for equity—mental health parity.

III. PARITY: CONGRESSIONAL INTENT TO BRING ABOUT HEALTHCARE JUSTICE FOR PEOPLE WITH MENTAL HEALTH CONDITIONS

Mental health parity means equal coverage or equal restrictions to coverage for both behavioral health—*e.g.*, mental illness, intellectual disabilities, and substance use disorder treatment—and medical/surgical coverage, *i.e.*, everything that is not behavioral health.⁷¹ Several pieces of state and federal law govern mental health parity in the United States and Congressional intent on the topic is clearest in the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA),⁷² and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).⁷³ Those three statutes, in chronological order, represent a progression towards undoing past acts of Congress that impose inequality on healthcare services and other public programs.

A. Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973⁷⁴ was the first post-IMD exclusion indication that Congress no longer wanted to single out people with disabilities like SMI and deny them the benefits of federally funded programs that people without disabilities may receive. Section 504 was the first step in a five-decade arc towards recognition that federal law systematically discriminates against some classes of people: “No otherwise qualified individual

70. Unless, of course, the government wants to oppress them. This is unlikely considering evolving congressional desire to protect and provide treatment for people with SMI. *See infra* Sections III & IV. But little scholarship exists addressing the question of whether the legislative and executive branches of federal and state governments have a nefarious but calculated interest in refusing the upward mobility of people living with mental illness.

71. *See generally What is Parity?* THE KENNEDY FORUM, <https://www.thekennedyforum.org/parity/> [https://perma.cc/DSSZ-NYT5] (last visited Feb. 19, 2024).

72. Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101-12213 (2018).

73. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (2008).

74. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355 (1973) (codified as amended in sections of 29 U.S.C. §§ 701 et seq).

with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”⁷⁵ A plain reading of Section 504 in a vacuum would invalidate the IMD exclusion; state Medicaid programs are “receiving federal financial assistance” as a function of their existence. In fact, CMS uses federal Medicaid funds to reimburse healthcare providers for literal rehabilitation services, and mental illness is the leading cause of disability in the United States.⁷⁶ But its intent and scope focused more on individualized plans for students with disabilities and some accommodations for adults.⁷⁷ Its relevance to this article lies in the wink and nod that Congress gave to the existence of federally sanctioned discrimination as well as the public push back when the federal Department of Health, Education, and Welfare (HEW) did not enforce the law as written.

HEW had promulgated no regulations to enforce Section 504 four years after its passage. The American Coalition of Citizens with Disabilities (ACCD) organized a sit-in of HEW’s headquarters in Washington, DC to vent frustration and draw attention to the lack of follow-through by the federal government.⁷⁸ The DC protest generated public support for people with disabilities and led to many more demonstrations around the country. The most visible and effective of the ensuing demonstrations was arguably an occupation of a HEW building in San Francisco that lasted twenty-five days.⁷⁹ Attention garnered by disability rights activists undoubtedly got the attention of both the White House⁸⁰ and Congress, but federal policy shifts happen slowly, and it was another thirteen years before either acted to address federal discrimination against people with disabilities in any meaningful way.

B. Americans with Disabilities Act of 1990

Congress passed the ADA in 1990 as the legislative apex of an advocacy effort, stretching at least from the time prior to Section 504 in the early 1970s, to extend civil rights protections and guarantee accommodations for people with

75. 29 U.S.C. § 794(a). This is the language of Sec. 504 from the enabling legislation.

76. *Mental Health Awareness*, CDC (January 20, 2011), <https://archive.cdc.gov/#/details?q=Mental%20Health%20Awareness&start=0&rows=10&url=https://www.cdc.gov/genomics/resources/diseases/mental.htm>.

77. See DORIS ZAMES FLEISCHER, *THE DISABILITY RIGHTS MOVEMENT: FROM CHARITY TO CONFRONTATION* 49-70 (2001).

78. See *id.* at 53-55.

79. See *id.* at 29, 53-55.

80. President Richard Nixon vetoed the first two attempts at the legislation, then finally gave in on the third bill that passed Congress. See e.g., Richard M. Nixon, *Veto of the Vocational Rehabilitation Bill*, THE AM. PRESIDENCY PROJECT (March 27, 1973), <https://www.presidency.ucsb.edu/documents/veto-the-vocational-rehabilitation-bill> (Nixon’s message on the veto of one of the two bills; the other was a pocket veto, meaning he allowed the bill to expire without his signature).

disabilities. This group, in the words of the 101st Congress, constitutes:

[A] discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society.⁸¹

The ADA specifically included mental health conditions alongside physical disabilities as conditions in need of federal protection against discrimination.⁸² Subsequent regulations authorized by the ADA and the ADA Amendments of 2008 further specify the severe mental illnesses of schizophrenia, bipolar disorder, and major depressive disorder all have the ADA's protections.⁸³ The ADA requires all public entities to avoid providing services in a way that discriminates on the basis of a disability.⁸⁴ Since state Medicaid departments are public entities and SMI is a disability under the ADA, failing to provide healthcare services equally for SMI patients and Medicaid enrollees without SMI has the practical effect of denying them accommodations for their disabilities.

If one Medicaid enrollee has a physical ailment, such as a broken leg, Medicaid will cover the entire spectrum of care that is medically necessary, from diagnosis and testing to hospital admission, through discharge and physical therapy. However, if another Medicaid enrollee has a mental health diagnosis, such as schizophrenia, Medicaid will only cover part of the continuum of care for the patient and will not usually provide the inpatient care adequate for stabilization.⁸⁵ It is the equivalent of denying the patient with the broken leg inpatient services needed to surgically reconstruct their leg but offering outpatient services that will never allow them to regain function and walk. As

81. Originally codified as 42 U.S.C. § 12101(a)(7), the 110th Congress subsequently deleted that paragraph but did nothing to counteract its intent or effect. The paragraph is still relied upon by the federal judiciary in valid case law, *e.g.*, *Martin v. Voinovich*, 840 F. Supp. 1175, 1209 (S.D. Ohio 1993).

82. *See e.g.*, 42 U.S.C. § 12101(a)(1).

83. *See* 29 C.F.R. § 1630.2(j)(3)(iii) (2011) (“[I]t should easily be concluded that the following types of impairments will, at a minimum, substantially limit the major life activities indicated . . . [including, *inter alia*] major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, and schizophrenia.”). By implication, this definition also includes schizoaffective disorder. Schizoaffective disorder is a condition in which an individual experiences the major “mood episode” symptoms of bipolar disorder and the delusions or hallucinations of schizophrenia. *See* Dolores Malaspina et al., *schizoaffective disorder in the DSM-5*, 150 SCHIZOPHRENIA RSCH. 21 (2013). (defining and discussing schizoaffective disorder).

84. *See* 28 C.F.R. § 35.130(b)(3) (2016).

85. This is both the very nature and the real-world effect of the IMD exclusion.

absurd as that would be, it is what happens to SMI patients denied medically necessary Medicaid benefits by the state because of federal law.⁸⁶ The effect of the IMD exclusion is to discriminate on the basis of disability, the exact behavior by a public entity that Congress intended to end with the ADA.

C. Mental Health Parity and Addiction Equity Act of 2008

Decades of advocacy for congressional action on parity resulted in the MHPAEA. Senators Paul Wellstone and Pete Domenici led a bipartisan effort for legislation to hold health insurance plans accountable and force them to treat mental health conditions and physical conditions equitably.⁸⁷ Despite several earlier attempts,⁸⁸ MHPAEA passed into law as a rider on a funding bill in late 2008 and required, *inter alia*, parity in deductibles and copayments, amount of coverage (*e.g.*, doctor visits or length of stay), parity in out-of-network care, and disclosure to those covered under a health plan of any medical reasons for denial of benefits.⁸⁹ It was a clear statement of Congressional intent to disallow discrimination by health plans in the form of coverage disparity.⁹⁰

Although Congress specifically carved out Medicaid and Medicare from MHPAEA, most states administer Medicaid via contracts with private entities

86. Medicaid is administered at the ground level by states but governed in large part by federal law. *See* 28 C.F.R. § 35.130(b)(3) (2016).

87. Sen. Ted Kennedy and his son Rep. Patrick Kennedy were also heavily involved in the formulation and passage of MHPAEA. For a brief general history of the legislation, *see* Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18390, 18391 (March 30, 2016).

88. Mental health advocates and their allies in Congress made a hard push for parity legislation in the mid-1990s. They succeeded in passing the Mental Health Parity Act of 1996 (MHPA). Pub. L. No. 104-204, 110 Stat. 2874 (1996). MHPA began with lofty goals but passed as a gesture to the mental health advocacy community. Senators Wellstone and Domenici attempted to amend the Health Insurance Portability and Accountability Act (HIPAA) with far-reaching parity language, but they were thwarted, in part, by a hefty price tag for their legislation. *See* C.B.O. Rep. May 13, 1996, https://www.cbo.gov/sites/default/files/104th-congress-1995-1996/reports/1996_05_13_parity.pdf [<https://perma.cc/5W8X-SPYX>] (projecting a 4 percent increase in the employers' share of private health plans). MHPA required group health plans that offered mental health coverage to apply the same annual limits for that coverage as for medical/surgical benefits. For a discussion of the history of mental health parity legislation, including MHPA, *see* Colleen L. Barray et al., *A Political History of Federal Mental Health and Addiction Parity*, 88 MILBANK Q. 404 (2010).

89. Pub. L. No. 110-343, 122 Stat. 3765 (2008).

90. The term "equity" in this context should not be confused with "equality." MHPAEA is about both, but equality means access to mental healthcare on an equal footing with primary healthcare. Equity, however, is about the appropriateness of that care. For a patient with SMI, access to psychiatric care may be useless unless qualified mental health providers treating the patient have expertise in the exact diagnosis and symptoms the patient exhibits. For a brief discussion of equality versus equity, *see* "How are Equity and Equality Different?" Just Health Action (2010), <http://justhealthaction.org/wp-content/uploads/2010/05/JHA-Lesson-Plan-3-How-are-equity-and-equality-different-final.pdf> [<https://perma.cc/8D6M-E8JZ>].

that manage the delivery of services for Medicaid enrollees. These entities, known as managed care organizations (MCOs),⁹¹ are subject to parity provisions under MHPAEA.⁹² The federal Centers for Medicare and Medicaid Services (CMS) promulgated a rule in 2016 addressing this issue.⁹³ CMS clarified which provisions of MHPAEA apply to MCOs,⁹⁴ but the agency performed some deliberate mental gymnastics in explaining why MHPAEA does not apply to the IMD exclusion.⁹⁵ While frustrating for advocates and members of Congress who see the IMD exclusion as stark disparity in coverage, it is not CMS' fault that it failed to apply MHPAEA to the exclusion through the regulatory process. CMS was faced with two statutes of conflicting purpose, and it is not the role of an executive branch agency to compare two eras of American political history and determine if Congress has shifted its position implicitly through statutory interpretation. That is, however, one of the roles of the federal judiciary.

IV. THE IMD EXCLUSION AS MENTAL HEALTH DISPARITY: THE SUBJECTIVITY OF GENERALITY

MHPAEA, the ADA, and the Rehabilitation Act render the IMD exclusion unenforceable because all four apply to mental illness treatment, but the IMD is broad compared to those subsequent legislative acts that contemplated mental healthcare and more specifically addressed disparity. An act of Congress that expresses explicit intent towards a specific goal supersedes a more general legislative act.⁹⁶ The Rehabilitation Act, ADA, and MHPAEA represent an evolution of congressional intent towards equality and equity between psychiatric care and other medical treatment. The IMD exclusion affected discrimination against people with SMI, but it was written both hastily and broadly, with varying implications for several groups of people. People living with SMI have taken the brunt of the IMD exclusion's discriminatory outcomes, but people living with less severe (although still serious) mental illnesses, substance use disorder, personality disorders, some juveniles living with severe emotional disturbances, and others are also victims of one small paragraph

91. Thirty-nine states and the District of Columbia contract with Medicaid MCOs. *See Total Medicaid MCOs*, KAISER FAMILY FOUNDATION, <https://www.kff.org/medicaid/state-indicator/total-medicaidmcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/2HZ9-PYB8>].

92. *See* Medicaid and Children's Health Insurance Programs *supra* note 86.

93. *See id.*

94. *See id.*

95. *See id.* at 18423. The regulation is shortsighted; it points out that, "The full range of covered services, including MH/SUD services, could be provided to beneficiaries when they are in facilities that are not IMDs," completely ignoring the highly specialized nature of psychiatry within the medical field. IMDs are staffed by doctors, nurses, and other staff who understand SMI and how to treat it in ways that general hospitals usually cannot.

96. *See e.g.*, *Dobbins v. Terrazzo Machine & Supply Co.*, 479 S.W.2d 806 (Tenn. 1972) (explaining the tendency of the court to apply specific statutory provisions over competing general language).

enacted nearly six decades ago. In the wake of that prejudicial paragraph, attitudes towards inpatient psychiatric treatment in the United States have changed, and Congress has changed along with its constituents. The specific aim of MHPAEA to ensure mental health parity in the ways that health plans reimburse healthcare providers is the strongest and most recent indication that the IMD exclusion cannot withstand an analysis of congressional intent.⁹⁷

A tenet of judicial statutory interpretation is that specific legislation regarding a given subject matter is paramount to general legislation on the same topic.⁹⁸ When a legislature presents the judiciary with two contradictory pieces of legislation, “a statute treating the subject in a general manner should not be considered as intended to effect the more particular provision.”⁹⁹ This common law principle is somewhat idealistic in its presupposition that legislative bodies are aware of the precedents they set and the existing law they supersede each time they pass a bill. It gives legislatures the (possibly unwitting) power to put courts in the position of having to decide what is general and what is “more particular.”

Legislative bodies generally lack the intentional insight into antecedents that are inherent in judicial review. The influence of electoral politics on legislative processes leads to outcomes that are not always tailored with an eye towards judicial scrutiny. Among the most illustrative examples is the Patriot Act, which passed a mere forty-five days after its introduction and faced a plethora of legal challenges.¹⁰⁰ Some bills with more robust history and more regard towards the wellbeing of the people affected by them can still have provisions that are crafted and passed so hastily they do not contemplate the generality or specificity of legislation if it runs afoul of an earlier statute. The very legislation that gave rise to the rule of general versus specific legislative language, *Woodruff v. City of Nashville*, determined a question of an attorney’s avenue for challenging a disbarment proceeding.¹⁰¹ It is doubtful that the court contemplated a matter as nuanced as the history of mental health treatment legislation and the more recent move towards parity. The Social Security Amendments of 1965 were not a hasty reaction to a horrible act of foreign terrorism like the PATRIOT Act nor a strictly procedural law like the state code interpreted by the *Woodruff* court, but the IMD exclusion was still conceived, drafted, heard in committees and both chambers’ floors, and passed at lightning

97. See 153 CONG. REC. S1864-5 (daily ed. Feb. 12, 2007) (statement of Rep. Patrick Kennedy regarding the intent of MHPAEA).

98. See *Dobbins*, 479 S.W.2d at 809.

99. *Id.* (quoting *Woodruff v. City of Nashville*, 192 S.W.2d 1013).

100. USA Patriot Act of 2001, Pub. L. No. 107-56, 115 Stat. 272 (2001). For one of the earlier, and arguably avoidable, challenges to the Patriot Act, see e.g., *Doe v. Ashcroft*, 334 F.Supp.2d 471 (S.D.N.Y. 2004). This is one of the most famous instances of Congress passing legislation so hastily that the legislature’s own internal failsafe mechanisms, like the Office of the Legislative Counsel, did not have the necessary time to vet all aspects of legislation against potential judicial challenges.

101. *Woodruff*, 192 S.W.2d at 86.

speed by congressional standards; the principle from Woodruff could still render it unenforceable as contraveningly vague.

Just as Congress and state legislatures do not always take the time to appreciate the impact of their actions upon legal precedents,¹⁰² its members take even less time to consider the practical future implications of legislative compromises necessitated by political realities at the time they are considering legislation.¹⁰³ Medicare was the political and public policy goal of the Social Security Amendments of 1965. Medicaid was a larger version of an earlier compromise meant to keep Medicare from ever passing the House of Representatives.¹⁰⁴ To save more money in the ever-expanding Great Society social reforms, Congress included the IMD exclusion.¹⁰⁵ Its intent was likely to save money at least as much if not more than to achieve any policy goals. Subsequent legislation related to mental health accommodations and treatment—the Rehabilitation Act, the ADA, and MHPAEA—carried the weight of Congress’ policy and contemplated consequences to people with mental illness.

The 89th Congress made no reference to specific SMI conditions when it created the IMD exclusion,¹⁰⁶ but Congress did express intent regarding mental illness in the other three statutes discussed above.¹⁰⁷ The IMD exclusion had both philosophical and financial underpinnings and has had both unethical and financial consequences,¹⁰⁸ but it very likely survived the legislative process and made its way into the final version of the Social Security Amendments of 1965

102. Or even, at times, governing law like the United States Constitution.

103. One of the most glaring examples of well-intended legislation leading to unintended consequences is related to the topics discussed in this article. The Community Mental Health Act of 1963, *supra* note 43, had the laudable goal of moving people who could thrive with only community-based outpatient treatment away from psychiatric institutions and back into their communities. However, federal support for outpatient care, likely envisioned by President Kennedy, never materialized after his assassination. For an analysis of the transition from Kennedy to Johnson administrations and its policy implications regarding mental healthcare, see Gray & Easdale, *supra* note 12, at 167-71.

104. *See Zelizer, supra* note 1. Chairman Mills dusted off an idea that had passed Congress during President Kennedy’s tenure, The Kerr-Mills Act, and greatly expanded its scope as part of the Social Security Amendments of 1965.

105. *See supra*, Section I.

106. The closest thing to specificity in the IMD exclusion is the term “institution for mental diseases.” *See* 42 U.S.C. §1396d(a)(31)(B). Congress later defined IMDs but did not specify categories of “mental diseases” barred from coverage. *See* 42 U.S.C. § 1396d(i). CMS has interpreted the exclusion broadly, meaning anyone with SMI, *e.g.*, schizophrenia, a serious mental illness like post-traumatic stress disorder, or substance use disorder. All those diagnoses, plus at least dozens more, fall under the wide umbrella of “mental diseases.”

107. *See, e.g.*, 42 U.S.C. § 12101(a)(1) (mental health in the context of ADA); mental health context in MHPAEA is *passim*.

108. The ethical implications involve the lack of parity and blatant discrimination. Regarding the financial toll of the IMD exclusion, several members of Congress have openly been seeking more data on the implications of repealing the exclusion. *See* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2023, 117th Cong. 182 (2022).

as a cost saving device.¹⁰⁹ The 89th Congress chose to single out two populations—those in need of psychiatric care and justice involved persons—and deemed them unworthy of an entitlement program.¹¹⁰ Subsequent landmark legislation represents a more humanitarian bent in the arc towards healthcare justice for the people who are compoundedly marginalized by both living in poverty and being in need of mental healthcare services.

With the MHPAEA, Congress expressed intent to end the discrimination caused by denying mental healthcare parity and with an array of services for people with disabilities, including SMI, under the ADA and Rehabilitation Act. The IMD exclusion fails the common law test of general versus “more particular” legislation in the face of those more recent bills. The newer laws are both more specific to the treatment of mental illness and show Congress’ evolution towards supporting a continuum of care for people living with mental health conditions.

V. CONCLUSION

If this Article correctly assesses Congress’ evolving attitude on protecting and providing services for people with SMI, then why did Congress not repeal the IMD exclusion in 1973, 1990, or 2008? The most likely answer is not just a lack of compassion but also a lack of willingness to pay for it. In the middle part of the last decade, the Congressional Budget Office (CBO) prepared a fiscal analysis of repealing the IMD exclusion and estimated a cost of \$40—\$60 billion over the first ten years.¹¹¹ That is a significant amount of money, but it is also the cost of ending federally sanctioned discrimination and no longer turning a blind eye to mental health disparity. Compared to the amount of overall federal spending—about \$6.27 trillion in the 2022 fiscal year—it would be a small price to ensure better access to healthcare, thus alleviating the suffering of a vulnerable population.

The fallout from a lack of inpatient services,¹¹² and the gap it leaves in the continuum of care, is driving cyclical homelessness,¹¹³ incarceration,¹¹⁴ suicide

109. *See supra*, Section I.

110. *See* 42 U.S.C. §1396d(a)(31) (2018).

111. C.B.O. Rep. Nov. 3, 2015, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr2646directspendingeffectsofitlev.pdf>. [<https://perma.cc/X69P-8SM4>].

112. *See generally* AMERICAN PSYCHOSIS, *supra* note 41.

113. *See* Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates*, 44 *Criminology* 45 (2006).

114. *See* Greg A. Greenberg and Robert A. Rosenheck, *Jail Incarceration, Homelessness, and Mental Health: A National Study*, 59 *Psychiatric Services* 170 (2008).

and other causes of death,¹¹⁵ and violence.¹¹⁶ Congress created this dystopian dichotomy within inpatient care—one group of people cannot access life-saving services while another can, based solely on the former having involuntary conditions. But the resources to counteract that disparity exist and the first steps are known by advocates and mental health providers. Congress can authorize and fund those resources, starting with repeal of the IMD exclusion. If Congress continues to ignore the harm done by the IMD exclusion, then the federal judiciary should question the validity of the exclusion given the shift of congressional intent towards protecting people with mental illness. Allowing this discriminatory law to persist through the 2020s will set the tone for increased suffering among the most vulnerable Americans for the duration of the twenty first century as the number of psychiatric inpatient beds continues to shrink with the number of specialized healthcare providers to deliver services. Either the judicial branch, the legislative branch, or both should bring down barriers to mental healthcare and parity, starting with the IMD exclusion.

115. See Mark Olsson et al., *Premature Mortality Among Adults with Schizophrenia in the United States*, 72 *Psychiatric Services* 1172 (2015) (A study of adult Medicaid recipients with schizophrenia showed decreased life expectancy compared to the general public); Carsten Hjorthøj et al., *Years of Potential Life Lost and Life Expectancy in Schizophrenia: A Systematic Review and Meta-Analysis*, 4 *The Lancet Psychiatry* 295 (2017) (survey of international studies showing decreased life expectancy in people with schizophrenia); Jennifer Boggs et al., *General Medical, Mental Health, and Demographic Risk Factors Associated with Suicide by Firearm Compared with Other Means*, 69 *Psychiatric Services* 677, 683 (2018) (recommending that a mental disorder diagnosis be taken into account when assessing an individual's risk of dying by suicide).

116. See K.S. Douglas et al., *Psychosis as a Risk Factor for Violence to Others: A Meta-Analysis*, 135 *Psychological Bulletin* 679 (2009) (concluding that psychosis is associated leads to a 49%--68% increase in violence towards others). It is indisputable that psychosis sometimes causes acts of violence towards others, but people living with SMI are more likely to the victims of violent acts than to commit them. See Norman Ghiasi et al., *Psychiatric Illness and Criminality*, <https://www.ncbi.nlm.nih.gov/books/NBK537064/#:~:text=People%20with%20mental%20illness%20are%20more%20likely%20to%20be%20a,compared%20to%20the%20general%20population.> [https://perma.cc/Y6EB-6P6S]. Furthermore, suicide is a form of violence, and untreated mental illness increases the risk of dying by suicide. See Boggs et al. *supra*, note 115.