DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: JOINT CONSIDERATION: DATE: November 30, 1981
"Institutions for Mental Diseases"
Docket Nos. 79-52-MN-HC
79-89-MN-HC
80-44-IL-HC
80-150-CT-HC
80-184-CA-HC
Decision No. 231

DECISION

The Board jointly considered five appeals by four different States (Minnesota, Illinois, Connecticut, and California), raising common issues of law and some common issues of fact. Each appeal was from a determination by the Health Care Financing Administration (Agency), disallowing Federal financial participation (FFP) claimed by a State under Title XIX (Medicaid) of the Social Security Act for services provided in a private facility certified by that State as a skilled nursing facility (SNF) or intermediate care facility (ICF). The Agency determined that the facilities were "institutions for mental diseases" and, therefore, FFP was not available under Medicaid for services provided by the facilities to individuals under age 65.

Our decision is based on the States' applications for review; the Agency's responses to the separate appeals; pre-hearing briefing submitted by the State of Connecticut; the transcript of a hearing held before the full Panel on April 22 and 23, 1981, involving all four States; exhibits submitted at the hearing; the Agency's consolidated brief, filed after the hearing; and the States' reply briefs. Although no party objected to joint consideration and, in fact, each State chose to rely on oral presentations by other States on various issues, each State was given a full opportunity to present its individual case.

Because of the complexity of the issues raised, and the number of parties and facilities involved, we have first briefly summarized our decision (Section I). We then present a more detailed analysis of the parties' arguments, divided into three major sections: issues related to the relevant statutory provisions and their legislative history (Section II); issues related to pertinent regulations (Section III); and issues related to certain Agency "criteria" for applying the regulations (Section IV). Finally, we discuss the factual issues raised by specific States (Section V).

I. Summary of Decision

Under Title XIX of the Social Security Act (Act), FFP is not available for certain services provided to any person under 65 who is a patient in an "institution for mental diseases" (IMD). The Act does not define this term. Agency regulations provide that an IMD is an institution "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases," and that whether a particular facility is an IMD is determined by its "overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." The Agency used unpublished supplementary criteria in applying the regulation.

Briefly, the Agency determined that high percentages of the patients in the SNFs and ICFs had mental diseases; that most of the facilities held themselves out as caring for the mentally ill; that some of the facilities had special programs designed specifically for the mentally ill; and that each facility had other characteristics of an IMD under the regulations.

The States did not challenge the validity of the Agency regulations. Rather, the States argued based on their reading of the Act and its history, and on their reading of the regulations, that the IMD exclusion should be interpreted to cover only the traditional mental hospital or its equivalent, not the SNFs and ICFs here. The States challenged the use of the Agency's supplementary criteria, arguing that the criteria were not properly published and, in any event, are flawed and were erroneously applied. In particular, the States attacked the Agency approach of counting patients with mental disorders in the facilities.

Our determinations, discussed in detail below, are as follows:

- The Agency's regulations reflect a reasonable interpretation of the Act and its legislative history, and were clear enough to put the States on notice that facilities such as these SNFs and ICFs are IMDs.

- There is persuasive evidence, by any reasonable standard, to show that the "overall character" of the facilities in question was that of institutions established and maintained primarily for the care and treatment of persons with mental diseases.

- Lack of publication of the criteria does not provide a basis for reversing the disallowances here, since these facilities were IMDs under any reasonable reading of the regulations.

> Although some of the Agency's findings developed through using the criteria carry less weight or represent some inconsistency in applying the criteria, these defects do not invalidate the Agency's findings as a whole.

Based on these findings and conclusions, we have upheld the disallowances.

In doing so, we are mindful that the dispute is, in large part, a consequence of the absence of explicit Congressional guidance in the face of changing circumstances in the care of the mentally ill. Neither side is supported definitively by the Act or its legislative history, and there are countervailing policy considerations involved: the disincentive that these disallowances might provide for the principle of deinstitutionalization of the mentally ill, and the concern of the Agency that States might inappropriately move patients out of mental hospitals into SNFs or ICFs to maximize FFP. But whether or not the law or the regulations should be changed are policy questions beyond the authority of this Board. Our decision essentially is that the Agency's rules, reflecting a reasonable interpretation of the statute, were fairly applied here and that there is substantial evidence in the record to support the conclusion that these facilities were IMDs.

II. The Statute and Legislative History

The major issue raised by the States is whether the statutory language, read in light of the legislative history of the IMD exclusion, compels a reading of the statute and regulations under which the exclusion applies only to institutions which are similar to, or the functional equivalent of, mental hospitals. Stated differently, the issue is whether the Agency application of the statute and regulations to the private, free-standing SNFs and ICFs here is consistent with legislative intent. For the reasons discussed below, we conclude that the Agency interpretation is supported by the language of the statute and that the legislative history does not compel a different reading.

Our discussion of this issue is divided into three parts: the history of development of the IMD exclusion and relevant provisions from Title XIX; a statement of the parties' arguments on this issue; and our analysis of the arguments.

A. Development of the Statutory Exclusion

The Social Security Act Amendments of 1950, Pub. L. 81-734, contained the original IMD exclusion. Those amendments defined "old age assistance," under Title I of the Act, to include payments to residents of most public medical institutions but to exclude "payments to or care

in behalf of ... any individual (a) who is a patient in an institution for tuberculosis or mental diseases, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof." Section 6 of the Act. 1/

When "medical assistance" for the aged was added in 1960, Pub. L. 86-778, that term was similarly defined to exclude payments with respect to long-term "care or services for ... any individual who is a patient in an institution for ... mental diseases ... ." Section 6(b).

The Social Security Act Amendments of 1965, Pub. L. 89-97, removed prohibitions on funding for the mentally ill in a general hospital and provided for the first time for medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. To receive Federal funding for such assistance, however, States had to have programs which met certain standards. Conditions included "the development of alternate plans of care ... for recipients 65 years of age or older who would otherwise need care in such institutions" and "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care." If a State plan included such assistance to patients in public institutions for mental diseases, the State had to show that it was making "satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public [IMDs]." 2/

1/ The relevant House Report states: "Your committee does not favor Federal participation in assistance to persons residing in public or private institutions for mental illness ..., since the States have generally provided for medical care of such cases." H.R.Rep. 1300, 81st. Cong., 1st Sess. 42 (1949). (Emphasis added.)

2/ These provisions were originally proposed as amendments to Titles I (Old-Age Assistance and Medical Assistance for the Aged) and XVI of the Act. Identical provisions were incorporated into Title XIX at Sections 1902(a)(20) and (21). The provisions were promoted on the Senate floor by Senator Carlson who spoke of "great strides in the field of mental disease," stating that he was "convinced that the time has come that these diseases should no longer be set apart from others ... ." He also referred to the need for greater flexibility in care of the aged than in other age groups, since it is difficult to determine whether an elderly person is mentally ill or merely senile, and "it may be appropriate for him at one time to be in a mental institution and at another to be in a nursing home, his own home, or in some other arrangement." 110 Cong. Rec. 21349 (1964).

The House Report on the 1965 Amendments referred to "payments to, or for, patients in mental hospitals ...." H.R.Rep. No. 213, 98th Cong., 1st Sess. 19 (1965). The exclusion was explained (at 126) as relating to patients in public or private mental hospitals since "long-term care in such hospitals had generally been accepted as a responsibility of the States." The term "hospital" was used in the report to explain removal of the exclusion and "nursing homes" were referred to as an alternative to care in such hospitals. 3/

In Title XIX of the Act, also enacted in 1965, the exclusion appears in the general definition of "medical assistance" for which FFP is available, as well as in conjunction with various levels of services. Section 1905(a) currently defines "medical assistance" as --

> payment of part or all of the cost of the following care and services ...
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> (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
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> * * *
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> (4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) ...;
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> * * *
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> (14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;
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> (15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) ...;
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> * * *
>
> except as otherwise provided in paragraph (16), such term does not include --
>
> (A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

3/ Similar language appears in the Senate Report. S.Rep. No. 404, Part I, 89th Cong., 1st Sess. 144-47 (1965). See also, Statement of Senator Ribicoff, 111 Cong. Rec. 15801 (1965).

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in any institution for tuberculosis or mental diseases.

For purposes of Title XIX, the term "intermediate care facility" is defined as --

> an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities ... . Section 1905(c). 4/

The provisions for coverage of ICF services were added by the Social Security Act Amendments of 1972. These Amendments also added paragraph (16) to Section 1905(a), including as "medical assistance" under certain conditions "inpatient psychiatric hospital services for individuals under 21 ... ." The conditions for coverage included that the institution in which the services were provided be "accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals" and that the services involve "active treatment" which could reasonably be expected to improve the patient's condition. Section 1905(h)(1). 5/

4/ This section further provides, "With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d), any public institution or distinct part thereof for mental diseases or defects." Subsection (d) provides that, under certain conditions, ICF services may include services in "a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions ... ."

5/ A Finance Committee amendment which would have also authorized funding of demonstration projects to determine the "potential benefits of extending medicaid coverage to mentally ill persons between the ages of 21 and 65," S.Rep. No. 1230, 92d Cong., 2d Sess. 57 (1972), was dropped in conference, H.R.Rep. No. 65, 92d Cong., 2d Sess. 65 (1972).

B. The Parties' Arguments on Legislative Intent

The States' position is that "Congress intended the term 'institution for mental diseases' to apply only to mental hospitals, which were the facilities traditionally used by states to care for the mentally ill." Brief of the State of Connecticut (CT Br.), p. 3. 6/ Under the States' interpretation SNF or ICF services would be excluded only if provided in a State mental hospital or the functional equivalent.

The Agency position is that SNF or ICF services are excluded if they are provided in any institution which meets the regulatory definition. Such an institution could be a private facility and it need not be part of or on the grounds of a mental hospital; the basic requirement is that the institution's overall character must be that of a facility established and maintained primarily for individuals with mental diseases.

For their position, the States rely primarily on the references to "mental hospitals" in the legislative history cited above and on several court opinions which refer to the exclusion. The States cite to language in the Supreme Court case of Schweiker v. Wilson, 450 U.S. 221 (1980), 7/ and to similar statements in two other cases, 8/ in

6/ See also, Post-Hearing Reply Brief of State of California (CA Reply Br.), p. 2 (relating the exclusion to "the traditional state mental hospital or the functional equivalent thereof").

7/ In that case, the Court related the IMD exclusion to Congress' assumption that the care of persons in public mental institutions was properly a responsibility of the States, citing for this conclusion the legislative history reference to "long-term care in such hospitals ... ." 450 U.S. at 237, n. 19. The States also rely on the following statement in the dissent in Schweiker: "The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the federal government has long distrusted the economic and therapeutic efficiency of large mental institutions. See S. Rep. No. 404, 98th Cong., 1st Sess., 20 (1965), reprinted in 1965 U.S. Code Cong. & Admin. News 1943, 2084." 450 U.S. at 242.

8/ Legion v. Richardson, 354 F. Supp. 456 (S.D.N.Y.), aff'd sub nom., Legion v. Weinberger, 414 U.S. 1058 (1973), and Kantrowitz v. Weinberger, 388 F. Supp. 1127, 1130 (D.D.C. 1974), aff'd 530 F.2d 1034 (D.C.Cir), cert. denied, 429 U.S. 819 (1976).

support of their view that "it was the large state-financed mental hospitals, which provided primarily custodial care, that Congress meant to exclude," not SNFs and ICFs. CT Br., pp. 19-20. The States argue that SNFs and ICFs were developed as alternatives to care in traditional institutions, as shown by the statutory provisions and legislative history associated with the 1965 Amendments. Since use of nursing homes was encouraged by Congress as part of the process of "deinstitutionalization," the States contend, these SNFs and ICFs cannot themselves be the type of institutions which Congress refused to fund.

The Agency responds that "although the statute does not specifically state that a SNF or an ICF can be an IMD, such an interpretation is the only reasonable one ... ." Consolidated Response of the Health Care Financing Administration to the States' Applications for Review (Cons. Br.), p. 31. The Agency relies primarily on the language of the Act, particularly Section 1905(a). The scheme of that section, as a whole, the Agency argues, supports the position that hospitals do not occupy some special status. Cons, Br., p. 36. Since that section lists hospital services separately from SNF and ICF services, and excludes each type of service in an IMD, the section must be read so that an SNF or ICF can be an IMD, the Agency contends.

Citing Section 1905(a)(14), the Agency argues:

> Acceptance of the States' argument that an IMD can only be a hospital, in effect, makes superfluous the term "hospital" in this provision since it presumably was the same as, and was already included, within the term IMD. If this was the intent, the provision would have stated simply "all services, including SNF and ICF services provided in an IMD." It was not so drafted and as a result the terms hospital, SNF, and ICF services must be interpreted consistently to permit any of these institutions to be IMDs.
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> Cons. Br., p. 33.

The States counter that the term "hospital" in the legislative history was not intended to refer merely to a level of care (acute care), like the term "hospital" in the Act itself. Rather, the States argue, Congress used the term in the legislative history to refer to "a 'total institution' setting, that is, a place where all the patient's needs were met by the facility." CA Reply Br., pp. 6-7; see also CT Br., p. 20, n.2. Since this kind of institution might offer different levels of care, the States argue, Congress needed to refer to all three levels to effect a complete exclusion of all services provided by the institution. See, e.g., CT Br., p. 20, n. 1; CT Reply Br., p. 4. The

States argue that, since section 1905(a) refers to services in an IMD, the section can reasonably be read to mean merely that no level of services can be provided to persons under 65 in a mental hospital. CA Reply Br., p. 8.

The Agency responds that the States' interpretation is not logical because, under it, an institution could never be an IMD, "even if the institution provided solely psychiatric services at a SNF level of care to 100% of its patients... ." Cons. Br., p. 37.

An additional State argument, related solely to ICFs, is based primarily on the statutory definition of an ICF at Section 1905(c). This section refers to ICFs providing "care and services to individuals who ... because of their mental or physical condition require care and services ... ." (Emphasis added.) The States argue, "It would be wholly inconsistent with this explicit statutory language to remove Medicaid coverage for an ICF simply because some percentage of the residents have been placed there because of a mental condition." CT Reply Br., p. 18. The States also point to legislative history which states that ICF coverage is for persons "who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." CT Reply Br., p. 19, citing 117 Cong. Rec. 44721 (1971). 9/ This shows, the States argue, that Congress intended Medicaid to cover those individuals in ICFs who otherwise would have been in a mental hospital.

The States argue, in addition, that applying the IMD exclusion to SNFs and ICFs contravenes Congress' intent in other respects. The States point out that the Agency approach can result in denial of Medicaid coverage to all individuals under 65 in an IMD, regardless of diagnosis. Such denial, the States contend, "seems consistent with congressional intent only where mental hospitals are involved, since all residents of such hospitals presumably are mentally ill." CT Br., p. 21.

The States also find the Agency interpretation to be inconsistent with statutory and regulatory prohibitions against discrimination on the basis of diagnosis. We discuss this question below in connection with the Agency's counting of patients with diagnoses of mental disorders in the facilities.

9/ The legislative history refers to intermediate care as "for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." Statement of Senator Bellmon, 117 Cong. Rec. 44720 (1971).

C. Discussion of the Legislative Issues

Both parties have recognized here that not all of the provisions of the statute or the legislative history can be reconciled with either party's position. As the States point out, "The statute is not easy to parse," Tr., p. 29, and, as the Agency acknowledges, "With regard to the legislative history of the terms 'IMD' and 'institutions,' no clear definitions are evident ... ." Cons. Br., p. 37. We conclude below however, that the Agency interpretation is supported by the language of the statute itself and consistent with the legislative history.

The States acknowledge that a private mental hospital, if traditionally used by a State for care of its mentally ill, could be an IMD and could be providing SNF or ICF services. See, e.g., Tr., pp. 115 and 118. This result is compelled by the statutory language, especially viewed in light of its history and context. Although used elsewhere in the statute, the modifier "public" is notably absent from the term "institution for mental diseases." 10/

The statute is less clear on the issue of whether the IMD exclusion encompasses private SNFs and ICFs of the type under consideration here. In using the term "institution for mental diseases" without definition, however, Congress can reasonably be assumed to have given the Agency leeway in determining what institutions would be excluded. Certainly, the term is not specifically limited to "traditional facilities" or to "large, warehouselike facilities" or to accredited psychiatric hospitals.

Further, the structure of Section 1905(a) supports the Agency position. The exclusion appears in reference to each specific level of care: hospital, SNF, and ICF. Although the States' explanation of this is not as "totally illogical" as the Agency says it is, the Agency interpretation that Congress meant to exclude each level of care, regardless of whether a facility encompasses only one or all three levels, makes more sense.

10/ In Section 1905(a), following paragraph (17), the exclusion for a patient in an IMD appears after a general exclusion for "an inmate of a public institution (except as a patient in a medical institution)." Also, in establishing conditions for States wishing to include coverage of patients 65 or over in IMDs, the statute requires different State plan provisions for such assistance "in institutions for mental diseases," Section 1903(a)(20), and for such assistance "in public institutions for mental diseases," Section 1902(a)(21). See also, the legislative history cited in footnote 1 above.

Moreover, we do not agree with the States that the legislative history compels the conclusion that Congress intended that the exclusion never apply to a private, free-standing SNF or ICF. The question simply is not addressed.

Although the legislative history is replete with references to "mental hospitals," there are several factors which make these references less meaningful in resolving the issue with which we are confronted.

As the States themselves point out, the term "hospital" is used differently in the legislative history than in the statute. The record indicates that, at the time the exclusion was originally enacted, a so-called mental hospital was most likely providing only custodial care and would not have qualified as an acute care hospital for Medicaid purposes. Therefore, we do not think that reference to mental hospitals as IMDs in the legislative history precludes a broader interpretation of the statutory term IMD. 11/ This is particularly true in light of the change in circumstances from the time when the exclusion was enacted to the present. Congress may not have contemplated that the States would use private SNFs or ICFs to fulfill the role that State mental hospitals had traditionally fulfilled, but neither did it state that this could not be so.

Moreover, given that the term "mental hospital" in the legislative history is not defined, and means something different than an institution meeting Medicaid hospital standards, even if we were to substitute this term for the statutory one of "institution for mental diseases" we would be left with an amorphous concept. The States have not clearly delineated a difference between the "traditional mental hospital," providing primarily custodial care, and these facilities here.

The statutory language and legislative history on which the States rely most heavily is related to the 1965 provisions permitting State plans to cover IMD services for the aged. Considered in context, however, the statements are not inconsistent with the Agency position. Section 1902(a)(21) of the Act does refer to nursing homes as an alternative form of care. This section deals, however, solely with public IMDs and nursing homes as an alternative to care in public IMDs.

11/ Also, the use of the phrase "in an institution for mental diseases" with respect to the various levels of services in Section 1905(a) does not necessarily imply that the services are provided by a facility that is part of a larger institution. SNF services, for example, are provided in an SNF and therefore would be in an institution whether the SNF is an institution itself or a distinct part of a larger institution.

In Section 1902(a)(20), which is not limited to public IMDs, nursing homes are not specifically mentioned as an alternative. 12/ The States' reliance on the phrase "readmittance to institutions where needed under alternate plans of care" in this section is also misplaced. As shown by the legislative history, alternate plans can include care in community mental health centers or the patients' own homes. From these alternate plans, readmittance conceivably could include readmittance to an institution which was a nursing home.

Further, the term "institution for mental diseases" for purposes of coverage for the aged is narrower in scope than the definition related to the general exclusion. Under implementing regulations now at 42 CFR §440.140, to be qualified to carry out the provisions of the Act with respect to services to aged recipients, an "institution for mental diseases" must meet general requirements for a psychiatric hospital under Section 1861(f) of the Act. 13/ Given this interpretation, references to mental hospitals as IMDs are less meaningful in the context of services to the aged than if the references had been associated with the general exclusion.

We also conclude that the Agency interpretation does not conflict with the statutory provisions and legislative history related solely to ICFs and relied upon by the States. That Medicaid covers some persons placed in an ICF due to mental condition, where those persons might otherwise have been placed in a mental hospital, does not necessarily mean that it covers all such persons. Under the Agency interpretation, a person with a mental condition is covered in an ICF so long as the

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12/ To a certain extent, the States' arguments based on these provisions have the same flaw which the States identify with respect to some Agency arguments on the sections. See, CT Reply Br., p. 3, n. 1. Both parties refer to the conditions for coverage as though those conditions determined the scope of the exclusion.

13/ The States were given a limited time period in which to bring their institutions up to these standards, but in the meanwhile had to meet other standards, including standards related to safety, to staffing requirements, and to an active program of treatment. See, Handbook of Public Assistance Administration (HPA), Supplement D, Medical Assistance Programs, Section D-5141.14.d.(2) (1966); 34 Fed. Reg. 9784, June 24, 1969 (extending deadline for compliance to July 1, 1970).

ICF is not an IMD and, even if the ICF is an IMD, the person may be covered if over age 65. 14/

Moreover, we are not persuaded that the Agency must adopt the description of the exclusion set forth in the court cases cited by the States. Those cases did not directly involve the issue presented here. Schweiker, in particular, involved an issue of payment of Supplemental Security Income benefits to inmates of public institutions who were not receiving Medicaid benefits. Thus, the Court was only concerned with the exclusion of patients in public IMDs and statements in the opinion must be taken in that context. 15/

As a matter of policy, the States present an appealing argument that classifying private SNFs and ICFs as IMDs may counteract Congressional incentives to move patients out of the large State mental institutions. The Agency has, however, based its interpretation on the policy judgment that if private, free-standing SNFs or ICFs could never be IMDs, the States might use these facilities as inappropriate substitutes for State institutions rather than as appropriate alternatives.

The Agency interpretation, while not the only possible one, is reasonable and is supported by the statute. Moreover, as we discuss in the following section of our decision, the Agency interpretation that SNFs and ICFs such as those involved here can be IMDs is embodied in duly promulgated regulations. 16/

14/ We also do not place any significance on the use of the term "public institution for mental diseases or defects" in Section 1905(c) of the Act with reference to ICFs. See footnote 4 above. That provision must be read in light of the exception for ICF services in public institutions for the mentally retarded in Section 1905(d), immediately following this language.

15/ We also note that the statement which provides the strongest support for the States' position is quoted from the dissent rather than the majority opinion in Schweiker.

16/ We do not here adopt the Agency's unqualified statement, expressed at the hearing, that the exclusion is meant to continue the States' "traditional financial responsibility for the mentally ill." Tr., p. 21. The exclusion is directed at the States' responsibility for individuals in a certain type of institution. The regulations, in using the term "overall character," reflect this emphasis. The Agency does not deny that Medicaid funding is available for patients with mental diseases placed in a "general" SNF or ICF. Moreover, prohibitions on assistance to individuals with a diagnosis of psychosis who were in general medical institutions were deleted in 1965.

III. The Regulations

The major issue concerning the Agency regulations is whether they were sufficient to give the States notice that the facilities involved should be classified as IMDs. The States contend that the regulations should be read in light of the legislative history of the exclusion to apply only to mental hospitals and are too vague as applied to the SNFs and ICFs here. As discussed below, we conclude that the regulations were clear enough to give the States notice that an SNF or ICF could be an IMD and, in the context of the specific facts here, the regulations were properly applied.

Our discussion of the regulations is divided into three parts: the history and wording of relevant provisions; a statement of the parties' arguments related to the regulations; and our analysis of the issues.

A. Relevant Regulatory Provisions

The Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs (HPA), published in 1966, restated the statutory provisions concerning IMDs and provided that FFP could not be claimed in medical assistance for --

> Any individual who has not attained 65 years of age and is a patient in an institution for ... mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with ... mental diseases (whether or not it is licensed).
>
> HPA, D-4620.2.

HPA provisions were later incorporated into codified regulations. Regulatory provisions at 45 CFR §249.10, added June 24, 1969, 34 Fed. Reg. 9784, dealt with the amount, duration, and scope of medical assistance. They contained a general limitation on FFP "with respect to ... any individual who has not attained 65 years of age and who is a patient in an institution for ... mental diseases." §249.10(c). "Inpatient hospital services" in which FFP was available were defined, in part, as "for the care and treatment of inpatients ... in an institution maintained primarily for treatment and care of patients with disorders other than ... mental diseases ... ." §249.10(b)(1). Skilled nursing home services were defined, in part, as "furnished by a skilled nursing home maintained primarily for the care and treatment of inpatients with disorders other than ... mental diseases ... ." §249.10(b)(4)(i).

Section 248.60, added to 45 CFR at 36 Fed. Reg. 3872, February 27, 1971, contained the provisions with respect to "institutional status" and its effect on availability of FFP under Medicaid. The section basically paralleled HPA §D-4620.2 language on "overall character" of an IMD. 45 CFR §248.60(a)(3)(ii). It also contained the following definitions:

> (1) "Institution" means an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and in addition, provides some treatment or services which meet some need beyond the basic provision of food and shelter.
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> * * *
>
> (7) "Institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services.
>
> 45 CFR §248.60(b). 17/

Current provisions are similar but reflect the addition of ICF services and of inpatient psychiatric facility services for individuals under age 21 and, also, the change to use of Medicare standards for skilled nursing services. The key definition of an IMD, at 42 CFR §435.1009, incorporates several earlier provisions as follows:

> "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

B. The Parties' Arguments on the Regulations

Basically, the States' position is that they had a reasonable expectation of funding for these SNFs and ICFs here because they relied on the legislative history of the exclusion and past practice of the

17/ Sections 249.10 and 248.60 were redesignated, 42 Fed. Reg. 52827, September 30, 1977, and then recodified, 43 Fed. Reg. 45176, September 28, 1978.

Agency in applying the regulation only to "mental hospitals." The States further argue that, even if the regulations could apply to private, free-standing SNFs or ICFs under some circumstances, the regulations were improperly applied here. On the latter point, the States focus on key words in the regulation, arguing either that the terms are too vague or that they should be interpreted a particular way.

For their view that the regulations should be interpreted to refer only to institutions with an "overall character" like a traditional mental hospital, the States rely in part on the legislative history of the exclusion.

They point out that the references to IMDs as mental hospitals in relation to the 1965 Amendments were made only a year before the medical assistance provisions of the HPA were issued. CT Br., p. 5, n. 2. Further, the States argue, the use of the term "overall character" in the regulations is an indication that the emphasis would be on the nature and type of institution rather than on the patients. The States point to those institutions which the States recognize as IMDs, the character of which is "unambiguous and a matter of public knowledge." CA Reply Br., p. 5. Focusing on the nature and purpose of the facilities, the States argue, allows for accepting the published regulations as valid since "[o]nly traditional state mental hospitals or their functional equivalents are truly institutions established and maintained for the purpose of diagnosis, treatment and care of persons with mental diseases." CA Reply Br., p. 5.

The States argue that their interpretation of the exclusion was a long-standing one, and that they acted on the basis of this understanding without attempting in any way to disguise their programs. CA Reply Br., p. 16. On the other hand, they argue, the Agency interpretation is a new one. According to the States, there had been no effort by the Agency to apply the regulatory definition of an IMD to nursing homes until the issuance of a General Accounting Office report, followed by field staff instructions in 1975. IL Reply Br., p. 2. Thus, the States argue, applying the definition to the facilities here amounts to a retroactive interpretation of the regulations.

This "retroactive" interpretation should be disfavored, the States argue, because it leads to "a proposed wholesale recoupment of federal funds," devastating to the States' budgets. CA Reply Br., p. 17. Given this effect, the States contend, the Board should apply the rationale set forth in the recent Supreme Court case of Pennhurst State School and Hospital v. Halderman, 101 S. Ct. 1531 (1980). That

decision is relevant, the States argue, because it points up the need to consider the legitimate expectations of the States in grant programs. CA Reply Br., p. 16; CT Reply Br., p. 15.

The Agency does not allege that the regulatory definition had been applied to private, free-standing SNFs and ICFs prior to these disallowances, but argues, "The States' contention that HCFA has in some way changed its policy with regard to the definition of IMD is completely unfounded." Cons. Br., p. 38. In support of this, the Agency points to the HPA, which, it states, "makes clear that hospital, SNF, and ICF services are all defined as services provided in those institutions." Cons. Br., p. 38. In particular, the Agency cites to the definition of a skilled nursing home for Medicaid purposes as one maintained primarily for patients without mental disorders. Cons. Br., p. 38, citing HPA D-5141.14.b. From this, the Agency concludes that the States have clearly known since 1966 that the Agency interpreted IMDs to include nursing homes.

The Agency states that, under the regulatory definition of an institution, hospitals, SNFs, and ICFs can all be institutions. Since the regulation sets no categories of institutions but looks to "overall character," the Agency argues, the regulation "requires an individual institution-by-institution determination, not a blanket prohibition as the states propose." Cons. Br., p. 37.

The States further argue, however, that the terms "diagnosis" and "treatment" in the regulatory definition provide a basis for distinguishing the SNFs and ICFs here from recognized IMDs covered by the definition. According to the States, an IMD performs a diagnostic service "to determine if a person is mentally ill through competent medically accepted, psychiatric techniques of diagnosis," and this is distinguishable from what SNFs and ICFs do, which is "relying upon historical diagnoses or diagnoses from some other institutional setting." Tr., p. 86.

The States also argue that the term "treatment" in the regulation must mean more than the mere "services" which are provided to anyone in an SNF or ICF. In the States' view, "treatment" as contemplated by the regulation means an attempt to cure, which "involves very active efforts in treating the underlying pathology." Tr., p. 87. 18/

18/ California distinguishes nursing home services from "clinical treatment" performed by recognized IMDs, associating the term "clinical" with treatment provided by psychiatrists and clinical psychologists. CA Reply Br., p. 3., n. 2. The Director of the Illinois Department of Mental Health referred to the distinguishing factor as "psychiatric intervention." Tr., pp. 287, 299.

The States recognize that SNFs and ICFs provide some services provided by mental hospitals, such as food, shelter, and management of daily problems. Yet, the States assert that this is not sufficient to characterize these facilities as IMDs because "there is no psychiatric component to any of those treatment modalities." Tr., p. 88.

The States challenge the Agency interpretation as so overbroad that under it any institution that provided some treatment or services to a person who is mentally ill would become an IMD. This is inconsistent, the States contend, with the Agency's own regulations which define "institution" broadly, but use IMD as a clearly limited subset of institutions. Tr., p. 85. See also, CA Reply Br., p. 6.

The Agency counters that an institution may be an IMD if engaged in providing diagnosis, treatment, or care, and therefore need not be performing diagnosis. In response to the States' interpretation of the term "treatment," the Agency points out that regulations at 42 CFR §456.380 require that ICFs provide a plan of treatment. According to the Agency, the regulatory definition of an IMD "mandates that facilities be classified according to the overall character of the patient population, not according to the services provided." Agency response to appeal, Docket Nos. 79-52-MN-HC and 79-89-MN-HC.

Finally, the States point out that the term "mental diseases," not defined in the regulation, is vague. In applying the regulation, the Agency referred to a disease classification system known as the ICDA. 19/ The States contend that the Agency definition, using mental disorders under the ICDA, was overbroad since it included mental states resulting from an underlying physical disease. CA Supplemental Statement in Support of Application of Review (CA Supp. App.), pp. 44-45, see also, CT. Br., pp. 44-45. The States also allege that the Agency confused use of the terms "mental impairment," "mental disability," and "mental disease" and this led to inconsistent application of definitions.

The Agency responds that --

> Congress used the term "mental disease" in 1965 ... to mean what were commonly known as mental disorders at that time. The [ICDA] is a reasonable guide to the universe of "mental diseases". Establishing a physical cause for "psychiatric symptoms" does not

19/ "International Classification of Diseases, Adapted for Use in the United States," Eighth Revision, Public Health Services Publication Number 1693.

> change the fact that "psychiatric symptoms are what Congress meant when it said "mental diseases."
> Agency response to appeal,
> Docket No. 80-184-CA-HC, p. 26.

C. Discussion of the Regulatory Issues

Although there is some basis for distinguishing the issue in the Pennhurst case from the issue presented here, 20/ we agree with the States that the Pennhurst rationale is relevant. If the States are to plan their Medicaid programs, they must know on what basis a facility will be classified as an IMD, particularly if that classification can be avoided by choices on patient placement. In examining whether the regulations in question were sufficient to inform the States that they could not expect funding for services in these particular facilities, however, the issue of clarity must be examined in light of the specific facts presented here.

The evidence discussed in section V below establishes that very high percentages of patients in these institutions had disorders which were identified as mental disorders under a generally accepted classification system, that the facilities in most instances held themselves out as caring for the mentally ill, that some of the services provided to the patients could reasonably be considered "treatment," and that the facilities had other characteristics supporting the conclusion that the regulations apply. Thus, we are not dealing here with close calls concerning the Agency's application of a questionable criterion; in virtually all cases, the facilities involved had attributes which placed them securely within any reasonable reading of the Agency's regulation.

The States' major argument is that the regulations must be viewed in light of the legislative history of the exclusion and the States' understanding of the exclusion. Since the States viewed the regulations this way, the States claim, they had an expectation of funding for these facilities and the disallowances result from an unfair retroactive interpretation of the regulation. Even if we were

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20/ In Pennhurst, the issue was whether a statutory statement of patients' rights imposed an affirmative duty on States to expend their own funds as a condition for receiving Federal funding. Here, we are dealing with the scope of an exclusion of funding, where the States' interest in clear notice must be weighed against the Federal government's interest in not funding services Congress has refused to cover.

to concede that the States interpreted the regulations in light of a certain understanding of the exclusion, we would not necessarily be led to the conclusion that the States' interpretation was reasonable, given the plain language of the regulations.

The regulations state that an IMD is, first of all, an institution. The term "institution" is defined for these purposes as "an establishment that furnishes ... some treatment or services to four or more persons ... ." This is a longstanding interpretation which is inconsistent with the view that the exclusion applies only to large, warehouselike facilities. We are not persuaded that this definition is not significant merely because IMDs are a specific subset of all institutions. There is nothing in the regulations to indicate that the scope of the IMD "subset" is related to institutional size.

Moreover, an institution may encompass a single facility or multiple facilities, and may be public or private. While the regulations do not specifically state that a single, private facility is an IMD if otherwise meeting the definition, it is a logical implication from the definition taken in context. 21/

The States also argue that the regulations should be interpreted in light of the statement in Schweiker that mental hospitals were treating only the mentally ill. This view does not comport with the use of the term "primarily" in the regulations. It is a clear implication from the use of that term that an IMD may also be providing care and treatment to persons other than patients with mental diseases. Moreover, the early definition of inpatient hospital services as services in an institution primarily for persons with disorders other than mental diseases (with the parallel definition of skilled nursing services) indicates that the nature of the patient population is pertinent. While we agree with the States that the term "overall character" reinforces a view that the focus of the exclusion is on the nature of the institution itself, we fail to see how one can totally separate the nature of the institution from the patients it serves.

The States' attempt to distinguish the facilities here from recognized IMDs on the basis that these facilities do not perform diagnostic services and do not provide the same degree of treatment also fails in

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21/ Congress apparently considered ICFs and SNFs to be institutions. The statutory definition of an ICF at Section 1905(c) refers to persons requiring care which could be made available only through "institutional facilities," and to "institutional services" deemed appropriate in certain sanatoriums. An SNF is defined at Section 1861(j) as "an institution (or a distinct part of an institution) ... ."

light of the plain language of the regulation. The term "diagnosis" appears before the disjunctive "or." The regulation cannot reasonably be read to infer that only institutions performing diagnosis are IMDs. 22/

With respect to the States' interpretation of the meaning of the term "treatment," we agree with the Agency that this interpretation is inconsistent with the States' own position that the regulation should be read in light of the legislative history and the circumstances at the time the exclusion was originally enacted. Congress has provided incentives to upgrade the quality of treatment in mental institutions and to ensure "active" psychiatric treatment for individuals for whom Federal funding would be available. See, Sections 1902(a)(20) and 1905(h)(1)(B)(i) of the Act. There is a substantial question, however, whether recognized IMDs were providing this kind of treatment at the time the exclusion was enacted. We also note that the regulation speaks of treatment of persons with mental diseases, not treatment for mental diseases.

Contrary to other statutory and regulatory provisions which specify a certain type of treatment, the regulatory definition of IMDs merely says "treatment." The States have pointed to nothing that supports a conclusion that the SNF and ICF services here did not constitute "treatment" within the meaning of the regulation. 23/

The term in the regulation which is most readily subject to various meanings is the term "mental diseases." Here, again, the States' arguments have internal contradictions. While the States accuse the

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22/ While the States have presented some evidence that SNFs and ICFs do not perform a full range of diagnostic services, the record does not fully support a conclusion that the facilities here did not engage in some diagnostic functions. In fact, a statement by a psychiatrist from the California Department of Mental Health who testified at the hearing was to the effect that he would not expect an emphasis on diagnosis in a SNF. Tr., p. 204. This implies that he would expect some diagnosis to occur.

23/ The States' position that these nursing homes were providing a level of services which does not constitute treatment of patients also does not comport with numerous statutory and regulatory uses of the terms. For example, Section 1905(c) of the Act describes ICF services as those for persons who do not require the "degree of care and treatment" provided by an SNF. Also, the original definition of skilled nursing home services included reference to homes for "care and treatment" of patients. HPA D-5141.4.

Agency of using an overbroad definition in light of current knowledge of the causes of mental symptoms, the State have not shown that that definition was broader than those categories of persons treated in mental hospitals at the time the exclusion was enacted.

The States would have us overturn the Agency determinations since the Agency included patients with mental disorders where the States say the primary diagnoses were physically-based diseases, and since the Agency included patients whose diseases were probably misdiagnosed. The regulations, however, merely say "persons with mental diseases." Thus, to the extent that the Agency evaluated patients at all on the basis of primary rather than secondary diagnosis, this was a narrowing of the regulation from which the States benefited. Moreover, for the most part, even excluding patients with physically-based mental disorders, these facilities were serving primarily persons with mental diseases.

We agree with the States that the Agency sometimes may have confused the use of various terms related to mental status. In clarifying proper usage, however, California's expert states, "Impairment and disability are terms describing the effects of disease on functioning, while disease is a diagnostic concept." CA Supp. to App., Exhibit C, p. 53 (footnote omitted). Since the Agency findings are related to diagnosis, we conclude that Agency misuse of terms, while unfortunate, did not prejudice any State and is consistent with Congress' use of the term "mental diseases."

Moreover, we agree with the Agency that its use of the ICDA was reasonable. The States have not disputed that the ICDA is a generally recognized classification system. While the States' testimony establishes that the ICDA is subject to some difficulties in application, it also establishes that any attempt to classify illness presents such difficulties. To preclude the Agency from adopting any classification system at all would render the exclusion totally unenforceable.

Thus, we conclude that the regulations were sufficiently clear to inform the States that these facilities were IMDs and funding would not be available for services to patients in the facilities. Given that the regulations are sufficiently clear to apply to these facilities, to the extent that the States relied on the fact that the exclusion had not been applied to this type of facility before, that reliance is unreasonable. Moreover, the Agency should not be precluded from fully enforcing a regulation merely because it has never been applied a particular way in the past. The Agency must be able to respond to changing circumstances, by enforcing an existing regulation.

IV. The Criteria

Thus far, we have considered the States' arguments related to Congressional intent and to the regulations themselves. In this section, we consider the States' arguments concerning the Agency criteria for applying the regulations, set out in instructions to field staff. We conclude that these arguments also do not provide a basis for overturning these disallowances.

Our discussion of the issues related to the criteria is divided into five parts: the history of development of the criteria; the parties' arguments on procedural issues related to the criteria; our analysis of the procedural issues; the parties' arguments on substantive issues related to the criteria; and our analysis of the substantive issues.

A. History and Statement of the Criteria

The Agency "criteria" for determining IMD status were set forth in a series of documents which were part of an Agency transmittal system called the Field Staff Information and Instruction Series (FSIIS). FSIIS FY-76-44, dated November 7, 1975, was addressed to the Regional Commissioners of the Social and Rehabilitation Service (SRS), then responsible for administering the Medicaid program, and informed them that regional office findings and a General Accounting Office study had indicated that FFP was being improperly claimed for Medicaid for individuals between 21 and 65 in IMDs. This document cites the regulatory definition of IMDs and states:

> The character rather than the licensure status of the institution is of paramount importance ... . An institution is characterized as "primarily" one for mental diseases if it is licensed as such, if it advertises as such or if more than 50 percent of the patients are in fact patients with mental disease. In some instances a facility may be "primarily" concerned with such individuals because they concentrate on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals, even if less than 50 percent of the patients have actually been diagnosed as having a mental disease. Mental diseases are those listed under the heading of mental disorders in the [ICDA], except that mental retardation is not included for this purpose.

The document requested information from the regions on the problem of improper claiming for services in IMDs, stating that the focus should be on SNFs and ICFs since "we assume, absent evidence to the contrary

that improper claims related to age are not a problem for care in psychiatric hospitals."

FSIIS FY 76-97, issued May 3, 1976, stated that responses to the earlier instruction "have heightened our awareness of great discrepancy in the understanding, interpretation, and implementation of policy" with respect to IMDs. The document points to the regulations as a basis for the conclusion that free-standing SNFs and ICFs may of themselves be IMDs, expresses concern with improper claiming, and advises regions to "assess or continue to assess the situation as it now exists in order to assist the States where necessary in complying with applicable Federal Regulations."

A third document, FSIIS FY-76-156, dated September 14, 1976, addressed mental health under Title XIX in general and noted progress in the efforts to assure observation of the prohibition on funding in IMDs. This document referenced the earlier transmittals and stated:

> Various methods in addition to those discussed in earlier issuances have been suggested to help States identify suspect facilities, including proximity to State institutions (for example, within a 25-mile radius) and age distribution uncharacteristic of nursing home patients (i.e. a preponderance of individuals under age 65). Also, included in these methods would be a determination as to whether the basis of Medicaid eligibility of patients under 65 in suspect facilities was due to mental disability.

FSIIS FY-76-156 recommended use of review teams "to review patients in those facilities where the determination [of IMD status] cannot be made without applying the 50% criterion." It also set out a system for classifying patients, according to physical problems and mental disability, to determine whether the person's need for skilled nursing or intermediate care resulted from a mental disability.

In a memorandum to the Regional Attorney, Region IX, HEW, dated September 16, 1977, the regional office requested a legal opinion on the criteria set out in the FSIIS series, summarizing the criteria as follows:

1. Licensed as mental institutions.

2. Advertises as mental institutions.

3. More than 50 percent of the patients have a disability in mental functioning.

4. Used by mental hospitals for alternative care.

5. Patients who may have entered mental hospital accepted direct from community.

6. Proximity to State mental institutions (a 25 mile radius).

7. Age distribution uncharacteristic of nursing home patients.

8. Basis of Medicaid eligibility for patients under 65 due to mental disability.

Attachment IV to Appendix D to CA Audit Report.

The October 28, 1977 response, prepared by an Assistant Regional Attorney, expressed the opinion that the criteria were interpretative rules which "constitute both clarification and more specific explanation of existing law and regulations." Appendix E to CA Audit Report. The Assistant Regional Attorney's memorandum, included with all but one of the Agency audit or review reports used here, further states:

> Obviously some of the above listed criteria are more probative as to whether a facility, given its "overall character", is "primarily" engaged in IMD type activity, e.g. the fact that a facility is used by mental hospitals for alternative care (#4) is more probative than the fact that a facility happens to be located within a 25 mile radius of a state mental institution ... .
>
> p. 8.

The memorandum warns that "every indication of any significance that a given facility is primarily engaged in IMD activity should be marshalled to fulfill the regulatory mandate that the determination be on the basis of the facility's 'overall character' ... ." pp. 8-9.

The auditors and reviewers making the determinations disputed here all used four or more of the criteria. Two additional factors, considered by the reviewers in Connecticut were --

9. Hires staff specialized in the care of the mentally ill.

10. Independent professional reviews conducted by state teams report a preponderance of mental illness in patients in facility.

CT Review Report.

With respect to the criteria, the States raise a number of procedural arguments. They also attack the criteria substantively, particularly challenging the so-called "51% rule" (Criterion #3) as inconsistent with the statute and regulations and with prohibitions on discrimination on the basis of diagnosis. The States allege that the criteria were inconsistently applied by the Agency and present serious administrative difficulties.

B. The Parties' Arguments on Procedural Issues

The States first argue that they did not have timely notice of the criteria and therefore cannot be adversely affected by the criteria since the criteria were not published in the Federal Register. In support, the States cite 5 U.S.C. §552(a)(1).

Whether the criteria are substantive rules or interpretative rules, the States contend, they should have been published because they have "general applicability." This "general applicability" is shown, in the States' view, by the "fact that HCFA issued the criteria to all SRS regional commissioners and has used them as a basis for disallowances against four states ... ." CT Br., p. 33. The States cite the case of Appalachian Power Co. v. Train, 566 F.2d 451, 455 (4th Cir. 1977), for the proposition that information is required to be published under §552(a)(1) if it is "of such a nature that knowledge of it is needed to keep outside interests informed of the agency's requirements in respect to any subject within its competence."

The States also argue that, under the Department's own regulations, 24/ the criteria should have been published in accordance with the notice and comment rulemaking procedures of Section 4 of the Administrative Procedure Act (APA), 5 U.S.C. §553. Since this section applies only to substantive rules, the States allege that the criteria were more than an interpretation clarifying or explaining existing law, and, in this connection, point out that the label assigned to a rule by an administrative agency is not determinative. CT Br., p. 35, citing Anderson v. Butz, 550 F. 2d 459, 463 (9th Cir. 1977); Continental Oil Co. v. Burns, 317 F. Supp. 194, 197 (D. Del. 1970).

Further reason why the criteria should have been published, the States argue, is that the criteria had a "substantial impact" on the States. Using the test for "substantial impact" set forth in Continental Oil

24/ On February 5, 1971, the Department of Health Education, and Welfare (HEW, now HHS) adopted notice and comment rulemaking for matters relating to "public property, loans, grants, benefits or contracts," otherwise exempted under the APA. 36 Fed. Reg. 2536.

Co., supra, 317 F. Supp. at 197, the States present an analysis to show that the criteria are complex and pervasive; represent significant changes from existing law; have retroactive effect; and have engendered confusion and controversy. CT Br., pp. 36-37; see also, IL Application for Review, pp. 10-11; Tr., pp. 74-76. Based on this analysis, the States conclude that the Agency's failure to use notice and comment rulemaking to promulgate the criteria renders them invalid.

Finally, the States attack the criteria as procedurally defective on the grounds that use of the criteria without giving notice to the States of the criteria themselves, of the Agency's intent to use them as an enforcement tool, and of the meaning of the criteria violates principles of due process and fundamental fairness.

The Agency does not dispute that the States may not have had notice of all the criteria, Tr., pp. 18-19, but explains its position as follows:

> The criteria ... discussed in the FSIIS's were never intended to be criteria as such. They were merely guidelines. ... they merely discuss the central office's view of what factors might be helpful in locating, identifying, possible IMD's and evaluating possible IMD's. They were never intended to be the kind of criteria that you would assign a numerical score to, and none of the criteria was ever considered determinative with respect to the nature of the facility. Tr., pp. 15-16.

In support of this, the Agency points to inclusion, with the reports, of the Regional Attorney's legal opinion on applying the criteria in relationship to the regulation. Tr., p. 16.

According to the Agency, the criteria are interpretative rules, constituting clarification of existing policy embodied in the duly promulgated regulations; they were not required to be published because they were not "for the guidance of the public." 25/

25/ In support of this, the Agency cites the Attorney General's Manual on the Administrative Procedure Act (1947) at 22 for the statement that "interpretations need be published only if they are formulated and adopted by the agency for the guidance of the public. The Act leaves each agency free to determine for itself the desirability of formulating policy statements for the guidance of the public." Cons. Br., p. 42; see also, Tr., p. 18. We note that the version of 5 U.S.C. §552(a)(1) quoted by the Agency appears to be an earlier version, prior to the 1967 amendments, Pub. L. 90-23. The (continued on p. 28)

The Agency further argues that the FSIIS "include obvious factors for determining which institutions might be primarily engaged in the treatment of persons with mental diseases. Cons. Br., p. 44. There is nothing confusing, drastic, or retroactive about the criteria, the Agency states, since they merely aid in the implementation of HCFA policy that has been clear and consistent since 1966." Cons. Br., p. 44. See also, Tr., p. 16.

C. Discussion of Procedural Issues

In view of our conclusion above that the regulation itself was sufficiently clear to give the States notice that these particular facilities were IMDs, we conclude that the Agency's failure to publish or otherwise give the States notice of the criteria would not provide a basis for overturning these disallowances. The adverse effect, and financial impact, of these disallowances is a result of the regulations rather than the criteria since these facilities had the requisite "overall character" under any reasonable reading of the regulation. Thus, we cannot say that the Agency's actions prejudiced the States, given the circumstances presented here.

The FSIIS series documents show that the Agency viewed the criteria as indicators of whether a facility was an IMD under the applicable regulations. The Agency used some or all of the criteria in making each of the disallowance determinations here, but none of the criteria was considered determinative. The cumulative evidence is that the facilities met the regulatory definition.

We also note that many of the States' arguments with respect to the need for notice or publication are premised on the view that the criteria amounted to a change in existing law, since their understanding was that only mental hospitals were IMDs. As stated above, the regulations in context clearly imply that private, free-standing SNFs and ICFs can be IMDs. Moreover, while it is unclear from the record at what point the States had actual notice of the criteria themselves, it appears likely from the record that the States were aware prior to

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25/ cont'
Agency version contains the phrase "for the guidance of the public" as a description of covered interpretations, whereas the current version places the phrase in the introductory language, requiring publication "for the guidance of the public." In view of our conclusion below, we do not address the significance of this difference.

the periods of disallowance that the Agency interpreted the regulation as applying to such SNFs and ICFs. 26/

D. Substantive Issues Related to the Criteria

The States also attack the criteria substantively, focusing primarily on the Agency's counting of patients with mental disorders (Criterion #3), but also making some general arguments. The parties' substantive arguments are summarized below, followed by our analysis.

1. Substantive Arguments Related to the Counting of Patients

The States direct their substantive attack on the criteria mainly against Criterion #3, referred to as the "51% Rule," arguing that it is arbitrary, invidious, and contrary to prohibitions against discrimination on the basis of diagnosis. For support of their proposition that the counting of patients is discriminatory, the States cite Social Security Act provisions which forbid a State from discriminating against any eligible individual with respect to the amount, duration, and scope of medical assistance, Section 1903(a)(10), and regulations which prohibit a State from denying a required service to an otherwise eligible individual solely because of diagnosis, type of illness, or condition. 42 CFR §440.230. The States also cite a policy guide and other Department issuances which reflect a policy of nondiscrimination on the basis of diagnosis. CT Br., pp. 25-26. Moreover, the States argue, the Agency approach "encourages segregation of individuals with mental diagnosis in certain facilities on the basis of considerations other than their individual needs," and thus violates Section 504 of the Rehabilitation Act of 1973, as amended. CT. Br., p. 28.

In response, the Agency asserts,

> The statute provides, quite simply, that no FFP is available for services provided in an institution for mental diseases.

26/ The FSIIS series documents indicate that the regional offices were to involve the States in addressing the problem of whether SNFs and ICFs were IMDs. There is also other evidence that some of the States knew of this application of the regulation. See, e.g., Letter of October 4, 1971 from Associate Regional Commissioner, SRS, to Director CA Department of Health Care Services (relating the IMD exclusion to services provided "by nursing homes or in hospitals"), Agency Admin. Record, Tab 1; Tr., p. 129 (Testimony of Connecticut Public Assistance Consultant that "around 1976" her Department was aware of the position that ICFs and SNFs could be IMDs); Letter of December 29, 1977, from Assistant Commissioner, Minnesota Department of Public Welfare, Attachment 6 to MN Audit Report.

> ... once a facility is determined to be an IMD, no federal financial participation is available for services to any resident of the facility, whether or not a resident is mentally ill. ... To paraphrase the Supreme Court's holding in Schweiker v. Wilson, ... the distinction is not between the mentally ill and a group composed of the nonmentally ill, but rather between residents of IMDs and residents of other long-term care facilities.
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> Cons. Br., p. 53.

Other problems which the States raise with respect to Criterion #3 include the arbitrariness of diagnostic labeling of patients, the difficulties of categorizing patients with multiple disorders, the problems inherent in using the ICDA, the unreliability of medical records, and the administrative headaches potentially caused by changes in patient population. The States presented testimony that the fact that a patient once carried a label of being mentally ill had nothing to do with the current status of the patient, and, since the auditors did not engage in a procedure to determine whether a patient still had an acute, active illness, use of a previously-given diagnosis amounted to "gross prejudice." Tr., p. 279; see also, Tr., p. 298. According to the States, diagnosis is a judgmental process, which may depend in part on the particular specialty of the doctor engaged in the process. Determining reasons for placement in a particular facility is particularly complex with respect to patients with multiple diagnoses, the States point out, with supporting testimony. Tr., pp. 187-188.

The States attack the use of the ICDA as a basis for categorizing patients by presenting testimony that SNFs and ICFs have no legal restrictions in terms of using the ICDA and concluding from this that an Agency reviewer might be confronted with diagnoses which do not fit the ICDA categories. Tr. pp. 182-183. The States also argue that a "51% Rule" is completely unworkable because patient population can shift and, under the rule, admission of one additional patient with a mental disorder could result in loss of Medicaid coverage for all patients in a facility.

The Agency in rebuttal presented testimony by a psychiatrist who was on the review team which examined the Connecticut facility involved here. He stated that he carefully weighed judgment as to why a patient with multiple diagnoses was placed in the Connecticut facility. He further expressed the opinion:

> I don't think non-medical or non-nursing auditors would be able to have necessarily the same kind of credibility that I was able to have concerning the medical records.

> But if you assume that they are accurate and of reasonable quality, they do give you, I think, an accurate understanding of what is being treated.
>
> Tr., p. 331.

The Agency also defends use of the ICDA as a reasonable guide to the universe of "mental diseases," given that "complete agreement cannot be revealed with regard to systems of diagnosis... ." Cons. Br., p. 46. The Agency points out that trained medical staff conducted or aided in the review of patient records and claim forms here in order to establish diagnosis. The Agency states that its evidence shows that "the review teams were if anything very cautious and conservative in their applications of the categories." Cons. Br., p. 47, citing Tr., pp. 312-407.

In general, the Agency argues:

> As stressed in the controlling regulation, it is the overall character of the facility, and not merely the percentage of residents with diagnoses of mental illness, that is determinative. Moreover, the FSIISs specifically recognized the problems inherent in the arbitrary application of a percentage standard, under which a facility's status could change day-to-day. It made clear that the character of the facility would be determined once, and that status would continue until a special request to change it was filed: ... FSSIIS (sic) FY-76-156 at 3. Thus, the admission of one patient with mental illness would not affect the character of a facility.
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> Cons. Br., p. 52.

2. General Substantive Issues Related to the Criteria

The States attack all the criteria on substantive grounds as impermissibly vague and the Agency's use of the criteria as arbitrary and capricious. In general, the States argue that the criteria "are ill-defined, and they appear to be wholly inadequate indicators of whether an institution meets the 'primarily engaged' or 'overall character' standards of the published regulations." CT Br., p. 42; see also, Tr., pp. 100-101. With respect to specific criteria, the States challenge each of them as "meaningless," "incomprehensible,"

"misleading," or otherwise irrelevant to the question of whether a facility is an IMD. 27/

The States also allege that the criteria were inconsistently applied. The States attribute this, in part, to what they say is a lack of objectivity to the criteria. Applying the criteria presents serious administrative difficulties, the States allege, because this method of identifying IMDs "involves a number of highly judgmental elements (e.g., what is 'mental disease,' how to deal with multiple diagnoses, how to categorize 'senility') which make it impossible for auditors to classify the facility, which make any classification likely to be both subjective and time-consuming, and which will inevitably lead to legitimate heated disagreements with the findings." CA Reply Br., p. 13; see also, CT Reply Br., pp. 8, 16.

In response, the Agency states:

> The "criteria", while varying widely in relative importance, are all useful in identifying possible IMDs. As indicated in the review reports that support the disallowances, none of them was ever deemed sufficient in itself to classify an institution.
>
> Cons. Br., p. 45-46.

The Agency argues that, in criticizing the Agency criteria but failing to suggest reasonable alternatives, the States appear to be saying that it is impossible to define an IMD and this would render the exclusion unenforceable. Tr., p. 20.

3. Discussion of the Counting of Patients

We agree with the States that there are difficulties with counting patients according to diagnoses based on medical records and with use of the ICDA. We also agree that it is not conclusive that a person is mentally ill merely because at one time the person was diagnosed as mentally ill. With a few exceptions discussed in Section V

27/ See, e.g., CA Application for Review, p. 9; CT Br., p. 42; Tr., p. 93 (Criterion #1); CA Application for Review, p. 9; CT Br., p. 43; Tr. p. 94 (Criterion #2); CA Application for Review, p. 10; CT Br., p. 47 (Criterion #4); CA Application for Review, p. 10; CT Br., p. 48 (Criterion #5); CA Application for Review, p. 10; CT Br., p. 49; Tr., p. 98 (Criterion #6); CA Application for Review, p. 10; CT Br., p. 49 (Criterion #7); CA Application for Review, p. 10; CT Br., p. 50 (Criterion #8).

below, however, the States' arguments on these points are generalized and speculative. The States have presented no evidence that, in any of these cases, the determination that the facility was an IMD was based solely on a finding that 51% of the patients had mental diseases.

As stated above, the Agency was reasonable in looking to patient population as a factor in determining "overall character" of a facility. Moreover, given the very difficulties in diagnosis and classification which the States point to, some choice had to be made of how to determine whether a resident was a person with a mental disease. The Agency did include some patients whose psychiatric symptoms might have been physically-based. On the whole, however, the Agency took a conservative approach, employing a current, generally recognized classification system. This approach benefited the States when viewed in light of the common understanding of the term "mental diseases" at the time the exclusion was enacted.

The Agency witness was persuasive on the general reliability of medical records and the ability of auditors to interpret them with relative accuracy. For the Agency to take some risk of misclassification was reasonable, where the patient population was not the sole basis for determining "overall character." While the ideal might be to engage in a lengthy diagnostic analysis to determine reasons for patient placement, it is simply administratively infeasible. We agree with the Agency witness, Tr., p. 331, that the degree of credibility in the medical record needed to understand what is going on is less than what would be demanded if someone were using it as a basis for treatment. Moreover, the States' arguments with respect to unreliability of records and possible misdiagnosis of patients ignore the consideration that, not only the Agency, but the facilities and the States were likely also dependent on historical diagnoses for their decisions on the appropriateness of placement. Even though a diagnosis of mental disease might be wrong, if it was a basis for placement of the patient in a facility, it is an indication of the nature of the facility as one engaged in care and treatment of mental diseases.

As stated above, we also think that the States benefited from the Agency excluding patients who were placed in the facility due to a physical problem even though they may have also been mentally ill. The regulation covers facilities for care and treatment of "persons with mental diseases," and this is not limited to persons with a primary diagnosis of mental disease.

We share the States' concern with administrative difficulties which might be caused by a shift from 49% to 51% population of mentally ill in a facility. This concern is irrelevant here, however, given

the high percentages of mentally ill in most of the facilities during the disallowance periods and since other significant factors also evidenced "overall character" of the facilities as IMDs.

We also do not find the counting of patients here to be discriminatory. As the Court in Schweiker, supra, found, the exclusion is directed at a type of institution, not at the patients. The resulting disallowances flow from classification of a facility as an IMD, not from the counting of patients per se. This classification may have unfortunate results on placement decisions made by the States, and lead to mentally ill patients being segregated in IMDs or placed in facilities farther from their homes so that the exclusion could be avoided. However, any discrimination in this situation would be a result of the exclusion and the State seeking to maximize funding, and only tangentially the result of the Agency's counting of patients.

We also note that Medicaid provisions forbid denial of "medical assistance" on the basis of diagnosis. The Agency is using diagnosis here as a basis for determining whether services are, indeed, "medical assistance" or are excluded from being "medical assistance" because they are provided in an IMD.

Our holding here does not imply that the Agency could never apply a "51% Rule" arbitrarily. Given the facts of these cases, however, the criterion itself does not provide a basis for reversal of the disallowances.

4. Discussion of General Substantive Issues Related to the Criteria

With respect to the remaining criteria, we also find that they were applied here in a reasonable manner. If the Agency had relied solely on any one of them, we might view the issue differently. The Agency itself recognized, however, that some of the criteria were more probative than others and here used the criteria as a guide for accumulating evidence that the regulatory definition was met.

While all of the criteria might not be as obvious as the Agency alleges, neither are they as obscure as the States allege. In these particular cases, the findings which result from the Agency's use of the criteria do support the general conclusion that the facilities were IMDs, or, at least, do not detract from that conclusion.

There was some inconsistency in application of the criteria to the different States' facilities. For the most part, this merely reflected the differences in the States' programs and did not prejudice any State since the inconsistency in no case led to a legally incorrect application of the regulation. Further, the inconsistency in some

instances favored the States since the Agency may have applied the criteria more conservatively than the regulations required.

Thus, given our conclusion that the regulations apply as a basis for the disallowances here, we further conclude that the Agency's failure to promulgate the criteria does not render these disallowances defective, and that, substantively, use of the criteria as tools for the application of the regulations was not arbitrary or discriminatory. We also conclude that while the criteria in some instances may have been inconsistently applied, these instances were not prejudicial and do not invalidate the Agency's findings as a whole. As discussed below, the Agency has presented persuasive evidence that each of these facilities met the regulatory definition of an IMD.

V. Analysis of Factual Issues

In this section, we discuss the facts related to the disallowances for each of the four States involved here, analyzing the issues each State raised with respect to its particular case. The order of discussion (Connecticut, Illinois, Minnesota, and California) is the order in which the States presented their arguments at the joint hearing. Each subsection is organized differently, depending on the types of issues the particular State raised.

A. Connecticut

Docket No. 80-150-CT-HC involves a disallowance of FFP claimed by the State of Connecticut for services provided by Middletown Haven Rest Home (Middletown Haven), during the period January 1, 1977 through September 30, 1979. The disallowance was based on a report submitted by an Agency regional office review team, 28/ which found that Middletown Haven was an IMD.

For reasons discussed below, we conclude that Middletown Haven was an IMD and uphold the Agency's disallowance.

1. The Reviewers' Findings in Connecticut

Both the Review Report itself and testimony at the hearing by the psychiatrist member of the review team show that the determination

28/ "Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home, Middletown, Connecticut, for the period January 1, 1977 through September 30, 1979," FM Control No. 3-8001, May 1980 (CT Review Report), submitted with Agency response to the appeal.

that Connecticut's Middletown Haven ICF met the regulatory definition of an IMD was based on careful consideration of a number of different factors. The reviewers specifically recognized that the criteria were factors to be cumulatively weighed, that they were not intended to be all-inclusive, and that they did not carry equal weight. CT Review Report, pp. 5-6.

The reviewers found that, during the disallowance period, Middletown Haven was certified as an ICF under the Medicaid program, but also had a license from the State with an "authorization to care for persons with certain psychiatric conditions" ("psychiatric rider"). CT Review Report, p. 6, and Attachment D. The reviewers reported:

> The staff of the facility stated that not only is it identified in the license but that they view the facility as a psychiatric facility. Statements were made with regard to the patient population that it consisted mostly of mentally ill patients, for the most part transferred from ... a State mental institution. Also, the statement was made that local hospitals have been advised of this specialty and will specifically refer patients with mental impairments. ... Other indications were given during the interview that supported the team's conviction that the facility administration regards its license seriously and viewed itself as a licensed facility for psychiatric conditions.
>
> CT Review Report, p. 6.

The other indications the reviewers relied on included that the facility advertised itself to sources of referral as a facility specializing in the care of persons with mental diseases. This finding was based primarily on statements by the facility's administrator, but was partially verified through other means. CT Review Report, p. 7.

The reviewers also found that Middletown Haven hired medical and other staff which specialized in care of the mentally ill. The facility had a contract with three psychiatrists, requiring each of them to be an active staff member, to come in a least weekly for consultation on patients, and to participate in in-service education programs for the staff. CT Review Report, p. 12.

The factor which the reviewers thought indicated most clearly that Middletown Haven was "primarily engaged" in treating the mentally ill was the determination that, of the 469 patients deemed to have been patients in the facility from January 1977 to December 18, 1979,

364 or 77% had a major mental illness which was a substantial part of their need for ongoing ICF care. 29/ CT Review Report, pp. 7-8 and Attachment F, p. 3.

This determination was based on a very careful review of the available data, under the guidance of the psychiatrist on the team, who performed an in-depth analysis of a test sample and a detailed review of all cases where other team members had a question about how to classify a patient. CT Review Report, p. 8. This psychiatrist testified at length at the hearing on the rationale he applied to patients with multiple diagnoses. See, Tr., pp. 312-328.

Additional review findings included that a large proportion of Middletown Haven patients came from State mental institutions, that the facility is within three miles of a State mental institution, and that approximately two-thirds of the patients were between the ages of 21 and 65, which is uncharacteristic of nursing home patients in general. CT Review Report, pp. 8-11. The reviewers also cited an Independent Professional Review report, prepared by State teams, which commented on the "high incidence of psychiatric patients" in the facility. CT Review Report, p. 13.

2. Analysis of the Issues in Connecticut

Connecticut does not dispute the correctness of the reviewers' findings with respect to the facility's specialization and staffing, but does question their relevance. Connecticut contends that the specialization at Middletown Haven can be explained because it makes economic sense to have some concentration of individuals with a particular condition, so that some specialized services can be developed. CT Reply Br., p. 23. Given some concentration of patients with mental problems, it was logical, Connecticut argues, for the facility to seek staff with some relevant experience. Indeed, Connecticut asserts, federal

29/ The 77% here included patients with diagnoses of alcoholism or organic brain syndrome where the record indicated that "the psychiatric causes, complications or sequelae of these disorders were a significant part of the patients ongoing need for ICF placement." CT Review Report, Attachment F, p. 2. The psychiatrist from the review team stated that the conclusion that a majority of the patients in the facility were mentally ill would still be valid, even excluding these categories. He further explained that the reason for including them was "their appearance as major mental disorders in ICD-8, DSM II, and all major textbooks of psychiatry, and the fact that the State of Connecticut treats this class of mentally ill in its state mental hospitals ... ." Attachment F, p. 2.

regulations require a facility to have a staff that meets the needs of its residents. CT Br., p. 51. Connecticut also points out that the Medical Director of Middletown Haven was a general practitioner, not a psychiatrist, CT Reply Br., p. 20, and that many long-term care facilities have some staff with experience in caring for mentally disturbed residents. CT Br., p. 51.

The evidence shows, however, that the degree of specialization which occurred at Middletown Haven was significant. The staff viewed Middletown Haven as a psychiatric facility, primarily caring for the mentally ill. Whatever the facility's motivation for concentrating on the mentally ill, we find that the resulting situation strongly indicated that the facility had the "overall character" of an IMD. We also do not think, based on the record, that Middletown Haven was a typical general ICF in the services it offered. The Agency presented convincing testimony by the review team psychiatrist that the level of psychiatric treatment offered by Middletown Haven to its residents was greater than one would normally expect in ICFs. Tr., p. 328.

Connecticut did attempt to factually rebut some of the reviewers' other findings, primarily through the testimony of a Public Assistance Consultant for the Connecticut Department of Income Maintenance. This consultant testified that a "psychiatric rider" to a Connecticut nursing home license merely means that the facility cares for at least one mentally ill patient and has one staff person with psychiatric training. The witness further testified as to the differences between Middletown Haven and State mental hospitals, including that a State hospital provides a greater intensity of treatment and cares for patients with "acute mental disorders." Tr., pp. 138-140. Middletown Haven's admission policy did not permit it to care for persons with acute mental disorders. CT Review Report, Attachment E, pp. 1, 3.

The Connecticut witness also discussed the results of a review she had performed, based on reports by Independent Professional Review (IPR) teams in accordance with federal utilization control requirements. The witness testified that she would not have concluded from her examination of these reports that in December 1979 a majority of Middletown Haven's patient population were persons with mental diseases. Tr., pp. 143-149; see also, Affidavit, Exhibit D to CT Br. She also gave examples of patients, with multiple diagnoses, whom she thought may have been misclassified by the reviewers as mentally diseased.

While we accept Connecticut's evidence as to the meaning of the "psychiatric rider" on Middletown Haven's license, and certainly would not view the presence of such a rider as determinative of the character of a facility, the fact that Middletown Haven had such a rider has some

weight when viewed in the context of the other evidence here. We also are persuaded that there were distinctions between Middletown Haven and State mental hospitals during the disallowance period. Given the regulatory definition of an IMD, however, the fact that Middletown Haven was unlike a mental hospital in some respects is irrelevant to the issue of whether it was an IMD.

On the whole, we find the Agency evidence more persuasive with respect to the reasons for patient placement in Middletown Haven. The testimony of Connecticut's witness on possible misclassification was based on speculation from her review of the IPR reports, not on first-hand knowledge of what the reviewers did.

Moreover, we find that, as between the two witnesses, the Agency witness had more credibility. The Agency witness was highly qualified in psychiatry, Tr., pp. 309-310, whereas Connecticut's witness was not, Tr. pp. 144-145. Even if we agreed with Connecticut that some mistakes may have been made with respect to classification of individual patients, however, there would still remain overwhelming evidence that the "overall character" of Middletown Haven was that of a facility established and maintained for the care and treatment of persons with mental diseases.

Accordingly, we uphold the disallowance of $1,634,655 claimed by the State of Connecticut for payments to Middletown Haven for quarters ending March 31, 1977 through September 30, 1979.

B. Illinois

Docket No. 80-44-IL-HC involves a disallowance of FFP claimed by the State of Illinois for services provided to persons under 65 years of age in nine ICFs and SNFs during quarters ending December 1, 1976 through September 30, 1978. The Agency concluded that the nine facilities were IMDs based on a comprehensive review of eleven Illinois long-term care facilities. The review was conducted by two Medicaid Program Specialists from the Regional Medicaid staff. 30/

1. The Reviewers' Findings in Illinois

The reviewers examined medical review or independent professional review documents as well as utilization review data prepared by the Illinois Departments of Public Aid and Public Health. These documents were prepared by registered nurses employed by the State

30/ See "Report on Review of Institutions for Mental Diseases under the Medicaid Program," March 5, 1979 (IL Review Report).

and contained the diagnoses and treatment for each Medicaid patient, as recorded in the patient's actual medical records. Diagnoses in the ICDA were used to classify persons with mental diseases. The reviewers also examined advertisements, residents' handbooks, newspaper articles and internal State memoranda concerning the facilities.

The number of Medicaid patients with mental diseases in each of the facilities was found to represent at least 60% of the Medicaid population. 31/ In all but two facilities, the number exceeded 85%. Statements in reports prepared by the Illinois Departments of Public Health and Public Aid confirmed for six of the facilities that resident population was made up primarily of mental patients or that the type of care was oriented towards mental patients. In the remaining three, the reviewers pointed to statistics concerning the use of each facility as alternative placement for mental hospitals or the number of former mental hospital patients in the facility. The reviewers noted that in five of the facilities, the average age of the patient population was uncharacteristically low for nursing homes, e.g., 46 years. IL Review Report.

2. Discussion of the Issues in Illinois

Illinois expended most of its effort in this case arguing general legal issues. To the extent the presentation related peculiarly to Illinois, it related primarily to State policy and to the characteristics of all Illinois ICFs rather than to the specific facilities found to be IMDs.

Illinois attacked the Agency criteria in general and the use of patient diagnosis in particular, presenting testimony on the dangers of patient labeling. Illinois also submitted evidence designed to show that its facilities certified as ICFs are distinguishable from State psychiatric hospitals. We have addressed these issues above.

With respect to the specific findings in Illinois, the State presented evidence primarily on three points: the legal requirements governing admission and discharge policies of Illinois ICFs; the nature of follow-up responsibility by the Illinois Department of Mental Health for patients in the facilities; and the significance of placement of

31/ The Illinois, Minnesota, and California reviews examined only records of Medicaid patients, and, therefore, the percentages found were percentages of the total Medicaid population, not the total patient population, for each facility. The States have presented nothing, however, which would lead us to conclude that the Medicaid population was not representative of the total population. The assumption that it was appears to be reasonable.

patients from State mental facilities into these ICFs. We do not find that any of this evidence overcomes the Agency's findings as to the overall character of the specific facilities as IMDs.

Illinois has established that State regulations governing admission and discharge policies of ICFs expressly prohibit the admission or retention of persons who require "mental treatment" as defined in the Illinois Mental Health Code. That definition, however, refers to a person needing "mental treatment" if "that person is afflicted with a mental illness and as a result of such mental illness is reasonably expected ... to intentionally or unintentionally physically injure himself or other persons, or is unable to care for himself so as to guard himself from physical injury or to provide for his own physical needs." IL Hearing Exhibit 5. Thus, need for "mental treatment" can certainly not be equated in Illinois with being mentally ill. In addition, the policies of the Illinois State Psychiatric Institute, a recognized IMD, indicate that a person might be discharged from a psychiatric hospital providing "mental treatment" into a long-term care facility "because of continuing illness, which has proved refractory to all available therapies which the hospital has to offer." IL Hearing Exhibit 2, p. 6.

Moreover, the admission policy of Grasmere Residential Home, Inc., one of the ICFs involved here, indicates that, while the Home did not provide "mental treatment," it did consider itself as providing some form of treatment to patients where therapeutically indicated. IL Hearing Exhibit 3.

Illinois also presented testimony regarding the scope of the jurisdiction of the Illinois Department of Mental Health and Developmental Disabilities. According to the Director of the Department, who testified at the hearing, the Department has jurisdiction only over the mentally ill in hospitals. Follow-up responsibility for persons placed from hospitals into facilities such as these ICFs does not include monitoring of individual patients, only evaluation of the patients' status as affected by the facilities' programs. Tr., p. 301. The Department merely acts as an advocate for persons discharged from State mental health facilities. Tr., p. 284. Based on this, the State argued that the Agency should not have placed any significance on the fact that the Department had follow-up responsibility for a number of the patients placed in the ICFs here. IL Reply Br.

Illinois' evidence on this point is convincing to show the scope of the Department of Mental Health's jurisdiction and the nature of its follow-up responsibility. We would also agree that the fact of follow-up responsibility does not necessarily indicate continuing mental illness. However, Illinois has not demonstrated that patients

for whom the Department had that responsibility were considered cured and were placed into these ICFs for purely physical illnesses. Indeed, the Agency's evidence shows that most of the patients were ambulatory and few had physical problems. Thus, while we do not consider the fact that the Department had follow-up responsibility for a number of the patients placed in the facilities here to have great weight, we nonetheless consider it some support for the general finding that high percentages of the patients were mentally ill.

The remainder of Illinois' evidence is intended primarily to show that the placement of patients from State mental facilities into these ICFs does not mean these facilities were used as alternatives to the State facilities. In addition to pointing to Illinois regulations on persons requiring "mental treatment," discussed above, Illinois presents evidence to show: 1) persons placed in ICFs are placed there solely because they need the care that an ICF normally provides, Tr., p. 283-287; 2) only a small percentage of persons discharged from State facilities were placed in long-term care facilities during the disallowance period, IL Hearing Exhibit 6; and 3) the Department of Mental Health has placed persons in approximately 400 different facilities during the disallowance period, Tr., p. 291.

The Agency has not rebutted these points, and Illinois' evidence does indicate, at least, that the State was not arbitrarily "dumping" patients from State mental hospitals into ICFs, using them as inappropriate alternatives to mental hospital care. The real issue here, however, is whether particular facilities were IMDs. As part of its findings supporting the conclusion that the facilities had the requisite overall character, the Agency found that the facilities had relatively large numbers of patients placed into the facilities from State mental hospitals. None of the State's evidence directly contradicts the Agency's findings, which are based on State census reports. Indeed, given that only small percentages of persons discharged from State facilities were placed in long-term care and that over 400 facilities received some patients, the relatively high number of placements into these facilities has greater weight in showing that these facilities were not typical ICFs than it would otherwise.

Thus, while we find Illinois' evidence sufficient to establish certain facts, those facts are not directly relevant to the issues before us and do not overcome the Agency's findings that high percentages of the patients in the facilities had mental disorders and that the State in some way recognized that the facilities were primarily serving the mentally ill. Thus, we conclude that the facilities met the regulatory definition and were IMDs.

Accordingly, we sustain the disallowance of $4,261,162 in FFP claimed for services provided in these facilities.

C. Minnesota

Docket Nos. 79-52-MN-HC and 79-89-MN-HC involve disallowances of FFP claimed by the State of Minnesota for services provided to persons under 65 years of age in three ICFs during quarters ending September 30, 1977 through June 30, 1978. The Agency concluded that the three facilities were IMDs based on a review conducted by the Region V Medicaid Bureau. 32/ The Agency states that these facilities were selected for review based on a list of facilities with a Minnesota "Rule 36" license for residential facilities providing programs for five or more mentally ill persons. The record indicates, however, that only two of the three facilities had this type of license. MN Review Report, Attachment 8.

1. The Reviewers' Findings in Minnesota

Utilizing methods similar to that employed by the Illinois review team, the reviewers examined Minnesota Department of Public Welfare records that included judgments by the State's medical personnel as to the primary reason for each Medicaid patient being in the facility. Diagnoses of mental diseases were based on the ICDA. The reviewers also considered correspondence from the facilities, statements by Minnesota concerning the facilities, and other information.

The reviewers concluded that all three facilities were "primarily engaged in providing treatment and care for persons with mental diseases." The findings for individual facilities are described below.

Andrew Care Home

90.4% of the Medicaid patients in this facility were found to have diagnoses of mental diseases. In a letter to the Agency concerning a requested waiver of a handrail requirement, counsel for the home characterized it as follows:

> "... the residents of Andrew Care Home are handicapped because of mental health rather than physical disability ... ."

32/ "Report on Review of Federal Financial Participation under Medicaid in Payments for Care in Institutions for Mental Diseases," November 8, 1978 (MN Review Report).

> "... only 10% of the total resident population is over 65 years old ... ."
>
> "The majority of residents of the facility carry a diagnosis of schizophrenia or paranoid schizophrenia or other neurological disorders."
>
> MN Review Report, Attachment 10.

In a subsequent letter, the same law firm referred to Andrew Care Home as a "mental health residential facility." MN Review Report, Attachment 11. According to State records cited by the reviewers, the average age of Medicaid patients in the facility in November 1977 was 39.88 years. Andrew Care Home was licensed under Rule 36 from December 1, 1976 to January 1, 1978 and the review report quotes the following statement, concerning the license, made in a memorandum of the Minnesota Department of Public Welfare:

> Rule 36 licensure is a direct admission, being a program license, that the facility has a fairly primary intent to provide specific care and treatment aimed at the mentally ill population.

Birchwood Care Home

86.4% of the Medicaid patients in this facility were found to have diagnoses of mental diseases. The Minnesota Department of Public Welfare in a letter dated December 27, 1977 stated that the average age of Medicaid residents in November 1977 was 58 years. Birchwood Care Home had a Rule 36 license for adult mentally ill persons from March 1, 1977 to March 1, 1978.

Hoikka House

The reviewers found that 94.9% of the Medicaid patients in this facility had diagnoses of mental diseases. The average age of Medicaid patients in November 1977 was 48 years and a majority of patients came to the house from State hospitals. A calling card of the Hoikka House program director refers to the facility as providing "Care of the Mentally Ill."

2. Discussion of the Issues in Minnesota

a. Availability of Psychiatric Treatment and Diagnostic Services on the Premises

Minnesota argues that the Agency criteria failed to address a critical element of the definition of an IMD by failing to consider the availability of psychiatric treatment at the facilities. Minnesota

presented affidavits from administrators of all three facilities, stating that residents did not receive psychiatric or psychological services on the premises of the facility. Any such services received by the patients were furnished outside the facility. The administrators characterize the services provided by the facilities as counseling in "basic living skills" designed to increase patients' capacity to function more independently and to deal with daily living needs.

As we discussed more fully in our section on the regulations, the regulatory definition of an IMD requires that a facility provide "treatment" for its patients, not a specific kind of treatment such as active psychiatric services. The Agency argues that, depending on the individual's condition, counseling in living skills may be just as significant in treating the individual as classic psychiatric therapy. Further, Minnesota does not deny that psychiatric treatment received by residents outside the facilities may complement the services received within the facility and may be considered to be part of the residents' comprehensive treatment program at the facility.

Minnesota also argues that the Agency's criteria are defective in that they do not consider the availability of diagnostic services at the facilities. We have previously addressed several aspects of this issue. The regulations do not require that a facility must provide diagnostic services for mental diseases in order to be classified as an IMD. Moreover, Minnesota has not presented evidence that the facilities here do not diagnose patients upon admission or at some subsequent time.

b. Recorded Diagnoses of Patients as an Indication of Type of Facility

Minnesota also argues extensively that the recorded diagnoses of the patients are not a reliable indicator of the type of facility since misdiagnosis frequently occurs and old diagnoses are not updated. Minnesota adds that the listing used for classifying mental diseases, the ICDA, is indefinite and of limited usefulness. Minnesota ignores the fact, however, that the diagnoses cited here were derived from the State's own records and were used by health professionals in placing and retaining the residents in the facilities under review. Regardless of whether the diagnoses were correct, the facilities apparently depended on them in providing patient treatment and care and in developing their services and programs. Moreover, it would be unreasonable to require the Agency to rediagnose each of the individuals in the facilities under review merely so it could administer the IMD provisions. While Minnesota criticizes the ICDA for lack of definiteness, it does not propose any preferable alternative method of classification.

Minnesota also argues that the key specialist that assisted in the Agency review lacked the background to assess the facilities and to evaluate patient diagnosis. As we understand the review procedures, however, the specialist depended largely on the State's own records. Minnesota does not allege that the statistics cited were inaccurately transcribed. Also, the Agency alleged that its reviewers were assisted by medical personnel when necessary and the State has not disputed this.

c. Other Arguments

The State also raises a series of arguments concerning individual criteria applied by the Agency. The Agency has never asserted that age distribution, former place of treatment, or Rule 36 licensure, if taken alone, would be a decisive indication of the facility's character. The Agency may properly consider these criteria, in our view, if it also considers more conclusive ones such as the facility's own representations and the makeup of the patient population. We certainly would not discount representations made by the facility's counsel relating to another Medicaid program requirement simply because the facility could "benefit" from the representation.

In conclusion, there is substantial evidence in the record that these facilities met the regulatory definition for IMDs. A very large percentage of the patient population in each of the facilities had diagnoses of mental diseases, and other significant indicators support the Agency's findings in each case. While Minnesota has raised legal arguments concerning the weight to be given to findings, it has not presented any evidence to persuade us that these findings were incorrect.

Accordingly, we sustain the disallowance of $896,159 in FFP claimed for these facilities during quarters ending September 30, 1977 through June 30, 1978.

D. California

Docket No. 80-184-CA-HC involves a disallowance of FFP claimed by the State of California for services provided to persons under 65 years of age in five SNFs during the quarters ended March 31, 1975, through September 30, 1977. Based on an HHS Audit Agency report, 33/ the Agency determined that the five facilities were IMDs.

33/ "Audit of Five Selected Skilled Nursing Facilities that Participated in California's Special Disabilities Services Program for the Mentally Disordered, February 1, 1975, through September 30, 1977," ACN 00150-09 (CA Audit Report), Exhibit A to CA Supp. to App.

In classifying the facilities as IMDs, the Agency primarily relied on four factors: participation by the facilities in a special State program for the mentally disordered; licensing status; program and admission policies; and patient population. Below we discuss each of these factors, as well as some general arguments the State makes. We conclude that the Agency has presented substantial evidence to show that these California SNFs were IMDs.

1. The Special Disabilities Services Program

In September 1974, the State of California authorized funding for a Special Disabilities Services (SDS) Program, through which a supplemental payment could be made to participating SNFs and ICFs for services to persons who were developmentally disabled, substance abusers (alcohol or drugs), or mentally disordered. California Administrative Code, Title 22, Division 5. In order for a facility to be certified for the mentally disordered component of the SDS Program, at least 30 of its patients had to be certified by the local mental health director as having a primary or secondary diagnosis of a mental disorder. CA Audit Report, p. 12. Participation in the SDS Program was used by Agency auditors as an initial screening device in choosing the five facilities in question here.

California does not deny that each of the facilities participated in the program, but attempted to show that it was irrelevant to IMD status. Through testimony, California implied that the fact of participation might be misleading since the SDS Program served the developmentally disabled and substance abusers, as well as the mentally disordered. Tr., pp. 258-262. As part of the administrative record on which it based its decision (Agency Record), however, the Agency has submitted materials which show that each of these facilities qualified for a component of the program called "mentally disordered rehabilitation," and that some of the facilities had more eligible patients than the required number. 34/ Agency Record, Tab 16. The State has not challenged the authenticity of these documents. These materials also show that both the facilities and the State referred to the program as a "special treatment" program. This undermines the State's position that the rehabilitation services provided should not be considered "treatment" within the meaning of the IMD regulatory definition.

34/ We do not think it significant that all of the patients were not eligible since the materials indicate that ineligibility may relate to lack of rehabilitation potential rather than to mental status.

b. Licensing Status

Another factor relied upon by the Agency auditors in determining IMD status was that the facilities were licensed by the State as skilled nursing facilities, "long-term mental." A California witness testified that this license classification (referred to as an "L-facility") was developed for "wandering geriatrics," and some people therefore thought the "L" referred to permission to have a locked door. Tr., pp. 225-226. Yet, the relevant licenses clearly say "long-term mental," and indicate for some facilities that the total bed capacity had that classification and for others that at least half the capacity did. Agency Record, Tab 16.

2. Program and Admission Policies

For their conclusion that the facilities were established and maintained primarily for the care and treatment of persons with mental diseases, the auditors also relied heavily on the facilities' program and admission policies. Some of the most significant statements in these materials, included in the Agency Record at Tab 16, are the following:

Facility A:

> This facility was self-described as having cared for "over 1000 mentally disabled residents" during its 4 and 1/2 years of experience. Its program was described as "a practical approach at teaching/reteaching the skills of living required for the severely mentally disordered." Patient profiles included "treatment" as the "functional level" which "includes the majority of residents." The program was described as a standard one, varying only "according to the specific patient's treatment plan." A Certification and Transmittal form for Medicaid eligibility of the facility identified as the "certification specialization and/or services" of the facility "mentally disordered/rehabilitation."

Facility B:

> Its own Program Philosophy described this facility as a "120 bed facility comprised primarily of mentally ill patients." An Information Booklet describing participation of the facility in the SDS Program stated that the extra funding "is expended strictly on additional psychiatric and recreational staff members ... ." Under "Admission Policies" is the following: "Only patients in need of 24 hour skilled nursing services for the management and observation of mental illness or other

> related behavioral disorders shall be admitted. ... Patients with only physical illnesses shall not be admitted."

Facility C:

> The admission policy of this facility was described as an intent "to admit patients who exhibited behavior compatible with the State's Special Treatment Program." The philosophy of the facility was "to care for those individuals who have a mental disorder requiring long-term care in a highly structured, secure environment," and the basic program was described as "utilization of behavioral intervention and rehabilitation techniques."

Facility D:

> Facility materials referred to "residents of our long-term psychiatric facilities." Program philosophy was described as "employment of all the latest, medically approved psycho-social treatment modalities." The facility also had "mentally disordered/rehabilitation" as a certification status.

Facility E:

> The admission policy of this facility was to exclude "patients that do not have a primary psychiatric diagnosis." The treatment program was described as "planned for the chronically mentally ill, not the mentally retarded."

California attacked the reliability of this evidence through testimony that it would be to a facility's financial advantage to advertise as a facility specializing in the mentally ill so as to qualify for the SDS Program. Tr., p. 223. We are not inclined on this basis, however, to conclude that these facilities misrepresented themselves, particularly since some of their statements were not purely advertising but related to certification for State programs.

3. Patients' Diagnoses

The points on which California did present some persuasive evidence mostly went to the issue of whether the auditors' findings were reliable with respect to diagnoses of the patients.

The auditors described their method for determining the characteristics of the patient populations of the five SNFs as follows:

> We randomly selected 210 Medicaid claims for each of the five SNFs, or 1,050 sample items in total, for the periods the SNFs participated in the [SDS] Program until September 30, 1977. We then made on-site visits to the five SNFs and reviewed patients' medical records for the periods covered by the paid claims. We obtained the patients' primary and secondary diagnoses and noted if the patients were being treated for physical illnesses or mental diseases. We categorized the patients' diagnoses as mental diseases based on those listed under the heading of Mental Disorders in the [ICDA].
>
> * * *
>
> Our review showed that 1,005, or 95.7 percent, of the claims were for patients with mental diseases and 45, or 4.3 percent, of the claims were for patients who had physical illnesses as their primary diagnoses.
>
> CA Audit Report, pp. 15-16.

The auditors' charts show that the auditors included as primary diagnoses of mental diseases the categories alcoholism, schizophrenia, chronic/organic brain syndrome, senility, psychosis, and "other mental diseases." CA Audit Report, pp. 16-17.

California attacks these findings on a number of different grounds, challenging the reliability of the findings as a whole, the specific inclusion of certain diagnoses as mental, and the use of medical records.

California's position is most fully elaborated in a report prepared by a clinical psychologist who is a Senior Mental Health Consultant for the State (Consultant). 35/ In her report and testimony at the hearing, this Consultant assessed the results of a study, performed at the request of the State, designed to provide accurate

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35/ "Assessment of the Diagnostic Composition of the Patient Population in a SNF Deemed by Federal Auditors To Be an IMD: Further Analysis of Results and Implications for Interpreting the Audit Approach and Findings," Exhibit C to CA Supp. to App. (Consultant's Report).

diagnostic characterization of the patients in one of the five SNFs audited (Diagnostic Study). 36/

The Consultant challenges the auditors' findings that 95.7% of the sample claims were for patients with mental diseases and only 4.3% were for patients with a primary diagnosis of physical illness. She states: "These proportions strikingly differ from those which would be anticipated on the basis of well-documented, methodologically sound studies of the extent of primary physical diseases in patient populations manifesting mental symptoms." Consultant's Report, p. 47. For this proposition, the Consultant relies on the Diagnostic Study mentioned above and on a "landmark study" which showed a 46% error rate of undiagnosed primary physical disorders in a group of 100 State hospital psychiatric admissions. 37/

While California presents convincing evidence to the effect that misdiagnosis of patients with mental symptoms is prevalent, we are not persuaded that we should therefore apply the 46% error rate to the auditors' findings, as California suggests.

Even though the Agency may have been relying on diagnoses in patients' records which were incorrect, to the extent that these diagnoses were in the records, they are evidence as to the "overall character" of the facilities. The facilities were admitting and treating the patients using those diagnoses. The Agency cannot be expected to perform for each patient the extensive diagnostic analysis which California's own evidence shows is necessary to properly determine whether there is a physical cause of psychiatric symptoms. Moreover, the "landmark study" on which California partially bases its thesis that many of these SNF patients were misdiagnosed is a study of patients in a State mental hospital. Therefore, misdiagnosis is hardly a basis for distinguishing these SNFs from recognized IMDs.

California's Consultant also presents a detailed analysis to show that the auditors did not properly apply the ICDA in classifying patients. The most cogent evidence of this which California presents relates to the categories of senility, alcoholism, and chronic/organic brain syndrome. The State presented expert

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36/ "Neurobehavioral Evaluation and Diagnostic Study of 102 patients in an 'L' Facility", prepared by Neurobehavioral Foundation, Exhibit B to CA Supp. to App.

37/ "Physical Illness Manifesting in Psychiatric Disease," Hall et al., reprinted in Consultant's Report.

testimony by a psychiatrist with the California Department of Mental Health (Psychiatrist), who pointed out the difficulties associated with use of the ICDA. He testified that "senility" is not a code in the mental disorders chapter of the ICDA. Tr., p. 183; see also, Consultant's Report, p. 50. California also questioned the auditors' use of the term "alcoholism." According to California's Consultant, there is a code in the ICDA for "alcoholism," meaning either episodic or habitual excessive drinking, as well as a code in the mental disorders chapter for "alcoholic psychoses," which come within the organic mental disorders. Consultant's Report, p. 50. With respect to the category "chronic/organic brain syndrome" (which the Psychiatrist describes as a constellation of symptoms which raises the suspicion that something has gone wrong with the brain itself, Tr., p. 203), California states that the ICDA guidelines require that patients with any organic mental disorder also be coded for the causal or associated physical disease. Consultant's Report, pp. 51-52; Tr. pp. 184, 190. Thus, California concludes that the auditors misused the ICDA.

The Agency did not present any evidence which would show that senility should have been included as a mental disease, although testimony by California's Psychiatrist suggests that this would not always be inappropriate. Tr., p. 183. The Agency also did not fully explain its rationale for inclusion of alcoholism and chronic/organic brain syndrome here. But see, CT Review Report, Attachment F.

The record shows that the State's underlying factual premises have some validity. We do not agree with the State, however, as to the conclusions to be drawn from those premises. California acknowledges that many persons whose diagnoses were senility, alcoholism, or organic brain syndrome were in State mental hospitals in the early sixties. Tr. pp. 116-117; see also, Tr. p. 193. Moreover, even if we were to exclude patients with these primary diagnoses on the grounds that including them was inconsistent with proper use of the ICDA, the auditors' sample still provides a basis for concluding that over 50% of the patients had mental diseases. Out of the 210 sample claims for each facility, patients placed by the auditors in the categories of schizophrenia, psychosis, and "other mental" total well over 50% of the claims. Excluding the "other mental" category as well would reduce the percentage of patients with primary mental disorders below 50% for one of the facilities only (Facility B). CA Audit Report, p. 17.

We consider it most important, however, that any defects in the auditors' findings here must be viewed in the context of other strong evidence that the facilities had the requisite "overall character." In particular, the facilities' own program and admission policies discussed above support the finding that the facilities were primarily engaged in treating persons with mental diseases.

4. Other Arguments by California

The State also attempts to show the unreliability of medical records for determining diagnosis and the need for exercise of medical judgment where there is more than one diagnosis. As we have previously mentioned, we think the Agency was reasonable in relying on medical records under these circumstances. Also, while the auditors here certainly do not have the credibility that the Connecticut review team had, the Agency has stated without contradiction that the auditors were advised by a physician-consultant whenever necessary and, in cases of doubt, the audit team would confer with the medical staff of the facility. Cons. Br., p. 9.

We also conclude that the State's remaining arguments do not have merit. The State points out that private-pay patients were not included in the auditors' sample, but has presented nothing to lead us to conclude that the characteristics of these patients would be significantly different from those of the Medicaid patients. This is highly unlikely in view of the facilities' program and admission policies. The State also argued at one point that the auditors presupposed their result and did not do a random sample of all the facilities participating in the SDS Program. The Agency responded that the audit was performed in accordance with generally accepted principles, that the auditors did not have a "preconceived purpose," and that there was no need for a random sample of all participating SNFs since the disallowance relates to only five of them. Agency Response, Docket No. 80-184-CA-HC, pp. 27-28. California did not press its arguments on these points during the later stages of the proceedings, and we do not find them convincing.

5. Conclusion in California

California has shown that there might have been some defects in the audit here, notably the inclusion of patients with senility. The evidence as a whole, however, convincingly demonstrates that these five facilities had the "overall character" of being IMDs.

Accordingly, we sustain the disallowance of $2,329,401 claimed by the State of California for services provided by these facilities in the quarters ending March 31, 1975 through September 30, 1977.

VI. General Conclusion

For the reasons stated above, we uphold the Agency disallowances in all five appeals considered jointly here.

/s/ Cecilia Sparks Ford

/s/ Donald F. Garrett

/s/ Norval D. (John) Settle, Panel Chair