University of Massachusetts Law Review

Volume 18 | Issue 2 Article 1

December 2022

Blatant Discrimination within Federal Law: A 14th Amendment Analysis of Medicaid's IMD Exclusion

J. Michael E. Gray

Madeline Easdale

UMass Law Review

Blatant Discrimination within Federal Law: A 14th Amendment Analysis of Medicaid's IMD Exclusion

J. Michael E. Gray & Madeline Easdale

18 U. MASS. L. REV 165

ABSTRACT

A discriminatory piece of Medicaid law, the institution for mental diseases (IMD) exclusion, is denying people with serious mental illness equal levels of treatment as those with only primary healthcare needs. The IMD exclusion denies the use of federal funding in psychiatric hospitals for inpatient care. This article discusses the history and collateral implications of the IMD exclusion, then examines it through the lens of the Equal Protection Clause of the Fourteenth Amendment, argues that people with severe mental illness constitute a quasi-suspect class, and that application of intermediate scrutiny would render the IMD exclusion unenforceable.

AUTHOR'S NOTE

J. Michael E. Gray is Director of Advocacy at the Treatment Advocacy Center. He holds a J.D. from the Brandeis School of Law at the University of Louisville and has taught political science at Simmons College of Kentucky.

Madeline Easdale holds a J.D. from Capital University in Columbus, Ohio, and is currently practicing as an immigration attorney in Ohio.

The authors thank Lisa Dailey for her feedback on the first draft.

People with severe mental illness (SMI) fall victim to a discriminatory federal law—the Institution for Mental Diseases (IMD) exclusion.[1] The federal government allows Medicaid funding for treatment of non-mental diseases but allows the persistence of this inequitable exclusion.[2] Medicaid's enabling legislation singles out low-income individuals with certain brain disorders and denies them the full benefit of psychiatric care needed to prevent further deterioration and even death.[3] Congress, however, has the power to repeal the IMD exclusion but has shown little desire to do so.[4] Until Congress corrects the historic inequities caused by the IMD exclusion, the federal judiciary should use tools already at its disposal—the Equal Protection Clause of the 14th Amendment and the Americans with Disabilities Act (ADA)—to render the IMD exclusion unenforceable.

This article explores the history and significance of the IMD exclusio,[5] explains discrimination as it relates to the exclusion and the appropriate standard of review,[6] then argues that a correct judicial analysis of the IMD exclusion would determine that it violates federal law.[7]

I. BACKGROUND

A. History, Reform, and a Tale of Two Presidents

Joseph Kennedy Sr. loved his family, but was a domineering father.[8] One of his nine children, Rosemary, was not like her siblings: she had

---

1 42 U.S.C. § 1396d(a)(31)(B) (2022).

2 *Medicaid: IMD Exclusion*, NAT'L ALL. OF MENTAL ILLNESS, https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Medicaid-IMD-Exclusion [https://perma.cc/WRW2-MJZF] (last visited Mar. 5, 2023).

3 42 U.S.C. § 1396d(a)(31)(B) (2022).

4 At the time of this article's publication, at least two bills are before Congress to repeal the IMD exclusion. Combined, they have a long list of cosponsors, but neither have had a hearing. *See* Increasing Behavioral Health Treatment Act, H.R. 2611, 117th Cong. (2021); Michelle Alyssa Go Act, H.R. 7803, 117th Cong. (2022).

5 *See infra* Part I.

6 *See infra* Part II.

7 *See infra* Part II.

8 *See generally* RONALD KESSLER, THE SINS OF THE FATHER: JOSEPH P. KENNEDY AND THE DYNASTY HE FOUNDED 3 (1996); E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL HEALTH

an intellectual disability, experienced seizures, and likely had a SMI.[9] When Rosemary was twenty-three years old, she was subjected to a frontal lobe lobotomy at her father's behest that robbed her of her personality.[10] The Kennedy siblings, generally a close-knit bunch, were not allowed to see their sister after the operation and she lived the rest of her eighty-six years institutionalized and in relative isolation.[11] Rosemary Kennedy's condition and brutal course of treatment left a lasting impact on her family, not the least of which on her eldest surviving brother, President John F. Kennedy.[12]

Kennedy's presidency occurred when many reform movements were nearing their head, including the so-called "deinstitutionalization" movement.[13] The movement, which was induced by state hospitals participating in "the gradual relocation of residents to . . . community-based housing" led to public outcry when conditions inside were

---

TREATMENT SYSTEM 2, 6, 8, 10-15 (2014) [hereinafter TORREY, AMERICAN PSYCHOSIS].

9 ROSE FITZGERALD KENNEDY, TIMES TO REMEMBER 286 (1974); Interview by John F. Stewart with Bertram S. Brown, Deputy Dir., Nat'l Inst. of Mental Health (Aug. 6, 1968); *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 8, at 10.

10 TORREY, AMERICAN PSYCHOSIS, *supra* note 8, at 10-13.

11 Rosemary did visit with some of her family later in life, but not before the death of her father. LARRY TYE, BOBBY KENNEDY: THE MAKING OF A LIBERAL ICON 220–21 (2016); TORREY, AMERICAN PSYCHOSIS, *supra* note 8, at 14-15; Liz McNeil, *Why Rosemary Kennedy's Siblings Didn't See Her for 20 Years After her Lobotomy*, *People*, PEOPLE, https://people.com/books/why-rosemary-kennedys-siblings-didnt-see-her-after-her-lobotomy/ [https://perma.cc/MMX6-PV42] (last updated Nov. 21, 2022).

12 Joseph Kennedy's exiling of his daughter was emotionally brutal on the Kennedy family, but history should also note that a person with Kennedy's wealth and connections felt he had no better options than to authorize an invasive, often harmful, and potentially deadly procedure. The state of mid-twentieth century mental healthcare was such that effective medications and other treatment methods were not an option, even for America's elite. *See generally* TORREY, AMERICAN PSYCHOSIS, *supra* note 8, at 1-15.

13 *See generally* Daniel Yohanna, *Deinstitutionalization of People with Mental Illness: Causes and Consequences*, AM. MED. ASSOC. J. OF ETHICS 886 (2013), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/mhst1-1310.pdf [https://perma.cc/W7N3-SGMA]; Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, AM. JOUR. PSYCHIATRY RESIDENTS J. (June 11, 2021), https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp-rj.2021.160404 [https://perma.cc/PZ4F-VYQ8].

publicized.[14] Advocates for better treatment of people with SMI were understandably outraged by practices like Rosemary Kennedy's frontal lobe lobotomy and the living conditions in public psychiatric hospitals that were, in some cases, worse than mid-twentieth century prisons.[15] New medications and therapy techniques gave advocates hope that mental health conditions could be treated in the community on an outpatient basis.[16] The public hospitals that advocates abhorred were seen by some as the traditional responsibility of individual states,[17] and states were not following through with outpatient services.[18] Theoretically, the federal government's commitment to enhancing outpatient services, combined with disincentives for inpatient commitments, would lead to outcomes that were both more humane and medically efficacious. With these goals in mind, President Kennedy

---

[14] *See* Yohanna, *supra* note 13, at 886-88; *What is Deinstitutionalization?*, OPEN SOCIETY FOUNDATIONS, https://www.opensocietyfoundations.org/explainers/what-deinstitutionalization **[**https://perma.cc/WU7H-9Z7N **]** (last visited Mar. 5, 2023).

[15] *See* Yohanna, *supra* note 13, at 886-88; Although the conditions of asylums were repressible, the medical side of those institutions were not solely the result of underfunding and lack of societal investment in the quality of life. Doctors often had no options other than dangerous and invasive procedures to stabilize patients. Miguel A. Faria, Jr., *Violence, mental illness, and the brain-A brief history of psychosurgery: Part 1-from trephination to lobotomy*, SURGICAL NEUROLOGY INT'L (Apr. 5, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3640229/pdf/SNI-4-49.pdf [https://perma.cc/SSD3-P4JH]; Rosemary Kennedy's lobotomy, for example, was more than a decade before the first antipsychotic drugs arrived on the U.S. market and about a half century before the introduction of clozapine. Winston.W. Shen, *A History of Antipsychotic Drug Development*, 40 COMPREHENSIVE PSYCHIATRY 407, 407 (1999)

[16] *See* YOHANNA, *supra* note 13.

[17] *See* Erickson, *supra note 13*. States have been responsible for the financial costs of psychiatric hospitals since before they were states, creating the historic misperception that they provided care to people with SMI. Jeffrey Gellerm, *The Rise and Demise of America's Psychiatric Hospitals: A Tale of Dollars Trumping Sense*, PSYCHIATRIC NEWS, (Mar. 14, 2019), https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2019.3b29 [https://perma.cc/YK5N-DCGX].

[18] *See* Erickson, *supra* note 13. *See generally* HENRY A. FOLEY & STEVEN S. SHARFSTEIN, MADNESS AND GOVERNMENT: WHO CARES FOR THE MENTALLY ILL? 94-104 (1983).

signed the Community Mental Health Act into law less than one month before his tragic death.[19]

Kennedy's successor, President Lyndon B. Johnson, immediately began working towards a contemporaneous reform movement which was not just about mental healthcare, but accessible and affordable healthcare as a whole.[20] Less than two years into his tenure, President Johnson was ready to sign the Social Security Amendments of 1965 into law, enacting Medicare and Medicaid.[21] However, Medicare and Medicaid were political compromises of historic proportions.[22] Congressional liberals wanted a single-payer federal health plan for most Americans, not just the elderly;[23] conservatives rejected this

---

[19] Community Mental Health Act, PUB. L. NO. 88-164, 77 Stat. 282 (1963) (codified as amended in sections of 42 U.S.C. §§ 2661–2698b). This was the last major piece of legislation President Kennedy signed. At the signing ceremony for the bill, the president remarked on a stated aim of reducing psychiatric inpatient numbers via increased availability of outpatient services. *See* President John F. Kennedy, Remarks on Signing Mental Retardation Facilities and Community Health Centers Construction Bill, (Oct. 31, 1963), JOHN F. KENNEDY PRESIDENTIAL LIBR. AND MUSEUM.

[20] Though partially fulfilled under President Johnson, the movement toward single payor health within the executive branch dates at least to the late 1940s under President Truman. *See* President Harry Truman, Annual Message to the Congress on the State of the Union, THE AM. PRESIDENCY PROJECT (Jan. 5, 1949), https://www.presidency.ucsb.edu/documents/annual-message-the-congress-the-state-the-union-21 [https://perma.cc/5DT8-VTLZ] ("We must spare no effort to raise the general level of health in this country . . . Moreover, we need—and we must have without further delay—a system of prepaid medical insurance which will enable every American to afford good medical care"). Truman's plan became the "Wagner-Murray-Dingell Bill" of 1943 but was never close to passage. *See generally* George Horvath, *The Fair Deal Universal Health Care Proposals: Historians' Perspectives from 1970 to 2003*, 83 ALB. L. REV. 501, 504-05 (2019). Several powerful interest groups, including the American Medical Association, adamantly opposed Truman's plan and were able to prevent any real public health insurance plans until 1965.

[21] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

[22] Julian E. Zelizer, *How Medicare Was Made*, THE NEW YORKER (Feb. 15, 2015), https://www.newyorker.com/news/news-desk/medicare-made [https://perma.cc/SS7C-DTHE] [hereinafter *How Medicaid Was Made*] (Medicaid is a federally funded health plan for low-income individuals.); *See generally* Jonathan Oberlander, *The Political History of Medicare*, 39 GENERATIONS: J. OF THE AM. SOC. ON AGING 119 (2015) (Medicare is a federally funded health plan for people over sixty-five.).

[23] *See generally* Julian E. Zelizer, *The Contentious Origins of Medicare and Medicaid,in* COHEN ET AL., MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE (Oxford Univ.

broader scope, but knew that liberals would not approve of a narrower approach that only provided for retirement-age adults.[24] Congressman Wilbur Mills, however,[25] brokered a compromise that dominated the healthcare framework in the United States for at least seven decades—Medicare for the elderly would be federally financed and administered, while Medicaid would be administered by the states and funded by both the federal and state governments.[26]

Medicaid was therefore a supplement for what President Johnson and congressional liberals wanted: an offering that combined with Medicare to cover the most vulnerable Americans. But even though the states would shoulder much of Medicaid's fiscal burden, the federal dollar amount needed to be as low as possible to win votes in the Senate. Thus, the House Health and Welfare Committee arrived at two major exceptions to Medicaid eligibility: incarcerated individuals would not receive Medicaid benefits,[27] nor would anyone in need of treatment in an IMD.[28] Medicaid was the afterthought of Medicare, and the IMD exclusion was an afterthought of Medicaid.[29] However, these afterthoughts keep millions of Medicaid eligible individuals from accessing life-saving care.[30]

Press, 2015) (discussing Medicare and Medicaid's origins, including the political maneuvering that led to its original state); Jonathan Oberlander & Teodore R. Marmor, *The Road Not Taken: What Happened to Medicare for All? in* COHEN ET AL., MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE (Oxford Univ. Press, 2015) (discussing Medicare and Medicaid's origins, including the political maneuvering that led to its original state).

24 Zelizer, *supra* note 23, at 16-17; *How Medicaid Was Made*, *supra* note 22.

25 Zelizer, *supra* note 23; *How Medicaid Was Made*, *supra* note 22.

26 *Medicaid*, CTR. FOR MEDICARE AND MEDICAID SERV., https://www.medicaid.gov/medicaid/index.html[https://perma.cc/XYY6-XPCC] (last visited Mar. 5, 2023). *Medicare and Medicaid Act 1965*, NAT'L ARCHIVES, https://www.archives.gov/milestone-documents/medicare-and-medicaid-act **[**https://perma.cc/56MZ-KJAK] (last visited Mar. 8, 2023). Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

27 42 U.S.C. § 1396d(a)(31)(A) (2022).

28 42 U.S.C. § 1396d(a)(31)(B) (2022). Congress would later define IMDs as facilities with 16 or more beds. 42 U.S.C. § 1396d(i) (2022).

29 *See generally* Oberlander, *supra* note 22, at 121; *How Medicaid Was Made*, *supra* note 22.

30 Medicaid covers about 45 million adults. *See December 2021 and January 2022 Medicaid and CHIP Enrollment Trends Snapshot*, CTRS. FOR MEDICARE & MEDICAID SERV., https://www.medicaid.gov/medicaid/national-medicaid-chip-

B. The Medicaid IMD Exclusion

With certain narrow exceptions, federal law prohibits the use of Medicaid funds for medical services provided in psychiatric hospitals.[31] For example, the Social Security Amendments of 1965 excluded IMDs from Medicaid coverage; Congress later defined IMDs as inpatient psychiatric facilities with more than sixteen beds.[32] Two important distinctions resulted from this exclusion. First, Medicaid will cover non-brain related conditions, which is one of many federal policies arbitrarily carving out only one form of care from coverage.[33] Second, there is no specific ban on Medicaid coverage of outpatient mental health services. These distinctions mean the people left without coverage by the IMD exclusion are those who require inpatient care– people who need psychiatric services the most and are at an acute stage of their illness.

1. People Impacted by the IMD Exclusion

Different mental health conditions necessitate different levels and types of treatment. The Diagnostic and Statistical Manual (DSM), the

---

program-information/downloads/dec-2021-jan-2022-medicaid-chip-enrollment-trend-snapshot.pdf [https://perma.cc/2KD4-VER2] (last visited Apr. 10, 2023).

31 42 U.S.C. § 1396d(a)(31)(A-B) (2022). Narrow exceptions include a rule promulgated by the federal Centers for Medicare and Medicaid Services that allows Medicaid Managed Care Organizations to reimburse via capitated contracted rates for stays in IMDs of up to fifteen days. *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 FED. REG. 27555, 27556 (May 6, 2016) (to be codified at 42 C.F.R. Part 438.6(e)). In addition, waivers that allow stays of up to sixty days if the statewide average length of stay is thirty days or less. *Waiver Renewal*, TEX. HEALTH AND HUM. SERV., https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-renewal [https://perma.cc/N5GM-7LBR] (last visited Jan. 28, 2022). Letter from Mary C. Mayhew, Deputy Adm'r and Dir., Ctrs. for Medicare & Medicaid Serv., to State Medicaid Dirs. (Nov. 13, 2018). Allen LeBlanc et al., *Medicaid 1915(c) Home and Community-Based Services Waivers Across the States*, HEALTH CARE FIN. REV. (2000). States must opt-in to the waivers and show that implementation of a waiver is "cost neutral" against projected Medicaid spending without a waiver. *Id.*

32 *See* 42 U.S.C. § 1396d(i) (2022).

33 42 U.S.C. § 1396(d) (2022) (defining services covered by Medicare.) The policy that non-brain related injuries are covered seems arbitrary. For another example of a discriminatory policy embedded in federal law, *See* 42 C.F.R. § 409.62 (2023) (requiring a Medicare lifetime limit of 190 days of inpatient psychiatric services).

professional guide of mental health conditions and diagnostic criteria, lists almost 300 different diagnoses that mental healthcare providers may encounter in their patients.[34] Not all these conditions require inpatient care and only a short list of diagnoses mean that an individual will need multiple inpatient hospitalizations throughout their life. Schizophrenia, bipolar disorder, schizoaffective disorder, and other disorders that present with psychosis are collectively known as severe mental illness (SMI).[35] These conditions often lead to the need for inpatient care during the acute stages of their illness.[36] Although a minority of mental illness cases, people living with these devastating diseases are impacted disproportionately by the IMD exclusion.[37] The IMD exclusion singles out individuals who need inpatient psychiatric care to survive. At a minimum, it intentionally limits access to life-saving treatments. At the very worst, however, it prevents some of the most vulnerable and disabled in society from ever receiving healthcare tailored to their illnesses, and disincentivizes states from providing a full continuum of care.

Geographic discrimination is another discriminatory consequence for people with SMI who live in urban areas. The 16-bed provision precludes Medicaid coverage in bigger facilities actually providing

---

[34] AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STAT. MANUAL OF MENTAL DISORDERS (5th ed. 2013). *See also*, *Mental Illness*, HEALTH DIRECT, https://www.healthdirect.gov.au/mental-illness#:~:text=There%20are%20nearly%20300%20mental,identify%20and%20diagnose%20mental%20illness [https://perma.cc/24YX-FT84] (last visited Mar. 8, 2023).

[35] AM. PSYCHIATRIC ASSOC., *supra* note 34. *Definitions*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness [https://perma.cc/39G4-QCY4] (last updated Mar. 2023) (SMI is defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.").

[36] The IMD exclusion also prevents specialized impatient care for substance use disorder (SUD). This article focuses solely on mental illness, but that omission is meant in no way to trivialize the impact of the IMD exclusion on Medicaid eligible individuals with SUD.

[37] SMI cases are inherently more severe than other forms of mental illness. *See Definitions*, NAT'L INST. OF MENTAL HEALTH, *supra* note 35. The debilitating nature of psychosis means that people with SMI are in greater need of specialized inpatient treatment. For an explanation of what sets schizophrenia, for example, apart from other conditions. *See* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL, 70–83, 205-220 (7th ed. 2019) [hereinafter TORREY, SURVIVING SCHIZOPHRENIA].

psychiatric treatment.[38] Because 16 beds is a fixed number, as opposed to a percentage or formula, this provision prejudices cities with larger populations.[39] Someone with SMI who lives in a large metropolitan area should hope that their state and local healthcare providers have the resources to start a great many individual facilities. Otherwise, they will have few options for inpatient care.

II. DISCRIMINATION BY STATE ACTORS AS IT RELATES TO THE IMD EXCLUSION

Discrimination is the act of prejudicial behavior that impacts one group differently than another, putting one class of people at an unjusti fied disadvantage.[40] While invidious discrimination is generally unacceptable in modern society, the federal judiciary requires a detailed analysis to prove that a statute like the IMD exclusion creates an unjust outcome.[41] This section explains legal discrimination, the appropriate standard of review, and argues that people with SMI constitute at a minimum a quasi-suspect class deserving of intermediate scrutiny by the courts.

A. Prima Facie Discrimination

Congress has unambiguously stated, "no qualified individual with a disability shall, by reason of such disability, be excluded from

---

[38] Michael E. Onah, *The Patient-to-Prisoner Pipeline: The IMD Exclusion's Adverse Impact on Mass Incarceration in United States*, 44 AM. J.L. AND MED. 119, 125-26 (2018).

[39] *Id.* at 126. Furthermore, operating a facility with such a small number of beds presents unique financial and practical challenges. *See, e.g.*, MONT. INTERIM COMM. ON CHILD., REP.: STATE-OPERATED INSTS. BLDG. AND OPERATING A 16-BED INPATIENT FACILITY, HJR 16, 2014.

[40] *Discrimination*, CAMBRIDGE DICTIONARY, https://dictionary.cambridge.org/dictionary/english/discrimination **[**https://perma.cc/S3X6-WM8U**]** (last visited Mar. 3, 2023). Peter J. Rubin, *Reconnecting Doctrine and Purpose: A Comprehensive Approach to Strict Scrutiny After Adarand and Shaw*, 149 U. PA. L. REV. 1, 17 (2000). ("Ultimately, no approach that relies on the abstract characteristics of the classification or the disadvantaged class in order to determine when strict scrutiny should apply is satisfactory . . . . Some classifications made on the basis of immutable characteristics . . . or of characteristics that have historically engendered discrimination have not been deemed suspect and have not been subjected to strict scrutiny.").

[41] *See, e.g.*, Grutter v. Bollinger, 539 U.S. 306 (2003); Adarand Constructors v. Pena, 515 U.S. 200 (1995); Plyler v. Doe, 457 U.S. 202 (1982).

participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[42] Individuals in a mental state severe enough to require inpatient psychiatric treatment are often temporarily or permanently disabled and thus protected by the Americans with Disabilities Act (ADA).[43] The IMD exclusion singles out disabled people, which is not only morally reprehensible, but contrary to the legislative intent of extending federal protection to people with mental illness.[44]

The federal Centers for Medicare and Medicaid Services (CMS) do not provide medical assistance to individuals between the ages of twenty-one and sixty-five who need specialized inpatient treatment for the disability of SMI while at the same time, allowing treatment for non-psychiatric conditions.[45] The Equal Protection Clause of the Fourteenth Amendment should render the IMD exclusion unenforceable for its blatant discrimination against individuals either temporarily or permanently disabled by severe mental illness (SMI).[46] The Equal Protection Clause prevents public entities from denying "to any person

---

42 42 U.S.C. § 12132 (2022). The ADA defines disability as "a physical or mental impairment that substantially limits one or more major life activities of such individual." 42 U.S.C. § 12102(1)(A-C) (2008).

43 Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101–12213 (2018); Position Statement on Repeal of the Medicaid IMD Exclusion, Nat'l Assoc. of State Mental Health Program Dirs. (June 6, 2000), https://www.nasmhpd.org/content/position-statement-repeal-medicaid-imd-exclusion [https://perma.cc/SS7V-RR3J].

44 Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101 (2008).

45 42 U.S.C. § 1396d(a)(1) (2022); 42 U.S.C. § 1396d(h)(2)(i) (2022).

46 *See* U.S. CONST. amend. XIV, § 1. The 14th Amendment generally prevents states from extending legal protection or benefits to one group of people while denying it to another. Medicaid provides health coverage within a widely accepted standard of medical care for non-mental conditions—*e.g.*, a broken arm or the flu—while denying coverage for the medically necessary treatment of SMI. "[T]he Equal Protection Clause can help to identify and correct inequalities in the institution of marriage, vindicating precepts of liberty and equality under the Constitution." Obergefell v. Hodges, 576 U.S. 644, 674 (2015). The Equal Protection Clause should also "help identify and correct inequalities" in other areas of discrimination under the law. *Id.* In the case of the IMD exclusion, some people are singled out for nontreatment because of their disability while others can receive treatment. Furthermore, the Equal Protection Clause does not apply only to the states. The Fifth Amendment's Due Process Clause extends protection to discrimination under federal law through the doctrine of reverse incorporation. *See* Bolling v. Sharpe, 347 U.S. 497, 500 (1954). *See also, Incorporation Doctrine*, CORNELL L. SCH., https://www.law.cornell.edu/wex/incorporation_doctrine [https://perma.cc/P6EA-F9HW] (last visited Feb. 20, 2023).

within its jurisdiction the equal protection of the laws."[47] The law may not invidiously discriminate, and benefits conferred upon people within the United States by the federal or state governments must generally be on an equal basis.[48] The IMD exclusion does the exact opposite by singling out people with SMI.

1. Specific Terms of the Exclusion and its Discriminatory Effects

The IMD exclusion prevents a narrow class of people—low-income individuals whose mental disorders cause symptoms so severe that they need inpatient care—from accessing lifesaving treatment or receiving sufficient inpatient stabilization to put the trajectory of treatment for a chronic and cyclical illness on the correct path. Precluding Medicaid coverage for individuals who receive treatment in IMDs, perpetuates the false idea that individuals experiencing SMI cannot improve their condition.[49] While it is true that, for a small number of individuals with SMI, "no placement outside the institution may ever be appropriate,"[50] whether a person is in an IMD or living in the community, improvement of one's condition is subjective and usually possible.[51] In addition to the appalling ethical implications of excluding a vulnerable class of people from Medicaid coverage while offering coverage to nearly everyone else, the specificity of the IMD exclusion's focus creates numerous practical issues in providing health coverage. The IMD exclusion leads facilities other than psychiatric hospitals to conclude that they may qualify as IMDs based on the services they provide, which disincentivizes those facilities from providing certain treatment options, causing them to prematurely discharge SMI patients, and reduce staffing of psychiatric clinicians.[52]

---

47 U.S. CONST. amend. XIV, § 1.

48 F. S. Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920) ("[A]ll persons similarly circumstanced shall be treated alike.").

49 Position Statement on Repeal of the Medicaid IMD Exclusion, Nat'l Assoc. of State Mental Health Program Dirs. (June 6, 2000), https://www.nasmhpd.org/content/position-statement-repeal-medicaid-imd-exclusion [https://perma.cc/SS7V-RR3J].

50 Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 605 (1999) (Kennedy, J. Concurring).

51 *See* TORREY, SURVIVING SCHIZOPHRENIA, *supra* note 37, at 205–23.

52 Onah, *supra* note 38, at 126-27.

People with SMI are treated in other medical facilities, like nursing homes, or general hospitals,[53] facilities that are not designed to provide adequate psychiatric care, and where staff are neither properly equipped nor properly trained.[54] Psychiatric hospitals can offer more specialized services catered to individual needs, while also providing a "continuum of psychiatric care services with transitions, supervised by the same medical and mental health professionals."[55] Additionally, the average per diem cost for a freestanding psychiatric hospital is even less than the per diem cost of inpatient care in a psychiatric unit at a general hospital.[56] Additionally, the average per diem cost for a freestanding psychiatric hospital is even less than that of inpatient care in a general hospital's psychiatric unit.[57]

It is also essential to note that despite medical advancements in outpatient treatment and medication, a significant number of people with SMI are treatment resistant. It may be a resistance to "standard psychotropic medications at the onset of their illness and initial intervention" or they may simply take longer to stabilize on the "appropriate treatment regimen."[58] The latter cases require that the possibility of extended psychiatric hospitalization be available.[59] The

---

53 Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J. L. AND MED. 159, 170 (2003).

54 *Id.*; John Fergus Edwards, *The Outdated Institution for Mental Diseases Exclusion: A Call to Re-examine and Repeal the Medicaid IMD Exclusion* 1, 12 (May 1997) https://mentalillnesspolicy.org/wp-content/uploads/imd-legal-analysis.pdf [https://perma.cc/LD66-AJG9] ("State psychiatric institutions and freestanding psychiatric hospitals are generally better suited to provide this type of care than psychiatric units in a general hospital.").

55 Edwards, *supra* note 54, at 12-13. Specialized services include individual and group therapy sessions, art therapy programs, and other psychosocial activities. *Id.* at 12. The continuum of care is "from inpatient psychiatric care to partial hospitalization services and/or outpatient-based services and, if need be, residential psychiatric care." *Id.*

56 *Id.* at 88-89. (This study found that the average cost per day in a freestanding psychiatric hospital was slightly less than the per diem costs of impatient psychiatric unit of general hospitals – $485.67 compared to $499.05. "The average length of stay (ALOS) at the freestanding psychiatric hospitals was 17.3 days, as compared to 13.36 days in general hospitals.").

57 As of 1995 the average cost per day in a freestanding psychiatric hospital was slightly less than the per diem costs of impatient psychiatric unit of general hospitals – $485.67 compared to $499.05. *Id.* at 88-89.

58 *Id.* at 11-12.

59 *Id.*

psychiatric community now understands that SMI has a biological basi s within the brain's structure, chemistry, and function.[60] Considering how the scientific understanding of SMI developed with time, so too should the understanding of the differences between an IMD facility and other facilities. Improved scientific development makes such a failure in distinction not only a policy contradiction but a healthcare absurdity. The federal government should provide the same funds to the treatment of mental illness as they would provide for physical ailments or even other neurological disorders.[61]

The exception that ostensibly narrows the class of people with brain disorders (e.g., bed size and nature of facility) appears to exist to prevent a claim that the exclusion "specifically and precisely target[s] and affect[s] only the mentally ill."[62] However, the IMD exclusion affects this group of vulnerable people above all other groups.[63] To pave the way to changing this approach, a discussion of the various standards of judicial review is warranted.

---

60 *Information about Mental Illness and the Brain*, NAT'L INST. OF HEALTH (2007), https://www.ncbi.nlm.nih.gov/books/NBK20369/ [https://perma.cc/4PG3-FY5K].

61 As stated *infra*, Medicaid provides funding to cover a large range of physical ailments and other neurological disorders while excluding IMD treatment for SMI. Elinor Mccance-Katz, *The Federal Government Ignores the Treatment Needs of Americans With Serious Mental Illness*, 33 PSYCHIATRIC TIMES (Apr. 21, 2016), https://www.psychiatrictimes.com/view/federal-government-ignores-treatment-needs-americans-serious-mental-illness [https://perma.cc/ZQ55-MMZC].

62 Susan M. Jennen, *The IMD Exclusion: A Discriminatory Denial of Medicaid Funding for Non-elderly Adults in Institutions for Mental Diseases*, 17 WM. MITCHELL L. REV. 339, 355 (1991).

63 *Id.* Furthermore, as stated in a blog on the *National Alliance on Mental Illness*'s website:

> Evidence has shown that health care providers are liable to display negative attitudes and stereotyping behavior toward people with mental illness and incorrectly attribute physical symptoms to a person's mental illness . . . . Three times as many people with SMI are housed in prisons and jails than in hospitals. Yet, only one in three prison inmates receive any form of mental health treatment.

Katherine Ponte, *The Many Forms of Mental Illness Discrimination*, NAT'L., ALL. ON MENTAL ILLNESS BLOG (Mar. 11, 2020), https://nami.org/Blogs/NAMI-Blog/March-2020/The-Many-Forms-of-Mental-Illness-Discrimination [https://perma.cc/J2KX-6RWC].

B. Standard of Review

Federal courts consider three standards of review when determining whether legislation is unconstitutional under the Fourteenth Amendment's Equal Protection Clause.[64] Generally speaking, a court will strike down a law as unconstitutional if it is found to be discriminatory. Under one standard of review, legislation is presumed to be valid if it is "rationally related to a legitimate state interest."[65] This "rational basis test" is reserved for cases where no fundamental rights are at issue and is the lowest standard used by courts. Strict scrutiny[66] is the highest standard of review and is reserved for evaluating legislation that discriminates against a suspect class, such as race,[67] or affects a fundamental right, like the right to practice a profession.[68] A State law fails the strict scrutiny test when it affects a suspect class and is not narrowly tailored to achieve a compelling government interest.[69] Then, there is the intermediate standard of review. Heightened scrutiny, or intermediate scrutiny, applies to a quasi-suspect class, or to a class that shares qualities of a suspect class without reaching the latter's legal status.[70] The Supreme Court has established certain criteria a class must

---

64 U.S. CONST. amend. XIV, § 1 ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States . . . nor deny to any person within its jurisdiction the equal protection of the laws.").

65 City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440 (1985). This is the highly deferential rational basis standard, which compels courts to validate legislation under this test, "even when there is an imperfect fit between means and ends." Heller v. Doe, 509 U.S. 312, 321 (1993).

66 *See* Grutter v. Bollinger, 539 U.S. 306, 326 (2003) (noting that classifications under strict scrutiny review are, "constitutional only if they are narrowly tailored to further compelling governmental interests.").

67 *See* Adarand Constructors v. Pena, 515 U.S. 200, 227 (1995) (classification by race falls under strict scrutiny review); Massachusetts Bd. of Retirement. v. Murgia, 427 U.S. 307, 311-14 (1976) (classification by age does not fall under strict scrutiny review).

68 *Compare* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33-36 (1973) (did not recognize education as a fundamental right), *and* Dandridge v. Williams, 397 U.S. 471, 485-86 (1970) (did not recognize public welfare as a fundamental right), *with* Hicklin v. Orbeck, 437 U.S. 518, 524, 526, 534 (1978) (recognizing the right to practice a profession as a fundamental right).

69 *Grutter*, 539 U.S. at 326.

70 *See* Plyler v. Doe, 457 U.S. 202, 220, 223, 230 (1982) (providing that, although illegal aliens are not a suspect class and education is not a fundamental right, a Texas statute denying school-age children free public education due to their undocumented status receives heightened scrutiny). For a quasi-suspect class, such as gender, the courts afford intermediate scrutiny, which states that

meet before it is considered a quasi-suspect class, which triggers intermediate scrutiny.[71] This article argues that people with SMI, who are discriminated against by the IMD exclusion, constitute a quasi-suspect class and should thus be afforded the protection of intermediate scrutiny, and that the federal judiciary should render the IMD exclusion invalid under the Equal Protection Clause.[72]

1. Quasi-suspect Consideration

Courts consider four factors when determining if a group of people are a protected quasi-suspect class:

1. whether the group has been subjected to "a history of purposeful unequal treatment,"[73]
2. whether the group possesses a characteristic that "frequently bears no relation to ability to perform or contribute to society,"[74]

"classifications . . . must serve important governmental objectives and must be substantially related to achievement of those objectives." *See* Craig v. Boren, 429 U.S. 190, 197, 210 (1976) (applying intermediate scrutiny and subsequently finding that the gender-based classification statute at issue violated the Equal Protection Clause).

[71] *See* Craig v. Boren, 429 U.S. 190, 197, 218 (1976) (Rehnquist, J., dissenting) (discussing how historical discrimination of women influenced their designation as a quasi-suspect class); *Plyler*, 457 U.S. at 210, 217 n.15, 220 (distinguishing between undocumented immigrants who choose to illegally immigrate and the undocumented children who did not); City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440-41 (1985) (stating that characteristics bearing no relation to one's ability to contribute to society trigger a heightened review); Mathews v. Lucas 427 U.S. 495, 505 (1976) (rejecting the discrimination of the uncontrollable circumstances an illegitimate child is born into); San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S.1, 28 (1973) (listing indicators of a suspect class, including history of unequal treatment and being placed into a position of political powerlessness).

[72] The court does not currently recognize mental illness as a suspect or even quasi-suspect class, but the law that established this precedent was wrongly decided. *Cf. City of Cleburne*, 473 U.S. at 442, 446.

[73] Massachusetts Bd. of Retirement. v. Murgia, 427 U.S. 307, 313 (1976).

[74] *City of Cleburne*, 473 U.S. at 440-41 ("'[W]hat differentiates sex from such non-suspect statuses as intelligence or physical disability . . . is that the sex characteristic frequently bears no relation to ability to perform or contribute to society.'" (quoting Frontiero v. Ricardson, 411 U.S. 677, 686 (1973))); *Mathews*, 427 U.S. at 505 (stating that illegitimacy, like race or national origin, is not within the control of the individual, and it, "bears no relation to the individual's ability to participate in and contribute to society.").

3. whether the group exhibits "obvious, immutable, or distinguishing characteristics that define them as a discrete group;[75] and
4. whether the group is "relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process."[76]

This section examines each of those criteria and argues that people with SMI satisfy each element.

a. History of Purposeful Unequal Treatment

When Congress created the ADA, it found that "physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities are precluded from doing so because of discrimination."[77] Congress went on to state that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvement, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[78] Furthermore, the historical discrimination against persons with mental illness is not

---

75 Bowen v. Gilliard, 483 U.S. 587, 602 (1987).

76 *San Antonio Indep. Sch. Dist.*, 411 U.S. at 28.

77 42 U.S.C. § 12101(a)(1) (2009). However, the legislature's high-minded synopsis of mental disabilities was not completely accurate. While the congressional assessment that disabilities do not diminish one's "right to fully participate in all aspects of society" is certainly true, it is not discrimination alone that precludes them from doing so. For some individuals, the nature and symptoms of their conditions cause the preclusion. *See Living Well With Serious Mental Illness*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., https://www.samhsa.gov/serious-mental-illness [https://perma.cc/L294-Y96N] (last updated June. 28, 2022).

78 42 U.S.C. § 12101(a)(2) (2018).

limited to congressional stipulations, exhibited in the areas of housing,[79] criminalization,[80] restricted personal liberties,[81] and public opinion.[82]

b. Ability to Contribute to Society

Some courts admit to allowing discrimination against people with mental illness or intellectual disabilities to continue because their conditions bear a "relation to ability to perform or contribute to society"; when juxtaposed with gender or illegitimacy, the latter categories have no impact on one's ability to "contribute."[83] Although the "ability to contribute to society" is not specifically defined by the courts, it is based on the principle that "legal burdens should bear some relationship to individual responsibility."[84] When the law violates this principle in the

---

79 *See* John C. Williams, Annotation, *Halfway houses: housing facilities for former patients of mental hospital as violating zoning restrictions*, 100 A.L.R.3d 876 *passim* (2022).

80 For a brief discussion of the criminalization of mental illness, *see* Sabah H. Muhammad & J. Michael E. Gray, *Race, Mental Illness, and Restorative Justice: An Intersectional Approach to More Inclusive Practices*, 20 SEATTLE J. OF SOC. JUST. 159, 164 n.13 (2021). An illustrative example of how symptoms of SMI are characterized as criminally culpable behavior by law enforcement is provided in Muhammad & Gray's introduction, describing how the defendant's SMI symptoms were deemed "belligerent." *Id.* at 159.

81 As of 1999, "approximately one-third of the 50 States restrict[ed] the rights of an individual with mental illness to hold elective office, participate in juries, and vote." The percentage of States limiting their right to remain married or to have custody of their children was even greater. Patrick W. Corrigan et al., *Structural Levels of Mental Illness, Stigma and Discrimination*, 30 SCHIZOPHRENIA BULLETIN 481, 482-83 (2004), https://www.fundacion-salto.org/wp-content/uploads/2018/11/Structural-Levels-of-Mental-Illness-stigma-and-discrimination.pdf [https://perma.cc/D9J7-NEWR].

82 Meta-regression analysis on six studies across several countries regarding attitudes of the public towards people with mental illness showed that, even with an increase in understanding about mental illness, there was no improvement in social acceptance of persons with mental illness. G. Schomerus et al., *Evolution of public attitudes about mental illness: a systematic review and meta-analysis*, 125 ACTA PSYCHIATRICA SCANDANAVICA 440, 446-48 (2012).

83 *See* City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440-41 (1985) ("'[What] differentiates sex from such nonsuspect statuses as intelligence or physical disability . . . is that the sex characteristic frequently bears no relation to ability to perform or contribute to society' . . . . [T]hose who are mentally retarded have a reduced ability to cope with and function in the everyday world . . . [so] the States' interest in dealing with and providing for them is plainly a legitimate one." (quoting Frontiero v. Richardson, 411 U.S. 677, 686 (1973))).

84 *Frontiero*, 411 U.S. at 686 (1973) (asserting that discrimination on the basis of sex, like discrimination based on race or national origin, violates, "the basic

context of a discrimination claim, it effectively relegates the entire class to an inferior legal status "without regard to the actual capabilities of its individual members."[85] The IMD exclusion relegates individuals with SMI to an inferior legal status, and the effect of such an exclusion—the unequal access to necessary psychiatric treatment—ignores the capabilities of this group's individual members.[86]

At first glance, citizenship status and SMI are seemingly unrelated. However, courts have found that, similar to the status of an "illegal alien," individuals experiencing mental illness are not "completely divorced from relevant factual considerations" in the quasi-suspect class analysis.[87] An undocumented individual's, "presence in this country in violation of federal law is not a 'constitutional irrelevancy,'" but is still considered quasi-suspect.[88] Therefore, those experiencing SMI can be considered a quasi-suspect class, even if their "ability to perform or contribute to society" is distinguished from another seemingly unrelated but legally relevant category such as gender or illegitimacy.[89]

In discussing the contribution to society by women or illegitimate children, the Supreme Court has elaborated both on the immutability of sex or illegitimacy,[90] and how sex and illegitimacy are often

---

concept of our system that legal burdens should bear some relationship to individual responsibility." (quoting Weber v. Aetna Casualty & Surety Co., 406 U.S. 164, 175 (1972))).Weber 406 U.S. at 175 ("[I]mposing disabilities on the illegitimate child is contrary to the basic concept of our system that legal burdens should bear some relationship to individual responsibility or wrongdoing.").

85 *See Frontiero*, 411 U.S. at 687.

86 *See City of Cleburne*, 473 U.S. at 442 (stating that people with mental disabilities are a "large and diversified group" that possess a broad range the severity of their disability).

87 J.W. v. Tacoma, 720 F.2d 1126, 1129-30 (9th Cir. 1983).

88 Plyler v. Doe, 457 U.S. 202, 223 (1982).

89 The IMD exclusion, and any other legal mechanisms that create barriers to treatment of SMI, effectively create a policy of keeping people from "contributing to society" by barring effective treatment. Federal jurisprudence punishes individuals with SMI even further by denying them the same legal status granted to those able to contribute to society. This is a cyclical hypocrisy of the legislative and judicial branches of the federal government.

90 Frontiero v. Richardson, 411 U.S. 677, 686 (1973) ("[S]ex, like race and national origin, is an immutable characteristic determined solely by the accident of birth . . . ."); Trimble v. Gordon, 430 U.S. 762,769-70 (1977) ("Obviously, no child is responsible for his birth and penalizing the illegitimate child is an ineffectual – as well as an unjust – way of deterring the parent." (quoting Weber v. Aetna Casualty & Surety Co., 406 U.S. 164, 175 (1972))).

distinguished due to outdated assumptions and bias.[91] The class of people with SMI share these immutable qualities with respect to their status and societal biases against them.

Although both genetic and environmental factors affect mental illness,[92] the genetic factors are stronger for SMI as opposed to less severe illness.[93] For example, bipolar disorder and schizophrenia each carry an heritability rate of up to 80%.[94] And although the genetic component of depression depends on the severity, studies based on the general population show that depression heritability is around 38%, while studies on depression requiring hospitalization show heritability between 48-75%.[95]

There are many ways to contribute to society including, but not limited to, their employment status. At least 15% of individuals with serious mental illness are employed, but 30-40% of the individuals within this class are capable of gainful employment.[96] Put simply, a

---

91 City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 441 (1985) ("Rather than resting on meaningful considerations, statutes distributing benefits and burdens between the sexes in different ways very likely reflect outmoded notions of the relative capabilities of men and women.").

92 Ming T. Tsuang et al., *Gene-environment interactions in mental disorders*, 3 WORLD PSYCHIATRY 73, 73 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414673/; Rudolf Uher, *Gene-environment interactions in severe mental illness*, 5 FRONTIERS IN PSYCHIATRY 1, 1 (2014), https://www.frontiersin.org/articles/10.3389/fpsyt.2014.00048/full ("The risk of SMI runs in families and is shared in proportion to the degree of biological relatedness . . . . Molecular genetic studies have recently identified a number of specific genetic polymorphisms that directly contribute to schizophrenia, bipolar disorder, or all types of SMI across populations.").

93 Uher, *supra* note 92 ("The overall contribution of genetic factors appears to be stronger for SMI than for common mental disorders.").

94 *Id.*; Jonathan Picker, *The Role of Genetic and Environmental Factors in the Development of Schizophrenia*, 22 PSYCHIATRIC TIMES (Aug 1, 2005), https://www.psychiatrictimes.com/view/role-genetic-and-environmental-factors-development-schizophrenia [https://perma.cc/NYT5-SAZM]; Neel Duggal, *Is Bipolar Disorder Hereditary?*, HEALTHLINE, https://www.healthline.com/health/is-bipolar-disorder-hereditary [https://perma.cc/QZJ4-Y49G] (last updated Feb. 12, 2018).

95 Uher, *supra* note 92.

96 Elise Stobbe, *Severe Psychiatric Disabilities and Employment*, BRAIN BLOGGER (May 13, 2006), https://brainblogger.com/2006/05/13/anti-stigmatization-severe-psychiatric-disabilities-and-employment/ [https://perma.cc/5PZ8-GESK]. This is not to be confused with the narrower population of people with severe mental illness. Serious mental illness, examined in the NAMI study, includes conditions

significantly higher portion of individuals with SMI would have the potential to maintain employment if they could access medically necessary treatment, and thus meet the courts' anachronistic standard of "contributing."[97] Employment, however, is only one metric used in determining an individual's overall ability to contribute to society.

Other ways of contributing to society include participating in self-development activities[98] and social networks.[99] More specifically, this can manifest as developing and maintaining healthy relationships with others and learning new skills.[100] Psychiatric care can enhance an individual's ability to participate in each of these areas; thus, a natural effect of treatment is gaining the ability to contribute to society.[101]

---

less debilitating than severe mental illness. Therefore, the numbers for severe mental illness would be even lower.

97 OFF. OF DISABILITY, AGING AND LONG-TERM CARE POL'Y, U.S. DEPT. OF HEALTH AND HUM. SERVS., HOW THE AFFORDABLE CARE ACT CAN SUPPORT EMPLOYMENT FOR PEOPLE WITH MENTAL ILLNESS (2014).

98 Dan Jasper, *How Can An Individual Benefit From Contributing To Society?*, STREET CIVICS, https://streetcivics.com/how-can-an-individual-benefit-from-contributing-to-society/ [https://perma.cc/TNF9-W7DH] (last visited Mar. 8, 2023) (Society benefits, as a whole, "by each person developing themselves . . . ."); Rukayya Zirapur, *What Do You Contribute To Society? Right Things To Do Today*, RUKAYYA ZIRAPUR, (Mar. 28, 2020), https://rukayya.com/what-do-you-contribute-to-society/ [https://perma.cc/P3AJ-2GHD] ("[w]hat you do to contribute to society s not judged by how well settled you are, but what kind of person you are.").

99 Jasper, *supra* note 98; Varangi, *Simple Ways to Contribute to Society*, LIFEISM (Aug. 30, 2021), https://lifeism.co/simple-ways-to-contribute-to-society [https://perma.cc/P3AJ-2GHD].

100 Ash Buchanan, *The purpose of education: Becoming yourself so you can contribute to society*, MEDIUM (July 11, 2016), https://medium.com/benefit-mindset/the-purpose-of-education-becoming-yourself-so-you-can-contribute-to-society-9b034d9c07e1 [https://perma.cc/T77Y-B6X4] ("The purpose of education is to become yourself so you can make meaningful contributions to society); Zirapur, *supra* note 98; Pruthviraja Sajjanar, *How each individual can contribute to the society?*, LINKEDIN (Jan. 5, 2020), https://www.linkedin.com/pulse/how-each-individual-can-contribute-society-pruthviraja-sajjanar [https://perma.cc/XC6P-5C8N] (improving social skills is contributing to society); *10 Ways You Can Make a Difference in Your Community*, MEDIUM (Feb. 14, 2018), https://medium.com/the-whole-family-happiness-project/10-ways-you-can-make-a-difference-in-your-community-26f699a6a4bd [https://perma.cc/G5WN-R8BH].

101 *See generally Understanding Mental Health as a Public Health Issue*, TUL. SCH. OF PUB. HEALTH AND TROPICAL MED. BLOG (Jan. 13, 2021), https://publichealth.tulane.edu/blog/mental-health-public-health/ [https://perma.cc/MWV5-HN8R].

Common misconceptions regarding individuals with SMI persist today and "perpetuate toxic stereotypes."[102] Such stereotypes may have fueled the courts' repeated use of the language "ability to contribute to society" to exclude individuals with mental illness.[103] If individuals with SMI are given access to necessary inpatient psychiatric care, there is a greater chance to improve their condition, regardless of what constitutes "contributing to society."[104] Mistreatment and exclusion from public services, such as publicly funded healthcare and the psychiatric care currently barred by the IMD exclusion, result in many more being classified as unable to contribute to society, powering the federal government's argument to continue withholding medical assistance.

c. Immutable, Discrete Group

Courts are hesitant to classify a group of people as discrete and insular unless that group has faced historic victimization and prejudice.[105] Society has consistently treated individuals with SMI as a

---

[102] *The Biggest Misconceptions About Mental Illness*, BANYAN MENTAL HEALTH, https://www.banyanmentalhealth.com/2020/09/07/the-biggest-misconception-about-mental-illness/ [https://perma.cc/8BTR-YL57] (last visited Mar. 8, 2023); *Mental Health Myths and Facts*, MENTALHEALTH.GOV, https://www.mentalhealth.gov/basics/mental-health-myths-facts [https://perma.cc/9GGM-G4K3] (last updated Feb. 28, 2022); J.W. v. Tacoma, 720 F.2d 1126, 1129 (9th Cir.1983) (the court stating the ordinance in question "may well result from 'archaic and stereotypic notions'"); Onah, *supra* note 38, at 131 ("American society marks untreated mentally ill people with indelible stigmas: 'crazy,' 'unstable,' 'unhinged,' 'dangerous.'").

[103] Courts should revisit the language of this factor in considering whether a class is quasi-suspect. *See, e.g.*, People v. Fox, 175 Misc. 2d 333, 339 (N.Y. Cnty. Ct. 1997) ("The class of people with mental disabilities, however unlike classes such as gender and illegitimacy, possess a characteristic that is in fact related to their ability, or inability as the case may be, to perform and contribute to society. Those who are mentally incompetent are not fully equipped to perform and comprehend to an extent that allows them to contribute to society as others do.").

[104] *Living Well With Serious Mental Illness*, *supra* note 77 ("With the right treatment, people with SMI can live productive and enjoyable lives."); Larry Davidson & Katherine Ponte, *Serious Mental Illness Recovery: The Basics*, NAT'L ALL. ON MENTAL ILLNESS (Aug. 11, 2021), https://www.nami.org/Blogs/NAMI-Blog/August-2021/Serious-Mental-Illness-Recovery-The-Basics [https://perma.cc/W6TS-W5BK] ("[U]p to 65% of people living with SMI experience partial to full recovery over time.").

[105] *See, e.g.*, San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 28 (1973) (listing indicators of a suspect class, including history of unequal treatment and being placed into a position of political powerlessness); Massachusetts Bd. of Ret.

separate, distinct group, illustrated by the existence of mental health policy and specific legislation governing psychiatric healthcare,[106] organizations dedicated to educating communities and advocating for those with serious mental illness,[107] the historic discrimination against people living with mental illness,[108] and the ongoing stigmatization of mental health issues and mental illness.[109] Although there are many types of mental illness, there are similar or overlapping symptoms,

v. Murgia, 427 U.S. 307, 313 (1976) (Discussing a need for the group to have been subjected to "a history of purposeful unequal treatment.").

106 *See* Rachel Jenkins, *Supporting governments to adopt mental health policies*, 2 WORLD PSYCHIATRY 14, 14-15, 18 (2003).See *also Active Legislation*, TREATMENT ADVOC. CTR., https://www.treatmentadvocacycenter.org/fixing-the-system/active-legislation [https://perma.cc/KY7A-9J4R] (last visited Feb. 21, 2023). For more examples of how the making of law and policy systematically deprive those with SMI of crucial resources, see MENTAL ILLNESS POL'Y ORG., https://mentalillnesspolicy.org/ [https://perma.cc/2SWE-GLR7] (last visited Feb. 21, 2023).

107 *See In Patient Care*, MENTAL HEALTH AM., https://www.mhanational.org/patient-care [https://perma.cc/RC7L-XYS9] (last visited Feb. 21, 2023). For examples of organizations dedicated to educating communities about SMI and advocating for those affected by it, see *About Mental Illness*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness [https://perma.cc/ZG6E-ACSV] (last visited Feb. 21, 2023). *Advocacy*, TREATMENT ADVOC. CTR., https://www.treatmentadvocacycenter.org/fixing-the-system [https://perma.cc/3UPU-N3PM] (last visited Feb. 21, 2023), and MENTAL ILLNESS POL'Y ORG., *supra* note 106.

108 Mental illness and those who suffer from it are met with some form of active disapproval in every corner of the globe. *See Stigma, Prejudice and Discrimination Against People with Mental Illness*, AM. PSYCHIATRIC ASS'N (Aug. 2020), https://www.psychiatry.org/patients-families/stigma-and-discrimination[https://perma.cc/64LA-U3B2]. *See also Mental health: Overcoming the stigma of mental illness*, MAYO CLINIC (May 24, 2017), https://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477 [https://perma.cc/VUM7-YU9H].

109 *See Stigma, Prejudice and Discrimination Against People with Mental Illness*, *supra* note 108. S*ee also Mental health: Overcoming the stigma of mental illness, supra* note 108*;* Patrick W. Corrigan & Amy C. Watson, *Understanding the impact of stigma on people with mental illness*, 1 WORLD PSYCHIATRY 16-20 (2002), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/ [https://perma.cc/73R8-CPDE]; *Stigma and discriminatio*n, MENTAL HEALTH FOUND., https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination [https://perma.cc/WH39-MHGR] (last updated Oct. 4, 2021).

treatments, treatment professionals, and treatment facilities that make those with SMI a discrete group and distinguishable from others.[110]

Having SMI is not something that people choose.[111] Although SMI can be changed and improved through proper treatment, it will never go away entirely, and must be managed over the course of a person's life.[112] Mental illness is not yet a condition with a "cure."[113] This class of people, distinct from others because of their mental illness, is an immutable group: the social position they occupy as people with SMI, loaded with the stigma and discrimination they face, is inescapable due to the ongoing nature of their condition.

d. Political Powerlessness

People who have been marginalized by the IMD exclusion are unlikely to file lawsuits challenging its constitutionality because the

---

110 *See Mental Health Treatments*, MENTAL HEALTH AM., https://mhanational.org/mental-health-treatments [https://perma.cc/6C8E-ET6T] (last visited Feb. 21, 2023). *See also Treatments*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Treatments [https://perma.cc/PQ5H-ZU2Z] (last visited Feb. 21, 2023); *Mental Illness*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/mental-illness/diagnosis-treatment/drc-20374974 [https://perma.cc/5SG8-49JJ] (last visited Mar. 9, 2023). There are 300 different types of mental illness in the DSM. Severe mental illness makes up a small portion of these and includes schizophrenia, severe bipolar disorder, and some cases of major depression. It is any condition that presents with psychosis. DJ Jaffe, *What is "Serious Mental Illness" and What is Not?*, MENTAL ILLNESS POL'Y ORG., https://mentalillnesspolicy.org/serious-mental-illness-not/ [https://perma.cc/33DV-6NW2] (last visited Feb. 22, 2023).

111 One's undocumented status is not "an absolutely immutable characteristic since it is the product of conscious, indeed unlawful, action." Plyler v. Doe, 457 U.S. 202, 220 (1982). Of course, this distinction directly opposes the status of having SMI, which is not a conscious or unlawful action.

112 *Living Well with Serious Mental Illness*, *supra* note 77 ("With early and consistent treatment, people with serious mental illnesses can manage their conditions, overcome challenges, and lead meaningful, productive lives.").

113 "[U]p to 65% of people living with SMI experience partial to full recovery over time. The term 'recovery' refers to the process of learning how to minimize the symptoms associated with SMI . . . . [R]ecovery does not mean symptoms stop entirely or that deficits disappear. Ultimately, recovery is not synonymous with 'cured.'" Davidson & Ponte, *supra* note 104; SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, SAMHSA'S WORKING DEFINITION OF RECOVERY, 5 (2012) https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf.

IMD exclusion has relegated them to a low socioeconomic status.[114] Further, the general nature of SMI and its symptoms make it more unlikely that strong candidates with the necessary financial assets could meet the burden of bringing a legal challenge as a plaintiff.[115] Historically, nonprofit advocacy organizations have financed legal challenges on behalf of marginalized classes, but the IMD exclusion is unique in that some of the mental health policy groups that routinely involve themselves in litigation support the perpetuity of the exclusion.[116] In sum, the legal system's financial hurdles and the lack of financial support from advocacy groups places the people harmed by the IMD exclusion in a unique position of political powerlessness, where they are unable to remedy their suffering through the judicial process.

Congress agreed with this assessment when it created the ADA: "Unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no

---

114 *See* Brittany La Couture, *The Problems with IMD Exclusion*, THE AM. ACTION F. (Oct. 15, 2015), https://www.americanactionforum.org/insight/the-problems-with-the-imd-exclusion/ [https://perma.cc/Q3WJ-G4EE] (discussing how IMD exclusion may lead to significant economic impacts due to lack of needed treatment, including job loss and homelessness on top of making in-patient psychiatric care less affordable and less accessible); Stephen Eide & Carolyn D. Gorman, *Medicaid's IMD exclusion: The Case for Repeal*, MANHATTAN INST. (Feb 23, 2021), https://www.manhattan-institute.org/medicaids-imd-exclusion-case-repeal [https://perma.cc/2S7L-FHAQ] (stating "Medicaid's core function is to attend to the healthcare needs of low-income Americans" and discussing how the IMD exception to Medicaid impacts low income mentally ill individuals).

115 *See Serious Mental Illness Among Adults Below the Poverty Line*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN. (Nov. 15, 2016), https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.html [https://perma.cc/2YYM-HYAN]. This data is for *serious* mental illness, so corresponding data for SMI would likely show even starker impacts of the conditions on income. *See Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/VHU9-S54G] (last visited Mar. 9, 2023) (Medicaid eligibility is generally 133% of the Federal Poverty Level in the thirty-eight states and D.C. that have expanded Medicaid under the Affordable Care Act and lower in the states that have not.).

116 *See e.g.*, Letter from Robert Bernstein, CEO, Bazelon Center for Mental Health Law, to Rep. Fred Upton et al. (Apr. 2, 2014), https://docs.house.gov/meetings/IF/IF14/20140403/102059/HHRG-113-IF14-20140403-SD005.pdf [https://perma.cc/94JT-YQ7B] (urging Congress to, *inter alia*, not repeal the IMD exclusion on ideological grounds).

legal recourse to redress such discrimination."[117] Congress implied that the class of individuals with mental illness is even less politically powerful than people classified by race, and the latter receives strict scrutiny from the federal judiciary.[118]

C. Case Law: One Court that Got it Right

Though those with SMI meet the above stated criteria, the Supreme Court has not specifically determined whether people with SMI constitute a quasi-suspect class.[119] One lower court has, however, considered people with a history of other mental disorders quasi-suspect and applied heightened scrutiny.[120] That same rationale should apply to people with SMI, who satisfy the four factors required of a quasi-suspect class.

Nearly three decades ago, a district court determined that a government actor may not discriminate on the basis of mental disabilities (intellectual disability in the specific case) by creating different classifications within a class of people with similar disabilities.[121] This is the correct and logical interpretation of the ADA with respect to services for people with mental disabilities. The plaintiffs in *Martin v. Voinovich* were a group of mentally disabled

---

117 42 U.S.C. § 12101(a)(4) (2009).

118 42 U.S.C. § 12101(a)(4) (2009). *See, e.g.*, Adarand Constructors v. Pena, 515 U.S. 200 (1995).

119 Schweiker v. Wilson, 450 U.S. 221 (1981) (declining to determine whether a class of mentally ill people receives heightened scrutiny because the court concluded the statute did not classify directly on the basis of mental health); United States Dep't of Treasury v. Galioto, 477 U.S. 556, 559-60 (1986) (The district court determined that former mental patients were quasi-suspect class, but U.S. Supreme Court vacated for mootness after statute was changed to afford due process); Heller v. Doe, 509 U.S. 312, 319 (1993) (the court entertained that heightened scrutiny may be the correct standard, but did not apply this standard because respondents were delayed in raising the argument).

120 Different classifications of certain groups should serve a "'substantial' state interest" rather than as a reflection of stereotype or prejudice. Galioto v. Dep't of Treasury, Bureau of Alcohol, Tobacco & Firearms, 602 F. Supp. 682, 686 (D.N.J. 1985) (concluding persons with a history of mental illness are members of a quasi-suspect class, but did not rest their decision on that ground, because the statute did not pass even the rational basis test); J.W. v. Tacoma, 720 F.2d 1126, 1130 (9th Cir. 1983).

121 *See* Martin v. Voinovich, 840 F. Supp. 1175, 1209-10 (S.D. Ohio 1993). *See also Galioto*, 602 F. Supp. at 686 (different classifications of certain groups should serve a "'substantial state interest" rather than serve as a reflection of stereotype or prejudice).

persons contending that the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) denied them community housing.[122] Although courts have established that intellectually disabled people and people with mental illness are not equivalent in the context of Equal Protection claims, the *Martin* plaintiffs did not claim discrimination based on their status as mentally disabled persons, but instead on the severity of their mental disability.[123] The Southern District of Ohio acknowledged that classifications between mentally disabled persons may have relevant state interests,[124] but noted that, "classifications for purposes of providing community residential services through existing state programs do not appear to this Court to involve such state interests," and so applied intermediate scrutiny.[125]

The court went on to state that "under Congress' findings in [the ADA's enabling legislation][126], a state may not permissibly distinguish between mentally handicapped persons on the basis of their disabilities when the distinction prevents otherwise qualified disabled persons from participating in an existing state program."[127] Such congressional

---

122 *Martin,* 840 F. Supp. at 1180.

123 *Id.* at 1208-09; City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 442 (1985) (concluding that intellectually disabled individuals are not a quasi-suspect class); *Heller*, 509 U.S. at 322 (allowed different standards for involuntary commitment of intellectually disabled and mentally ill persons).

124 *Martin,* 840 F. Supp. at 1209-10.

125 *Id.*

126 *Id.* This court cited to 42 U.S.C. § 12101(a)(7), in the findings section of the ADA, which stated "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society." This includes several specific terms within the factors of consideration for quasi-suspect classes, and the court in *Martin* determined it could not "ignore Congress' finding," including those with mental disabilities as a quasi-suspect class. *Martin*, 840 F. Supp. at 1209. Although the language of this section was changed in 2008, there is nothing to suggest that this was in an attempt to preclude this class from being considered a quasi-suspect class, as the updated findings section of the ADA still mentions historical mistreatment and discrimination, isolation, and political powerlessness through "no legal recourse to redress such discrimination." 42 U.S.C. § 12101(a) (2009).

127 Martin v. Voinovich, 840 F. Supp. 1175, 1209-10 (S.D. Ohio 1993). If applied to the IMD exclusion, the Martin standard would consider all Medicaid eligible individuals with mental illness—some having SMI and needing more frequent and intensive inpatient care, and some with less severe cases of mental illness—

findings, if applied to the IMD exclusion, would render the exclusion unconstitutional for distinguishing between individuals with SMI to those with less severe mental illness on the basis of their disability, preventing "otherwise qualified" (*i.e.*, Medicaid eligible) persons from participating in a state program.

Because the federal and state governments provide medical assistance through Medicaid for outpatient services and exclude a particular set of inpatient services, its discriminatory acts are not based solely on the status of mental illness, but also on the severity of one's disease. *Olmstead* allows the judiciary to judge discrimination within the category of mentally ill individuals based on their condition or severity.[128] Since the U.S. Supreme Court has found it discriminatory to not provide community-based care when appropriate, that same reasoning should hold that it is discriminatory to not provide inpatient care when appropriate.[129] The IMD exclusion limits access to inpatient psychiatric care, even when that is the appropriate treatment for an individual.[130]

Although individuals living with SMI may receive outpatient services, they often require inpatient treatment first in order to step down to community-based outpatient treatment.[131] If individuals with SMI are admitted into outpatient programs before they are ready, the likelihood of returning to a more restrictive treatment environment is far higher.[132] Other federal courts should follow Congress' lead, as Ohio's Southern District has done in *Martin*, which strongly supports the application of a quasi-suspect, heightened scrutiny; by doing so, other

---

and find that the statute excludes "otherwise qualified disabled persons from participating in an existing state program," *i.e.*, Medicaid benefits.

128 Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 587, 596 (1999) (to unnecessarily institutionalize a person that can be effectively treated in a community-based setting is discrimination under the ADA).

129 *See id.*

130 *Id.* at 596 (Under 28 CFR § 35.130(d)(1998), "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The Court here emphasizes "*appropriate*" because for some individuals, "no placement outside the institution may ever be appropriate."). Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 605 (1999) (Kennedy, J. concurring).

131 Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates*, 44 CRIMINOLOGY 45, 47 (2006).

132 *See* YOHANNA, *supra* note 13, at 888.

federal courts may better protect individuals with SMI from the sort of discrimination that the Supreme Court aimed to prevent in *Olmstead*.

1. Legitimate State Interest

Typically, when legislation blatantly discriminates against certain classes of people, that discriminatory action must be substantially related to serving an important government interest, in order to pass a heightened level of scrutiny.[133] This article has argued that the IMD exclusion should be reviewed using a heightened level of scrutiny. However, even when rational basis review has been used the courts have erred in finding a legitimate interest in discriminating against people with SMI. The IMD exclusion and the resulting lack of federal support for mental healthcare services does not meet the standard.

2. The Misconception of the Traditional State Responsibility

The Supreme Court in *Schweiker* made an egregious assumption that has led to substandard SMI treatment for over four decades: "[A]s no party denies, [the IMD exclusion] was adopted because Congress believed the States to have a 'traditional' responsibility to care for those institutionalized in public mental institutions."[134] The harm done was not merely that the court accepted that statement as truth without further investigation, but that it used that assumption to dissatisfy criteria of determining whether a traditional state responsibility exists. The Court did ask "whether the States do, ever have, or ever will provide this benefit to residents of large mental institutions," but somehow determined that question was irrelevant.[135]

This supposed State responsibility is not "traditional" if the States do not and never have provided adequate assistance. If this State responsibility is not in fact traditional, then the offered legitimate government interest is no more than a government attorney's attempt to defend a discriminatory classification after the fact.[136]

---

133 *See* Plyler v. Doe, 457 U.S. 202, 217, 239 (1982). *See also* Galioto v. Dep't of Treasury, Bureau of Alcohol, Tobacco & Firearms, 602 F. Supp. 682, 686 (1985). Special Children's Village, Inc. v. Baton Rouge, 472 So. 2d 233, 235 (La. Ct. App. 1st Cir. 1985).

134 Schweiker v. Wilson, 450 U.S. 221, 236-37 (1981). *See also* Connecticut Dep't of Income Maintenance v. Heckler, 471 U.S. 524, 533 (1985).

135 *Schweiker*, 450 U.S. at 242.

136 Schweiker v. Wilson, 450 U.S. 221, 244 (1981). (Powell, dissenting) ("When a legislative purpose can be suggested only by the ingenuity of a government lawyer litigating the constitutionality of a statute, a reviewing court may be presented not so much with a legislative policy choice as its absence."). In the years since the

The Court also did not entertain the question of whether a state responsibility should continue to exist given the Court's own evolving Fourteenth Amendment jurisprudence throughout the twentieth century.[137] In other words, it is one thing to ask whether there has historically been a legitimate state interest and another thing to ask whether the Fourteenth Amendment itself delegitimizes the interest. The *Schweiker* Court did neither. It is worth noting that the Court did not have the benefit of the congressional commentary contained in the ADA.

Congress determined under the ADA that proper goals regarding disabled individuals are "to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals."[138] These are all legitimate state interests, decided prior to the creation of legislation, as opposed to a cover-up after the fact. These proposed legitimate state interests are all served by removing the IMD exclusion. Thus, the IMD should fail even rational basis review, and under intermediate scrutiny, where the standard is even higher there should be no question that the IMD exclusion violates the Fourteenth Amendment.

One of the four listed purposes for the ADA is "to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities."[139] The federal government grants financial assistance for outpatient mental health services yet neglects the most severely mentally disabled individuals in direct opposition to its "central role" in enforcing equal opportunities for individuals with disabilities.

Through the IMD exclusion, Congress forced responsibility of people with SMI and SUD onto the states, but Congress took responsibility for people with intellectual disabilities with the enactment of the ADA. Past and present practice does not prove the existence of the "traditional" state responsibility to provide financial assistance for

---

IMD exclusion became law, the number of state psychiatric beds has fallen dramatically. *See generally* DORIS A. FULLER ET AL., TREATMENT ADVOCACY CENTER, GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS 1 (2016), https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf [https://perma.cc/5HXP-PVQJ] (examining the reduction in state psychiatric beds from 1955 through 2016 and finding that the total number declined from a peak of 558,922 to 37,679).

137 *Schweiker*, 450 U.S. at 237.

138 42 U.S.C. § 12101(7) (2009).

139 42 U.S.C. § 12101(b)(3) (2009).

care of people with SMI but it does prove the historic discrimination and political powerlessness of people living with SMI. Therefore, the states' supposed traditional responsibility of providing financial assistance to people with SMI is not a government interest worthy of allowing discrimination.[140]

III. DEINSTITUTIONALIZATION/DISTRUST OF LARGE INSTITUTIONS

Deinstitutionalization may have met some of its shortsighted goals, but it led to more devastating problems for people with SMI and the states that supposedly provide for their care. Nearly half of individuals with SMI do not receive treatment.[141] The number of state inpatient psychiatric beds has decreased by more than 96% since the mid-twentieth century.[142] Parallel with the drastic decrease in state inpatient psychiatric beds is the decrease in length of stay (LOS).[143] Many patients are discharged too soon, significantly increasing the likelihood of rehospitalization within a few weeks or months.[144] Patients in states with the shortest LOS were nearly three times more likely to be re-admitted into a state hospital within 30 days or 180 days of discharge than patients in states with the longest LOS.[145] Not only does rehospitalization reduce continuity of care and quality of life for persons

---

140 This "traditional state responsibility" argument also ignores a political reality of the congressional negotiations for the Social Security Amendments of 1965—the IMD exclusion was most likely about money. Congress was able to pass some health coverage for vulnerable Americans but not for all of them; people with SMI did not survive the fiscal chopping block. *See supra* Part I.

141 PREVALENCE OF SERIOUS MENTAL ILLNESS AMONG ADULTS BY STATE (2020), TREATMENT ADVOCACY CENTER, https://www.treatmentadvocacycenter.org/storage/PREVALENCE_CHART_-_2020.pdf. (last visited Feb. 23, 2023). [https://perma.cc/97FR-3SZ2].

142 DORIS A. FULLER ET AL., RELEASE, RELAPSED, REHOSPITILIZED LENGTH OF STAY AND READMISSION RATES IN STATE HOSPITALS 1(2016).

143 *Id.* (In 1980, the median LOS for an acute episode of schizophrenia was 42 days. By 2013, it was approximately 7 days).

144 Markowitz, *supra* note 131.

145 FULLER ET AL., *supra* note 142, at 2 ("Eleven states had a median LOS of two weeks or less[]" where 10.8% of patients were readmitted within 30 days of discharge, and 22% were readmitted within 180 days. Nine states had a median LOS of four months or more, where 2.8% patients were readmitted within 30 days of discharge, and 7.9% were readmitted within 180 days); *Id.* at 9 (This data only includes patients readmitted to the same psychiatric facility from which they were most recently discharged.).

with SMI, it is costly for every level of government responsible for providing care.[146]

People with SMI who do not have access to inpatient hospitalization, or rehospitalization, are very frequently transinstitutionalized to other large settings like jails, prisons, and homelessness encampments.[147] Police are now a main referral source for individuals to receive psychiatric treatment. One study of 81 major U.S. cities shows a correlation between inpatient hospital capacity, an increase in homelessness, crime, and arrests.[148] There was not a correlation in a city's total mental health expenditures with levels of homelessness, crime, and arrests, which took into account the city's outpatient treatment options.[149] Deinstitutionalization and the lack of access to necessary inpatient psychiatric treatment increases homelessness and crime, which costs more than the inpatient treatment itself.[150] About one-third of people experiencing homelessness meet

---

146 *Id.* at 1 (Schizophrenia hospitalization cost $11.5 billion in 2013, of which $646 million resulted from readmission within 30 days of discharge.).

147 Transinstitutionalization refers to the "moving of mental health clients from one institution, such as a mental hospital, to being dependent on another type of institution, such as a shelter, community hospital, jail, or nursing home facility." Ashley Primeau et al, *Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospital to Penal Institutions[]*, 2 COMPREHENSIVE PSYCH. 1, 2 (2013). H. Richard Lamb & Linda E. Weinberger, *Rediscovering the concept of asylum for persons with serious mental illness*, 44 J. OF THE AM. ACAD. OF PSYCHIATRY & THE L., 106, 107 (2016); FULLER ET AL., *supra* note 142, at 3. FULLER ET AL, *supra* note 136, at 9 ("In 44 states, and the District of Columbia, a prison or jail holds more individuals with [SMI] than the largest remaining state psychiatric hospital.").

148 Markowitz, *supra* note 131, at 60.

149 *Id.* at 61.

150 42 U.S.C. § 12101(8) (2009) (The continuing existence of discrimination against those with disabilities "costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity."); *Ending Chronic Homelessness Saves Taxpayers Money*, NAT'L ALL. TO END HOMELESSNESS (Feb. 17, 2017), https://endhomelessness.org/resource/ending-chronic-homelessness-saves-taxpayers-money-2/ [https://perma.cc/MWT5-CKVE] ("A chronically homeless person costs the taxpayer an average of $35,578 per year."); Veronica Morely, *Breaking down the cost of homelessness*, 23ABC, https://www.turnto23.com/news/homeless/breaking-down-the-cost-of-homelessness[https://perma.cc/22B2-QE9W] (last updated July 13, 2021) ("The US Department of Housing and Urban Development estimates that it costs about $40,000 a year for a homeless person to live on the streets."); Ronnie K. Stephens, *Annual Prison Costs A Huge Part of State and Federal Budgets*, INTERROGATING JUSTICE (Feb. 16, 2021), https://interrogatingjustice.org/prisons/annual-prison-

diagnostic criteria for SMI.[151] Completing the cycle, homelessness is another funnel into jails and prisons.[152] The SMI status of these persons make them more vulnerable to be victims of crime as well.[153]

Concurring with the Court in *Olmstead*, Justice Kennedy specified that "[t]he ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting."[154] Yet, this is exactly what has resulted from the IMD exclusion. The actual results after decades of deinstitutionalization prove it serves no important or even legitimate government interest. The IMD exclusion, through the appropriate lens of intermediate scrutiny, fails to pass constitutional muster.

---

costs-budgets/ [https://perma.cc/2D29-QJUR] ("Most states average $25,000 to $30,000 per incarcerated individual annually."); Beatrix Lockwood & Nicole Lewis, *The Hidden Cost of Incarceration*, THE MARSHALL PROJECT (Dec. 17, 2019), https://www.themarshallproject.org/2019/12/17/the-hidden-cost-of-incarceration [https://perma.cc/T2S3-B8SW] ("Prison costs taxpayers $80 billion a year."); Paul Rowan et al., *Impact of Serious Mental Illness on Medicaid and Other Public Healthcare Costs in Texas*, ADMIN. & POL'Y IN MENTAL HEALTH & MENTAL HEALTH SERV. RES. (Mar. 19, 2019), https://link.springer.com/content/pdf/10.1007/s10488-019-00929-y.pdf [https://perma.cc/9V62-9ZNE] (A study found the average total acute care costs for adults in Texas with SMI was $18,181 per year.); Elizabeth Sinclair Hancq, *Hospitalization for Serious Mental Illness Among Most Frequent Inpatient Stays*, TREATMENT ADVOCACY CENTER (Aug. 11, 2021), https://www.treatmentadvocacycenter.org/about-us/features-and-news/4431-research-weekly-hospitalization-for-serious-mental-illness-among-most-frequent-inpatient-stays#:~:text=The%20mean%20cost%20per%20stay,aggregate%20cost%20of%20%243.7%20billion [https://perma.cc/BQA4-BGXE] ("The mean cost per stay for inpatient stays for schizophrenia and related disorders was $9,300 per hospitalization.").

151 Markowitz, *supra* note 131, at 51.

152 *Id.* (Mentally ill offenders are more likely than other inmates to have been homeless at the time of arrest and in the year prior to arrest.).

153 *Id.*

154 Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 604-05 (1999) (Kennedy, concurring); Taylor Elizabeth Eldridge & Ashley Nerbovig, *Sent to a Hospital, But Locked in Prison*, THE MARSHALL PROJECT (July 30, 2018), https://www.themarshallproject.org/2018/07/30/sent-to-a-hospital-but-locked-in-prison [https://perma.cc/TC4W-KYNE] (New Hampshire authorizes civil patients who have not committed a crime to receive psychiatric treatment in a state prison.); FULLER ET AL., *supra* note 136, at 20 (In Colorado, legislation was under consideration to authorize jails to be used in lieu of psychiatric hospitals when no bed is available for individuals who have not committed crimes.).

While it is true that if a classification does not involve either a fundamental right or a suspect or quasi-suspect class, it is presumed valid if there is a "rational relationship" between the disparity of treatment and a legitimate governmental purpose, applying a rational basis standard to the IMD exclusion does not save it from running afoul of the Fourteenth Amendment.[155] Such a classification can pass rational-basis review "even when there is an imperfect fit between means and ends."[156] Even if courts find that mentally ill persons are not a quasi-suspect class, neither the traditional responsibility of states nor deinstitutionalization are legitimate government interests. As noted above, the IMD exclusion also fails under the rational basis test.[157] It is a federal law that discriminates by any legal or common-sense interpretation of the Constitution and subsequent congressional guidance.

IV. CONCLUSION

Removal of the IMD exclusion will not increase unnecessary institutionalization or decrease outpatient treatment options. It is unrelated to whether the treatment is voluntary or involuntary. The removal of the IMD exclusion is instead about people with SMI gaining equal access to treatment options best suited to their individual needs.

Individuals with SMI, who require a higher level of treatment and seek treatment voluntarily are still unable to receive Medicaid assistance tailored to their conditions. According to the ADA, these individuals have the same right to access public benefits, such as Medicaid, as anyone else. However, in practice, the most severely mentally ill individuals are denied federal assistance and denied the same access to treatment. The IMD exclusion has remained for decades because the group against which it discriminates does not have a voice or the resources to make a change and Congress has been willing to turn a blind eye to a facially discriminatory law due to fiscal concerns. Plaintiffs with appropriate standing to litigate this issue go untreated due to their inability to access inpatient treatment and Medicaid eligibility, meaning they also have limited financial resources.

---

155 Heller v. Doe, 509 U.S. 312, 319-321(1993). For more additional discussion on rational basis review, *see supra* section II B.

156 *Id.*

Enough time has passed that every possible rationale for the initial implementation of the IMD exclusion has played out and proven false, fruitless, or based on incorrect assumptions. Even granting the existence of good intentions, we are faced with several negative results of the IMD exclusion. It is not an academic debate – untold numbers of lives have been lost as a result of the damage to treatment access which the IMD exclusion has wrought over the years of its existence. Instead of trying to rationalize past actions, the federal courts should revisit and invalidate this archaic and harmful law.