OFFICIAL TRANSCRIPT PROCEEDINGS BEFORE

THE SUPREME COURT OF THE UNITED STATES

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ORIGINAL

DKT/CASE NO. 83-2136

TITLE CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE, Petitioner V. MARGARET M. HECKLER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

PLACE Washington, D. C.

DATE March 27, 1985

PAGES 1 thru 48

(202) 628-9300

1 IN THE SUPREME COURT OF THE UNITED STATES

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3 CONNECTICUT, DEPARTMENT OF :
INCOME MAINTENANCE, :

4 :
Petitioner :

5 :
v. : No. 83-2136

6 :
MARGARET M. HECKLER, SECRETARY, :

7 DEPARTMENT OF HEALTH AND :
HUMAN SERVICES, ET AL. :

8 :
- - - - - - - - - - - - - - - - - -x

9
Washington, D.C.

10
Wednesday, March 27, 1985

11
The above-entitled matter came on for oral

12
argument before the Supreme Court of the United States

13
at 11:08 a.m.

14
APPEARANCES:

15
CHARLES ALVIN MILLER, ESQ., Washington, D.C.; on

16 behalf of the Petitioner.

17 MS. KATHRYN ANNE OBERLY, ESQ., Assistant to the
Solicitor General, Department of Justice,

18 Washington, D.C.; on behalf of the Respondent.

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1 C O N T E N T S

2 ORAL ARGUMENT OF PAGE

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on behalf of the Petitioner 3

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MS. KATHRYN ANNE OBERLY, ESQ.,
5 on behalf of the Respondent 24

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1 PROCEEDINGS

2 CHIEF JUSTICE BURGER: Mr. Miller, you may

3 proceed whenever you're ready.

4 ORAL ARGUMENT OF CHARLES ALVIN MILLER, ESQ.,

5 ON BEHALF OF THE PETITIONER

6 MR. MILLER: Thank you, Mr. Chief Justice, and

7 may it please the Court:

8 This case presents questions as to the meaning

9 of terms in the Medicaid law, and the State of

10 Connecticut is grateful for the Court for hearing its

11 case today.

12 The outcome of this case is unusually

13 important because of its bearing on the future care of

14 needy mentally ill in the United States, and because of

15 its impact on the states and their position as partners

16 with the federal government in carrying out the Medicaid

17 program.

18 Two statutory terms must be construed in this

19 case. The first is the term "institution for mental

20 diseases," which I will refer to as IMD. That is an

21 exception in the statute that limits the coverage that

22 otherwise would be extended for certain medical services.

23 The second term is "intermediate care

24 facility," or ICF. This is one category of facility

25 that is covered by the Medicaid program, and it is

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1 defined in the statute to mean a facility that provides
2 a specified level of service to persons requiring it
3 because of their mental or physical condition.

4 And the ultimate question presented is the
5 extent to which, if at all, the IMD exception limits
6 Medicaid coverage for ICFs.

7 The briefs of the parties have treated that
8 question exhaustively, and in so doing have exposed the
9 complexity of the Medicaid laws and the subtlety of many
10 of its standards and distinctions.

11 QUESTION: May I inquire about the
12 consequences of a ruling adverse to your position? If
13 the Government is correct in its view of this statute,
14 would it be possible for states to simply scatter mental
15 patients around among the intermediate care facilities
16 and just not put as many of them in a single facility,
17 as existed here, and succeed in having reimbursement by
18 that device?

19 MR. MILLER: Yes, Justice O'Connor, from the
20 point of view of the mentally ill that would be the
21 principal consequence.

22 QUESTION: Yeah. And so we're not really
23 talking about the money so much as the inconvenience
24 perhaps of having to scatter them?

25 MR. MILLER: I wouldn't call it

1 inconvenience. The principal impact is on the care that
2 would be given to mentally ill people. As the record
3 shows in this case, because Middletown Haven was
4 recognized by everyone involved as being a very fine
5 facility, a facility that specializes in the care of
6 people with mental conditions, it does a much better job
7 for them, even at this intermediate level, than a
8 facility which is treating people for a broad range of
9 conditions, including the many physical conditions
10 associated with those who need some sort of residential
11 care, albeit not the intensive care of hospitals.

12 So that is a major distinction, and the
13 evidence has shown that in this facility and others like
14 it that specialize in the care of the mentally ill,
15 those people get the kind of care they need and they
16 cannot get elsewhere.

17 QUESTION: What do you know about the
18 practical application of the Government's test? Do they
19 look to see whether 50 percent or more of the patients
20 are mental cases, or 30 percent, or how is that being
21 applied in your experience?

22 MR. MILLER: Well, we have the experience of
23 the present case and the three companion cases that
24 started out with them at the administrative level. And
25 there are some other cases that are working their way

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1 through the system now.

2 The answer is that, to begin with, the

3 Government has applied a 50 percent litmus test. It has

4 a number of other standards as well that it seeks to

5 apply. All of those standards are designed to find out

6 whether the facility in question is functioning as an

7 alternative to the care of persons in mental hospitals.

8 And that's one of the points I wanted to make in the

9 argument this morning, that that set of criteria is

10 fundamentally flawed in the sense that it looks to apply

11 a distinction contrary to what the statute applies. And

12 as I will try to say later, the whole point of the

13 statute here which I am going to refer to, specifically

14 the Long amendment, was designed to encourage the

15 development of alternatives to mental hospitals and to

16 provide funding for the care of people who are placed in

17 these alternatives to the extent the alternative types

18 of facilities are covered by the statute.

19 Not all alternatives to mental hospitals are

20 covered by the Medicaid program. The most common

21 alternative is send someone home and have care in the

22 home or in a community-type facility. But some

23 alternatives are covered by Medicaid, and nursing homes,

24 either at the skilled level or the intermediate care

25 level, are two that are covered. And we believe the

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1 statute makes fairly evident that that is exactly the
2 way Congress wanted people who are mentally ill to be
3 treated where appropriate.
4 I said at the outset that the statute was
5 complex, and it is. It has been described as Byzantine
6 and as an aggravated assault on the English language.
7 All that is true. But those sorts of descriptions ought
8 not be allowed to obscure what is the intended meaning
9 and purpose of the provisions that are under
10 consideration in this case. And in that connection
11 there are two general propositions that have a central
12 bearing on the case that I would like to make.
13 The first is that contrary to the position
14 taken by the court below and by the Department of Health
15 and Human Services in its briefs here, Congress has not
16 broadly excluded the mentally ill from the benefits of
17 public assistance under the Social Security Act
18 programs, by which I refer to Medicaid and the financial
19 assistance programs that preceded it in the statute.
20 It is not true that the mentally ill as a
21 class were left solely to the states for aid in meeting
22 their basic subsistence and health needs. The mentally
23 ill, if they satisfy the tests for financial eligibility
24 categorical membership, have always qualified for the
25 financial assistance provided by the act. That includes

1 not only the elderly mentally ill, but also the mentally
2 impaired when the statute was amended in 1950 to provide
3 assistance for those who were disabled. And when the
4 separate Medical Assistance Program for the Aged was
5 adopted in 1960 -- that's the immediate precursor to
6 Medicaid -- the elderly mentally ill, like others who
7 qualified as needy, were eligible for payment of their
8 services such as doctors, hospital services, and clinic
9 services, and drugs and all the other items listed in
10 the statute, and that carried over into the Medicaid law
11 which was enacted in 1965.

12 Now, there was an exemption -- an exception, I
13 should say, to this eligibility for federally-supported
14 assistance. Beginning in 1950, a resident in an
15 institution for mental disease, IMD, was not eligible
16 for any of the services that I described. The scope of
17 that exception is the issue to be decided here. But
18 this brief review that I have just given of the other
19 forms of assistance that are available under the law,
20 including medical assistance available to the mentally
21 ill, should show that the scope of the IMD exception
22 cannot be decided by an assumption that Congress
23 intended to treat the mentally ill as solely a state
24 responsibility.

25 The Social Security Act is animated by no such

1 assumption. And the contrary premise of the court below
2 and of the Department here cannot substitute for an
3 objective analysis of the intended scope of the IMD
4 exception.
5 And so the absence of a broad policy to
6 exclude the mentally ill from the benefits of the public
7 assistance program leads me to my second general
8 proposition, which is that the IMD exception is a
9 facility specific limitation predicated not only on cost
10 concerns, but also upon a deep hostility to state mental
11 hospitals.
12 By mid-century these enormous and remote and
13 often demeaning institutions were broadly perceived as
14 the antithesis of how the mentally ill should be treated
15 in this country, and the animus towards these facilities
16 was reflected in the -- many ways, including the seminal
17 report of the Joint Commission on Mental Illness and
18 Health that we've referred to in our brief. That's the
19 study that was commissioned by the Congress, and which
20 was reported in 1960, and which was followed by the
21 principal legislation that is before the Court today.
22 So by the time the Medicaid law was enacted in
23 1965, there was a clear consensus, not only in the
24 Congress but also in the profession and the best
25 thinking around the country that state mental hospitals

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1 as they then existed were outmoded, and that successful
2 care of the mentally ill depended upon the development
3 of more suitable facilities and treatment techniques.
4 And that's the setting in which the IMD provisions of
5 the Medicaid law were adopted.
6 Now, with those two general propositions as
7 background, let me turn to the specifics of the task at
8 hand today, starting with the words of the statute. All
9 acknowledge that the IMD exception is not expressly
10 defined in the statute, but the statutory terms do tell
11 us enough to resolve this case, because the IMD
12 exception was part of a group of provisions that have
13 become known as the Long amendment. That amendment
14 includes the exception to the exception that permits
15 coverage in IMDs, in mental hospitals for the elderly,
16 those over 65 years of age. That was a change made when
17 Medicaid was adopted in 1965. But the Long amendment
18 also includes certain conditions that attach to that new
19 coverage, and most specifically, there is the
20 requirement that the states who opt for such coverage
21 adopt comprehensive plans for the care of the mentally
22 ill, and the statute specifically lists nursing homes as
23 one of the alternatives to IMDs that are to be
24 considered and encouraged. This is, using the U.S. Code
25 designation, it's Section 1396(a)(A)(21). Any statute

1 with numbers like that is necessarily complex.

2 And it is -- but that statute is strong proof

3 that on its face, the Congress did not intend the term

4 IMD to include nursing homes.

5 Now, the Department in its briefs points to

6 parenthetical clauses in the listing of covered services

7 in the statute to support its claim that the IMD

8 exception goes beyond mental hospitals and embraces

9 other types of facilities, specifically skilled nursing

10 homes and intermediate care facilities, and it's the

11 latter that's involved in this case.

12 We've shown in our brief that these

13 parenthetical clauses are to skilled nursing or

14 intermediate care levels of service, and that

15 distinction is very critical. It refers, those clauses

16 do, to that type of service when offered in a mental

17 hospital setting, as frequently those services are.

18 QUESTION: Mr. Miller, do you think you should

19 win the case if you can show that your reading is the

20 better reading, or is the only reading that is possible?

21 MR. MILLER: Justice White, I'm familiar with

22 the doctrine of deference, to which I think you're

23 alluding, and I suppose if this were a 51-49 case we'd

24 have some deference on the scales for the Government

25 which would made our case more difficult. But I don't

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1 think this is just a case of the better reading.

2 When one looks not only at the words of the

3 statute, including the section that distinguishes IMDs

4 from nursing homes, but also the broad setting in which

5 this whole context arose, it's not difficult to conclude

6 what Congress meant when it used the term IMD. At least

7 it's not difficult to conclude what it didn't mean to

8 include.

9 QUESTION: Well, apparently the Government has

10 great difficulty concluding that it means what you say

11 it does.

12 MR. MILLER: Yes. I guess that causes

13 disputes.

14 QUESTION: Yes.

15 MR. MILLER: This Court has never taken the

16 view that just because the Government takes one side of

17 an issue that this is enough reason to --

18 QUESTION: Are you saying there is just no

19 room in this language for the Government's construction?

20 MR. MILLER: I wouldn't say that, Mr. Justice,

21 because as I said before, this statute is so complex and

22 the language of it in many respects to obtuse that

23 there's room for any kind of interpretation of it,

24 depending on how you read it.

25 What we've tried to do is not only analyze the

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1 specific language of the wording of the statute here,
2 but also try to understand what was the Congress getting
3 at here, what were the concepts and the purposes and the
4 meaning behind this collection of words, three or four
5 pages of one that consists of one sentence in the
6 statute.

7 And when you conclude that analysis, we think
8 it's not a close case, even just on the meaning of the
9 term IMD, which is all I'm focusing on right now.

10 QUESTION: So you think the Court should just
11 make its own independent -- take its own independent
12 look at the statute and figure out what it means without
13 regard to what the agency says.

14 MR. MILLER: I don't think the Court would
15 ever construe the statute without regard to what the
16 agency says. In fact, much of our argument --

17 QUESTION: Well, you asked certainly --

18 MR. MILLER: -- lies in this --

19 QUESTION: -- disregard it.

20 MR. MILLER: I'm asking you in the end not to
21 accept it. I'm saying that, as in a moment I'll come to
22 the regulations and will show, I believe, that when the
23 statute was first passed that the agency adopted the
24 interpretation we now espouse. It is only the later
25 administrative interpretation that we ask you to

1 reject. I hesitate to say disregard it. Not disregard
2 it initially but disregard it ultimately. And we in a
3 sense are asking you to do what this Court last term in
4 the Security Industry case said it does when it
5 approaches statutes of this kind, and a reviewing court
6 must reject administrative constructions of a statute --
7 QUESTION: Well, when were --
8 MR. MILLER: -- if inconsistent with the
9 statutory mandate or that frustrate the purpose.
10 QUESTION: When were the intermediate care
11 facilities covered?
12 MR. MILLER: They were added to the statute in
13 1967.
14 QUESTION: '67.
15 MR. MILLER: But not the Medicaid provisions.
16 They were added to Medicaid in 1971.
17 QUESTION: '71.
18 MR. MILLER: Yes. In both cases after
19 Medicaid's original enactment of 1965.
20 I wanted to complete the point I was making
21 about the parenthetical clauses in the definitions of
22 hospital, skilled nursing and intermediate care services
23 of the statute, because that's what the Government
24 relies upon most.
25 The Department says that our view of the

1 statute, Connecticut's view, doesn't give effect to all
2 the words of the statute, and particularly those words.
3 We think it's the Department's view that is subject to
4 that criticism, because its reading of these
5 parenthetical clauses makes them redundant of the IMD
6 exception that appears at the end of the listing of all
7 these services. According to the Department's view,
8 those parenthetical clauses mean the same thing as the
9 general IMD exception that comes at the end.
10 That's not what was meant by the Congress, and
11 it's relatively clear when one reads the legislative
12 record what was meant by those parenthetical clauses.
13 They were not in the lists of services in the original
14 Medical Assistance for the Aged Program, the precursor
15 to Medicaid, that was adopted in 1960, nor were they in
16 the House version of the Medicaid law that was enacted
17 in 1965. That, by the way, is the version that
18 President Johnson referred to as the great breakthrough
19 in the establishment of national health programs in this
20 country.
21 These --
22 QUESTION: Mr. Miller, may I just interrupt,
23 because I think you'll be coming to this right now. It
24 would be helpful to me if you would tell me at what
25 stage in the chronology the people that you now say are

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1 covered became covered. They were clearly not covered
2 before 1967, I guess.
3 MR. MILLER: That's correct.
4 QUESTION: And I guess they weren't covered by
5 the '67 amendment or the '71 amendment. Just when did
6 they become covered?
7 MR. MILLER: The '67 amendment provided that
8 financial assistance could be provided to residents of
9 intermediate care facilities, so that if a person
10 qualified for financial aid under the elderly or
11 disabled line program --
12 QUESTION: That was the aged, blind and
13 disabled, wasn't it?
14 MR. MILLER: Yeah. Then they would be covered
15 even though they were resident in those facilities.
16 In 1971 those facilities were brought under
17 Medicaid in a category of service, a category of medical
18 service described as intermediate care facility
19 services, was brought under the statute which wasn't
20 there before.
21 QUESTION: But are you contending that the
22 coverage here was created in 1971?
23 MR. MILLER: Yes, sir, Justice Stevens. It
24 was 1971, because the coverage that's at issue here is
25 the medical care --

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1 QUESTION: I understand.

2 MR. MILLER: -- given to these people.

3 QUESTION: So the -- you don't have to rely on
4 the '72 amendment then.

5 MR. MILLER: No. The '72 amendment?

6 QUESTION: Well, maybe I'm --

7 MR. MILLER: There was a '72 amendment, but
8 we're not relying upon it, and it's not pertinent here.

9 The clauses in question -- and I'll try to
10 finish up on these clauses -- they were added by the
11 Senate Finance Committee the same place where the
12 proposal to cut back on the IMD exception was initiated,
13 and the Senate report explains those clauses. It says
14 that they were put in to make clear that the new type of
15 service that was being authorized for people over 65 in
16 IMDs was not mandatory. A state didn't have to do it.
17 It was only optional. That was an important addition,
18 because otherwise, under the statute, hospital and
19 skilled nursing services are mandatory. So this was --
20 and they remain mandatory except for those over 65 in
21 IMDs.

22 Now, the statute -- the Department's brief
23 just ignored that evidence. It's in our brief at page
24 67. And I think it not only explains what Congress
25 meant, it supports our reading of the statute, and it

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1 invalidates the Department's reading.

2 I'd like to turn now to the regulations that

3 were adopted. Justice White, you referred to them, I

4 think, when you asked me a question.

5 After Medicaid was enacted in 1965, the

6 Department set about to put out regulations in the form

7 of a handbook, as that's the form that regulations took

8 at that time. Since the law did now permit coverage in

9 IMDs for people over 65, it became necessary for the

10 Department to define just what an IMD was, and it did

11 so. And in the 1966 regulation it defined an IMD, and

12 it said to be an IMD you had to qualify as a psychiatric

13 hospital, and it recited the Medicare definitions of

14 psychiatric hospital, and if you qualified for that, you

15 were an IMD.

16 That seemed to us to be pretty strong evidence

17 that the contemporaneous understanding was that an IMD

18 meant a mental hospital and not a nursing facility.

19 Now, the Department's answer to this is that the

20 regulation confining IMDs to qualifying psychiatric

21 hospitals was eventually changed. I don't think,

22 however, that this detracts from the showing of the

23 original understanding of the scope of the term IMD.

24 Now I'd like to make one sort of a side

25 comment. In our reply brief at page 28 we went further,

1 and we said that the Department was in error because the
2 original regulation remained on the books. I have
3 reviewed that regulation again in its present form, and
4 I'd like to modify that comment slightly.
5 The format of the regulation has been
6 altered. The provision in question is still on the
7 books. But there's a semantic argument that could be
8 made now that it is not an exclusive definition of IMD.
9 And so I do want to correct an impression to the
10 contrary that our reply brief most likely created. I
11 don't think it's --
12 QUESTION: I want to be sure about the page.
13 Twenty-eight did you say?
14 MR. MILLER: I think it's page 28 of the reply
15 brief, yes.
16 And I was answering the point that the
17 Government made that that original definition was no
18 longer on the books. It is on the books. But as I say,
19 I don't want to leave the impression that it remains an
20 exclusive definition. The regulations are sufficiently
21 complex. As I looked at it, Justice White, again, I
22 could see that you could construe it as being
23 nonexclusive.
24 QUESTION: Well, you have to -- you certainly
25 are making this argument, though, to say that this

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1 definition seems to foreclose or tends to foreclose
2 defining this kind of facility that you represent as an
3 IMD.
4 MR. MILLER: That's correct.
5 QUESTION: They say that -- in effect they say
6 that because this facility serves such a high percentage
7 of mental patients, it is, in effect, an IMD.
8 MR. MILLER: That's what the Government is
9 saying.
10 QUESTION: Yes.
11 MR. MILLER: All that this regulation does on
12 the books today --
13 QUESTION: But they certainly don't claim it's
14 a psychiatric hospital.
15 MR. MILLER: They do not claim it's a
16 psychiatric hospital, but they treat it like a
17 psychiatric hospital for purposes of coverage.
18 QUESTION: Yes.
19 MR. MILLER: The Government does rely also on
20 the regulation that says a facility's -- whether a
21 facility is an IMD is to be determined by its "overall
22 character," which are the words I put in quotes. I just
23 don't think that that general phrase can be used to save
24 a position that's otherwise not defensible.
25 This not very helpful standard was in the

1 original regulation and undoubtedly designed to give
2 some flexibility in applying the IMD exception, and is
3 of some help particularly where it's being applied to
4 private mental hospitals which might not have been as
5 easily identifiable as the traditional state mental
6 hospital. But flexibility in applying a definition is
7 not a justification for applying the definition to a
8 class of facilities which were not intended to be
9 embraced by it and which were not covered by the
10 affirmative definition of the term IMD that was included
11 in the regulations at the very same time.

12 Just to summarize on this aspect of our
13 argument on the meaning of the IMD exception, the
14 wording of the statute and the regulations, the
15 legislative record which we've tried to spell out in our
16 briefs, the evident statutory purpose, the history of
17 the exception to the Social Security Act, and the widely
18 perceived experience with state mental hospitals over
19 the past century all combine to demonstrate beyond any
20 real doubt that the IMD exception was meant to cover
21 mental hospitals and only mental hospitals and certainly
22 not the kinds of alternative facilities like nursing
23 homes which have been developed as alternatives.

24 These considerations in our view alone would
25 establish the error of the court below in applying the

1 IMD exception to Middletown Haven in Connecticut. But
2 to this we add the other side of the story: the
3 provisions of the Medicaid Act relating to intermediate
4 care facilities, ICFs, the category into which
5 Middletown Haven falls and which was added to Medicaid,
6 as I said, Justice Stevens.
7 On both occasions that the ICFs were
8 recognized -- in 1967 and then when they were brought
9 under Medicaid in 1971 -- they were defined to mean
10 places that provide a specified level of treatment for
11 persons whose mental or physical conditions requires
12 that degree of care. There's no qualification in this
13 law to the definition, no suggestion that it applies
14 only to the elderly, or only to some mental conditions,
15 or only if mental conditions are an incidental function
16 of the facility in question.
17 These were speculative possibilities on
18 limiting the statute that were advanced by the court
19 below and by the Department's brief here. And the court
20 and the Department said maybe it means this; these are
21 plausible, possible interpretations. But these are not
22 valid speculations. They're the product really of the
23 mistaken assumption I referred to at the outset, that
24 the mentally ill were carved out as a class for coverage
25 under the Medicaid law, and that's just not so.

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There's no reason not to give full scope to the statutory definition of ICFs, for that was the intent of Congres. The Senate Finance Committee, which initiated the Medicaid amendment to cover ICFs, made clear the intent. Its report states that the ICF provision was for people who would otherwise have to be cared for in the higher cost and higher level skilled nursing homes or in mental hospitals. That was the clear statement that means that Medicaid was intended to cover people in ICFs who otherwise would be in IMDs. Mental hospitals are clearly IMDs.

And I just don't think it's sensible that Congress meant that ICFs were to be used to cover people with mental conditions, but only if they don't specialize in that type of care.

Middletown Haven did care for these people and did so well. It specialized in the treatment of mental conditions, but it wasn't a psychiatric facility, and when the conditions of the residents became sufficiently severe, they had to be returned to the mental hospitals, and they were in substantial number whenever that was called for. But Middletown Haven is exactly the kind of facility that was contemplated by Congress when the Medicaid program was expanded to take in ICFs in 1971.

I spoke of the severe negative impact that the

1 Department's -- acceptance of the Department's position
2 would have in this case on the proper care of the
3 mentally ill. I'd like to add just one word, and that
4 is the impact it has on the states that finance these
5 programs.
6 This is not a case where vast new federal
7 outlays will occur if the Court sustains the state's
8 position. We're dealing here with funds that have been
9 received under the Medicaid program and expended by the
10 states in the care of people who are mentally ill in
11 intermediate care facilities. If the Department's
12 position prevails, the states involved will have to
13 figure out how to raise and return to the federal
14 government tens, if not hundreds of millions of dollars
15 of funds already received and already expended, and
16 that's going to have a severe negative impact on the
17 states, as well as on their future ability to provide
18 care not just for the mentally ill but all objects of
19 Social Security Act programs.
20 Thank you.
21 CHIEF JUSTICE BURGER: Ms. Oberly.
22 ORAL ARGUMENT OF MS. KATHRYN ANNE OBERLY, ESQ.,
23 ON BEHALF OF THE RESPONDENT
24 MS. OBERLY: Thank you, Mr. Chief Justice, and
25 may it please the Court:

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1 There is only one narrow question before this
2 Court today, in response to Justice O'Connor's questions
3 to my colleague at the beginning of his argument. The
4 single question before this Court is whether ICFs and
5 IMDs are mutually exclusive types of facilities in any
6 and all circumstances. The Court does not have before
7 it, because Connecticut has not presented as a question
8 for the Court to decide how the Secretary should
9 determine whether any particular ICF is also an IMD.
10 The 50 percent rule --
11 QUESTION: That's true, but I think it's of
12 general interest to know whether the states can just
13 scatter the mentally ill around in more facilities that
14 presumably will have less specialized staff to take care
15 of them, and if that satisfies the law in your view.
16 MS. OBERLY: In theory, Your Honor, they
17 could. What Connecticut has done in this case is a good
18 example actually of responsible state behavior in
19 response to the Department's action. Instead of
20 scattering the patients at Middletown Haven once the
21 disallowance issue came up at this facility, Connecticut
22 took all of the non-mental patients out of Middletown
23 Haven, the people -- the stroke patients, the physically
24 disabled -- put them in general ICFs or skilled nursing
25 facilities, and converted Middletown Haven to a 100

1 percent mental facility for which it is now claiming no
2 reimbursement whatsoever. And we don't think that the
3 Court ought to decide the case on the assumption of bad
4 faith by the states in shifting their patients to places
5 that may not be suited for their needs simply to
6 maximize federal funding. And the way Connecticut has
7 responded demonstrates that states aren't going to act
8 that way if they in fact have the best interests of
9 their mentally ill citizens --
10 QUESTION: Perhaps. Perhaps.
11 MS. OBERLY: -- at heart.
12 QUESTION: Ms. Oberly, is it correct that the
13 Government would be seeking to recoup vast sums of money
14 from the states if your position is sustained here?
15 MS. OBERLY: As far as recoupment is
16 concerned, all we know is the $18 million involved in
17 the four consolidated cases, of which Connecticut's is
18 one, which is a substantial amount of money. But the
19 greater --
20 QUESTION: Well, was the interpretation of
21 Connecticut widespread among the states?
22 MS. OBERLY: Pardon?
23 QUESTION: Was the interpretation placed on
24 the statute --
25 MS. OBERLY: Yes, yes.

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1 QUESTION: -- by Connecticut the same
2 interpretation most states placed on it?
3 MS. OBERLY: Some states have no facilities
4 like this. California, on the other hand, I think has
5 probably about 26, so it varies widely from state to
6 state. They haven't all been audited yet.
7 But in a general answer to your question, yes,
8 most states thought that -- there's uncontroverted
9 testimony in the record in this case that Connecticut
10 was shifting patients from its state mental hospitals to
11 Middletown Haven in order to maximize federal funding;
12 and I think that was common among a number of states. I
13 mean that was the purpose, to get Medicaid coverage that
14 they knew they couldn't get if the patients remained in
15 a mental hospital. I don't think that was unique to
16 Connecticut. But not enough of the states went through
17 the audit process for me to be able to tell you if that
18 was a nationwide phenomenon.
19 I would -- I do think it's important, though,
20 although the criteria, the 50 percent rule, that sort of
21 thing is of some interest, it is not before the Court.
22 QUESTION: Has the Department, the Government,
23 HHS, ever taken a different view of the proper meaning
24 of the statute?
25 MS. OBERLY: No, Your Honor, we have not, and

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1 we disagree with Mr. Miller's characterization of our
2 early regulations. There was, beginning in 1966, which
3 was the year after Medicaid was passed, and continuing
4 to the present one regulation which defined an IMD as a
5 psychiatric hospital. But as Mr. Miller has just
6 conceded in his argument, the interpretation he gives to
7 that regulation in his brief is really probably not the
8 correct interpretation. It appears at page 27 of his
9 reply brief, not page 28. And in fact, the purpose of
10 that regulation is to make sure that the elderly, as to
11 which all parties agree do get coverage in mental
12 hospitals, are not placed in substandard psychiatric
13 hospitals.
14 So there is a need for a regulation defining
15 an IMD in terms of a psychiatric hospital that's been
16 accredited as a psychiatric hospital by the Joint
17 Commission on the Accreditation of Hospitals. But there
18 is also side by side with that regulation and has been
19 since 1966 the overall character regulation, which is
20 the one we rely on for skilled nursing facilities and
21 intermediate care facilities, that provides that when
22 you're not talking about a hospital, when you're talking
23 about a different type of facility, the relevant
24 criteria is the overall character of the facility,
25 whether the facility was established and maintained

1 primarily to care and treat the mentally ill. And that
2 regulation has been HHS's position since 1966, since the
3 first chance it had to enact any regulations after
4 Medicaid. It has never changed. And it stands side by
5 side with the psychiatric hospital regulation, but they
6 each serve and cover different facilities. So we see no
7 inconsistency and no change in the Department's position
8 for the entire applicable time period.

9 QUESTION: Was the Government ever asked by
10 states for an interpretation of this regulation? I mean
11 are there letters that have been sent out giving
12 different interpretations?

13 MS. OBERLY: I would suggest that the states
14 should have sought advice. In 1976 Connecticut
15 acknowledges that it was aware of the federal
16 government's position, but it wasn't until some time in
17 1979 that it wrote a letter asking for clarification of
18 that position. The answer it got back covered a
19 multitude of different possible factual possibilities.
20 But as to a facility like Middletown Haven, the answer
21 it got back was crystal clear, that the Department would
22 treat that sort of facility as an institution for mental
23 diseases.

24 Connecticut says it knew in 1976 what the
25 Department's position was, or at least that there was

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1 some question that it differed from the state's
2 position. It certified Middletown Haven to open in
3 1977, claimed reimbursement for two years without in
4 that two-year period going back to the Department and
5 saying will we really get to keep our reimbursement for
6 this facility. But it was always open to the state to
7 seek clarification, and in fact, it didn't do it until
8 it had expended substantial funds at this facility, and
9 then raised the question of clarification somewhat late,
10 in our view.
11 We do agree with petitioner on one thing, and
12 that is that this statute is incredibly complex. In
13 fact, petitioner has said it far more often than I would
14 have felt I could have said it, but under these
15 circumstances, we think that the Court's rules of
16 deference are at their highest.
17 The Court has recognized that the Medicaid
18 statute of the Social Security Act is one of the most
19 complicated Congress ever enacted. The Secretary's
20 position doesn't have to be right, although we contend
21 that it is right. It doesn't even have to satisfy a 50
22 percent rule of probably right. When the Court is faced
23 with a statute that's as complex as this one, if the
24 Secretary's interpretation is reasonable, even if it's
25 not the interpretation that Connecticut or this Court

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1 might initially have adopted, then the Court is bound to
2 defer to that interpretation unless and until Congress
3 says that that's not what it meant to enact.
4 Connecticut's arguments really are quite
5 simple. Connecticut says that these two facilities can
6 never cross. An intermediate care facility, no matter
7 what it's factual characteristics, can never be an
8 institution for mental diseases.
9 The Secretary, on the other hand, looks, under
10 her regulation, to the overall character of the
11 facility. The facts of this case show how reasonable
12 the Secretary's position is. Middletown Haven during
13 the time of the audit in question, which covered two
14 years of patient population at the facility, had 77
15 percent of its patients there suffering from major
16 mental illnesses. It had psychiatrists as its medical
17 staff. Its nonmedical staff, including its cafeteria
18 workers, its janitors were trained to care for the
19 mentally ill. They were told as a condition of being
20 hired that you will be dealing with the mentally ill and
21 given in-service training. Many of the patients could
22 not live, could not continue to live at Middletown Haven
23 Hospital -- excuse me -- Rest Home, and had to be
24 returned rather quickly, one in the case of one day, to
25 the mental hospital from which they had originally been

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1 discharged, which suggests to us not that Middletown
2 Haven was a desirable substitute for a mental hospital,
3 but that these patients didn't and weren't able to leave
4 a mental hospital in the first place, that the state was
5 doing exactly what the testimony shows, which was using
6 Middletown Haven as a way to get federal funding for the
7 coverage of patients that it knew belonged it mental
8 hospitals, but that it also knew if it kept in mental
9 hospitals, Medicaid would not pay for.
10 QUESTION: But I take it you certainly concede
11 that Middletown was not a mental hospital.
12 MS. OBERLY: It was not a mental hospital, but
13 --
14 QUESTION: It was an intermediate care
15 facility.
16 MS. OBERLY: That's correct.
17 QUESTION: But also an IMD, is that it?
18 MS. OBERLY: That's correct. But some
19 intermediate care facilities are not IMDs.
20 QUESTION: Right.
21 MS. OBERLY: But that's not the issue before
22 the Court. And I want to stress again the only issue is
23 whether an ICF can ever be an IMD. And we would point
24 out that the facts of this case show that it would be
25 quite unreasonable to say that the two are always

1 mutually exclusive no matter what the facts are.

2 QUESTION: Is the name we give it or the

3 function the controlling factor?

4 MS. OBERLY: We think the labels are not

5 material at all. I mean a state should not be able to

6 get around the restrictions by just changing the label

7 of its facilities. The patients that are there, the

8 treatment they're receiving, the staff, where they come

9 from, where the patients go when they leave -- all of

10 those factors are relevant in determining what is an

11 institution for mental diseases, not the label. But

12 again, we don't have to decide in this case how to apply

13 the factors. We only decide whether looking at factors

14 as opposed to labels is an appropriate way for the

15 Secretary to proceed.

16 QUESTION: Would you clarify something for me

17 I thought I understood, but I'm not sure I do. In this

18 particular facility, say there were 75 percent of the

19 people were mental patients and 25 percent were

20 nonmental or tuberculosis patients, if it is an IMD, as

21 you contend, and if they continued to have the 25

22 nonmental patients there, they would not be reimbursed

23 for them, would they?

24 MS. OBERLY: That's correct, Your Honor, and

25 that's why it's facilities. I mean Medicaid pays for

1 services in facilities; that this by virtue of its
2 characterization as an IMD becomes an ineligible
3 facility.
4 Now, those patients who are not suffering from
5 mental disabilities can get Medicaid coverage in a
6 different facility, and in fact Connecticut moved them
7 to facilities that are called general ICFs or general
8 skilled nursing facilities, and they're getting coverage
9 there presumably. They could not get coverage had they
10 remained at Middletown Haven.
11 QUESTION: Does that suggest they are mutually
12 exclusive categories then? I mean you can't -- if you
13 are --
14 MS. OBERLY: No. It just suggests that
15 there's a limitation, as the Court recognized in general
16 terms in O'Bannon v. Town Court Nursing Home, that there
17 are general limitations on the types of facilities that
18 Medicaid patients have access to. They will get
19 coverage. Mentally ill Medicaid patients can get
20 coverage in the psychiatric word of a general hospital.
21 The statute does not exclude all treatment for the
22 mentally ill, even those under 65, but it does limit the
23 types of facilities that Medicaid will pay for, and
24 that's all that's involved in this case is whether they
25 put in -- these patients have been put in a facility

1 where Congress expressed an intent not to pay for that
2 type of facility.
3 The statutory language we think clearly
4 supports the Secretary as well as the common sense
5 aspect of the facts of this case. The IMD exclusion, as
6 Mr. Miller has pointed out, is repeated in several
7 parenthetical phrases in Section 1396(a) -- excuse me --
8 1396(d)(A) in about five different places in that
9 section. The exclusion appears not just after the
10 provision relating to inpatient hospital services, which
11 is where you would expect it to appear and only where
12 you would expect it to appear if we were talking simply
13 about mental hospitals, but it also appears in the
14 section following the definition of skilled nursing
15 facility services. It appears in the definition -- in
16 the section defining intermediate care facility
17 services. It appears in two other places in the statute
18 where it authorizes these services for the elderly and
19 where it prohibits the services for those under 65. In
20 fact, it appears in five different sections, subsections
21 of the same part of the statute.
22 Connecticut's answer to this parenthetical
23 clause on which the Government does indeed rely quite
24 heavily doesn't make sense to us, and we think it leads
25 to absurd results. Connecticut's position is that if

1 ICF services are provided in a mental hospital, what we
2 all would agree is a mental hospital, then those
3 services cannot be paid for or covered under Medicaid.
4 On the other hand, Connecticut contends that
5 if ICF services are provided in a freestanding ICF, a
6 separate building, then Medicaid should pay for them.
7 QUESTION: Ms. Oberly, what year was it that
8 the Department of Health and Human Services adopted its
9 criteria, including the 50 percent figure?
10 MS. OBERLY: The 50 percent figure, which I
11 stress again is not before the Court --
12 QUESTION: Yes, I know.
13 MS. OBERLY: -- and is not determinative, was
14 first adopted --
15 QUESTION: I asked what year it was --
16 MS. OBERLY: It was first adopted I believe in
17 either 1975 or 1976, again before Middletown Haven
18 opened, as one of eight to ten criteria that HHS
19 auditors should look at when they went to examine
20 particular facilities.
21 QUESTION: May I ask again about the
22 subparagraph 15 of the section we were talking about?
23 Why wouldn't their reading make sense if the regulation
24 read the way they thought it did; in other words, that
25 IMDs were defined as psychiatric hospitals. Wouldn't it

1 make perfectly good sense that that was the -- because
2 you could conceivably have --
3 MS. OBERLY: If you assume the answer to the
4 case in their favor, it makes sense.
5 QUESTION: Well, then what I'm suggesting is
6 one can read it either way. That's all I -- it makes
7 sense.
8 MS. OBERLY: But what I would like to point
9 out is the anomalous results that flow from their
10 reading that we don't think Congress could have
11 intended. First of all, under their reading, you could
12 have a mental hospital take -- let's say it's seven
13 stories high, and it decides to convert the fourth floor
14 of its hospital into an ICF ward. Connecticut would
15 agree without any hesitation at all that the patients on
16 that fourth floor receiving ICF services are not
17 eligible for Medicaid coverage.
18 Now, let's say the mental hospital decides to
19 take the whole fourth floor and move it to a different
20 building, a new facility that they called Middletown
21 Haven Rest Home. It provides the same care and services
22 to the patients that they were previously getting on the
23 fourth floor of the mental hospital. All of a sudden,
24 under Connecticut's interpretation of the statute, those
25 people become eligible for Medicaid coverage.

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1 To us and to the court of appeals that's an
2 irrational, artificial distinction that finds absolutely
3 no support in the legislative history.
4 QUESTION: I'm puzzled by the first example,
5 because the end of the section -- there's one definition
6 of -- I don't know what it is -- intermediate care
7 facility, the last part of it says, "any public
8 institution or distinct part thereof for mental diseases
9 or mental defects."
10 I thought you could divide up institutions by
11 floors.
12 MS. OBERLY: You can if you get separate
13 certification for them.
14 QUESTION: Oh, I see.
15 MS. OBERLY: But that doesn't mean you'll get
16 Medicaid compensation for them if they're still in a
17 mental hospital.
18 Another problem we think with Connecticut's
19 reading -- pardon?
20 QUESTION: This is incredible.
21 MS. OBERLY: I hope it's not anything I said.
22 But another problem we think with
23 Connecticut's interpretation of the statute, of the
24 parenthetical clauses is that if you will look at all cf
25 those provisions in 1396(d), they deal with covered

1 Medicaid services. They deal with eyeglasses, they deal
2 with physician services. They also deal with
3 residential services such as in skilled nursing
4 facilities, hospitals or intermediate care facility
5 services.
6 The parenthetical we're concerned about only
7 appears following the definition of residential
8 services. It doesn't appear following physician
9 services or following eyeglasses services. To us it
10 seems only logical that the place you're going to look
11 for ICF services is in an ICF. If you're looking for
12 doctor services, you go to a doctor's office. You might
13 find those services somewhere else, and it's possible
14 you'll find ICF services in a mental hospital. But we
15 don't think that it's logical to assume that Congress
16 would have written a statute that focuses on the quite
17 unique and unusual situation of when someone is looking
18 for services that is not normally set up to provide that
19 type of service. And that is another effect of reading
20 the parenthetical the way Connecticut reads it is that
21 Congress has taken great pains to repeat this
22 parenthetical to cover a situation that will hardly ever
23 arise. And at the same time it's found it unnecessary
24 to include the parenthetical in the situation of
25 services that have nothing to do with residence,

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1 residential facilities, such as eyeglasses, therapy,
2 x-rays. So that the structure of that whole Section
3 1396(d) suggests to us that this parenthetical does mean
4 that an ICF or a skilled nursing facility can be an IMD
5 if the facts of the particular case warrant that
6 conclusion.
7 QUESTION: On the practical level do you know
8 how it works, Ms. Oberly? In order to be eligible for
9 reimbursement of Medicaid funding, does an ICF apply to
10 some office of HHS and ask for certification with that
11 status as an ICF?
12 MS. OBERLY: My understanding is the
13 certification comes from the state. It's a cooperative
14 state-federal program. The state does --
15 QUESTION: They'd apply through the state who
16 acts for the federal government, in other words, in
17 making a certification?
18 MS. OBERLY: The state does the certifying. I
19 think that HHS retains power to say we disagree with the
20 certification. But basically it's a state
21 certification. The money goes to the state, which in
22 turn pays it to the vendor, which in this case would be
23 Middletown Haven.
24 QUESTION: And, of course, no application is
25 ever made to be certified as an IMD. That's a category

1 that --

2 MS. OBERLY: That's correct.

3 QUESTION: -- would be determined by the

4 federal government following an audit, presumably?

5 MS. OBERLY: That's correct. That's correct.

6 Unless you're dealing with what we all concede is a

7 psychiatric hospital where there is no dispute from the

8 beginning that that's an IMD. But in the case of these

9 sort of hybrid facilities, it couldn't be until after

10 the facility had opened and had some patients, and you

11 could tell what went on at the facility.

12 QUESTION: And the listed criteria are imposed

13 flexibly by the federal government? It could be any

14 combination of the listed eight or nine criteria?

15 MS. OBERLY: No single criteria is

16 determinative. The 50 percent criteria is not

17 determinative. No single one carries ultimate weight.

18 QUESTION: So an ICF would certainly have no

19 very comfortable basis for knowing whether a later audit

20 would be --

21 MS. OBERLY: That we would disagree with, Your

22 Honor. Certainly in the case that you have before you

23 and in the case of all the audits that were before the

24 grant appeals board in this case, because they weren't

25 even borderline cases. We're talking about facilities

1 that had patient populations ranging from 77 to 90
2 percent mental illness patients, patients that --
3 facilities that by their own admission -- Connecticut
4 doesn't dispute that Middletown Haven was a facility
5 specializing in the care of the mentally ill.
6 QUESTION: Might there be other facilities
7 around the country where it would be quite an uncertain
8 question?
9 CHIEF JUSTICE BURGER: We will resume there at
10 1:00.
11 (Whereupon, at 12:00 p.m., the case in the
12 above-entitled matter was recessed for lunch, to be
13 reconvened at 1:00 p.m., the same day.)
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1 AFTERNOON SESSION

2 CHIEF JUSTICE BURGER: Ms. Oberly, you may

3 resume. You have eight minutes remaining.

4 ORAL ARGUMENT OF MS. KATHRYN ANNE OBERLY, ESQ.,

5 ON BEHALF OF THE RESPONDENT -- RESUMED

6 MS. OBERLY: Thank you.

7 I'd like to use my remaining time to address

8 some of Connecticut's policy arguments. Connecticut

9 doesn't really rely on the statute. Instead, what

10 they're relying on is extensive legislative history that

11 shows a quite sincere and detailed concern on the part

12 of Congress for the elderly and for the health costs,

13 both mental and nonmental, of the elderly.

14 We find it somewhat hard to believe that

15 Congress would have devoted as much time as it did --

16 and it was a lot -- to discussing the health problems

17 and costs of the elderly and then, without uttering a

18 single word, extend virtually the same coverage to the

19 patients in the age group we're talking about here,

20 between the ages of 21 and 64.

21 We also, I might mention as an aside, find it

22 somewhat ironic that for Connecticut to rely on this

23 legislative history relating to the elderly, because

24 Congress made coverage in mental institutions optional

25 with the states, even for those over 65.

1 Connecticut has chosen as a part of its state
2 plan in exercising that option not to provide ICF or
3 skilled nursing facility services for the elderly under
4 Medicaid. And so here we have a state that has not done
5 what Congress was most anxious to encourage. It was not
6 required to do it. That was its choice. But at the
7 same time it's here asking this Court to have the
8 federal government reimburse it for coverage for a
9 different age group of patients on whom Congress has not
10 focused attention.
11 In the end we think that the issue before the
12 Court is one for Congress. We think our interpretation
13 of the statute is correct, but if there's any doubt
14 about the matter, it's quite clear that Congress has
15 apprcached the entire subject of increased federal
16 funding for the mentally ill on a step-by-step basis.
17 It started off with basically no federal funding for
18 residential services. It did provide cash assistance,
19 but in 1935, which is what Connecticut talks about in
20 its reply brief, it was $15 a month, which is clearly
21 not enough to support anyone in a residential facility.
22 And instead, Congress has gone step by step,
23 first removing the exclusion for the elderly; then
24 removing the exclusion for children under 21; adding the
25 mentally retarded after reaching the conclusion that

1 they're in a different medical category than the
2 mentally ill. But Congress hasn't taken the step that
3 Connecticut is asking this Court to take for it, and we
4 think that that decision is one that properly belongs to
5 Congress. And in light of the cost we're talking about
6 -- and we are not in this case talking about the $1 1/2
7 million disallowance at issue for Connecticut; we're
8 talking about the future cost of all states who might
9 seek reimbursement under this program in the future.
10 And I can't give a dollar amount on that, but it's
11 clearly quite substantial.
12 QUESTION: Do you suppose -- I take it, then,
13 you don't think there's room in this statute for the
14 Department to take a different view, to take
15 Connecticut's view?
16 MS. OBERLY: No, Your Honor, I don't. I think
17 that when faced with the facts that it has before it
18 that the only fiscally responsible position for the
19 Department to take in order to carry out Congress'
20 intent is the position it's taken, because Congress has
21 been throughout, it repeatedly said that it viewed the
22 cost of longterm care for the mentally ill as a state
23 responsibility. And it's chipped away at that step by
24 step, but it hasn't taken the step that Connecticut is
25 asking the Court to take.

1 So that I think the agency would be running
2 contrary to years of congressional intent of assuming
3 that this was a state fiscal responsibility if it were
4 to take Connecticut's position.
5 Also, I think it's quite significant that just
6 last summer, the summer of 1984, Congress looked at the
7 very provisions of the statute we're looking at today.
8 Every place that the parenthetical exclusion for
9 institutions for mental diseases appears in the statute
10 there previously also appeared an exclusion for
11 institutions for tuberculosis.
12 In 1984 Congress removed the TB exclusion.
13 That wasn't any great act of generosity on Congress'
14 part. Congress knew that tuberculosis is simply not
15 much of a problem in the United States any more. It
16 doesn't require longterm care. It responds to
17 antibiotics. The patients are ambulatory. And so to
18 bring TB coverage within the scope of Medicaid was not
19 saddling the federal government with a large fiscal
20 responsibility.
21 But when Congress examined that very same
22 parenthetical and left the IMD exclusion untouched, we
23 think again that that's another strong indication that
24 unless and until Congress says something different about
25 the Secretary's interpretation, the Court should uphold

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1 it.

2 One final point is that extending coverage to

3 the group we're talking about here, the mentally ill

4 between 21 and 64 in ICFs and skilled nursing

5 facilities, would be particularly inappropriate because

6 when Congress has extended mental health coverage, it's

7 done so with strict cost and therapeutic efficiency

8 controls. For the elderly and for the children and for

9 the mentally retarded it's written into the statutes

10 provisions that require that those patients be getting

11 effective treatment, that those patients be getting

12 treatment that's designed to lead to their eventual

13 release and return to community living.

14 There are no such standards for the patients

15 that Connecticut seeks to bring within the scope of

16 Medicaid coverage. There are general standards for

17 patients in ICFs and in skilled nursing facilities, but

18 none that pertain specifically to mental illness. And

19 with Congress' unquestioned concern for cost

20 effectiveness, it seems to us highly unlikely that it

21 would have intended this sort of open-ended coverage for

22 the group Connecticut is talking about without also

23 providing the same cost effective and treatment-oriented

24 standards that it's provided for the other groups that

25 we all agree are covered by the statute.

1 Thank you.

2 CHIEF JUSTICE BURGER: Thank you, counsel.

3 The case is submitted.

4 We'll hear arguments next in Aspen Skiing

5 Company against Aspen Highlands.

6 (Whereupon, at 1:05 p.m., the case in the

7 above-entitled matter was submitted.)

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CERTIFICATION

Alderson Reporting Company, Inc., hereby certifies that the attached pages represents an accurate transcription of electronic sound recording of the oral argument before the Supreme Court of The United States in the Matter of:

#83-2136-CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE, Petitioner V. MARGARET M. HECKLER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

and that these attached pages constitutes the original transcript of the proceedings for the records of the court.

BY Paul A. Richardson

(REPORTER)

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