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MEDICAID COVERAGE FOR MENTAL ILLNESS: BALANCING ACCESS AND COSTS

by Carl A. Taube, Howard H. Goldman, and David Salkever

Prologue: As tight federal and state budgets constrain the growth of the Medicaid program, there is growing concern that the nation’s poor are being denied access to needed medical care. This tension between controlling costs and expanding access to beneficiaries is especially apparent in the provision of mental health services under Medicaid. For example, “the interests of a state’s mental health agency to maximize access to mental health services, especially those financed with a mix of state and federal dollars, may be opposed by the cost containment interests of the state’s Medicaid authority,” write Carl Taube, Howard Goldman, and David Salkever. In this essay, they make several recommendations for state and federal policymakers to balance these interests. Taube, who died in September 1989, was a leader and pioneer in the fields of mental health services research and mental health economics. At the National Institute of Mental Health (NIMH) from 1966 to 1987, he served as Chief of Survey and Reports and as deputy director and finally director of the Division of Biometry and Applied Sciences. Taube organized a program of mental health economics within NIMH and initiated its Mental Health, United States series. He earned a doctorate in sociology from the American University. After his retirement from NIMH, he joined the faculty of The Johns Hopkins University in the Department of Mental Hygiene and the Department of Health Policy and Management. Goldman, who holds degrees in psychiatry, public health, and social welfare research, is a professor of psychiatry at the University of Maryland School of Medicine and coprincipal investigator at the Johns Hopkins University–University of Maryland Center on Organization and Financing of Care for the Severely Mentally Ill. Salkever is a professor of health policy and management and director of the interdepartmental program of health economics at Johns Hopkins. He holds a doctorate in economics from Harvard University.
During the past decade, Medicaid costs have escalated, and the federal/state health insurance program for the poor has become the principal source of public funding for long-term care for elderly and disabled people, and for institutional care for people with mental retardation. Medicaid originally aimed to provide access to medical care for the poor—those who are eligible for such welfare programs as Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) and who are “categorically” or “medically” needy. This is now tempered with concern for controlling rising costs.\(^1\)

Medicaid also has become a major source of financing of care for the indigent mentally ill. The total federal costs of the mental health component of Medicaid are difficult to assess with precision. Crude estimates indicate that about 15 percent of total Medicaid dollars are spent on mental illness. The bulk of these costs are spent on skilled nursing facility (SNF) and intermediate care facility (ICF) care (over $2 billion), state psychiatric hospital care (almost $1 billion), and general hospital psychiatric care (about $2 billion).\(^2\) The balance of the costs are associated with care in community-based facilities and physicians’ offices.

Medicaid costs are dependent on several factors: the size of the enrolled population, the demand of this population for the offered benefits, and the supply of services, given the method of payment to providers. State Medicaid policies affecting these factors often pit the opposing interests of two state agencies against one another. The interests of a state’s mental health agency to maximize access to mental health services, especially those financed with a mix of state and federal dollars, may be opposed by the cost containment interests of the state’s Medicaid authority. An overall state perspective is critical in resolving this tension, especially because costs in one area of expenditure may generate savings in another, making proposed changes in Medicaid policy budget-neutral or perhaps cost saving. A federal/state Medicaid policy must balance these interests.

The purpose of this article is to describe Medicaid’s mental health policy and make recommendations for change. In an era of cost containment, Medicaid should provide needed access to the most appropriate and efficient services. Our recommendations focus on increasing enrollment; promoting outpatient substitution for inpatient care, especially in state-operated facilities; and improving the available supply of care by increasing financial incentives for providers to participate in Medicaid.

The Medicaid Mental Health Program

Persons served. Although persons may become eligible for Medicaid from two mandatory eligibility categories—AFDC and SSI for the blind,
aged, and disabled—most mentally ill Medicaid beneficiaries are from the SSI group. Mentally ill Medicaid users differ from other users primarily in the greater intensity of their use of services and the greater number of heavy users. In 1980, less than 10 percent of the mentally ill Medicaid population generated more than one-third of the treatment costs. Also in 1980, the SSI and state-only eligibility groups had significantly higher costs per capita than the AFDC group.

Trevor Hadley has described three types of adult Medicaid users of mental health services: (1) heavy users, who consume large quantities of emergency and inpatient care; (2) episodic users, who attend six to ten outpatient visits and then disappear; and (3) persistent users, who consume less expensive services, such as outpatient or partial hospitalization, and remain in the care system for a long time. Schizophrenia, affective disorders, and other long-term mental illnesses are the most common diagnoses for both heavy and persistent users, while episodic users have a variety of diagnoses. Richard Surles testified in 1987 that children and adolescents also are using emergency mental health care more frequently. Many are referred for serious problems, such as a suicide attempt. He estimated that in Philadelphia approximately half of these children admitted for emergency care were Medicaid-eligible.

Based on data from the National Nursing Home Survey conducted in 1985 by the National Center for Health Statistics (NCHS), 348,313 of the total 1,491,400 residents in nursing homes might be considered to have a mental disorder. This represents 23 percent of the total population in nursing homes. Of the mentally ill resident population, 104,800 had Medicaid as their primary source of payment—37 percent of persons under age sixty-five and 27 percent of persons age sixty-five and over.

Available services. The Medicaid benefit package for mental health services is broad. Coverage is divided into mandatory and optional services. General hospital inpatient care, physician services, outpatient services in general hospitals, emergency room services, and nursing home care are mandatory. Optional services include care by nonphysicians, freestanding outpatient clinics, case management, rehabilitation, and home health care. Mandatory services cover the basic mental health care needs of acutely ill patients and persons who need to be in a nursing home. Many of the optional services help patients with chronic impairments living in community settings.

One service that is particularly limited is care in so-called institutions for mental disease. These institutions have been defined primarily by the guideline known as the “50 percent rule.” If more than half of the residents of a facility with sixteen or more beds are mentally ill, the facility is classified as an institution for mental disease. This is the case for nursing
homes without exception. In 1982, the “50 percent rule” was clarified to state that residents with senile and presenile organic psychotic conditions were not to be counted against the 50 percent ceiling. An additional clarification, published in September 1986, stated that patients with organic brain syndrome should not be counted as mentally ill.

A state may choose to provide any of three levels of care for persons over age sixty-four in institutions for mental disease: inpatient hospital services, SNF services, and ICF services. For those under age twenty-two, states may provide SNF services and inpatient psychiatric services. As of 1986, thirty-three states had elected both the over-sixty-four and under-twenty-two options, an additional ten had elected the over-sixty-four option only, and two had elected only the under-twenty-two option. Small residential facilities, such as halfway houses, adult residential foster homes, and crisis centers, cannot qualify for Medicaid. The Medicaid program also specifically excludes payments to persons ages twenty-two to sixty-four in an institution for mental disease.

**Reimbursement policy.** Medicaid policy dictates that reimbursement be based on reasonable cost or charges and that freedom of choice for the beneficiary be preserved. Prior to 1981, Medicaid was a retrospective cost reimbursement system, whose unit of payment was the per diem. Providers who agreed to participate in Medicaid were required to accept Medicaid reimbursement as payment in full. To constrain cost increases, three changes have been made: first, the Omnibus Budget Reconciliation Act (OBRA) of 1981 allowed states to adopt alternative payment mechanisms for hospitals; second, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 encouraged the application of a prospective payment system for inpatient settings; third, OBRA 1983 enabled states to reimburse nursing homes on a prospective basis. Many other changes were introduced in these acts but need not be discussed here.

States are currently free to set payments for physician services at their discretion, so long as they are “adequate and reasonable.” For outpatient hospital and clinic reimbursement, states may use cost-based principles or alternative methods, such as fee schedules. The only specification provides that Medicaid payment for hospital outpatient services not exceed charges to Medicare. Below this ceiling, rates can be altered downward to reflect local conditions. Generally, there are different fees for emergency room care, specialized outpatient clinics, and primary care services.

**Major Problems In Medicaid’s Mental Health Care Component**

**Low enrollment of potential SSI eligibles.** Access is unnecessarily restricted in current state programs, because persons who are eligible for
Medicaid are not enrolled. For example, although there are estimated to be over a million chronically mentally ill adults living in noninstitutional settings, only about half that number are on the SSI and Social Security Disability Insurance (SSDI) rolls. States may choose not to extend eligibility to optional coverage groups, such as the categorically or medically needy. Furthermore, the enrollment process for SSI and Medicaid is bureaucratic and time-consuming for would-be beneficiaries and providers alike. The would-be beneficiary must negotiate the complex process of enrollment with little knowledge of procedures and with little assistance. This can be a serious obstacle to enrollment, especially for a chronically mentally ill person.

There is little incentive for private providers to take the time to help a patient to enroll in Medicaid. The time spent helping a patient apply for SSI may not be reimbursed, and there is a risk that, after having gone through the process, the person will not be eligible. If a person is already on SSI, however, private providers are somewhat more willing to enroll the person in Medicaid.

There is also usually little incentive for public-sector providers to enroll individuals in Medicaid. Many public providers are not eligible for Medicaid payment. For example, state mental hospitals are not covered for most adults, so they have no incentive to enroll admissions (except the over-sixty-four and under-twenty-two age groups). In addition, some community mental health centers or outpatient programs are deficit-funded, so their costs are covered, no matter how energetic they are about enrolling persons in Medicaid. Some deficit-funded programs, however, may still seek Medicaid payments to enrich their overall revenues.

**Restricted coverage of community treatment models.** Three factors restrict availability of appropriate services, such as case management and psychosocial rehabilitation, for Medicaid beneficiaries who need them. First, many states have not adopted Medicaid’s optional elements. Second, there are gaps in the range of services available under the optional services. Finally, eligible providers are reluctant to participate, due to low rates of reimbursement.

**Uneven adoption of optional benefits.** States have the option of not participating in Medicaid and of offering minimal or no optional benefits. For example, although most states offer optional services for beneficiaries over age sixty-four and under age twenty-two in institutions for mental disease and most offer outpatient services under the mental health clinic option, only nine offer case management services, and fourteen offer rehabilitation services for the mentally ill. Fearing uncontrolled expenditures, state Medicaid authorities are cautious about introducing new benefits. In addition, states may not perform a comprehen-
sive budget analysis to determine the overall impact of a change in Medicaid policy. For example, it may not be known if an increase in expenditures from an expansion of ambulatory benefits would be offset by a reduction in state mental hospital expenditures. Furthermore, the Medicaid office may have little incentive to be concerned about decreases in the mental health authority’s budget.

Uncovered services. Gaps exist in the range of services covered under the optional program. Some of the services needed by chronically impaired individuals, such as those who qualify for Medicaid through SSI disability, do not fit the standard definition of medical treatment services. For example, there is some controversy about whether psychosocial rehabilitation should be covered under Medicaid or by vocational rehabilitation programs instead. However, some gaps are clearly within Medicaid’s scope, and these could be addressed by expanding the benefit package.

Foremost among these is the restriction of clinical services to on-site locations. This prevents the reimbursement of clinical services by clinicians in mobile emergency programs and in intensive case management programs. Proponents argue that such programs could have a major impact on inpatient costs, perhaps offsetting their own costs through savings in inpatient utilization.

Low rates of reimbursement. The pricing of care and restrictions in the definition of services and providers affect the availability of appropriate services for the mentally ill Medicaid beneficiary. The Medicaid program, in general, sets rates lower than those paid by commercial and other third-party insurers. The rate for an inpatient day in a general hospital for psychiatric care is not too different from the standard hospital rate. (Day limits and other mechanisms are used to reduce costs.) The wide discretion that states have in setting outpatient rates, however, allows much lower payment for psychiatrists, specialty outpatient clinics, and community mental health centers, when compared to psychiatric outpatient and emergency room services provided in general hospitals. Most of such pricing is unrelated to actual costs. In fact, in many states, rates are below actual cost. Providers in Maryland report that Medicaid reimburses $40 for a service that costs a mental health center $60–$80 to provide.

The rate paid for specialty psychiatric services, when provided by physicians, is lower than that paid for general medical services in Medicaid, which, in turn, is lower than that of other payers. This results in lower participation rates for psychiatrists. Furthermore, other physicians generally do not wish to treat mentally ill patients, exacerbating the shortage in access to physician services.

Other pricing problems. Medicaid payment policy encourages the use
of general hospital services over other settings for care. Medicaid rates come closer to covering costs for inpatient care than for ambulatory care. Consequently, beneficiaries may be admitted to the hospital unnecessarily because appropriate outpatient services are unprofitable and unavailable. Furthermore, the differential rates paid for general hospital outpatient and emergency room mental health services, compared to those paid to private physicians, freestanding outpatient clinics, or mental health centers, may create an additional perverse incentive. Under such an incentive, lower-cost providers specializing in mental health care, such as community mental health centers, are unable to participate in Medicaid, or they affiliate with general hospitals to receive the higher Medicaid rate. Access may be limited, and unit costs to Medicaid are higher.

Several payment mechanisms have been employed to control inpatient costs in general hospitals. (Medicaid already excluded freestanding psychiatric hospitals from reimbursement for adults.) Prior to the introduction of the prospective payment system (PPS) using diagnosis-related groups (DRGs), the most common hospital payment system used “caps” or limits on the number of inpatient days allowable. Many states have caps on the number of days covered in general hospitals. Maryland, for example, restricts payment for 120 percent of the DRG average for Medicaid patients. Such restrictions result in more referrals or transfers to the state mental hospital system and more costly readmissions, and they probably contribute to the alleged reluctance of general hospitals to admit Medicaid patients expected to have a longer stay.

Many states now use some variant of a PPS/DRG system to restrict the use of general hospital psychiatric days. According to a recent Prospective Payment Assessment Commission (ProPAC) report, the most widespread type of Medicaid inpatient hospital reimbursement system (in use in twenty-one states) applies a tightly controlled prospective rate of increase to allowable base-year costs. The fastest-growing type (in seventeen states) uses prospective payment adjusted for case-mix, using the DRGs or some other patient classification. A third type, in use in four states, sets payment rates according to a negotiated agreement between the state and the hospitals or through competitive bidding.

The problems with the DRG system for psychiatric hospital care have been explored in depth. First, numerous studies have shown that the explanatory power of DRGs and other classification groups is weak, explaining only 5–10 percent of the variance in the cost of a psychiatric hospitalization. Second, DRG-based payments would create systematic profits or losses for different groups of facilities. Randall Ellis and Thomas McGuire suggest experience rating by groups of facilities as a possible way to solve this problem.
Restructuring Financial Incentives

Several attempts to better structure incentives for appropriate management of care have been proposed. Although they do not all directly address the problems identified in the previous section, they attempt to control costs by promoting more efficient use of Medicaid resources. Some of these policy options are within the Medicaid program; another option calls for the reorganization of local mental health services so that they might better use Medicaid (and other) resources. Their feasibility and effectiveness with mentally ill patients are discussed below.

“Soft match.” The “soft match” option uses state funds from the mental health authority budget as the Medicaid matching contribution for the state. (Each state must pay a fixed percentage of its Medicaid costs to receive “matching” funds from the federal government.) This mechanism permits the expansion of Medicaid benefits without approaching the legislature to appropriate additional funds. The use of the “soft match” has made the expansion of Medicaid benefits under some options attractive to states. Their hope is that introducing clinic and psychosocial rehabilitation services under Medicaid options will enable them to reduce expenditures currently supported by state mental health agencies’ budgets.

Not all states use the “soft match,” and few have furnished new state funds recently for expanded Medicaid services for mentally ill people. Advocates for expanded mental health benefits hope that states will make more widespread use of the “soft match.” They hope not only that using existing mental health funds will meet the Medicaid agency matching requirement, but also that state legislatures may use any state savings to fund additional mental health services.

Capitation. Capitation can only be used in Medicaid with a special waiver, assigning eligible persons to a health maintenance organization (HMO). Results from the RAND Health Insurance Experiment indicate that the pattern of care provided in HMOs for mentally ill patients is different from that received in a fee-for-service setting. The probability of receiving a mental health visit is higher, but the average number of visits, given use, is much lower. HMOs may be a cost-effective means for providing care for acutely ill patients but may underserve the chronically mentally ill.

Providing an identified, usual source of care for a mentally ill patient via assignment to an HMO would seem beneficial. Experience, though limited, has indicated other problems for the chronic patient in HMOs. Staff of HMOs are not geared to providing ongoing long-term care to the chronically mentally ill. They do not have the training needed to handle
the chronically mentally ill, and the disruption of the relationship of such a patient with a community mental health center, if there was one, is a difficult adjustment for the patient. HMOs usually do not provide the nonmedical day care services and psychosocial rehabilitation that the chronically mentally ill need. Experience in Wisconsin and Minnesota indicates that chronically mentally ill patients are gradually excluded from the HMO. The state therefore pays twice for the care of these persons, once when they join an HMO and again when they return to the public system.26

In 1989, a new Medicaid capitation demonstration was initiated in West Philadelphia under the auspices of the City Office of Mental Health and Mental Retardation. The demonstration, under investigation at the University of Pennsylvania, is an element of a larger project in Philadelphia, sponsored by The Robert Wood Johnson Foundation Program on Chronic Mental Illness.27

Primary care physician case management programs. Medicaid managed care programs provide medical service to a designated population. They are characterized by the following features: incentives focus on the primary care physician; freedom of choice of provider is limited; and service patterns are modified through changes in service delivery, often due to risk-sharing arrangements with providers.

These programs generate an overall savings of about 5 percent, but they do not have experience with the mentally ill.28 The body of research on the treatment and identification of mental illness by primary care physicians, however, would indicate that this is not a preferred option for the mentally ill Medicaid patient.29 The willingness of primary care physicians to take on chronically mentally ill patients is questionable, even if they were trained in case management for these patients. Further, the need to provide “off-site” services and to provide nonmedical services extends the case management role beyond the program scope of the Medicaid primary care physician case management structure, as currently defined. Fortunately, Medicaid recently has initiated the “targeted case management” option, which potentially comes much closer to meeting the needs of the chronically mentally ill patient. It allows services to be provided to selected beneficiaries where they live, rather than in mental health facilities.

Case management by mental health providers. Case management for the chronically mentally ill may assume a variety of forms, depending on the specific program objectives, treatment setting, and delivery system. Regardless of the model adopted, case management is generally thought to consist of five integrated functions: assessing patients’ needs, planning service strategies in response to identified needs, linking clients to appro-
appropriate services, monitoring clients’ progress to detect changing needs, and providing follow-up and ongoing evaluation of clients. Additional functions that may be performed by case managers include direct provision of services, including crisis intervention, case identification and outreach, and advocacy. Although Medicaid may cover the core functions, these additional functions are excluded from coverage in the guidelines for targeted case management. Under Medicaid, off-site provision of clinical care is allowable only for the homeless. This is unfortunate, because many providers and policymakers consider home care a critical element of patient management, responsible for savings in emergency room and hospital inpatient use.

Case management services probably are effective in breaking the cycle of hospital emergency room, outpatient department, unnecessary inpatient use. Studies support this assertion, however, only for persons at risk of repeat state psychiatric hospitalizations. Despite promises of benefits and cost savings, there are disincentives to the use of case management, including high “up-front” costs to implement comprehensive case management services, the time lag in reductions of Medicaid costs in general hospital settings, and the time lag in the occurrence of state psychiatric hospital savings. For these reasons, it has been difficult for state mental health authorities to sell case management to state Medicaid programs, and for both of these agencies to sell them to legislatures.

Local public mental health systems. Another possible solution for using Medicaid resources more effectively is to create a local public mental health system. Such systems resemble capitation programs but are program budgeted and generally encompass a much larger geographic area than an HMO encompasses. These programs are characterized by some or all of the following elements: (1) recentralization of the fiscal, administrative, and clinical control to a local county, city, or independent authority; (2) responsibility for all persons eligible for public programs in a defined geographic area; (3) responsibility for the full range of services required by this population, including general hospital inpatient care, state mental hospital system care, outpatient services, rehabilitation services, special residential housing needs, day treatment, and other related programs; (4) fiscal responsibility for the cost of state mental health care by its eligible population (no passthrough of these costs to the state hospital budget); (5) pooling of all funds (state mental health authority, Medicaid, and so on) to create a prospective annual budget; (6) authority to retain savings and reprogram such savings at the discretion of the system; (7) fiscal risk for budget overruns, although leniency is usually observed by the state mental health authority; and (8) authority to disperse funds by contract, grant, or direct provision of care, in
whatever mix is optimal for the local circumstances.

Such programs have been successful in maximizing the clinical appropriateness of the mix of services used by a population but need more evaluation to determine the cost savings and critical components necessary for implementation. Local public mental health systems are inherently difficult to implement, due to the magnitude of the reorganization of the existing system and to the legislative changes that sometimes are necessary to create them. For example, they may require a merger of the state mental hospital system budget, the community service system budget, and the mental health component of the state Medicaid budget.

Wisconsin has such a program statewide; Michigan has one in “full management board” counties; and Ohio has just passed legislation enabling the implementation of such a system. The Robert Wood Johnson Foundation Program on Chronic Mental Illness, under way in nine cities, incorporates many of the features of the local public mental health systems outlined above.

Summary And Recommendations

With the extreme pressure of cost containment in the past ten years, Medicaid is suffering from strong tensions between containing costs and promoting access. In mental health care, this tension is embodied in the conflict between the short-term interests of the state Medicaid authority (cost containment) and the overarching interest of the state mental health authority (access).

As a result, there are too few covered service benefits for nonhospital community providers. Yet, paradoxically, many of the cost containment efforts have been directed at this area, even though such services account for a minority of Medicaid mental health expenditures. These efforts are only partially successful at reducing community costs. They generally produce short-run savings, which do not build the groundwork for long-term savings and may exacerbate current system inefficiencies. Little effort is directed at the state mental hospital system, and efforts are just beginning to address the costs of nursing homes. Recent nursing home reform, mandating reviews of the appropriateness of care for the mentally ill in nursing homes, may result in simply shifting the cost of the mental health expenditures for nursing home care back to the state mental health authority.

From a programmatic point of view, the problems of using Medicaid to finance mental health care are multifaceted. First, much of the eligible SSI population is not enrolled. This exacerbates underuse by a population already prone to noncompliance with treatment. Also, access is
reduced. Providers are reluctant to participate in the program because of low reimbursement rates. For those providers who do participate, the rate structure encourages lower-quality care. Categorically funded public-sector budgets are stretched even thinner when they are used to subsidize care provided to Medicaid beneficiaries. Effective services are not covered (for example, off-site emergency care); covered services are unevenly available across states, because they are optional.

**Recommendations.** In addition to continuing demonstration programs, such as those discussed above, we recommend using Medicaid mental health resources more efficiently and flexibly to address the problems of eligibility, service coverage, and pricing.

Specific recommendations are: (1) Develop financial incentives for providers to serve as “treating sources” of information for adjudicating SSI claims, potentially increasing the number of people receiving SSI and becoming eligible for Medicaid benefits. (2) Expand the covered services to include “off-site” treatment services. (3) Encourage wider adoption of optional benefits. (4) Consider making case management a required service for certain targeted populations, such as mentally ill SSI beneficiaries. (5) Improve the fee structure to reduce perverse incentives and to improve the supply of providers willing to provide Medicaid services to the mentally ill poor. Improved fees may also improve the quality of care provided in some settings unable to serve the mentally ill appropriately, such as nursing homes. (6) Refocus cost containment efforts on inappropriate institutional care rather than on limits to acute care, especially care provided in community-based ambulatory settings.

It is important to encourage state mental health authorities and state Medicaid offices to view mental health expenditures as a common pool of valuable resources for the mentally ill. Medicaid could provide the incentives to states to accomplish this cooperation. Efforts must be directed at balancing the wish for improving access with the realities of limited resources. Although there are many problems with the use of Medicaid as a financing system for the care of the mentally ill, it currently represents a major resource for giving the poor and disabled access to services in both the private and the public sectors.

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NOTES

2. Ibid.
17. Ibid.
18. Jencks et al., “Bringing Excluded Psychiatric Facilities under the Medicare Prospective Payment System.”


23. Ibid.


26. Ibid.


35. Omnibus Budget Reconciliation Act (OBRA) of 1987, P.L. 100-203.