Nursing home reform and the mentally ill

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Prologue: New legislation targets Medicaid-funded nursing homes to improve the overall quality of care and provide more appropriate care for persons with mental illness. However, the 1987 Omnibus Budget Reconciliation Act also risks displacing the mentally ill from nursing homes with no other viable housing options. In this article, Marc Freiman, Bernard Arons, Howard Goldman, and Barbara Burns explore the national implications of these newly implemented reforms and estimate the number of mentally ill nursing home residents who might be displaced as a result. Freiman, a service fellow at the Agency for Health Care Policy and Research, holds a doctorate in economics from the University of Wisconsin at Madison. He was the project director for two National Institute of Mental Health (NIMH) studies to analyze Medicare reimbursement for psychiatric hospitalization. Goldman is director of the mental health policy center 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. He holds a joint medical/phd degree of public health degree from Harvard University and a doctorate in social welfare from the Heller School at Brandeis University. Arons is the director for mental health financing, Division of Applied and Services Research at NIMH. Formerly a medical director and physician at St. Elizabeth’s Hospital, he holds a medical degree from Case Western Reserve University. Burns is codirector of the psychiatric epidemiology and health services research program of the department of psychiatry at Duke University Medical Center. Burns, who was affiliated with NIMH’s Division of Biometry and Applied Sciences from 1978 to 1987, holds a doctorate in psychology from Boston College.
In the twenty-five years since the enactment of Medicaid, the joint federal/state medical assistance program for the poor, Medicaid has become the primary source of federal payment for nursing home care. Medicare, the federal program responsible for the health care of elderly and disabled Americans, does not cover long-term nursing home care. In 1987, legislative reform, in the form of the 1987 Omnibus Budget Reconciliation Act (OBRA 1987, P.L. 100-203), targeted nursing home care provided under Medicaid. One set of reform measures focuses on the mentally ill.

These provisions require preadmission screening of nursing home applicants, as well as annual review of nursing home residents, for mental illness and mental retardation. Nursing home placement for residents and applicants so identified may be considered inappropriate if an individual does not require nursing services. Individuals who remain in nursing homes but who also require active mental health treatment must be provided with these services, but largely at other than federal expense. More broadly speaking, OBRA 1987 requires a written plan of care based on an annual (or more frequent) assessment to address the “medical, nursing, and psychosocial needs of the resident,” with the requirement that the nursing facility must provide services and activities “to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”

Some of these provisions took effect 1 January 1989; the others were to take effect in 1990, or later if a state has received approval for an alternative disposition plan.

These nursing home provisions appear to be aimed at resolving the potential problem of thousands of mentally ill nursing home residents either who do not need this level of care or whose mental health needs are not being met (and possibly could never be met) in a nursing home. Some of these individuals may have been moved to nursing homes during the “deinstitutionalization” of the late 1960s and 1970s, when state mental hospitals were criticized for inadequate and overly restrictive treatment of the mentally ill. Financial incentives may also have contributed to shifts from state mental institutions to Medicaid-funded nursing homes. Recent concern over the poor quality of care for the mentally ill and retarded in nursing homes, coupled with federal concern that Medicaid pays for care that is properly the responsibility of state governments, has motivated policymakers to search for another remedy.

While there is anecdotal evidence of inappropriately placed mentally ill persons in nursing homes, there is only limited evidence in the scientific literature of the overall magnitude of this particular problem or of related characteristics of the nursing home population. In addition, while some states or localities have estimated the number of mentally ill
in nursing homes or the effects of some aspects of OBRA 1987, these estimates are incomplete and may be based on widely varying methodologies.\(^4\) Therefore, there is substantial uncertainty over the effects, costs, and implications of the new law for the nation as a whole.

Mental health professionals, hospital administrators, nursing home officials, advocates for the aged, state and federal government officials, and others are understandably concerned about the major changes in nursing home procedures. While agreeing that it is important to improve nursing home care, many have expressed concern over the elaborate procedures for screening and review and their potential effects. There is a fear that some mentally ill individuals will be turned out of nursing homes with no viable housing alternative.

This article explores the national implications of the provisions of OBRA 1987 nursing home reform that relate to the mentally ill. We cannot present precise estimates of the number of persons who might be affected by the detailed review and screening process, which involves state-level variation in its implementation. We can, however, provide some rough estimates of the sizes of groups who might potentially be moved from nursing homes. In the process, we estimate the number of mentally ill and retarded in nursing homes and their need for nursing services. We also draw out some less familiar financial and resource implications of the OBRA regulations.

**Implementation Of OBRA 1987**

Final regulations specifying how states are to implement the requirements of OBRA 1987 have not yet been promulgated by the Health Care Financing Administration (HCFA), although several drafts of proposed procedures have been issued (most recently, a Proposed Rule in the *Federal Register*, 23 March 1990).\(^5\) However, the law states that its provisions are to be carried out even without specific implementing regulations.

Some issues appear to be noncontroversial; others have led to intense exchanges and are even the subject of lawsuits. Perhaps most importantly, the law is being interpreted as applying to all residents of and applicants to Medicaid-certified nursing homes, including residents paying with private funds.

Under the proposed procedures, the federal minimum elements for state determinations are categorized into two levels. Level I determines those individuals who are suspected to have mental illness or mental retardation. Level II determines whether an individual found to have mental illness or retardation requires the nursing services provided in a
nursing home, and whether an individual requires “active” treatment for that illness that is most appropriately provided in an acute care setting. We discuss each of these levels of screening in turn.

**Determination of mental illness/mental retardation.** The Level I screen for mental illness or mental retardation includes all such diagnoses, even minor ones. States may determine that individuals with certain categories of mental illness need not be further screened, but attempts by HCFA to restrict initial screening to major mental illnesses were rejected by HCFA attorneys, who maintained that the law specifies that individuals with any mental illness diagnoses must initially be screened. Individuals found to have a primary diagnosis of Alzheimer’s disease or related dementias are excluded from the control of these regulations and are not required to undergo a Level II screening.

**Service determination criteria.** Individuals with mental illness (without a primary diagnosis of Alzheimer’s disease or related dementias) or mental retardation must then be screened in Level II with regard to needed service provision in two areas: nursing services and active mental health treatment. The following three categories describe the effects of these determinations, which are summarized in Exhibit 1.

(1) Persons who are found to need nursing services are considered appropriate for continued residence or placement in a nursing home. However, the subset of these persons who need active treatment for mental illness/mental retardation must also be provided with such services, but largely at other than federal expense. (2) Persons who are found to need neither nursing services nor active treatment are considered to be inappropriate for placement or continued residence in a Medicaid-certified nursing facility and should be placed in a less restrictive environment (for example, a board and care home). (3) Persons who do not need nursing services but are found to need “active treatment services” are also considered inappropriate for a nursing home. More appropriate locations for these individuals would include psychiatric hospitals, institutions for

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**Exhibit 1**

<table>
<thead>
<tr>
<th>Need active mental health treatment?</th>
<th>Need nursing services?</th>
<th>More than 30 months</th>
<th>Fewer than 30 months</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Stay</td>
<td>Stay</td>
<td>Move</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Choice</td>
<td>Stay</td>
<td>Move</td>
<td></td>
</tr>
</tbody>
</table>

*Time of residence in nursing home.*
mental disease, and intermediate care facilities for the mentally retarded. However, a person in this category who has lived in a nursing home for thirty months or more may choose to remain there, regardless of the determinations.

States were allowed to file and request approval for an alternative disposition plan, which allows them to postpone for several years both the transfer of persons found inappropriate for continued residence in a nursing home and the provision of active treatment to those individuals remaining in nursing homes who require it. Forty-six states requested and gained approval for such plans, which means that the impact of OBRA 1987 will continue to evolve for some years to come.

Simulating The Regulations

In our simulations of persons identified by several aspects of the OBRA 1987 regulations, we use data from the 1985 National Nursing Home Survey (NNHS). The NNHS contains data for a stratified random sample of 1,079 facilities. The sampling frame for this survey included all types of nursing and related care homes with three or more beds that routinely provide nursing and personal care services. Board and care homes and residential care facilities were excluded. The frame was also designed to exclude intermediate care facilities for the mentally retarded as well as institutions for mental disease, both of which are Medicaid designations, as well as any other facilities that deal primarily with the mentally ill or the mentally retarded. The current resident file of the NNHS contains a sample of 5,243 residents drawn from the responding facilities.

In our analysis, we focus on this current resident component of the survey, which allows us to analyze some aspects of the OBRA regulations for current nursing home residents. No component of the NNHS dealt directly with new admissions, so this survey is not well suited for analyzing OBRA impacts on prospective admissions. All of the results presented below are for Medicaid-certified facilities only. Our simulation basically follows the two-level process described earlier.

**Level I.** There are two sources of current diagnostic data on the NNHS: variables containing primary and secondary diagnoses, supplied from the patient’s chart by a member of the nursing staff familiar with the patient; and checklist variables containing the responses to direct questions about whether the resident had specific mental illness diagnoses. Preliminary analyses revealed that the checklist responses displayed a greater prevalence of mental illness conditions than did the diagnosis variables.

The regulations currently require Level I screening to identify all residents with any type of mental illness. Furthermore, the proposed rule
specifically states that extensive individualized evaluations must be performed for each resident or applicant with the more severe category of mental illness often referred to as psychoses.” However, the proposed rule allows states to construct lists of minor mental disorders that would categorically be assumed not to require active treatment. We therefore used two versions of a mental illness screen. Our “higher” estimate was derived by counting all residents who had any diagnosis (primary or secondary) of mental illness or for whom there was an affirmative response to any of the checklist questions concerning mental illness. Our “lower” estimate was derived from residents who had either a listed diagnosis or a positive checklist response for psychoses.

We created two estimates for the exclusion from review of persons with a primary diagnosis of dementia. The lower estimate was made solely on the basis of the primary current diagnosis variable. The higher estimate used either a primary current diagnosis of dementia or a positive response to the checklist question concerning whether the patient had “senile dementia/chronic brain syndrome.” This latter measure is most certainly an overestimate of the impact of this particular provision because the checklist question does not distinguish between primary and secondary diagnoses, yet only a primary diagnosis qualifies a resident for this exclusion.

The presence of mental retardation was determined by either a diagnosis of mental retardation or a positive response to the checklist question for this condition.

**Level II.** Using a two-stage process, based on clinical experience, we determined a need for nursing services. In the first stage, any resident with at least one of the following more severe limitations was considered to need nursing services: bedfast; chairfast; requiring assistance transferring out of bed; requiring assistance in caring for an ostomy or a catheter; difficulty controlling bladder or bowels; requiring assistance using the toilet; or fed totally by another person. In the second stage, two or more of the following types of limitations indicated need for nursing services: difficulty in seeing; difficulty in hearing; requiring assistance in bathing; requiring assistance in dressing; requiring assistance in eating; requiring help walking; or having an ostomy or a catheter.

Either set of criteria was sufficient to indicate a need for nursing services; it was not necessary to meet both. However, the two sets are highly correlated. For the entire NNHS population, we find 85.6 percent with a need for nursing services when both sets of criteria are required to be met. If we use just the second set, the figure is 83.6 percent.

We found the need for active treatment services to be the most problematic determination. Little data in the NNHS allow such deter-
There are indications of whether a resident currently receives therapy, but this represents at best only a subgroup of those who may need active treatment, in part because many facilities simply do not offer such services. Furthermore, the survey does not indicate what types of services are being provided. They may only involve, for example, a group session once a week—no the type of intensive treatment relevant to the regulations, which characterize active treatment as being at a level similar to that found in a psychiatric hospital. Some residents receiving less intensive forms of therapy in a nursing home might therefore not be found to need active treatment. The NNHS also includes indicators of disruptive behavior and psychopathology, but these are inconclusive as markers for the need for active treatment. Without specifying the intensity, persistence, or duration of these indicators, it is not possible to use them to distinguish individuals who require nursing home care from those who should be hospitalized or placed in some other form of active treatment.

Consequently, we did not attempt to distinguish between those who do and those who do not need active treatment for mental illness. The inability to simulate this aspect of the regulations is not as problematic as it might seem. Persons who need nursing services are allowed to remain, regardless of their need for mental health treatment. And those who do not need nursing services are required to be moved, unless they need active mental health treatment and choose to remain after having resided in the facility for thirty months. In other words, for many of these persons who do not need nursing services, alternative placement is required when a determination is made of the presence of mental illness. The further determination of whether they need active treatment is more relevant in these cases to where the person should be placed outside the nursing home.

We therefore assumed for the purpose of our estimates that all persons with mental illness who do not need nursing services would be candidates for placement elsewhere. This will clearly result in an overestimate of the number of persons who are potentially identified thus, but only by at most (as an upper bound) the size of the group in the lower left corner of Exhibit 1: those nursing home residents who do not need nursing services, do need active mental health treatment, and have been in the nursing home for thirty months or more.

We were able to measure the length of nursing home residence directly using date of interview and date of admission. Furthermore, we moved the date of admission back in time to the start of a prior admission to the nursing home, if the time between these two stays was spent in a hospital. However, this dimension is only relevant with respect to those who are determined to need active mental health treatment, which we do not
attempt to measure. Therefore, we present simple descriptive figures on the number of residents having lived in a nursing home for thirty months or more but do not use this characteristic in our simulations of the number of residents potentially identified for placement out of the nursing home.

Simulation Results

In total, 1.28 million people resided in Medicaid-certified nursing homes in 1985. Using the lower estimate of the prevalence of mental illness, we find that 28 percent of these residents would be identified as mentally ill or mentally retarded, while for the higher estimate, the figure is 51 percent (Exhibit 2). The range in the number of actual nursing home residents represented by these percentages is from 356,000 to 661,000.

Our lower estimate of dementia identifies 7.9 percent of all patients in Medicaid-certified facilities (102,000 residents) as having this diagnosis, while our higher estimate identifies 47.1 percent, or 604,000 residents. This large range no doubt reflects the fact that our higher estimate includes many residents with only a secondary diagnosis of dementia.

Level II screening must be performed on those persons found to have mental illness or mental retardation except for those mentally ill who also have a primary diagnosis of dementia. Using our higher and lower estimates of these two criteria simultaneously yields estimates of residents requiring Level II screening of between 217,000 and 626,000 (or 17 to 49 percent). This is a wide range, but even the lowest estimate of 217,000 persons indicates that a great many persons would require the full screening process. Some early data indicate that the added costs for states to conduct Level II screening for new admissions, beyond the costs of the state’s preexisting procedures, amount to several hundred dollars per

<table>
<thead>
<tr>
<th>Exhibit 2</th>
<th>Nursing Home Residents Identified Under Various Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of residents</td>
</tr>
<tr>
<td>Mental illness/retardation</td>
<td></td>
</tr>
<tr>
<td>Lower estimate</td>
<td>27.8% (.9)</td>
</tr>
<tr>
<td>Higher estimate</td>
<td>51.5 (1.0)</td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
</tr>
<tr>
<td>Lower estimate</td>
<td>7.9 (.5)</td>
</tr>
<tr>
<td>Higher estimate</td>
<td>47.1 (1.0)</td>
</tr>
<tr>
<td>Thirty months or more residence</td>
<td>42.6 (1.0)</td>
</tr>
<tr>
<td>Need for nursing services</td>
<td>90.4 (.6)</td>
</tr>
</tbody>
</table>

Note: Standard errors are in parentheses.
AAs percent of all residents in Medicaid-certified nursing homes (1,282,085 residents).
admission.\textsuperscript{7} If such a cost level also applies to screening persons already residing in nursing homes, this would imply total screening costs for current residents in the tens of millions of dollars.

Finally, 43 percent of all residents were in nursing homes for thirty months or longer, and fully 90 percent of all residents met our definition of need for nursing services. This high percentage needing nursing care is not surprising, given that states have regular review processes that evaluate the continuing need of residents for the services provided by nursing homes.

**Impact of screening.** We estimated the numbers of persons who would be identified, as a result of both levels of screening, as possibly needing alternative placement out of Medicaid-certified nursing homes (Exhibit 3). These results were obtained by evaluating each person on the NNHS data base according to the OBRA selection criteria and counting the number of persons who met all of the following conditions: they had mental illness or retardation, did not have a primary diagnosis of dementia, and did not need nursing services.

Using the higher and lower estimates for mental illness and the higher and lower estimates for dementia along with the nursing services criterion yields four possible combinations. The range of these four estimates of the number of residents possibly displaced from nursing homes is from 37,890 to 65,600. This range represents from 3.0 to 5.1 percent of the nursing home population in Medicaid-certified facilities. The higher of the two figures is something less than twice the lower, but both represent a small percentage of residents.

The fairly narrow percentage range for our estimate of the cumulative impact of the screening procedures might at first appear surprising, given the large magnitudes and ranges of the individual components as presented in Exhibit 2. However, each of the criteria (presence of mental

<table>
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<tr>
<th>Exhibit 3</th>
<th>Nursing Home Residents Identified For Possible Placement Out Of The Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection and exclusion criteria\textsuperscript{a}</td>
<td>Selection and exclusion criteria\textsuperscript{a}</td>
</tr>
<tr>
<td>Must have mental illness or retardation</td>
<td>Must have mental illness or retardation</td>
</tr>
<tr>
<td>Must not have primary diagnosis of dementia</td>
<td>Must not have primary diagnosis of dementia</td>
</tr>
<tr>
<td>Must not need nursing services</td>
<td>Must not need nursing services</td>
</tr>
<tr>
<td>Residents identified</td>
<td>residents identified</td>
</tr>
<tr>
<td>MI=lower\textsuperscript{b} OBS=higher</td>
<td>MI=lower\textsuperscript{b} OBS=lower</td>
</tr>
<tr>
<td>MI=higher\textsuperscript{b} OBS=higher</td>
<td>MI=higher\textsuperscript{b} OBS=lower</td>
</tr>
<tr>
<td>37,890</td>
<td>46,830</td>
</tr>
<tr>
<td>(3,690)</td>
<td>(4,510)</td>
</tr>
<tr>
<td>48,620</td>
<td>65,600</td>
</tr>
<tr>
<td>(4,760)</td>
<td>(5,610)</td>
</tr>
<tr>
<td>As percent of all residents</td>
<td>As percent of all residents</td>
</tr>
<tr>
<td>MI=lower\textsuperscript{b} OBS=higher</td>
<td>MI=lower\textsuperscript{b} OBS=lower</td>
</tr>
<tr>
<td>MI=higher\textsuperscript{b} OBS=higher</td>
<td>MI=higher\textsuperscript{b} OBS=lower</td>
</tr>
<tr>
<td>3.0%</td>
<td>3.7%</td>
</tr>
<tr>
<td>(0.3)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>3.8%</td>
<td>5.1%</td>
</tr>
<tr>
<td>(0.4)</td>
<td>(0.4)</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Figures shown also incorporate exclusion relating to need for nursing services. Standard errors are in parentheses.
\textsuperscript{b} MI = mental illness or retardation. OBS = organic brain syndrome (dementias and related conditions).
illness, presence of dementia, need for nursing services, and so on) has a multiplicative impact on the ultimate probability of a person’s being identified for alternative placement, and only seldom do residents possess some of the necessary characteristics for alternative placement (such as an absence of need for nursing services). Therefore, the cumulative impact of the several criteria (each of which serves to exclude from consideration a portion of the overall nursing home population) might reasonably be expected to result in a low probability that a resident will be required to leave a nursing home.

While this probability may be low, the total number of persons so identified may be large relative to the number of available slots in alternative types of facilities, especially in some states. For example, in 1986, there were only about 8,000 vacant beds in state and county mental hospitals. While this probability may be low, the total number of persons so identified may be large relative to the number of available slots in alternative types of facilities, especially in some states. For example, in 1986, there were only about 8,000 vacant beds in state and county mental hospitals. Furthermore, these vacant beds are not necessarily in those states where they would be most needed.

Implications Of The Legislation

We have presented four different estimates of the number of persons who might be eligible for placement out of nursing homes as a result of the OBRA regulations. However, we think it doubtful that in actual practice persons with less severe types of mental illness would be directed to leave nursing homes explicitly on the basis of the presence of such a condition, even though this is an implication of the law as it currently stands. We therefore attach greater weight to those estimates that use our lower measure of more severe mental illness. These estimates indicate that between approximately forty and fifty thousand nursing home residents, or between 3 and 4 percent, might be required to leave that setting.

Although the standard errors of our estimates from the 1985 NNHS are small, we in no way intend to convey the impression that we are presenting precise estimates of the implementation of OBRA 1987. Rather, we have taken most of the major dimensions of the screening criteria and simulated the number of nursing home residents who would be identified by these criteria on a national basis. The limitations of this effort must be noted. We cannot provide an estimate of the number of residents for whom active treatment in their nursing homes may be required. There is also expected to be variation in how states implement OBRA 1987. The use of alternative disposition plans may increase the magnitude of this variation, although the need to comply with the basic law will constrain its extent. In addition, but of lesser magnitude, changes in the nursing home population between 1985 and the present will also affect the accuracy of our estimates.
These estimates are for residents of nursing homes only. It would be particularly difficult to estimate the continuing resource costs of screening prospective residents, because as the enforcement and interpretation of the regulations become clearer, attempts to gain admission to nursing homes for the target population may be expected to decrease.

Nevertheless, our estimates make several important empirical points about the overall number of persons potentially identified for alternative placement, the magnitude of the screening process, and the implied costs of identifying the population that is the focus of the regulations. It is useful to place a discussion of these points within the context of recent mental health policy discussions published elsewhere. Analysts and critics have commented on the use of nursing homes as an alternative to the public mental hospital as a site for the long-term care of the elderly. The introduction of Medicaid in the mid-1960s facilitated the use of nursing homes for the care of the mentally ill, at a time when states sought to reduce the resident population of mental hospitals. This use of nursing homes during the period of deinstitutionalization has been decried as “transinstitutionalization,” simply moving people from one form of institutional neglect to another. Although some nursing homes are “community-based facilities,” they vary in quality, are difficult to monitor, and have had little experience in caring for the mentally ill. Furthermore, there are few financial incentives (and some regulatory disincentives) to provide specific care for residents with significant behavioral problems. The standard rate of reimbursement is too low to provide appropriate care to the mentally ill, and “active treatment” of mental disorders in a nursing home may lead a facility to be considered an “institution for mental disease,” making it ineligible for Medicaid reimbursement for residents between ages twenty-two and sixty-four.

Our results indicate that if screening is pursued according to the letter of the law, then under a broad range of assumptions almost all of those who undergo the screening process will be allowed to remain in the facility. In other words, the majority of mentally ill residents are appropriately placed with regard to nursing needs. If some of the more narrowly focused exclusions, such as those relating to residents of advanced years, are abused, then even fewer residents would be identified for placement in a less restrictive environment or one better able to provide specialized care. An implication of these findings may simply be that the magnitude of the problem that was the apparent motivation for the legislation may be less than initially imagined, at least in Medicaid-certified facilities.

Given that this result is in large part determined by a resident’s need for nursing services, we further examined this dimension. We made both
parts of a need for nursing services more restrictive, focusing more on explicit indications of a need for assistance. Specifically, we eliminated “chairfast” from the first group of limitations (where only one limitation is necessary), moved “difficulty controlling bladder or bowels” from the first to the second group (where at least two limitations are necessary), and eliminated “difficulty in seeing,” “difficulty in hearing,” and “requiring help walking” from the second group. As a result, the number of residents who did not need nursing services rose from 9.6 to 15.2 percent. Consequently, the numbers of residents potentially identified for placement out of nursing homes increased, but they still represented only a small percentage of all residents. For example, using our lower measures of both mental illness and dementia (which yielded one of our middle estimates), the number of residents identified for potential outplacement with these more restrictive nursing criteria increased from 46,800 to 63,400. As a percentage of all nursing home residents, this represents an increase of only 1.2 percentage points, from 3.7 to 4.9 percent. We therefore conclude that although the definition of need for nursing services is an important determinant of the ultimate number of residents who may need alternative placement, a tightening of this definition still leaves only a small percentage of residents potentially affected.

While the goals of the OBRA 1987 regulations may be laudable, it appears that the manner of implementation might not be cost-efficient. Substantial costs might be incurred in screening a large segment of the nursing home population to identify the relatively small percentage of residents who might require placement outside the nursing home. Unless the continued placement of the target group in a nursing home were considered particularly harmful, such broad screening might not be the best use of these funds. Modifications of the screening process or legislative changes in the definition of the target population to be screened would improve the cost-effectiveness of the proposed policies.

The regulations also indicate that those residents with mental illness or retardation must be reviewed at least once a year. If this aspect of the regulations is not modified, either a significant portion of these costs would recur every year, or the process would become rote and deprived of useful content.

The regulations require that state mental health agencies must delegate or contract the review process to an independent entity. This requirement was apparently intended to ensure an accurate and impartial determination. However, it may also result in the construction of an entirely new review apparatus whose effects will need to be monitored. Initial reports indicate that in some states the review process has been turned back over to the Medicaid review agencies. While such an approach uses existing
evaluation entities and is independent of the state mental health agency, it may, to a greater degree than planned, simply ratify the status quo.

**Impact on other federal programs.** On a broader scale, there may be implications for other federal health programs of the interpretation of the statute as applying to all residents of Medicaid-certified nursing homes, not just to those individuals covered by Medicaid. This component of the regulation has been a subject of proposed legislative changes, as well as legal action, that would restrict the law's coverage to only those residents specifically covered by Medicaid. In our analyses, we followed the intent of the law that it apply to all residents of Medicaid-certified facilities. If the law is changed to apply only to those residents actually covered by Medicaid, then our estimates of persons affected would be considerably lower.

While OBRA 1987 seeks to identify mentally ill and retarded residents of nursing homes and determine whether they are inappropriately placed, it does not directly address the underlying problem of providing adequate long-term care for this population. The regulations do provide some regulatory assistance by improving the requirements for psychiatric and psychosocial care in the conditions of participation for Medicaid nursing homes. They also suggest that optional services in state Medicaid plans could be used to cover some components of an active treatment program. However, for the most part, they do not provide financial incentives to deliver this care. Existing regulations actually provide disincentives for nursing homes to engage in intensive treatment (such as that provided in an inpatient setting) for mental illness. This may result in a Catch-22 for mentally ill residents who need active treatment, have been residents for longer than thirty months, and wish to remain in the nursing home. The state is obligated to provide active treatment, and Medicaid will (for the most part) not pay for the care. This combination of circumstances may well obligate other federal, state, or private payers to provide coverage for this treatment.

OBRA 1987 mandates an elaborate screening process to determine who among the mentally ill should be retained in nursing homes, which have little incentive to keep them, and who should be removed, without regard to the availability of alternatives. It may be difficult to find adequate alternatives for those who have psychiatric problems but who are found to be inappropriately placed in a nursing home. Many will simply be sent to the acute and long-term care units of public mental hospitals. Others will go to board and care homes, single-room occupancy hotels, or the streets. For some the move may be an improvement; for others it will be an unnecessary, and perhaps harmful, relocation. Efforts at identifying the mentally ill in nursing homes, such as those embodied
in OBRA 1987, would be enhanced by increased focus on the fundamental problem of financing the long-term care of the mentally ill.

The views expressed in this paper are those of the authors, and no official endorsement by the Department of Health and Human Services, the Agency for Health Care Policy and Research, or the National Institute of Mental Health is intended or should be inferred.

NOTES

1. Social Security Act, par. 1919(b)(3) and (4).
6. Ibid., 10966.
8. Unpublished provisional estimates, Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health, based on the 1986 Inventory of Mental Health Organizations and General Hospital Mental Health Services. These estimates indicate that for state and county mental hospitals, beds “set-up and staffed” were 119,033, and the number of inpatients at the end of the reporting year was 111,135.
9. E.L. Cicchinelli et al., A Review and Analysis of Factors Influencing the Deinstitutionalization of the Mentally Ill (Final contract report for the National Center for Health Services Research, Denver Research Institute, University of Denver, 1981); N.D. Dittmar and J.L. Franklin, “State Hospital Patients Discharged to Nursing Homes: Are Hospitals Dumping Their More Difficult Patients” Hospital and Community Psychiatry 31(1980): 251-254; Burns et al., “Mental Disorder among Nursing Home Patients;” Goldman et al., “Chronic Mental Patients in Nursing Homes;” and Talbott, “Nursing Homes Are Not the Answer.”