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How Should We Address Warehousing Persons With Serious Mental Illness in Nursing Homes?

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Abstract

Despite long-standing efforts to keep patients with serious mental illness (SMI) out of nursing homes, many persons with schizophrenia, bipolar disorder, or psychoses become long-stay nursing home residents. This article discusses why this trend is inappropriate clinically and ethically and suggests how to reform federal review requirements to accomplish 2 goals: to better identify people with SMI at risk of nursing home placement and to support them to live in the community.

Patients With Serious Mental Illness in Nursing Homes

The proportion of nursing home residents with a serious mental illness (SMI) has risen dramatically over the last 2 decades.[1,2] In 2019, 1 in 5 long-stay nursing home residents had a diagnosis of bipolar disorder, schizophrenia, or another psychotic disorder.[3] Although hospital discharges to nursing homes are usually intended for short-term post-acute care, they frequently turn into long-stay placements.[4] Much like the criminal justice system, nursing homes have become an unwitting mental health provider—and not a very good one. This article examines factors that result in nursing home placement of persons with SMI and offers policy change recommendations.

Preadmission Screening

In 1987, widespread concern over the warehousing of people with SMI and people with intellectual disability (ID) in nursing homes prompted Congress to establish the Preadmission Screening and Resident Review (PASRR) process. As part of this process, facilities and hospital discharge planners are required to screen for both SMI and ID, then refer those so identified to a state agency. The state must then assess the appropriateness of nursing home placement and, when necessary, provide specialized services for diversion to a different setting.[5]

Nevertheless, the proportion of nursing home residents with SMI continues to grow.[1,2] Although the Centers for Medicare and Medicaid Services (CMS) has recently indicated that a portion of nursing home schizophrenia diagnoses are potentially erroneous,[6] prior work relying on preadmission schizophrenia diagnoses shows that middle-aged persons with SMI are still significantly more likely to enter nursing homes than their peers

without mental illness.[7] State PASRR programs have struggled to fulfill their obligations owing to unclear expectations, inconsistent enforcement, and insufficient community services.[8,9] According to the Bazelon Center for Mental Health Law, "the PASRR process in most states diverts a very small number of people from nursing home placement and instead functions to screen them *in* rather than *out* of nursing facilities."[10]

The PASRR requirement also suffers from a serious loophole: admissions for post-acute care that are anticipated to take less than 30 days are exempted.[11] Although evaluation is required if residents are later found to require a longer stay, return-to-community efforts are less likely to be successful the longer a resident has been institutionalized,[12] owing to disruptions in housing, natural supports, and community-based services. Prior research suggests that this exemption plays a role in the nursing home placement of many long-stay residents with SMI.[13] Concerningly, a February 2020 CMS proposal would expand PASRR exemptions to permit emergency, respite, and convalescent new admissions and all readmissions to enter a nursing home without receiving an evaluation as to the suitability of such placement.[14]

Although new admissions with SMI are less likely to have significant physical support needs, they are at greater risk of long-stay conversion than other new residents. One study found that approximately half (51%) of new admissions with SMI convert to long-stay status as compared to only 35% of persons without SMI.[4] Nursing homes have become a new way for people with SMI to be warehoused, serving as a setting to which hospitals can discharge individuals who no longer need acute care but who lack adequate supports in the community.

Ethical Obligations

Given the high risk that patients with SMI will experience long-term institutionalization if they enter a nursing home for post-acute care purposes, physicians and hospital systems should do everything in their power to avoid such discharges, as nursing home placement is generally inappropriate for persons with SMI. Nursing homes are ill equipped to provide mental health services.[15] Moreover, facilities with lower-quality rankings, which struggle to attract residents with greater ability to "shop around,"[16] have significant financial incentives to retain persons with SMI longer than they might strictly require, leading to greater risk of long-term institutionalization.

When planning the post-acute care needs of persons with SMI, clinicians and organizations should be frank about the risks of nursing home care. They should clearly state that admissions intended to be short-term frequently extend indefinitely and highlight other risks, including chemical restraint,[17,18] infectious disease (including COVID-19),[19] lack of expertise,[15] and the absence of meaningful treatment options. These risks are present across nursing home settings but may be exacerbated for persons with SMI, who are more likely to enter lower-quality facilities (as are Black Americans, people with low incomes, people with disabilities under age 65, and higher-acuity admissions).[3,20,21]

When patients with SMI have stable housing or family support, a suitable home health agency option for post-acute care services should be identified. Even when patients are homeless, other options may exist. Hospital discharge staff should build relationships with providers of intensive community mental health services and Medicaid home- and community-based services (HCBS). Such provider networks are often unfamiliar to clinicians and hospital personnel, as they usually do not provide post-acute care but

instead focus on the long-term services and support needs of persons with SMI. For persons with SMI, however, nursing home placement rather than discharge to the community often results from such ongoing support requirements.

Given that 81.6% of long-stay nursing home residents under age 65 are between the ages of 50 and 64,[3] clinicians might also give serious consideration to the Program of All-Inclusive Care for the Elderly (PACE), which receives capitated payments from Medicare and Medicaid to provide comprehensive services to persons over age 55 eligible for nursing home placement but living in the community.[22] According to the National Program of All-Inclusive Care for the Elderly (PACE) Association, an industry group, over 40% of PACE participants have a mental illness.[22] However, some caution is warranted. While more integrated than a nursing facility, PACE programs have historically relied on a center-based model for the delivery of day services and are not under the same requirements as Medicaid HCBS providers to facilitate service-recipients' integration into the broader community.[23]

Hospital systems should also seek to incorporate the needs of persons with SMI in alternative payment models. Recent work has found that accountable care organization participation is associated with significant reductions in both hospitalization and post-acute care utilization for persons with SMI without reducing mental health spending.[24]

Reform

Given persons with SMI's high risk of converting from post-acute to long-stay nursing home placement, Congress should repeal the present PASRR exemption for post-acute admissions. Rather than weaken PASRR through additional exemptions, federal regulators should look for opportunities to strengthen the program, including through auditing state practices.

In addition, reform is necessary to expand the availability of community-based alternatives to nursing home placement to enhance efforts at diversion. States should expand funding for community-based services, such as assertive community treatment and caregiver respite. One of the primary financing vehicles available to states is the Medicaid HCBS waiver, authorized by Section 1915(c) of the Social Security Act, which supports community services in lieu of institutionalization.[25] However, such waivers include a cost-neutrality requirement, indicating that states may not spend more on average for community services than they would have on institutional care for the same population.[3,25,26] Moreover, under the Medicaid Institutions for Mental Diseases (IMD) exclusion, states are usually not permitted to use Medicaid dollars to pay for placing working-age adults in an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.[27] To be clear, clinicians and policy makers should not look to IMD as an alternative to nursing home placement for people with SMI. But the requirements of the 1915(c) waiver and the IMD exclusion interact to create a serious challenge for funding community-based mental health supports, as states may not count avoided IMD expenses as cost savings that can be reinvested in 1915(c) waiver services.[3,25,26] This practice is particularly unfortunate, given evidence that HCBS can successfully divert people with SMI from institutionalization.[28]

Although some have proposed repealing the IMD exclusion altogether,[29] doing so would be ill-advised, as it would open the door to warehousing of persons with SMI in mental institutions and consume resources that could be invested in more appropriate

community supports.[27] Instead, Congress and CMS should clarify Section 1915(c) cost-neutrality rules to make it easier for states to fund HCBS for people with SMI.

CMS also possesses substantial authority to issue demonstration waivers to states, thereby allowing them to experiment with services that would typically violate Medicaid law. The agency should indicate its willingness to issue such waivers to permit states to pay for rental assistance for targeted populations at risk of institutionalization, such as persons with SMI. Although typically not permitted under Medicaid, funding housing could substantially reduce nursing home placement, offsetting its costs.[30] Such housing investments should follow the well-validated Housing First model by prioritizing the placement of persons with SMI in independent housing without requiring them to adhere to therapeutic or service requirements to maintain their residence.[31,32,33,34,35]

Conclusion

People with SMI have significant ongoing support needs that are best met with community support. The growing role of the nursing home industry as a mental health provider should concern both clinicians and policy makers. Both individual clinicians and hospital systems have an ethical obligation to work to divert persons with SMI from nursing home placement, including via discharges for post-acute care. At the same time, hospital systems and policy makers should work collaboratively to build more effective infrastructure for supporting persons with SMI in community-based settings.

References

1. Hua CL, Cornell PY, Zimmerman S, Winfree J, Thomas KS. Trends in serious mental illness in US assisted living compared to nursing homes and the community: 2007-2017. *Am J Geriatr Psychiatry*. 2021;29(5):434-444.
2. Laws MB, Beeman A, Haigh S, Wilson IB, Shield RR. Prevalence of serious mental illness and under 65 population in nursing homes continues to grow. *J Am Med Dir Assoc*. 2022;23(7):1262-1263.
3. Ne'eman A, Stein M, Grabowski DC. Nursing home residents younger than age sixty-five are unique and would benefit from targeted policy making: study examines policies that could benefit nursing home residents younger than sixty-five. *Health Aff (Millwood)*. 2022;41(10):1449-1459.
4. Aschbrenner K, Grabowski DC, Cai S, Bartels SJ, Mor V. Nursing home admissions and long-stay conversions among persons with and without serious mental illness. *J Aging Soc Policy*. 2011;23(3):286-304.
5. Preadmission Screening and Resident Review. Medicaid.gov. Accessed July 5, 2023. https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html
6. Wright DR; Quality, Safety and Oversight Group. Updates to the Nursing Home Care Compare website and Five Star Quality Rating System: adjusting quality measure ratings based on erroneous schizophrenia coding, and posting citations under dispute. Centers for Medicare and Medicaid Services; 2023. Accessed June 23, 2023. https://www.cms.gov/files/document/qso-23-05-nh-adjusting-quality-measure-ratings-based-erroneous-schizophrenia-coding-and-posting.pdf
7. Andrews AO, Bartels SJ, Xie H, Peacock WJ. Increased risk of nursing home admission among middle aged and older adults with schizophrenia. *Am J Geriatr Psychiatry*. 2009;17(8):697-705.

8. Barooah A, Nadash P. Admission and care of individuals with mental illness in Massachusetts nursing homes: an exploratory study. *J Appl Gerontol*. 2023;42(2):252-258.
9. Bucy T, Moeller K, Skarphol T, et al. Serious mental illness in nursing homes: stakeholder perspectives on the federal preadmission screening program. *J Aging Soc Policy*. 2022;34(5):769-787.
10. Mathis J. Comments on proposed rule: Preadmission Screening and Resident Review, file code CMS-2418-P, RIN 0938–AT95. Bazelon Center for Mental Health Law. May 20, 2020. Accessed January 26, 2023. https://downloads.regulations.gov/CMS-2020-0015-0270/attachment_1.pdf
11. Basic Rule. 42 CFR §483.106(b)(2) (2023).
12. Hass Z, Woodhouse M, Kane R, Arling G. Modeling community discharge of Medicaid nursing home residents: implications for money follows the person. *Health Serv Res*. 2018;53(suppl 1):2787-2802.
13. Grabowski DC, Aschbrenner KA, Feng Z, Mor V. Mental illness in nursing homes: variations across states. *Health Aff (Millwood)*. 2009;28(3):689-700.
14. Medicaid Program; Preadmission Screening and Resident Review. *Fed Regist*. 2020;85(34):9990-10028.
15. Gammonley D, Wang X, Simons K, Smith KM, Bern-Klug M. Serious mental illness in nursing homes: roles and perceived competence of social services directors. *J Gerontol Soc Work.* 2021;64(7):721-739.
16. Perraillon MC, Konetzka RT, He D, Werner RM. Consumer response to composite ratings of nursing home quality. *Am J Health Econ*. 2019;5(2):165-190.
17. Molinari VA, Chiriboga DA, Branch LG, et al. Reasons for psychiatric medication prescription for new nursing home residents. *Aging Ment Health*. 2011;15(7):904-912.
18. Thomas K, Gebeloff R, Silver-Greenberg J. Phony diagnoses hide high rates of drugging at nursing homes. *New York Times*. September 11, 2021. Accessed January 20, 2023. https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html
19. Ouslander JG, Grabowski DC. COVID-19 in nursing homes: calming the perfect storm. *J Am Geriatr Soc.* 2020;68(10):2153-2162.
20. Hugunin J, Chen Q, Baek J, Clark RE, Lapane KL, Ulbricht CM. Quality of nursing homes admitting working-age adults with serious mental illness. *Psychiatr Serv*. 2022;73(7):745-751.
21. Cai S, Yan D, Wang S, Temkin-Greener H. Quality of nursing homes among ADRD residents newly admitted from the community: does race matter? *J Am Med Dir Assoc*. 2023;24(5):712-717.
22. Kelly L, Archibald N, Herr A. Serving adults with serious mental illness in the Program of All-Inclusive Care for the Elderly: promising practices. Center for Health Care Strategies. September 2018. Accessed April 10, 2023. https://www.chcs.org/resource/serving-adults-with-serious-mental-illness-in-the-program-of-all-inclusive-care-for-the-elderly-promising-practices/
23. Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE); final rule. *Fed Regist*. 2019;84(106):25610-25677.
24. Figueroa JF, Phelan J, Newton H, Orav EJ, Meara ER. ACO participation associated with decreased spending for Medicare beneficiaries with serious mental illness. *Health Aff (Millwood)*. 2022;41(8):1182-1190.
25. Disabled and Elderly Health Programs Group. *Application for a §1915(c) Home and Community-Based Waiver [version 3.6, January 2019]: Instructions, Technical Guide, and Review Criteria*. Centers for Medicare and Medicaid

Services; 2019. Accessed April 10, 2023. https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf
26. Andrews C, Grogan CM, Brennan M, Pollack HA. Lessons from Medicaid's divergent paths on mental health and addiction services. *Health Aff (Millwood).* 2015;34(7):1131-1138.
27. Mathis J. Medicaid's institutions for mental diseases (IMD) exclusion rule: a policy debate—argument to retain the IMD rule. *Psychiatr Serv*. 2019;70(1):4-6.
28. Urdapilleta O, Kim G, Wang Y, et al. National evaluation of the Medicaid demonstration waiver home- and community-based alternatives to psychiatric residential treatment facilities. IMPAQ International; 2012. Accessed June 22, 2023. https://nwi.pdx.edu/pdf/nationalevaluationPRTF.pdf
29. Glickman A, Sisti DA. Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: a policy debate—argument to repeal the IMD rule. *Psychiatr Serv*. 2019;70(1):7-10.
30. Mathis J. Housing is mental health care: a call for Medicaid demonstration waivers covering housing. *Psychiatr Serv*. 2021;72(8):880-884.
31. Richter D, Hoffmann H. Independent housing and support for people with severe mental illness: systematic review. *Acta Psychiatr Scand*. 2017;136(3):269-279.
32. Richter D, Hoffmann H. Preference for independent housing of persons with mental disorders: systematic review and meta-analysis. *Adm Policy Ment Health*. 2017;44:817-823.
33. Loubière S, Lemoine C, Boucekine M, et al; French Housing First Study Group. Housing First for homeless people with severe mental illness: extended 4-year follow-up and analysis of recovery and housing stability from the randomized *Un Chez Soi d'Abord* trial. *Epidemiol Psychiatr Sci*. 2022;31:e14.
34. Panadero S, Vázquez JJ. Victimization and discrimination: forgotten variables in evaluating the results of the "housing first" model for persons experiencing homelessness. *J Soc Distress Homelessness*. Published online December 21, 2022.
35. Aubry T, Goering P, Veldhuizen S, et al. A multiple-city RCT of housing first with assertive community treatment for homeless Canadians with serious mental illness. *Psychiatr Serv*. 2016;67(3):275-281.

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