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Fact Sheet for the Honorable
Daniel K. Inouye, U.S. Senate

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MEDICAID

Views on Changes Needed in Mental Health Benefits

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GAO

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The Honorable Daniel K. Inouye
United States Senate

Dear Senator Inouye:

In response to your request in the Senate Report on the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 1986 (S. Rep. 99-151), we have obtained information on mental health services available to Medicaid recipients. As agreed with your office, we

-- identified the services available to mentally ill Medicaid recipients and

-- solicited the views of Medicaid and mental health directors on changes in federal laws, regulations, or procedures needed to improve the delivery of mental health services to Medicaid recipients.

To solicit views, we sent a questionnaire to state Medicaid and mental health directors in the 50 states and the District of Columbia. We received responses from state Medicaid directors in 49 states and the District of Columbia (Pennsylvania did not respond) and from state mental health directors in 45 states and the District of Columbia (Arkansas, Illinois, Kansas, New Mexico, and Pennsylvania did not respond).

This report summarizes changes state officials believe could improve delivery of mental health services. We did not attempt to evaluate the relative merits of the proposed changes, their costs, or the effects such changes would have on the ability of states to meet the health care needs of other Medicaid beneficiaries. A separate report will describe mental health services provided in the 50 states.

The state directors most frequently expressed concerns about the

-- exclusion of Medicaid coverage for services provided to people aged 22 to 64 in institutions for mental diseases (IMDs), that is, psychiatric hospitals or other facilities for the mentally ill;

-- limited coverage of home and community-based mental health services;

-- administrative requirements for the Medicaid waiver programs;

-- administration of the Medicaid program; and

-- strict income and asset limits for Medicaid eligibility.

Medicaid officials from 19 states and mental health officials from 16 states proposed that Medicaid provide coverage to those aged 22 to 64 in IMDs. The current coverage includes mental health care to the mentally ill of all ages who are in general hospitals--facilities that are not primarily engaged in treating mentally ill patients. Each state has the option of providing Medicaid coverage to (1) those over 64 years of age in IMDs and (2) those 21 years of age and under in IMDs if the mental health services are medically supervised and the facility is an accredited psychiatric facility. The Medicaid law does not authorize coverage of mental health services provided in IMDs to those 22 to 64 years old (see p. 10).

Medicaid officials from 12 states and mental health officials from 17 states proposed increased Medicaid coverage of home and community-based services. These services can include homemaker and home health aides, personal care, adult day care, respite care, day treatment or other partial hospitalization, and psychosocial rehabilitation (see fn. 4). The Omnibus Budget Reconciliation Act of 1981 permits states to offer an array of these services if a person needs them in order to avoid institutionalization; to do so, however, states must obtain a waiver of statutory requirements from the Secretary of Health and Human Services.

To allow an alternative to institutionalization, other officials proposed more overall flexibility to provide additional mental health services in the home and community. Still others proposed Medicaid reimbursement for specific types of services or settings including (1) residential treatment settings, (2) psychosocial rehabilitation services, and (3) clinic services in settings other than clinic facilities (see p. 11).

Medicaid officials of 7 states and mental health officials of 18 states commented on the administration of Medicaid waiver programs. Under the 1981 act, the Secretary of Health and

Human Services may grant "freedom of choice" waivers and "home and community-based services" waivers, both intended to help contain Medicaid costs. According to some state officials, the process of applying for and carrying out these waivers is cumbersome. Officials of several states proposed that (1) waiver requirements be eliminated and (2) each state have the option of providing services now only permitted under a waiver. Other officials proposed altering the requirement that home and community-based services programs be cost effective and not increase per capita expenditures (see p. 15).

Overall administration of the Medicaid program was addressed by Medicaid officials from 6 states and mental health officials from 14 states. The concerns included (1) lack of consistency in interpreting Medicaid laws and applying regulations, (2) problems with the process for issuing regulations and providing guidance, and (3) the lack of guidance concerning the definition of certain mental health services (see p. 19).

Medicaid officials from 5 states and mental health officials from 12 states called for less stringent eligibility requirements to make it easier for the mentally ill to be designated as disabled and meet income and asset limitations. States must provide Medicaid coverage to the "categorically needy," those receiving federally administered Supplemental Security Income (with certain exceptions) or state-administered (and federally supported) Aid to Families With Dependent Children. In addition, each state can have the option of extending Medicaid coverage to the "medically needy"--those who (1) meet all criteria for categorically needy assistance with the exception of income and (2) have incurred relatively large medical bills. Mentally ill recipients who become employed face potential loss of Medicaid benefits if their income exceeds the limitations established by the state, according to officials from five states. Other officials said that it is too difficult for the mentally ill to be certified as disabled under the Supplemental Security Income program if they are able to work, thus making them ineligible for Medicaid (see p. 22).

We obtained comments on the technical accuracy of matters discussed in this report from responsible program-level officials of the Health Care Financing Administration. Their comments have been incorporated where appropriate.

Copies of this report are being sent to the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Senate Committee on Appropriations; the Secretary of Health and Human Services; the state Medicaid and mental health directors; congressional committees with oversight responsibility for the Medicaid program; and other interested parties.

Sincerely yours,

Michael Zimmerman

Michael Zimmerman
Senior Associate Director

Contents

ABBREVIATIONS

AFDC	Aid to Families With Dependent Children
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
GAO	General Accounting Office
IMD	institution for mental diseases
SSI	Supplemental Security Income

VIEWS ON CHANGES NEEDED IN MENTAL HEALTH BENEFITS

INTRODUCTION

Medicaid, authorized under title XIX of the Social Security Act, is a federally aided, state-administered medical assistance program for low-income people. Generally, those receiving cash assistance under the Aid to Families With Dependent Children (AFDC) or Supplemental Security Income (SSI) programs are eligible for Medicaid assistance. In addition, each state has the option of providing Medicaid benefits to those who cannot afford needed health care, but have income above the maximum allowable for public assistance.

Medicaid coverage of mental health services is available through a variety of mandatory and optional services financed under title XIX. Generally, services for the mentally ill must be available to recipients on the same basis as for recipients of all other title XIX services. Title XIX, however, specifically excludes federal reimbursement for the care of the mentally ill aged 22 to 64 in institutions for mental diseases (IMDs), which are defined in Medicaid regulations as institutions primarily engaged in providing diagnosis, treatment, or care (which includes medical attention, nursing care, and related services) for people with mental diseases. A state has the option of providing institutional care for the mentally ill who are 21 years of age and under or over 64 years of age.

Each state is allowed to set use and dollar limitations on the amount, duration, and scope of Medicaid coverage. Each state also has the option of covering or not covering certain mental health services. As a result, each state has considerable flexibility in establishing the nature and extent of mental health services available to Medicaid recipients.

The Department of Health and Human Services (HHS) has overall responsibility at the federal level for administering Medicaid. Within HHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations. Depending on a state's per capita income, the federal share of a state's Medicaid costs for health services in fiscal year 1987 ranged from 50.0 to 78.5 percent. Although all states participate in Medicaid, Arizona is operating an alternative program and has received waivers of some federal requirements.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Senate Report on the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation

Bill, 1986 (S. Rept. 99-151, Oct. 4, 1985), included a request from Senator Daniel Inouye that we study mental health coverage under Medicaid. In subsequent meetings with the Senator's office, we agreed to

-- identify the services available to mentally ill Medicaid recipients and

-- solicit views of Medicaid and mental health directors on changes in federal laws, regulations, or procedures they believed would improve the delivery of mental health services to Medicaid recipients.

To solicit views, we wrote to the state Medicaid and mental health directors in December 1986, asking them the following question: What changes to federal Medicaid law, regulations, policies, and procedures would improve the delivery of mental health services? In responding to this question, the directors were asked to identify problems or concerns and to propose solutions to the issues raised. The directors were also asked to present comments in their own words on any matter within the scope of the question; the directors were not restricted as to the number of specific comments or asked to weigh the costs versus benefits of the proposed solutions. Responses were received from 50 Medicaid and 46 mental health directors during the period December 1986 through April 1987.[1]

From program-level officials of HCFA, we obtained oral and, in some instances, written comments on the technical accuracy of the Medicaid and mental health directors' comments. Their comments have been incorporated where appropriate.

We have presented the views of the state directors without attempting to evaluate relative merits, costs, or the effects such views would have on the ability of the states to meet the health care needs of Medicaid beneficiaries other than the mentally ill.

To identify the services available to mentally ill Medicaid recipients, a questionnaire was sent only to Medicaid directors. A subsequent report will summarize their responses.

Our work was done between September 1986 and October 1987 and conforms with generally accepted government auditing standards.

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[1]Mental health authorities in Arkansas, Illinois, Kansas, New Mexico, and Pennsylvania, as well as the Medicaid authority in Pennsylvania, did not respond.

STATE DIRECTORS' CONCERNS

State Medicaid and mental health directors most frequently suggested changes in (1) Medicaid coverage of inpatient mental health services for those between the ages of 22 and 64 and home and community-based services for beneficiaries of all ages and (2) HCFA's administration of the waiver and other aspects of the Medicaid program (see table 1).

Table 1:

Summary of State Directors' Comments

Change suggested in	Comments: Medicaid directors	Comments: Mental health directors	States[a]	States with comments (in percent)
Inpatient coverage for people aged 22-64 in facilities for the mentally ill	19	16	25	50
Increased coverage of home and community-based services	12	17	23	46
Administration of Medicaid waiver programs	8	18	20	40
HCFA's administration of the Medicaid program	6	14	16	32
Eligibility requirements	5	12	13	26
Utilization control regulations and requirements	5	6	9	18
IMD definition	5	5	8	16
Amount of federal financial assistance	4	5	6	12
Requirement that clinic services be under physician direction	4	3	6	12

[a]A state is considered to have comments if the Medicaid or mental health directors made a response about a particular change.

The following sections summarize the state directors' comments.

PROVIDE COVERAGE FOR PEOPLE AGED 22 TO 64 IN IMDs

Medicaid officials from 19 states and mental health officials from 16 states proposed that Medicaid provide coverage for those aged 22 to 64 in IMDs. Medicaid covers mental health care to the mentally ill of all ages in general hospitals, facilities not primarily engaged in treating mentally ill patients. Each state has the option of providing Medicaid coverage to those over 64 years of age in IMDs. Each state may also cover those 21 years of age and under in IMDs if the mental health services are medically supervised and the facility is an accredited psychiatric facility.[2]

Provision of appropriate care is impaired because federal coverage is not available for those under 65 years of age in IMDs or for those over 21 years of age in psychiatric facilities or programs, according to a Maryland Medicaid official. The age exclusion has caused difficulties in procurement or treatment for many people, according to a New Jersey Medicaid official; the group aged 22 to 64 is the most vulnerable to mental illness, yet receives the fewest services because of the age exclusion, according to a Kansas Medicaid official.

Among the proposals to provide coverage for this group was the suggestion, from a Louisiana Medicaid official, that each state should have the option of providing such services (but each state should not be required to provide the services). This group should be covered, but with limitations on patients' length of stay in IMDs, according to a Kentucky Medicaid official.

INCREASE MEDICAID COVERAGE OF HOME AND COMMUNITY-BASED SERVICES

Medicaid officials from 12 states and mental health officials from 17 states commented on the need for more Medicaid coverage of home and community-based services, including case management, homemaker and home health aide, personal care, adult day health care, habilitation, respite care, day treatment or

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[2]If a person receives psychiatric services just before reaching the age of 21, the person may continue to receive such services until the age of 22.

other partial hospitalization,[3] psychosocial rehabilitation (see fn. 4) and clinic services for people with chronic mental illness; and other services requested by the Medicaid agency and approved by HCFA as cost effective.

The Omnibus Budget Reconciliation Act of 1981 authorized the Secretary of Health and Human Services to waive traditional Medicaid requirements and allow states to provide home and community-based services. Per capita Medicaid expenditures for those receiving home and community-based services cannot exceed the estimated expenditures that would be incurred without the waiver services.

Many state officials advocated more flexibility in providing home and community-based services as alternatives to institutionalization. Other officials proposed coverage of specific home and community-based services or settings including (1) residential treatment settings, (2) psychosocial rehabilitation services, and (3) clinic services outside the clinic setting.

Allow More Flexibility to Provide Home and Community-Based Services

According to Medicaid officials from three states and mental health officials from seven states, more flexibility is needed to provide mental health services in the home and community as an alternative to institutional care. According to a Michigan mental health official, current Medicaid financing (1) hinders the trend to community-based placement for those eligible to receive Medicaid services and (2) prevents use of the least restrictive and best options for the care of clients; therefore, the home and community-based care waiver should be eliminated, and states should be given the option to offer these services.

Other Medicaid and mental health officials expressed similar views:

> -- Medicaid services have a bias towards inpatient care instead of community-based services. Incentives should be redirected toward more relevant, lower cost and higher benefit services for the mentally ill, including case management, vocational training, care outside the premises of a medical facility, nonmedical crisis intervention, and family support services. (Conn., mental health)

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[3]According to a HCFA official, partial hospitalization refers to a formal program of care in a hospital or other institution for periods of less than 24 hours a day; it includes services usually provided to outpatients.

-- Emphasis has been placed on treatment of patients removed from the family setting. Increased emphasis should be placed on home-based services (both coverage and availability) that focus on the family unit rather than on the individual. (Nebr., Medicaid)

-- Follow-up care should be required for those discharged from mental hospitals into the community. Existing Medicaid regulations provide for periodic evaluation of recipients' needs while institutionalized, but these regulations include no specific requirements for follow-up when those recipients are returned to the community. For these people, either a section of Medicaid regulations (42 C.F.R. 441.103) should be expanded or a new section requiring follow-up evaluation should be added. (Miss., Medicaid)

Expand Medicaid to Cover Residential Treatment Settings

Medicaid officials from three states and mental health officials from five states cited the need for Medicaid coverage of residential treatment settings. There is no coverage for treatment in residential treatment programs; such settings should be eligible for Medicaid reimbursement for all age groups, according to a Massachusetts mental health official.

Other state Medicaid and mental health officials expressed similar views, for example:

-- New York has developed an inpatient day treatment program with a residential component for patients with acute conditions who need overnight care but not inpatient hospitalization. Although the residential component is integral to the success of the program and reduces inpatient costs, it is not reimbursable under Medicaid. Legislation should be introduced to make the residential component reimbursable. (N.Y., mental health)

-- Residential treatment, which is less expensive than inpatient hospital care and more effective than outpatient care, is needed for adolescents. (Ark., Medicaid)

-- The quality of care and the long-term perspective for mental health patients would probably be better in a community setting (that is, group home) than in an institution. States should be allowed, within general guidelines, to determine the best setting for the treatment of the mentally ill. (Utah, Medicaid)

Expand Medicaid to Cover Psychosocial Services in Noninstitutional Settings

Psychiatric and psychosocial rehabilitation should be reimbursable Medicaid services,[4] according to one Medicaid official and mental health officials from seven states. Psychiatric rehabilitation, according to a Rhode Island mental health official, is one of the most important services required for the treatment of the chronically mentally ill in a noninstitutional setting; it is important not only to mitigate the effects of their illness, but also to help them on their way back to as normal a life as possible. Therefore, states attempt to include such services as part of other categories of services that they may offer (for example, clinics). Because psychiatric rehabilitation is not clearly identified as a covered service under title XIX, however, it is open to varied interpretations by HCFA regional offices; these interpretations, said the official, tend to eliminate reimbursement for psychiatric rehabilitation because it is not one of the traditional medical treatments.

Other mental health and Medicaid officials expressed similar concerns about the coverage of psychiatric and psychosocial rehabilitation services, for example:

-- Effective psychiatric rehabilitation services are ineligible for Medicaid because they are not deemed medical. (Vt., mental health)

-- As part of their treatment plan, many patients receive psychosocial services that are not currently reimbursable under Medicaid since these services do not meet the definition of a medical service. (N.Y., mental health)

-- Psychosocial services should be available for education- and vocation-related treatment. (Maine, Medicaid)

-- Apart from waiver services (see p. 15), medical services

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[4]According to the National Institute of Mental Health, psychosocial rehabilitation refers to a spectrum of programs for people with long-term, severe psychiatric disabilities. The goal of this rehabilitation is (1) to assist these people in assuming responsibility for their lives and (2) to enable them to function as actively and independently in society as possible. Specific services include opportunities to meet social and recreational needs, vocational training and job placement, rehabilitative residential services, training in the skills of daily and community living, and case management services.

are overemphasized and rehabilitation services are underemphasized. (Oreg., mental health)

Medicaid should reimburse psychiatric and psychosocial rehabilitation services provided in a noninstitutional setting, according to mental health officials from five states.

Allow Reimbursement for Services Provided Outside the Clinic Premises

According to Medicaid officials from three states and mental health officials from seven states, services provided outside the clinic setting are not reimbursable under Medicaid regulations. These define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative,[5] which are provided (1) to outpatients; (2) by a facility that is not part of a hospital but is organized and operated to give medical care to outpatients; and (3) generally, by or under the direction of a physician or dentist. In addition, the regulations define an outpatient as a patient who receives professional services at an organized medical facility or distinct part of such a facility, which provides the patient with professional services for less than a 24-hour period, whether or not a bed is used or the patient remains in the facility past midnight.

HCFA has defined by a facility to mean in a facility; this further clarification causes problems in providing clinic services outside the clinic setting, especially to the homeless and chronically mentally ill, according to a Colorado mental health official. For clinic services, according to a California mental health official, the term outpatient should be defined as a person who receives services from an organized medical facility rather than in an organized medical facility. This distinction would allow staff from a clinic to provide services to the mentally ill outside of the clinic, rather than only in the clinic itself; clinics would then have maximum flexibility to deal with the chronically mentally disabled in the most appropriate and cost-effective manner.

Nonreimbursement for services outside a clinical setting limits the ability of mental health centers to serve targeted populations, such as the elderly in home settings or mentally ill offenders in jail; nonreimbursement also limits the ability to provide a more cost-effective delivery of home and community-based services to children and families, a South Dakota Medicaid official commented. Precluding reimbursement for services outside of the clinic site inhibits the delivery of medically

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[5]The treatment of incurable disease in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

necessary outpatient services to the most needy and least motivated mentally disabled patients, that is, those who will not or cannot seek such services at a clinic, according to the California mental health official.

Services outside the clinic could be provided under the licensed practitioner option, according to a HCFA official. Under Medicaid, licensed practitioners can provide medical or remedial services, other than physicians' services, within the scope of practice, as defined by state law; payments to clinics, however, include an allowance for facility overhead, whereas licensed practitioner payments do not.

IMPLEMENT CHANGES IN THE ADMINISTRATION OF MEDICAID WAIVER PROGRAMS

Medicaid officials from 7 states and mental health officials from 18 states commented on the waiver program. The Omnibus Budget Reconciliation Act of 1981 authorizes the HHS Secretary to grant waivers pertaining to "freedom of choice" (section 2175) and "home and community-based services" (section 2176).

Freedom of Choice Waivers

Although Medicaid recipients are permitted to obtain services from any qualified provider willing to accept Medicaid patients, states may request waivers that enable them to restrict recipients' access to providers. A waiver that allows the state to constrain a recipient's freedom of choice to select providers is known as a freedom of choice waiver. Under an approved waiver, renewable every 2 years, states may

-- implement a case management system in which a physician or other health care provider coordinates a recipient's primary and other medical care and rehabilitation;

-- allow a locality to act as a central broker in assisting Medicaid recipients in selecting among competing health plans;

-- share with recipients, through additional services, savings resulting from use of more cost-effective medical care; and

-- restrict recipients to receiving services, except in an emergency, from providers found to be efficient and effective.

Home and Community-Based Services Waiver

This waiver enables states to provide a number of home and community-based services to those who would otherwise require services in an institution. The services are frequently nonmedical in nature and, therefore, not usually reimbursed under Medicaid. Services that can be provided include case management, homemaker, home health aide, personal care, adult day care, habilitation, and respite care. States would also be permitted to provide these services: day treatment or other partial hospitalization, psychosocial rehabilitation and clinic services (whether or not furnished in a facility) for those who are chronically mentally ill, and other services requested by the state and approved by the Secretary. State officials' comments focused on the (1) process for applying for and carrying out waiver programs, (2) requirement that the waiver programs be cost effective, and (3) performance criteria and review of waiver programs.

Eliminate or Alter Cumbersome Waiver Application Process

Medicaid officials from 4 states and mental health officials from 10 states commented on the waiver application process. For example, the process of applying for waivers is slow, time-consuming, and wasteful of scarce administrative resources, according to a Vermont Medicaid official. Waivers have generally proven too difficult to get approved and too complicated to administer, according to a Tennessee Medicaid official.

Other state officials expressed similar concerns about the waiver process, for example:

-- It is exceedingly difficult to get HCFA approval of waivers. (Mass., mental health)

-- The waiver process and regulations for home and community-based services are overly restrictive and discourage states from applying for waiver programs. (Okla., Medicaid)

-- Current law requires that states go through the waiver process to limit client choice of provider, thus creating delay and increased expense. (Minn., mental health)

Waiver program services should be eliminated and incorporated as optional or regular Medicaid services, according to Medicaid officials from two states and mental health officials from four states. State mental health officials also proposed the following:

-- making approval for waived services permanent rather than time limited (Ore.);

-- designing waiver applications similar to the state plan approval process and letting each state decide whether to approve or disapprove the applications (Hawaii); and

-- streamlining the waiver process by (1) standardizing HCFA review of waiver requests and renewals and (2) establishing an appeals process for states to dispute a denial by HCFA (Mass.).

In July 1987, the HCFA State Medicaid Manual (transmittal no. 29) described the items to be included in a home and community-based waiver proposal. By carefully following these guidelines, according to a HCFA official, states should be able to submit requests that closely address the statutory and regulatory requirements. The result, the official believed, should be more expedient approval.

Alter Cost-Effectiveness Requirement

Medicaid officials from three states and mental health officials from four states were concerned with the requirement that programs implemented through section 2176 waivers should be cost effective. In applying for these waivers, states must submit data to show that the waivers will not increase Medicaid costs; states must also demonstrate that home and community-based services substitute for, rather than supplement, more costly nursing home care. For example, states must show that the per capita expenditure will not increase as a result of the waiver.

Medicaid officials from two states and mental health officials from three states believed that the cost-effectiveness requirement was unduly restrictive, for example:

-- Recent legislation allows states to apply for home and community-based care waivers for the chronically mentally ill, but the requirement that costs be less than or equal to institutional care is unrealistic. The cost effectiveness of home community-based care may be a long-term rather than a short-term outcome; reporting requirements for such care should be adjusted to reflect this. (Utah, Medicaid)

-- Since Medicaid does not cover services to those aged 22 to 64 in IMDs, most institutionalized Medicaid recipients are not eligible for home and community-based waivers. States have to demonstrate that costs to serve the mentally ill are less in the community than they are to the same population in an institution; the average costs

> of institutional care (regardless of whether covered by Medicaid) should be allowed when determining the cost effectiveness of home and community-based care. (N.H., mental health)

The home and community-based services waiver is based on the belief that the Congress did not intend that funds be spent on those ineligible for a Medicaid institutional payment, according to a HCFA official. Therefore, the criteria used by HCFA are predicated on the state's ability to show that without the waiver, these people could have been institutionalized and, if institutionalized, would be eligible for a Medicaid payment.

Improve Other Aspects of Waiver Program Performance

Mental health officials of four states commented on reporting requirements for waivers. For example, states that have home and community-based waivers are required to provide information annually to HHS on the impact of the waiver on (1) the type, amount, and cost of medical assistance provided and (2) the health and welfare of recipients. Reporting requirements are excessive and confusing, and flexibility has been replaced by narrow interpretations of the statutes, according to an Oregon mental health official. The generation of required reports is difficult and excessively costly for the states, according to a Massachusetts mental health official; some reporting requirements should be eliminated or HCFA should share with the states, at no cost, the computer technology or software necessary to generate these reports.

A lack of established criteria by which to evaluate program performance under waiver conditions is a cause for concern; states should be provided, in advance, with criteria against which performance under the waiver will be evaluated, according to a Wisconsin mental health official.

In an April 1987 report, we recommended that HCFA (1) develop measures of the adequacy of services under home and community-based waivers to prevent or postpone nursing home care and (2) use these measures to evaluate the cost effectiveness of waiver programs.[6]

Mental health officials of two states commented on waiver program results. Studies show that waivers are successful, according to a mental health official from Vermont, and should

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[6]Medicaid: Determining Cost-Effectiveness of Home and Community-Based Services (GAO/HRD-87-61, Apr. 28, 1987).

become a state plan option. Anecdotal evidence seems to indicate that administration of home and community-based waivers has not supported the congressional intent to increase the availability of home and community-based care; therefore, the actual practice and administration of home and community-based waiver programs should be reviewed to see if this intent is being met, according to a Virginia mental health official.

IMPROVE HCFA'S ADMINISTRATION OF THE MEDICAID PROGRAM

Medicaid officials from 6 states and mental health officials from 14 states commented on the administration of the Medicaid program by the federal government.

State Medicaid and mental health officials' concerns included (1) lack of consistency in interpreting Medicaid laws and applying regulations; (2) problems with the process of issuing regulations and providing guidance; and (3) lack of guidance concerning the definition of certain mental health services.

Interpret Laws and Apply Regulations More Consistently

Mental health officials of four states believed that HCFA's interpretation of laws and regulations varied from region to region:

-- Interpretation varied even within HCFA regions. (R.I. and Ga.)

-- HCFA issued contradictory rulings about Medicaid services and settings. (Va.)

-- HCFA may approve a program as Medicaid reimbursable in one state and disapprove the same program in another state. (R.I.)

-- States spend extensive amounts of time trying to interpret what will meet HCFA requirements. (Wyo.)

State mental health officials proposed a variety of solutions to the lack of consistency, including the following:

-- At the national level, dialogue should be established between state offices and HCFA central as well as regional offices to ensure that (1) the different levels of government work together effectively and (2) HCFA has a good understanding of mental health service delivery. (Ohio)

-- HCFA should clearly and concisely specify the requirements for Medicaid mental health services so that all participants know in advance the expectations for major issues. (Wyo.)

-- A central office or a clearinghouse should compile information on Medicaid coverage on a state-by-state basis. (Tex.)

-- HCFA should demonstrate more clarity and consistency in enforcing regulations, particularly concerning program definitions. (R.I.)

-- Patterns of program approvals and denials should be reviewed with particular attention to variability among regional officials. (Va.)

Improve Process for Issuing Regulations and Providing Guidance

Changes in HCFA's process for issuing regulations or providing guidance could improve the provision of mental health services, according to mental health officials, for example:

-- HCFA has overcentralized decisionmaking, which has resulted in regional offices' being less responsive to state needs. States are not given the partnership status that is required to develop a meaningful medical program for the poor. (Vt.)

-- HCFA is not responsive to changes in the laws governing Medicaid. Long periods pass between the time legislation is enacted and regulations or guidelines are published. Some reasonable time should be established for issuance of these regulations or guidelines. (Oreg.)

-- Interpretation and emphasis are often changed (by HCFA or the Medicaid agency) without notification of state agencies and providers. HCFA should ensure that the state Medicaid agency informs other state agencies and providers when changes occur. (Tenn.)

-- Reporting requirements constantly change, resulting in additional costs to HCFA and state agencies; these requirements should be agreed upon and not changed. (Vt.)

Give Additional
Guidance to States

Medicaid officials from four states and mental health officials from four states sought additional guidance from HCFA on a variety of issues associated with coverage and delivery of Medicaid mental health services, which needed clarification. The following are some examples:

-- There is a need for precise definitions of mental health facilities and programs. Definitions, rules, and regulations that apply to all mental health facilities for those under 21 years of age, such as residential treatment centers, should be established or clarified. (N.J., Medicaid)

-- Precise definitions are needed for covered Medicaid services: A Medicaid supplemental manual defining the services that HCFA deems appropriate in the clinic setting would be helpful. In addition, HCFA should work with the states in establishing definitions for (1) physician qualifications needed to direct services in mental health clinics, (2) qualifications of therapists, and (3) site of service. (Va., Medicaid)

-- Outpatient mental health services are not clearly defined. A clear description of, and program standards for, outpatient mental health services should be developed. (S.C., mental health)

-- Criteria and standards should be written for day treatment of the chronically mentally ill. Also needed are guidelines for identifying those who need this type of program and could potentially benefit from it. (Ark., Medicaid)

-- Neither the state agency nor providers are well informed on standards and requirements for providers, which are sometimes conveyed orally by HCFA auditors. Provider standards and requirements should be logically codified and clearly stated; changes should be disseminated in writing. Deficiency findings should be tied to specific regulations. (Okla., mental health)

-- There is a lack of consistency in determining when to allow correction of deficiencies before decertifying psychiatric institutions. Federal guidelines should be available to providers for their use in making such determinations. (Oreg., mental health)

-- Health care professionals who provide services, write plans of service, and supervise care are not always

expert in the needs of the developmentally disabled. A mechanism should be established for monitoring qualifications of health professionals practicing in the community setting who are providing services to the developmentally disabled. (Mich., mental health)

MAKE ELIGIBILITY REQUIREMENTS LESS STRINGENT

Medicaid officials from 5 states and mental health officials from 12 states expressed concern about eligibility requirements for the mentally ill. All called for less stringent requirements, making it easier for the mentally ill to be designated as disabled and meet income and asset limitations.

Medicaid eligibility provisions allow states flexibility, but also have certain requirements for breadth of coverage. At a minimum, states must cover the "categorically needy." These are people receiving cash payments from the AFDC program or, with certain exceptions, the SSI program.

Each state has the option of extending Medicaid to certain other groups similar to the categorically needy. One such group is the "medically needy"--generally, those who would be eligible for Medicaid except that their income or resources or both are in excess of the requirements for cash assistance. After deductions for medical expenses, however, their income must not exceed a state's eligibility standard for the medically needy. For federal matching purposes, the state standard must not exceed 133-1/3 percent of the applicable AFDC cash payment level. Recipients' assets also must not exceed maximum eligibility levels established by each state.

Make Medicaid Eligibility Standards Concerning Income Less Stringent

Mental health officials from three states and Medicaid officials from two states called for an increase in the level of earnings allowed Medicaid recipients. New York Medicaid and mental health officials commented on the earnings guidelines used to determine if a person is disabled. Under SSI, those who receive earnings averaging more than $300 per month ordinarily are considered able to do substantial, gainful activity and, if so, are not considered disabled. The $300 earnings limit used to determine ability to do substantial, gainful activity is too low and should be increased, according to New York officials.

Mentally ill recipients who become employed face potential loss of Medicaid benefits, according to mental health officials from four states and one Medicaid official. Coverage of case management services and medications should be continued after cessation of more comprehensive coverage, according to a

Minnesota mental health official. The determination of eligibility should be expedited for those who lost benefits after becoming employed but subsequently became eligible again, according to a New Hampshire mental health official.

Make Medicaid Eligibility Rules Concerning Assets Less Stringent

Increase allowable asset limits or otherwise make Medicaid eligibility rules for assets less stringent, suggested mental health officials from three states and Medicaid officials from two states. Effective for the year beginning January 1987, SSI Medicaid recipients must have no more than $1,800 and, if married, no more than $2,700 in assets. Mental health officials of two states (Okla. and Md.) stated that the allowable assets limit is too low.

According to SSI regulations, the value of an applicant's resources during any given month is determined at the beginning of that month. Both New York and Minnesota Medicaid officials called for a change in the policy. The Minnesota official suggested that recipients be allowed to decrease their assets within the month and still be eligible for benefits.

Make Certification of the Mentally Ill As Disabled Easier

It has been difficult for the mentally ill to be certified as disabled, according to mental health officials from five states and Medicaid officials from two states. Under the Social Security Act, disability refers to the inability to do any substantial, gainful activity because of a medically determinable mental or physical impairment. The Social Security Administration evaluates one or more of a series of factors in determining disability. As previously mentioned, a person is ordinarily considered able to carry out substantial, gainful activity if he or she receives earnings averaging more than $300 per month.

The impairment must be severe, expected to result in death, or have lasted (or be expected to last) for a continuous period of at least 12 months. The Social Security Administration (or the delegated state agency) assesses whether the nature and severity of the impairment meet the criteria for a disabling mental illness listed in the regulations. If the impairment is assessed as severe, but does not meet the criteria listed in the regulations (and the person can no longer do the same job done before the illness), the Social Security Administration may still consider the person disabled, after assessing factors such as age, education, and work experience.

Mental health and Medicaid officials indicated concern with the difficulties people with mental problems face in becoming certified as disabled. The standards and methodology used to determine whether the mentally ill qualify for assistance make it extremely difficult for them to receive SSI disability payments; mental illness should be explicitly described as a disabling condition; in addition, state mental health agencies should be responsible for determining SSI and Medicaid eligibility for the mentally ill so that these applications could receive priority attention, according to an Oklahoma mental health official. Other officials reported the following:

-- Mental illness is sporadic and, as a result, the mentally ill are often able to work intermittently; therefore, the sporadic nature of mental illness should be taken into account when a person's ability to function is assessed. (R.I., mental health)

-- Since a mentally ill person often cannot provide needed proof of identity, the requirement that Medicaid recipients prove their identity should be changed to enable such people to obtain needed services. Another difficulty is the complexity of and length of time needed for processing applications for SSI and Medicaid benefits. (N.Y., mental health)

-- The process should be streamlined or the SSI and Medicaid benefits application process consolidated. (Conn., mental health)

-- New eligibility criteria applicable to children's disorders should be developed. Since child disability listings are very specific, if a child's mental illness does not meet a specific list of impairments, then the child is not considered disabled. (N.Y., Medicaid and mental health officials)

MODIFY REGULATIONS AND REQUIREMENTS FOR UTILIZATION CONTROL

Mental health officials from five states and Medicaid officials from six states commented on regulations and requirements concerning utilization control. This refers to methods and procedures that a state establishes under its Medicaid plan (1) to safeguard against unnecessary or inappropriate use of covered care and services as well as excess payments to providers and (2) to assess the quality of covered services.

Medicaid regulations focus on utilization control in general hospitals, mental hospitals, skilled nursing facilities, and intermediate care facilities. These regulations also (1)

describe utilization control procedures for those under the age of 21 and (2) cover various utilization control activities: certification that a patient's admission or continued stay is needed, development and updating of a plan of care for each patient, review of admission certifications, annual "inspections of care" received by each recipient, and preparation of medical care evaluation studies.

Officials of nine states called for a change in utilization control requirements. Medicaid officials from New Jersey and Oklahoma commented on the requirement that every patient's record in a psychiatric institution should be reviewed during annual inspections of care. Officials from both states suggested that a statistically valid sample would be sufficient; the Oklahoma official proposed a 50-percent sampling of records.

Hospitals face similar surveys, a Tennessee mental health official pointed out, by Medicaid and Medicare programs and the Joint Commission on Accreditation of Hospitals (now the Joint Commission on Accreditation of Healthcare Organizations). The official suggested consolidating the surveys. To minimize duplication and maximize expertise, a mental health authority should conduct utilization review and control activities, suggested a New Jersey official. Other concerns of officials were as follows:

-- The degree of consistency between HCFA survey teams that certify facilities is questionable. Emphasis on consistency should be incorporated into education and training programs for the survey teams. (Md., mental health)

-- Utilization control regulations pertaining to mental hospitals (42 C.F.R. 456, subpart D) are not relevant to those under 21 years of age in nonhospital settings. Rewriting of subpart D should make it applicable to both hospital and nonhospital settings. (La., Medicaid)

-- Guidelines on evaluation studies of the quality of medical care were not specific enough; criteria should be developed for such studies. (Ark., Medicaid)

-- Utilization review had too little concern for client outcome and too much concern for meeting complex and meaningless paper standards. Existing regulations should be scrapped and new ones adopted that focus on patient outcomes. (Vt., Medicaid)

NARROW IMD DEFINITION

Concern about the Medicaid regulation and guidelines defining what constitutes an IMD was expressed by Medicaid

officials from five states and mental health officials from five states. The regulation and accompanying guidelines increase the number of institutions, particularly nursing homes, that are categorized as IMDs and, therefore, eliminate Medicaid coverage for their patients aged 22 to 64, according to three state mental health officials.

As mentioned earlier, Medicaid regulations define an IMD as an institution that is primarily engaged in providing diagnosis, treatment, or care of those with mental diseases. HCFA has issued ten guidelines, used in combination, to determine whether a facility is an IMD. According to the state Medicaid manual, a critical guideline in this determination is whether more than 50 percent of the patients have mental diseases requiring inpatient treatment. This critical guideline was focused on by Medicaid officials from two states and one mental health official.

Mentally ill people who need nursing care at an intermediate care facility could best be served in a facility that provides specialized psychiatric and mental health services, according to a Utah mental health official. If more than 50 percent of the patients were institutionalized for mental illness, however, such a facility could be defined as an IMD. Services to adults aged 22 to 64 at such a facility, therefore, would not be eligible for Medicaid reimbursement.

The definition of IMDs excludes federal financial participation for community crisis stabilization and community residential treatment programs because the facilities are classified as IMDs,[7] according to Florida Medicaid and mental health officials.

Proposed solutions by state officials focused on criteria that would narrow the definition of an IMD. For example, limiting the IMD definition in its application to state-operated mental institutions, suggested an Illinois Medicaid official. As an alternative, the official proposed, certain basic services could be provided to recipients, regardless of the kind of place in which they live. HCFA should amend guidelines that result in nursing homes with significant numbers of mentally ill patients

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[7]Community crisis stabilization units offer an alternative to inpatient hospitalization by providing brief, intensive services 24 hours a day, 7 days a week, for those mentally ill who are in an acutely disturbed state, according to a Florida Medicaid official. Community residential treatment facilities provide shelter and treatment to individuals exhibiting symptoms of a mental illness who are in need of a 24-hour, 7-days-a week structured living environment, respite care, or long-term community placement.

being defined as IMDs, suggested a Maryland mental health official.

The process for determining whether a facility is an IMD is too subjective and does not seem to be applied in a consistent manner, according to Washington state Medicaid and mental health officials.

INCREASE AMOUNT OF FEDERAL FINANCIAL ASSISTANCE

Changes in the financing of the Medicaid program could improve the availability of mental health services, according to Medicaid officials from four states and mental health officials from five states.

The federal government shares with states the cost of providing Medicaid services, using a variable matching formula based on a state's per capita income. The formula magnifies differences between a state's per capita income and the U.S. average, thus reducing the state share for states with low per capita income.[8] The federal share, called the federal medical assistance percentage, is 100 percent minus the state share. Under title XIX, however, the federal share may not be less than 50 percent or greater than 83 percent. During fiscal year 1987, the federal share varied from 50 to 78.5 percent of a state's Medicaid cost of health services.

Most of the state responses called for an increased amount of federal matching funds. For example, Washington state Medicaid and mental health officials believed that (1) the federal match was too low to enable all needy recipients to be served and (2) should be raised from 50 to 75 percent. Delaware Medicaid and mental health officials indicated they would like to see federal funding raised to a 60-percent minimum matching rate and a 90-percent maximum. Funding formulas are unfair to states with a high cost of living; therefore, formulas should be changed to reflect equal buying power in all states, according to a Hawaii mental health official.

RELAX PHYSICIAN REQUIREMENT FOR CLINIC SERVICES

Concerns that clinic services must be provided under the direction of a physician were expressed by Medicaid officials from four states and mental health officials from three states. Federal Medicaid law provides for clinic services to be furnished

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[8]See Grant Formulas: A Catalog of Federal Aid to States and Localities (GAO/HRD-87-28, Mar. 23, 1987) for a more detailed discussion of the grant formula.

by or under the direction of a physician, without regard to whether the clinic, itself, is administered by a physician.

Whatever the advantages and disadvantages of requiring physician oversight, it prevents states from exploring alternative arrangements for service delivery that may also be appropriate, according to a Medicaid official from Illinois. Mental health professionals meeting state licensing requirements should be allowed to provide and supervise mental health services at clinics, he proposed.

Examples of comments by other state mental health and Medicaid officials follow:

-- Physician supervision requirements under current law are often excessive and costly. Services delivered by nonmedical staff are efficient and cost effective; these services can be supervised by mental health professionals with adequate psychiatric consultation. (Minn., mental health)

-- In a rural setting, requiring a psychiatrist to sign an outpatient treatment plan is impractical, unnecessary, and costly. HCFA should allow treatment plans to be approved by a licensed psychologist, a licensed master of social work, or a psychiatric nurse. (Fla., mental health)

-- Physician direction is often not available in the mental health clinic setting, thereby limiting Medicaid coverage of services. A study should address (1) the circumstances in which physician direction is required and (2) how the federal government and states should resolve access-to-care problems. (Va., Medicaid)

OTHER COMMENTS CONCERNING MENTAL HEALTH SERVICES

State Medicaid and mental health directors offered comments on coverage and delivery of services in addition to those reported in previous sections.

Separate Coverage of Mental Health Services

Separate coverage of Medicaid's mental health services was proposed by Medicaid officials of two states. Mental health services are fragmented, including gaps in coverage and overlap, because they are covered by several programs (Medicaid, Medicare, and others), according to a Texas Medicaid official. She suggested removing mental health services from Medicaid and

Medicare and creating a separate program under the Social Security Act.

Funding for mental health should be separate from Medicaid, according to a New Hampshire Medicaid official. Costs are proportionally higher for the mentally ill and developmentally disabled; therefore, Medicaid funds should be limited to physical illness and mental health services should be funded separately, he proposed.

Modify Treatment Goals

Those over the age of 64 would benefit from an "active treatment" program similar to that required in treatment of those under the age of 21, a Missouri Medicaid official proposed. Currently, the treatment goal for those over the age of 64 is to ensure that the recipient is maintained at or restored to the greatest possible degree of health and independent functioning. The goal for those under the age of 21 is to achieve discharge from inpatient status at the earliest possible time.

Cover Additional Mental Health Services

Medicaid and mental health officials of two states focused on specific areas not covered by Medicaid. Regulations prevent reimbursement for crisis intervention and outreach services in nursing homes; the regulations should be changed to permit these services, according to a New Jersey mental health official.

Alcoholism is considered a psychiatric disorder; therefore, inpatient care in IMDs for those aged 22 to 64 is not covered, according to a New York Medicaid official. To determine whether a diagnosis should be termed a mental disease, HCFA uses the International Classification of Diseases, which classifies alcoholism as a mental disease; it classifies various alcohol-related conditions, however, like cirrhosis of the liver, as physical diseases. The official called for statutory changes to allow alcoholism to be classified as a physical disease.

Cover Selected Nonmedical Services

Medicaid does not cover nonmedical needs important to the recovery of the mentally ill, according to mental health officials of several states. Many disabled clients (especially children) are attending programs that combine medical and educational services, but Medicaid will not provide reimbursement

for education-related services,[9] said a New York mental health official. Similarly, therapeutic after-school services for school-aged youth under 18 years are not covered, reported a Kentucky official.

Legislation should be enacted to allow Medicaid to reimburse educational services provided in conjunction with medical services, the New York mental health official proposed. All mentally ill in residential treatment or 24-hour community placements, such as foster homes, should receive coverage for pre-vocational and vocational skills training, according to a Wyoming mental health official.

Collateral services on behalf of a child that are provided by mental health staff were not covered; therefore, Medicaid should reimburse these services, placing limitations on the definition of collateral activities, those eligible to deliver services, and service providers' relationships with the clients, according to a Kentucky mental health official.

A thin line exists between active treatment services and vocational and educational services, a Massachusetts mental health official observed. The state Medicaid agency is very cautious in what it will cover for fear that HCFA will disallow federal financial participation for such services; as a result, the Department of Mental Health loses some federal financing to which it is entitled. The solution, according to this official, is for HCFA and HHS to standardize, in regulations, the definitions of educational and vocational services.

Provide Greater Flexibility in Delivery of Mental Health Services

In addition to comments previously presented, officials of five states sought greater flexibility in delivery of mental health services. Medicaid regulations tend to be turf-oriented, protecting providers; most outpatient services can be provided by people and programs from different disciplines, a Wisconsin Medicaid official commented. For example, states

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[9]The Medicare Catastrophic Coverage Act of 1988 contains a provision clarifying this: Federal Medicaid matching funds are available for the cost of those health services (1) covered under a state's Medicaid plan and (2) provided to a handicapped child or a handicapped infant or toddler. This is so even though such services are included in the child's individualized education program or individualized family service plan. Such services include speech pathology and audiology, psychological services, physical and occupational therapy, and medical counseling and services for diagnostic and evaluation purposes.

should be allowed greater flexibility to certify programs rather than being tied to hospitals or clinics, she suggested. Mental health professionals should have flexibility to select the treatment most efficient and beneficial, a Washington state Medicaid official advocated.

States should have the flexibility to restrict the selection of providers, according to officials of two states. HCFA's policy prohibits the state from limiting its selection of IMD service providers to state-operated facilities only; an Ohio Medicaid official expressed concern over this. In order to provide coordinated services, the state must be able to confine its contracts to community mental health centers, said a Michigan mental health official. Currently, any private or public agency, he said, is eligible to receive contracts.

A legislative change would make it easier for states to restrict a person's choice of providers through case management, a Minnesota Medicaid official advocated. Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. States may offer case management as a medical service covered under the state's Medicaid plan. In order to encourage cost effectiveness, states may also use case management to restrict a person's choice of provider. But to do so, according to a HCFA official, states must provide case management under a waiver (section 2175) restricting choice of providers.

The need to obtain a waiver creates delay and increases expense, the Minnesota Medicaid official stated. States should be allowed to restrict the choice of providers through case management without the necessity of first obtaining a waiver, he proposed.

Improve Coordination Among Governmental Agencies Providing Mental Health Services

The federal government should insure coordination among state agencies providing mental health services to Medicaid recipients, according to Medicaid officials of two states and mental health officials from two states. Officials of Nevada and Massachusetts were concerned about coordination between state Medicaid and mental health agencies. The state Medicaid agency is responsible for the compliance of other state agencies providing Medicaid services; the state mental health agency should also be responsible, a Nevada Medicaid official suggested.

A Massachusetts mental health official provided another perspective. The state Medicaid agency is under no mandate to involve the state mental health agency in its policy development, she indicated. Problems have arisen, she said, when the Medicaid

agency changes its regulations concerning mental health services; federal regulations should require the inclusion of the state mental health agency in the development of policies, procedures, and regulations affecting mental health services.

Other state officials called for more coordination between agencies concerned with services reimbursed by Medicaid. For example, a Nebraska Medicaid official commented that state agencies should be more actively involved in the planning for service delivery, and coordination with the state Medicaid agency should be mandated. An Idaho mental health official also proposed a federal requirement for collaboration between state agencies.

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