

December 2000

MENTAL HEALTH

Community-Based Care Increases for People With Serious Mental Illness



G A O

Accountability * Integrity * Reliability

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Abbreviations

ACT	assertive community treatment
APA	American Psychiatric Association
BBA	Balanced Budget Act of 1997
CMHC	community mental health center
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
IPS	Individual Placement and Support
NASMHPD	National Association of State Mental Health Program Directors
NIMH	National Institute of Mental Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SMHA	state mental health agency
SMI	serious mental illness



United States General Accounting Office
Washington, D.C. 20548

December 19, 2000

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

Mental disorders take an enormous toll on the nation's families and finances. The indirect costs of mental illness, such as for lost productivity, were estimated at \$78.6 billion in 1990. In 1997, \$73 billion was spent on mental health services. The Surgeon General has estimated that about 20 percent of the U.S. population is affected by a mental disorder in a given year.¹ About 5 percent of the population are considered to have a serious mental illness (SMI). SMI, which includes, among other diseases, schizophrenia, bipolar disorder, and major depression, is a chronic condition that can substantially limit a person's ability to function in many areas of life such as employment, self-care, and interpersonal relationships. Effective treatment can reduce the severity of these problems for the majority of people with SMI. Much of this treatment can now be provided in the community rather than in institutions.

Because of your long-standing concern with the availability and financing of mental health services, you asked us to review mental health services for people with SMI. Specifically, you asked us to (1) provide information on mental health spending and how it has changed since the 1980s; (2) identify the types of community-based services that are provided to adults with SMI, including people who are homeless, and difficulties in providing these services; and (3) determine how the Health Care Financing Administration (HCFA), which administers the Medicaid program, supports the provision of community-based services for adults with SMI who are eligible for Medicaid.

To answer these questions, we interviewed and obtained documents from officials at the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA), HCFA, and the National Institute of Mental Health (NIMH). We also visited

¹*Mental Health: A Report of the Surgeon General* (Rockville, Md.: U.S. Department of Health and Human Services, 1999).

state mental health and Medicaid officials and service providers in Michigan and New Hampshire, states that have been identified as operating exemplary community-based programs. In addition, we reviewed documents from the National Association of State Mental Health Program Directors (NASMHPD). Finally, we interviewed officials from several organizations concerned with mental health issues as well as individual experts on mental health. (For additional information on our methodology, see app. I.) We conducted our work between May and November 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Between 1987 and 1997, the growth in mental health spending in the United States roughly paralleled the growth in overall health care spending. After adjusting for overall inflation, spending on mental health services grew by 4 percent a year, on average, compared with 5 percent a year for spending on all health care. However, federal mental health spending grew at more than twice the rate of state and local spending. This led to the federal government's share surpassing that of state and local governments, while the share attributable to private sources declined slightly. Increasing Medicaid and Medicare expenditures accounted for the larger federal share, with combined federal and state Medicaid expenditures accounting for 20 percent of all mental health spending in 1997.

The focus of care for adults with SMI has continued to shift from providing services in psychiatric hospitals to providing services in the community. The ability to care for more people in the community has been facilitated by the continued development of new medications that produce fewer side effects and are more effective in helping people manage their illness. Furthermore, treatment approaches such as assertive community treatment (ACT), supported employment, and supportive housing have been developed to provide the multiple forms of ongoing assistance that adults with SMI often need if they are to function in the community. These approaches can also help homeless people with SMI, whose treatment needs are additionally complex, partly because many of them also suffer from a substance abuse disorder. Coordinating and integrating services can be effective in treating people with multiple needs, and organizing care in this way is especially important for people making the transition from institutions to the community.

Medicaid is a major source of support for people with SMI. HCFA has encouraged the use of community-based services for Medicaid beneficiaries with SMI by disseminating information on the use of new

medications and treatment models, which can help people function better in the community. HCFA has also supported states' use of Medicaid managed care waivers to provide a wider array of community-based mental health services. However, incentives associated with capitated payment can lead to reduced service utilization. Recognizing the risks for people with special health care needs, such as serious mental illness, the Congress required HCFA to take steps to ensure that beneficiaries enrolled in managed care receive appropriate care. HCFA is developing a set of safeguards for such people enrolled in Medicaid managed care. The safeguards provide measures that states can take to better ensure that beneficiaries can obtain the services and supports they need to function. HCFA has indicated that it will devise a plan to implement these safeguards, such as through legislative or regulatory action or making changes in Medicaid administrative policies. Effective oversight to ensure that adequate safeguards are implemented will be essential to provide meaningful protection to this vulnerable population. SAMHSA and HCFA commented on a draft of this report and generally agreed with our findings.

Background

Historically, people with SMI were cared for primarily in hospitals. States developed a system of public mental hospitals, but by the 1960s they were viewed as ineffective and inadequate because of overcrowding, staff shortages, and poor facilities. Advocates and reformers contended that long-term institutional care in the hospitals had been characterized by patient neglect and ineffective treatment. Improved medications that reduced some of the symptoms of mental illness allowed more people to live in the community with support.

Certain legislative and judicial actions contributed to a changed focus of providing community-based rather than institutional care. In 1963, the Community Mental Health Centers Act authorized the development of a nationwide network of community mental health centers (CMHC) to replace state institutions as the main source of treatment for people with SMI and to decrease the incidence of mental illness in the broader population.² The act and amendments created federal grants for states to build the CMHCs and staff them for 8 years. Funds were intended to supplement existing state and local revenues to help communities develop the new services necessary for adequate community mental health care.

²Pub. L. No. 88-164, title II, 77 Stat. 290.

States and communities were expected to develop alternative funding sources to eventually replace the federal funds. CMHCs were required to provide a number of services, including inpatient, outpatient, emergency, and day care services; follow-up care for people released from mental health facilities; and transitional living facilities. CMHCs were also required to coordinate service delivery with other mental health and social service providers in the community.

The vision of a national network of community mental health centers was not fulfilled. Many communities were unable to find the funds to match federal dollars to build the CMHCs or to provide all the required services; others were unable to find qualified professionals to staff the centers.³ As of 1980, only 768 of the projected 2,000 CMHCs had been funded. Moreover, implementation of the CMHC act did not adequately address the needs of people with SMI who were released from institutions. The CMHC program's regulations emphasized the prevention and treatment of mental disorders in the broader population, and CMHCs did not provide the intensive, more comprehensive services people with SMI required, such as housing, support services, and vocational opportunities in addition to treatment. Medication was the only service provided to many patients. Further, the extent to which CMHCs coordinated with mental hospitals concerning the release of patients to their communities varied. Section 901 of the Omnibus Budget Reconciliation Act of 1981 ended federal funding to states specifically for community mental health centers and replaced it with block grants to the states to support services for people with SMI.⁴

A series of court decisions in the 1970s establishing that institutionalization is a deprivation of liberty also played a role in moving people with SMI away from institutions into the community. States had previously exercised broad latitude in allowing an individual with mental illness to be involuntarily confined, but court rulings recognizing individuals' right to refuse treatment made it difficult to commit people to a psychiatric hospital without their consent. In 1975, the Supreme Court held that mentally ill individuals could not be committed involuntarily unless they were found to be dangerous to themselves or others.⁵ This led to a reform

³Later amendments set out more specific requirements for CMHCs. Community Mental Health Centers Amendments of 1975, Pub. L. No. 94-63, title III, 89 Stat. 304, 308.

⁴Pub. L. No. 97-35, 95 Stat. 543.

⁵O'Connor v. Donaldson, 422 U.S. 563 (1975).

of state laws, which now generally allow involuntary inpatient commitment only if persons present a clear danger or threat of substantial harm to themselves or others. Some state laws specify that inpatient commitment is appropriate only after full consideration of less restrictive alternatives, such as involuntary outpatient commitment. (See app. II for a discussion of involuntary outpatient commitment.) A recent Supreme Court opinion has brought additional pressure on states to offer community-based treatment to people with mental illness when such treatment is appropriate, the individuals do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the state's resources.⁶

The public mental hospital population declined. Many people with SMI returned to communities without adequate mental health services and some of these people became homeless. Other major factors contributing to homelessness were unemployment, a decline in the supply of low-income housing, and alcohol and drug abuse.

The State and Federal Roles in Supporting Mental Health Services

State mental health agencies (SMHA) have primary responsibility for administering the public mental health system, through their role as a purchaser, regulator, manager, and, at times, provider of mental health care. The public mental health system serves as a safety net for people who are poor or uninsured or whose private insurance benefits run out in the course of their serious mental illness. Many people with SMI are unemployed, and they are often poor and financially dependent on government support. SMHAs arrange for the delivery of services to more than 2 million people each year, most of whom suffer from a serious mental illness. Services are delivered by state-operated or county-operated facilities, nonprofit organizations, and other private providers. The sources and amounts of public funds SMHAs administer vary from state to state but usually include state general revenues and federal funds.

The federal funds that SMHAs administer generally include Medicaid and Medicare payments for services provided in state-owned or state-operated facilities and other Medicaid payments when the state Medicaid agency has authorized the SMHA to control all Medicaid expenditures for mental health services. HCFA's Medicaid and Medicare programs pay for certain mental health services for eligible beneficiaries. States operate their own Medicaid programs within broad federal requirements. Medicaid pays for

⁶Olmstead v. L.C., 527 U.S. 581 (1999).

mandatory services, such as physician services, and optional benefits that states may choose to provide, such as rehabilitation and targeted case management. Since Medicaid is an entitlement program, states and the federal government are obligated to pay for all covered services that are provided to an eligible individual.⁷ Each state program's federal and state funding share is determined through a statutory matching formula, with the federal share ranging from 50 to 80 percent.⁸

In the 1990s, state Medicaid programs increasingly turned to capitated managed care plans to provide medical and behavioral health services as a way to control costs and improve services. Twenty-two states have “carved out,” or separated, mental health services from physical health services in contracting with managed care plans, placing them under separate financing and administrative arrangements. Some states create separate capitated arrangements and others use fee-for-service arrangements.⁹

Medicare covers elderly persons and persons who receive Social Security Disability Insurance, and it pays for a range of inpatient and outpatient mental health services.¹⁰ The Medicare statute requires a 50-percent co-payment from beneficiaries for outpatient care of mental disorders, compared with 20 percent for other medical outpatient treatment.¹¹ Furthermore, the Medicare statute limits treatment in a freestanding psychiatric hospital to a total of 190 days in a patient's lifetime.¹²

⁷For adults aged 22 to 64, Medicaid does not cover most services provided in institutions for mental disease, which are hospitals, nursing facilities, or other institutions of more than 16 beds primarily engaged in caring for people with mental illness. In addition, some states restrict the number of mental health services a person can receive in a year, require prior authorization for certain services, or both.

⁸In 1995, the average size of the federal match was 57 percent.

⁹States may require people eligible for Medicaid to enroll in a managed care plan if the state receives a waiver from HCFA under section 1115 or 1915(b) of the Social Security Act (42 U.S.C. 1315 and 1396n(b)). In addition, section 4701 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act to authorize states to establish Medicaid managed care programs simply by amending their state Medicaid plans. Pub. L. No. 105-33, 111 Stat. 251, 489 (classified at 42 U.S.C. 1396u-2).

¹⁰After receiving Social Security Disability Insurance benefits for 24 months, a person becomes eligible for Medicare.

¹¹42 U.S.C. 1395j(c).

¹²42 U.S.C. 1395(d)(3).

SMHAs also administer the funds they receive from SAMHSA's Community Mental Health Services Block Grant program. Block grants are allocated to states according to a statutory formula that takes into account each state's taxable resources, personal income, population, and service costs. The grants give states and territories a flexible funding source for providing a broad spectrum of community mental health services to adults with SMI and children with a serious emotional disturbance. Funding for the block grant program totaled \$356 million in fiscal year 2000; SAMHSA used about \$18 million for state systems development, including technical assistance, data collection, and evaluation. The remainder was awarded to the states and territories, with an average award of about \$5.7 million. (See app. III for other SAMHSA programs that help implement community-based mental health services.)

Federal Mental Health Spending Grew Faster Than State and Local Spending, and the Role of Medicaid and Medicare Increased

In 1997, the nation spent about \$73 billion for the treatment of all mental illness, up from \$37 billion in 1987.¹³ Mental health spending grew at about the same rate as overall health spending during this period. After adjusting for overall inflation, spending for all health care grew by 5 percent a year, on average, compared with 4 percent for spending on mental health services.¹⁴ In 1997, the public sector (that is, federal, state, and local governments) provided 55 percent of mental health spending, in contrast to providing less than half (about 46 percent) of overall health care spending.

From 1987 to 1997, adjusted annual federal spending for mental health grew, on average, more than twice as fast as state and local mental health spending (6.3 percent versus 2.4 percent). This led to the federal government's share of total mental health expenditures increasing from 22 to 28 percent during the period, while state and local governments' share of spending declined from 31 to 27 percent.¹⁵ The proportion from private spending sources also declined slightly from 46 to 45 percent (see fig. 1).

¹³National information is not collected specifically on the amount of money spent to treat serious mental illness. HCFA, SAMHSA, and others collect information only on overall mental health spending.

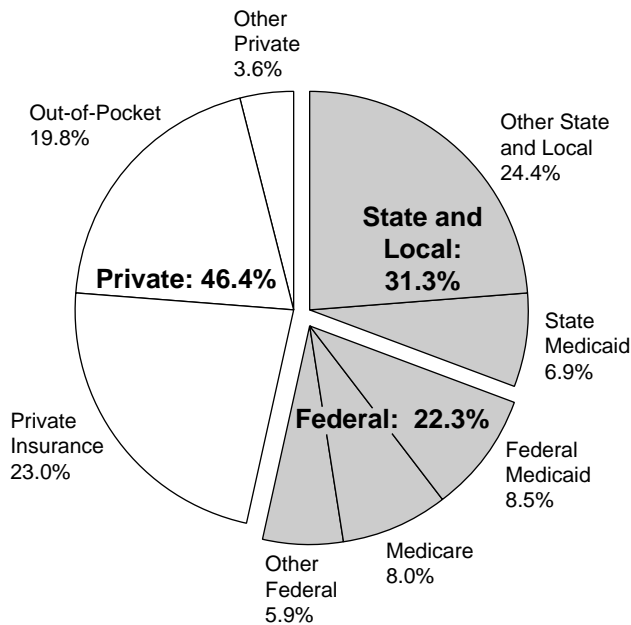
¹⁴Growth rates are based on data in *National Expenditures for Mental Health and Substance Abuse Treatment 1997* (Rockville, Md.: U.S. Department of Health and Human Services, 2000). The gross domestic product deflator was used to adjust for inflation.

¹⁵Federal expenditures included Medicaid's contribution, Medicare payments, and other federal expenditures, such as those from the Community Mental Health Services Block Grant and the departments of Defense and Veterans Affairs.

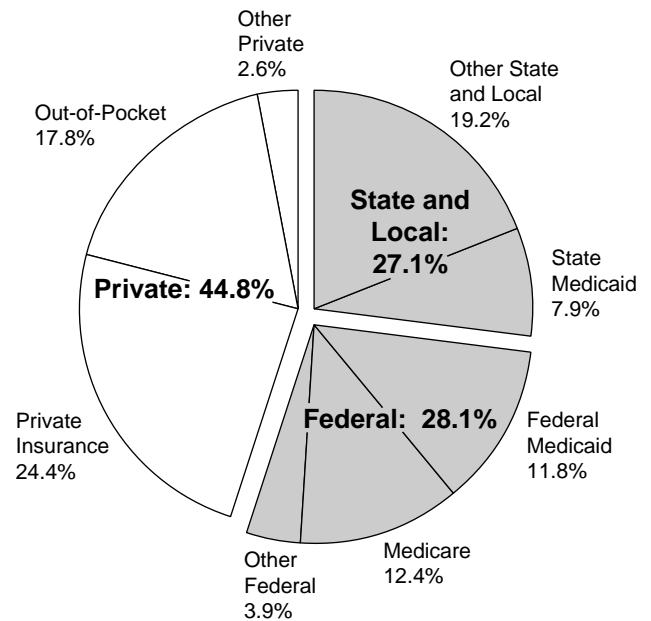
Figure 1: Percentage of Total Mental Health Expenditures by Funding Source, 1987 and 1997

1987

1997



Total Expenditures = \$37.1 billion



Total Expenditures = \$73.4 billion

Note: Percentages may not total 100 because of rounding.

Source: *National Expenditures for Mental Health and Substance Abuse Treatment 1997* (Rockville, Md.: U.S. Department of Health and Human Services, 2000).

Medicaid and Medicare played increasingly important roles in funding mental health services between 1987 and 1997. Medicaid's proportion of mental health spending (federal and state) rose from slightly more than 15 percent (\$5.7 billion) to about 20 percent (\$14.4 billion). Medicare's share rose from 8 percent to slightly more than 12 percent, with expenditures increasing from about \$3 billion to \$9 billion. HCFA and SAMHSA officials have suggested several reasons for Medicaid's increase. These include the trend toward Medicaid beneficiaries receiving their inpatient care in psychiatric units of general hospitals, where services are covered by Medicaid, rather than in psychiatric hospitals, where services are not covered; increased costs for psychiatric medications; and states' increased use of Medicaid to pay for community-based mental health services. The increase in Medicare spending may be associated in part with a 1990

statutory change that expanded coverage to nonphysician professionals providing mental health services, such as psychologists, clinical social workers, and nurse practitioners.¹⁶

Community-Based Services Are Designed to Address the Complex Needs of Adults With Serious Mental Illness

Over the past 20 years, states have largely shifted the care of people with SMI from institutions to the community. The continued development of psychotropic medications that both are more effective and produce fewer side effects has facilitated the ability to care for more people with SMI in the community. Furthermore, treatment approaches such as ACT, supported employment, and supportive housing can provide the multiple forms of ongoing assistance that adults with SMI often need to function. These approaches can also help homeless people with SMI, who have particularly complex treatment needs and who often have difficulty gaining access to the multiple services they need. Integration and coordination of services have been found to be effective in treating people with multiple needs.

Care Emphasis Continues to Shift From Institutions to Community Services

The focus of mental health services for people with SMI has continued to shift from providing care in psychiatric hospitals to providing community-based care. From 1980 to 1998, the number of patients institutionalized in state and county mental hospitals decreased by almost 60 percent—by the end of 1998, about 57,000 people were in state or county psychiatric hospitals.¹⁷ Although nationwide expenditure data are not available, data from 33 states show that state mental health agencies' expenditures for psychiatric hospitals dropped from 52 percent to 35 percent of total expenditures between 1987 and 1997, while community-based spending rose from 45 percent to 63 percent.¹⁸

The continued development of new antidepressant and antipsychotic medications has helped make it possible to care for more people with SMI

¹⁶Before 1990, generally only mental health services delivered by physicians were covered under Medicare.

¹⁷*Additions and Resident Patients at End of Year, State and County Mental Hospitals by Age and Diagnosis by State, United States 1998* (Rockville, Md.: SAMHSA, Center for Mental Health Services, 2000).

¹⁸Expenditure data were reported to NASMHPD by the 33 states, representing 74 percent of the U.S. population in 1997, in state fiscal years 1987 and 1997.

in the community. The newer medications further improve the ability of people with SMI to live in the community, receive care at a general hospital or in other clinical settings, and manage symptoms of their illness. The Surgeon General recently reported, for example, that the newer antipsychotic medications show promise for treating people with schizophrenia for whom older medications are ineffective, by reducing symptoms such as delusions, hallucinations, disorganized speech and thinking, and catatonic behaviors.¹⁹ Further, the Surgeon General reported that some of the newer drugs carry fewer and less severe side effects, generally resulting in better compliance with medication regimens, and that they may improve a person's quality of life and responsiveness to other treatment interventions. Patients using certain medications, however, require careful monitoring to ensure that they are receiving the appropriate dose and to minimize side effects. For example, in about 1 percent of patients, clozapine causes agranulocytosis, a potentially fatal loss of white blood cells that fight infection. Because this condition is reversible if detected early, weekly blood monitoring is critical.

States have supported an array of community-based services that are designed to enable people with SMI to remain in their communities and live independently. States frequently provide services directly or contract with county or community mental health organizations to offer services. Although most care is provided on an outpatient basis, people with SMI sometimes experience periods when they are unable to care for themselves and need short-term hospitalization. Table 1 describes types of mental health services for adults with SMI provided in the community.

¹⁹*Mental Health: A Report of the Surgeon General.*

Table 1: Community Mental Health Services Designed to Address Needs of Adults With SMI

Service	Description
Ambulatory	<p>Services provided in an outpatient setting that may include the following:</p> <p><i>Counseling</i>—individual, family, or group therapy that can be provided in an office or community setting, such as the person’s home or employment site;</p> <p><i>Medication dispensing and monitoring</i>—directly administering medications to an individual and observing the individual to identify both beneficial and inadvertent or undesirable side effects;</p> <p><i>Case management</i>—helping clients obtain financial, housing, medical, employment, social, transportation, and other community resources;</p> <p><i>Crisis intervention</i>—screening, psychiatric evaluation, emergency intervention, and stabilization; and</p> <p><i>Day treatment/psychosocial rehabilitation</i>—structured program activities including services such as social support, vocational training, and independent living skills</p>
Residential	<p>Services provided in group homes, independent or shared apartments, and single-room occupancies that may include training, support, medications, and supervision of routine activities, including community orientation, meal preparation, financial management, and transportation</p>
Inpatient	<p>Services provided in facilities such as a general hospital or inpatient unit of a community mental health clinic, including diagnosis and treatment services</p>

Many people with SMI need a range of services to help them function in the community. Several approaches to providing ongoing assistance and coordinated services have been developed to meet the varying needs of this population, such as ACT, supported employment, and supportive housing. ACT is a model of providing intensive care to people with the most severe and persistent mental illness. It is generally targeted toward people who have recently left institutions, typically do not schedule or keep appointments, or do not do well without extensive support. Under the ACT model, multidisciplinary teams are to be available to provide services around the clock in community settings, such as at the person’s home. Services can include administering medications, interpersonal skills training, providing crisis intervention, and providing employment assistance and are intended to be available as long as the person needs them. Supported employment programs assist people who have SMI to work in competitive jobs. Some supported employment programs emphasize quick placement into regular jobs, rather than training people before job placement, and then help enable individuals with SMI to perform acceptably in their jobs. Supportive housing programs attempt to address the needs of people with SMI who have been homeless or who are at risk of

becoming homeless by combining housing with other needed services, such as case management and substance abuse treatment. (For more detailed information on ACT, supported employment, and supportive housing, see app. IV.)

Homelessness Complicates the Treatment of Adults With Serious Mental Illness

Approximately 1 in 20 adults with SMI are homeless; they account for an estimated one-third of the approximately 600,000 homeless adults in the United States. At least half of homeless people with SMI also have substance abuse disorders. Mental illness in combination with substance abuse may predispose individuals to homelessness, as their conditions often lead to disruptive behavior, loss of social supports, financial problems, and an inability to maintain stable housing. Homelessness adds to the complexity of treatment needs for people with SMI; beyond mental health services, they need a range of physical health, housing, and social services. Compared with other homeless people, those with SMI are generally in poorer physical health, are homeless for longer periods of time, and often reside on the streets.

Homeless people with SMI have difficulty gaining access to the full range of health care, housing, and support services they need. Typically, they lack the income verification documentation necessary to enroll in entitlement programs, such as Medicaid; they have problems maintaining schedules; and they lack transportation. The Department of Housing and Urban Development (HUD) funds programs, including rental assistance and housing development grants, that have been used to help homeless people with SMI obtain housing. (See app. V.) Researchers and experts widely agree that the demand for low-income housing and housing subsidies far exceeds the supply. According to the National Coalition for the Homeless, many traditional mental health providers are neither equipped to handle the complex social and health conditions of homeless people nor typically linked to the range of services needed for their recovery and residential stability. Traditionally, separate systems have provided these services—such as the mental health, substance abuse, public housing, and social welfare systems—each of which has its own eligibility and program requirements. It is particularly difficult for people with SMI to negotiate systems in which services are separate and uncoordinated.

Research indicates that coordinated service delivery is important for meeting the numerous and complex needs of homeless people with SMI.²⁰ One study found that homeless people with SMI who participated in programs using an integrated treatment approach—in which multiple services were provided through a single entity—spent more days in stable housing (such as an apartment or group home) and reduced their alcohol use more than those receiving services through multiple agencies.²¹ SAMHSA's Access to Community Care and Effective Services and Supports program—an interdepartmental demonstration program integrating housing, mental health, substance abuse, employment, and social support services—found that service system integration was associated with improved access to housing services and better housing outcomes for homeless people with mental illness.²²

Efforts are under way to coordinate services to reduce the number of homeless people with SMI who become incarcerated.²³ SAMHSA is funding a study of programs for diverting adults with mental illness and substance abuse problems from the criminal justice system to community-based treatment. According to SAMHSA, diversion programs are often the most effective way to integrate an array of mental health, substance abuse, and other support services to help people break the cycle of repeated incarceration. In some communities, mental health courts are designed to hear the cases of people with mental illness who are arrested for misdemeanors such as loitering or creating a public nuisance. In these

²⁰We discuss the issues of coordination and integration of services for homeless people in more detail in *Homelessness: Coordination and Evaluation of Programs Are Essential* (GAO/RCED-99-49, Feb. 26, 1999) and *Homelessness: State and Local Efforts to Integrate and Evaluate Homeless Assistance Programs* (GAO/RCED-99-178, June 29, 1999).

²¹Robert E. Drake and others, "Integrated Treatment for Dually Diagnosed Homeless Adults," *The Journal of Nervous and Mental Disease*, Vol. 185, No. 5 (1997), pp. 298-305.

²²The departments of Agriculture, Education, Housing and Urban Development, Labor, and Veterans Affairs were also involved in this program.

²³In 1999, the Department of Justice reported that 60 percent of inmates with mental illness were under the influence of alcohol or drugs at the time of their offense and that 20 percent of those with mental illness had been homeless at some time during the 12 months before they were arrested.

programs, people with mental illness can have their case heard by the mental health court and can agree to follow a plan of mental health treatment and services instead of going to jail.²⁴

HCFA Is Supportive of New Community-Based Services and Is Developing Safeguards for the Use of Managed Care

HCFA has disseminated information to states about the more effective medications and treatments for adults with SMI and has supported states' use of Medicaid managed mental health care to provide a wider array of services not covered by traditional fee-for-service Medicaid. HCFA is developing safeguards to help ensure that states that use managed care arrangements furnish appropriate services to people with special health care needs, including people with SMI.

HCFA Has Encouraged States to Provide Advanced Treatments

HCFA has taken steps to encourage states to use new modes of care for adults with SMI. In June 1999, HCFA issued a letter to state Medicaid directors noting that research had demonstrated that ACT is an effective strategy for treating persons with SMI. The letter stated that states should consider these positive findings in their plans for comprehensive approaches to community-based mental health services.²⁵

HCFA has also encouraged the use of newer medications. In a letter to state Medicaid programs in 1998, it provided information on the effectiveness of new antipsychotic medications in treating schizophrenia. HCFA noted that

²⁴A federal demonstration program to promote mental health courts has been authorized for fiscal years 2001 through 2004. Under the America's Law Enforcement and Mental Health Project, in consultation with the Secretary of HHS, the Attorney General is to make matching grants to states and municipalities to establish up to 100 such courts throughout the nation. These courts will hear cases involving individuals with SMI charged with misdemeanors or nonviolent offenses, with the purpose of diverting many of them into appropriate mental health treatment. Among other things, grant funds will also be used to provide specialized training of law enforcement and judicial personnel. Pub. L. No. 106-515, 114 Stat. 2399 (2000) (to be classified at 42 U.S.C. 3796ii et seq.).

²⁵HCFA is also jointly sponsoring a contract with SAMHSA to examine the factors that contribute to the successful implementation of ACT programs at the state level. HCFA states that this contract will also review how states are using Medicaid and other resources to support ACT programs, how programs are designed to meet the needs of people with serious and persistent mental illness, and the outcomes of services.

some states and managed care organizations with formularies have already adjusted them to recognize these new medications.²⁶ HCFA suggested that all states consider the medications' advantages in reducing side effects, increasing patient compliance with treatment regimens, and possibly reducing psychiatric hospital readmissions.

HCFA has used its waiver authorities to support some states' initiatives to use Medicaid managed care carveout programs to enhance their provision of mental health services. With a waiver, states may gain the opportunity to provide some community-based mental health services that are not usually covered by fee-for-service Medicaid, provided they do not increase overall spending. For example, while many ACT program services can be reimbursed under existing Medicaid policies, some services, such as family counseling and respite care, are typically not reimbursable through Medicaid's traditional fee-for-service program. A survey of states with mental health carveout waivers found that some states did use the waiver to add coverage for services not previously included in their Medicaid plans, most frequently psychiatric rehabilitation and case management.²⁷

Safeguards Are Important to Ensure Access to Care for Medicaid Beneficiaries in Managed Care

As HCFA has noted in a draft report on strengthening Medicaid managed care, managed care organizations are often not accustomed to serving people with special health needs, such as adults with SMI, and may lack the expertise and provider networks required for treating them appropriately.²⁸ Moreover, while managed care arrangements can provide greater flexibility in the design and development of individualized services, capitated payment arrangements create incentives to limit access and underserve enrollees.

In a previous study of Medicaid managed mental health care, we found that HCFA had provided limited oversight of mental health managed care

²⁶A formulary is a list of drugs or classes of drugs a health care system or other organization has identified as appropriate for treating patients.

²⁷Chris Koyanagi and Jennifer Stevenson, *Assessing Approaches to Medicaid Managed Behavioral Health Care*, prepared by the Bazelon Center for Mental Health Law (Washington, D.C.: Kaiser Commission on the Future of Medicaid, July 1997).

²⁸This draft report was prepared for the Congress in response to the BBA requirement that HCFA develop a set of safeguards for individuals with special health needs who are enrolled in Medicaid managed care, including persons with SMI. Pub. L. No. 105-33, sec. 4705(c)(2), 111 Stat. 251, 500.

carveouts.²⁹ Most monitoring occurred when the waiver application was made or renewed, and it varied in content and intensity across HCFA's regional offices. This stemmed in large part from a lack of central office guidance on the type of program monitoring and oversight that HCFA staff should perform. HCFA officials told us that the agency has recently revised the monitoring guide that regional offices use when conducting site visits of managed care programs, including those that provide services to people with SMI.³⁰ In addition, SAMHSA now reviews all waiver applications to help HCFA ensure that waiver applications appropriately address issues such as the capacity of the proposed delivery system, the array of benefits covered, and quality of care.

Recognizing the risks for vulnerable individuals with special health care needs, the Congress in the BBA required HCFA to determine what safeguards may be necessary to ensure that the needs of these individuals who are enrolled in Medicaid managed care organizations are adequately met. HCFA's draft report in response to its BBA mandate contains a series of recommendations for HCFA, states, and managed care organizations regarding safeguards to help ensure that adults with SMI obtain needed services. HCFA recommends, for example, that states take steps to ensure that necessary services and supports are reasonably available to beneficiaries whose ability to function depends on receiving them. For example, HCFA suggests that states require in their contracts that managed care organizations' medical necessity decisions not always require improvement or restoration of functioning but may also provide for services needed to maintain functioning or compensate for loss of functioning. The draft indicates that HCFA intends to develop plans to implement its recommended safeguards, such as through legislative or regulatory action or changes in Medicaid administrative policies. HCFA has taken comparable action to protect children with special needs, another vulnerable population, when they are enrolled in state Medicaid managed care programs. HCFA developed interim review criteria with mandatory safeguards, which the agency plans to use to review state waiver applications that include these children in managed care.

²⁹ *Medicaid Managed Care: Four States' Experiences With Mental Health Carveout Programs* (GAO/HEHS-99-118, Sept. 17, 1999).

³⁰ Although the guide is in draft, it was distributed to HCFA regional offices in August 2000.

Concluding Observations

As people with SMI increasingly receive their care in the community, it is important that they have access to the variety of mental health and other services they need. Because of the nature of SMI, people with this condition are often poor and must rely on the public mental health system for their care. Recently, states have stepped up their efforts to provide community-based services that give ongoing support to adults with SMI. These services are especially critical for people making the transition from institutions to the community, to help prevent their becoming homeless or returning to institutions. Homeless people with SMI especially need to receive a range of mental health, substance abuse, social support, and housing services to function in the community, and it is important for providers to link these services effectively.

The use of managed mental health care by some state Medicaid programs has resulted in the flexibility to provide a wider array of services. However, given the potential for managed care providers reducing access to needed services, it is important for HCFA and state Medicaid programs to ensure that beneficiaries enrolled in managed care receive appropriate care. HCFA's current effort to identify safeguards recognizes the importance of people with SMI receiving the necessary services and continuity of care that are fundamental to their well-being. The agency has indicated that it will devise a set of actions to implement these recommended safeguards. Identifying the appropriate actions and effectively implementing them will be essential if the safeguards are to provide meaningful protection to this vulnerable population.

Agency and Other Comments

We provided a draft of this report to SAMHSA and HCFA for comment. SAMHSA generally agreed with the report's information on community-based mental health services for people with SMI. SAMHSA noted two developments that it considers important—an increase in the number of people with SMI who are treated in the criminal justice system because of inadequate resources for community mental health supports and states' support of consumer-run services and increasing solicitation of consumers' views on the delivery of community-based services. We did not evaluate the link between the number of people with SMI treated in the criminal justice system and the adequacy of community mental health resources or assess the participation of people with SMI in the operation of community-based services. In its technical comments, SAMHSA highlighted several efforts on which SAMHSA and HCFA work collaboratively. For example, SAMHSA staff have accompanied HCFA staff on site visits to monitor various states'

waiver programs, and a joint workgroup is developing indicators that states can use to predict problems or ensure success in their managed care programs.

In its comments on the draft report, HCFA summarized additional efforts by the Medicaid and Medicare programs to serve the needs of people with SMI. For example, HCFA has made grant money available for states to test demonstration projects that focus on removing barriers to employment for people with disabilities, including people with SMI. SAMHSA and HCFA provided technical comments, which we incorporated where appropriate. (SAMHSA's and HCFA's comments are in apps. VI and VII.)

We are sending copies of this report to the Honorable Donna E. Shalala, Secretary of HHS; the Honorable Joseph Autry, Acting Administrator of SAMHSA; the Honorable Robert A. Berenson, Acting Administrator of HCFA; officials of the state mental health and Medicaid agencies we visited; appropriate congressional committees; and others who are interested. We will also make copies available to others on request.

If you or your staffs have any questions, please contact me at (202) 512-7119. An additional GAO contact and the names of other staff who made major contributions to this report are listed in appendix VIII.



Janet Heinrich, Director
Health Care—Public Health Issues

Scope and Methodology

To do our work, we interviewed officials at the Health Care Financing Administration (HCFA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Mental Health (NIMH), and the National Association of State Mental Health Program Directors (NASMHPD), and we reviewed documents such as SAMHSA's *National Expenditures for Mental Health and Substance Abuse Treatment 1997*, SAMHSA's Center for Mental Health Services 1998 Survey of Mental Health Organizations and General Hospitals with Separate Psychiatric Services, and NASMHPD reports and data regarding the funding sources and expenditures of state mental health agencies. Although other federal agencies, such as the Department of Defense and the Veterans Administration, provide services to people with mental illness, we generally restricted our scope at the federal level to the Department of Health and Human Services (HHS) because HHS programs account for most federal mental health spending.

We conducted site visits to Michigan and New Hampshire, where we interviewed state mental health and Medicaid officials and administrators of selected treatment programs. We selected these states for site visits because experts identified them as implementing exemplary programs. We also reviewed several states' Center for Mental Health Services monitoring reports, annual implementation reports, and Community Mental Health Services Block Grant applications.

We also reviewed relevant literature and obtained information from individual experts as well as a number of organizations interested in mental health issues such as the American Psychiatric Association (APA), the American Psychological Association, the Bazelon Center for Mental Health Law, the International Association of Psychosocial Rehabilitation Services, the National Alliance for the Mentally Ill, the National Mental Health Association, and the Treatment Advocacy Center.

We conducted our work between May and November 2000 in accordance with generally accepted government auditing standards.

Involuntary Outpatient Commitment

Most states have laws authorizing involuntary outpatient commitment, also referred to as mandatory or assisted outpatient treatment. APA defines mandatory outpatient treatment as court-ordered outpatient treatment for patients who suffer from severe mental illness (SMI) and who are unlikely to comply with such treatment without a court order.¹ APA considers this a preventive treatment for people who do not meet criteria for inpatient commitment and who need treatment in order to prevent relapse or deterioration that would predictably lead to their meeting inpatient commitment criteria in the foreseeable future. Some states have adopted standards for involuntary outpatient commitment that reflect this approach, but most have adopted the criterion of individuals presenting danger to themselves or others, the same standard they use for involuntary inpatient commitment. Mandatory outpatient treatment may also be used as part of a discharge plan for persons leaving inpatient facilities or as an alternative to hospitalization.

Although 41 states and the District of Columbia have adopted involuntary outpatient commitment laws, they are rarely used in many of these states. The approach of using involuntary outpatient commitment has generated some controversy.² People who support it believe that it helps ensure treatment for people who need services but whose very illness prevents them from recognizing their need, thus enabling them to remain in the community instead of deteriorating in ways that could result in their being institutionalized. Those who oppose it are concerned that it threatens civil liberties, diverts scarce resources, and undermines the relationship between people with mental illness and service providers. Some states have preferred to take other approaches, such as the use of advance directives. These legal documents allow individuals to express their choices about mental health treatment or appoint someone to make mental health care decisions for them in case they become incapable of making their own decisions.

¹APA, *Mandatory Outpatient Treatment: A Resource Document of the American Psychiatric Association* (Washington, D.C.: 1999).

²See also National Health Policy Forum, "Outpatient Commitment in Mental Health: Is Coercion the Price of Community Services?" Issue Brief 757 (Washington, D.C.: 2000).

Selected SAMHSA Efforts to Help the Implementation of Community-Based Programs

Program	Description	Funding
Community Action Grants for Services Systems Change	Awards community groups grants of less than \$150,000 to sponsor a best practice targeted toward adults with SMI or adolescents and children with serious emotional disorders.	\$18.9 million over fiscal years 1997-2001
Employment Intervention Demonstration Program	An eight-site demonstration program to learn about the most effective approaches for helping adults with SMI find and maintain competitive employment.	\$15.5 million over fiscal years 1997-2001
Knowledge Exchange Network	Uses various media to provide information about mental health to users of mental health services, their families, the general public, policymakers, providers, and researchers.	\$9.3 million over fiscal years 1997-2001
National GAINS Center for People with Co-Occurring Disorders in the Justice System	A partnership with the National Institute of Corrections, the Office of Justice Programs, and the Office of Juvenile Justice and Delinquency Prevention, this program collects information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system and disseminates it to states, localities, and criminal justice and provider organizations. Its goals include assessing which services work for which people, interpreting information, putting it into a useful form, and stimulating the use and application of information.	\$4.7 million, including \$200,000 from the Department of Justice, over fiscal years 1995-2000
Center for Mental Health Services' Jail Diversion Program	A nine-site program to examine the relative effectiveness of pre- and post-booking diversion to community-based services for people with mental illness and substance abuse disorders in the justice system.	\$11 million over fiscal years 1998-2001
Access to Community Care and Effective Services and Support Program	A demonstration program that is testing the hypothesis that integrating fragmented service systems will substantially help end homelessness among people with SMI.	\$93 million over fiscal years 1994-2000
Projects for Assistance in Transition From Homelessness	Annual formula grant that provides states and territories with a flexible funding source specifically to serve homeless individuals with SMI, including those with substance abuse problems. The program is designed to provide services that will enable homeless people with a mental disorder to find appropriate housing and mental health treatment.	\$31 million in fiscal year 2000
Consumer-Operated Services Program	Eight-site program to evaluate the extent to which services operated by people with SMI are effective in improving outcomes of adults with SMI when used as an adjunct to traditional mental health services.	\$19.6 million over fiscal years 1998-2001

Selected Community-Based Approaches to Treating People With Serious Mental Illness

The development of varied community-based treatment models has increased the ability to meet the complex needs of adults with SMI. Following are descriptions of several approaches and examples of how they are implemented in New Hampshire and Michigan.

Assertive Community Treatment

Assertive community treatment (ACT) is designed to provide comprehensive community-based services to people with SMI. ACT is intended for people with the most severe and persistent illnesses, including schizophrenia and bipolar disorders. It is also appropriate for persons who are significantly disabled by other disorders and have not been helped by traditional mental health services. Experts report that ACT is a good approach for people with SMI who have recently left institutions, typically do not schedule or keep appointments, or do not do well without a lot of support. ACT programs use a variety of treatment and rehabilitation practices, including medications; behaviorally oriented skill teaching; crisis intervention; support, education, and skill teaching for family members; supportive therapy; cognitive-behavioral therapy; group treatment; and supported employment.

Under the ACT model, services are delivered by a mobile, multidisciplinary treatment team. Unlike traditional case management, in which the case manager often brokers services that others provide, the ACT staff are to work as a team to provide services directly. These services are to be available 24 hours a day, 365 days a year. The majority of ACT services are to be provided in the community, including the person's home, employment site, or places of recreation rather than in an office setting. The treatment team is to adapt and individually tailor interventions to meet the specific needs of the person with SMI rather than requiring the person to adapt to the team or the rules of a treatment program. Under the ACT model, services are to be designed to continue indefinitely, as needed.

In order to provide the type and intensity of services required, ACT, as a program model, has a number of staffing requirements. First, the ACT team typically includes 10 to 12 mental health professionals, depending on the number needed to be able to provide services around the clock. All teams have a full-time leader or supervisor, a psychiatrist, a peer specialist, and a program assistant. ACT programs are designed to have a ratio of no more than 10 clients for each staff person, not counting the psychiatrist and program assistant. As a result, the typical maximum caseload is 120 for urban teams and 80 for rural teams.

A provider we visited in New Hampshire operates three types of ACT teams. Two of these teams, one of which works exclusively with people who have both mental illness and a substance abuse disorder, are designed for people with SMI who generally reject treatment and need care available to them around the clock. These teams do not routinely operate in the evenings or on weekends, but staff are on call at all times. People are moved from these programs as their need for intensive services decreases, partly because the programs are very expensive to operate. The third team operates during normal business hours and is designed for individuals who have been institutionalized but accept treatment and do not require 24-hour care.

Michigan offers ACT services statewide. Its program delivers a comprehensive set of treatment, rehabilitation, and support services to persons with SMI through a team-based outreach approach. A provider we visited in Michigan offers ACT services to persons who have been repeatedly hospitalized and who have failed to become stabilized on their medications. The provider generally does not offer ACT services until less intensive services have been tried and have failed. After 15 years of operation, about 65 to 70 percent of the original participants continue to receive ACT services.

Studies have found that ACT may be associated with reduced hospital admissions, shorter hospital stays, better social functioning, greater housing stability, fewer days homeless, and fewer symptoms of thought disorder and unusual activity.¹ Studies have also found that ACT services

¹Anthony F. Lehman and others, "Cost Effectiveness of Assertive Community Treatment for Homeless Persons With Severe Mental Illness," *British Journal of Psychiatry*, Vol. 174 (1999), pp. 346-52. Anthony F. Lehman and others, "A Randomized Trial of Assertive Community Treatment for Homeless Persons with Severe Mental Illness," presentation at the Annual Meeting of the American Psychiatric Association (Miami, Fla.: May 1995). Gary Morse and others, "An Experimental Comparison of Three Types of Case Management for Homeless Mentally Ill Persons," *Psychiatric Services*, Vol. 48, No. 4 (1997), pp. 497-503. Jerry Dincin and others, "Impact of Assertive Community Treatment on the Use of State Hospital Inpatient Bed-Days," *Hospital and Community Psychiatry*, Vol. 44, No. 9 (1993), pp. 833-38. Gary R. Bond and others, "Assertive Community Treatment for Frequent Users of Psychiatric Hospitals in a Large City: A Controlled Study," *American Journal of Community Psychology*, Vol. 18, No. 6 (1990), pp. 865-87.

cost less than other services, especially inpatient and emergency room care.²

Supported Employment

Supported employment is an approach to help people with SMI succeed in regular work settings by providing them ongoing training and support as needed. In supported employment, participants generally earn money for their work (usually at the prevailing wage) and work as regular employees alongside nondisabled employees (not segregated with other employees with disabilities, either mental or physical).

Individual Placement and Support (IPS), the most studied supported employment approach, focuses on finding adults paid work in regular work settings and providing them training and support as long as necessary after placement, in contrast to more traditional approaches that provide testing, counseling, training, and trial work experiences before they seek competitive employment. IPS focuses on integrating clinical and vocational services, performing minimal preliminary assessments, conducting rapid job searches, matching people with jobs of their choice, and providing ongoing supports, such as helping with transportation or finding a substitute for the position if the person is having trouble with illness symptoms. Studies have found that participants in IPS programs have had higher employment rates than people involved in traditional programs. For example, an early study of IPS found that 56 percent of IPS participants had competitive jobs during their first year in the program, compared with 9 percent of those who stayed in a day treatment program that emphasized skills training groups, socialization groups, and sheltered work within the mental health center.³

The provider we visited in New Hampshire began offering IPS in 1995 because staff found it was effective at getting persons with SMI back to work. Further, they had earlier found that participants were not able to apply the skills learned in the provider's prior sheltered vocational training program to jobs outside that sheltered environment. The provider serves

²Anthony F. Lehman and others, "Cost Effectiveness of Assertive Community Treatment for Homeless Persons With Severe Mental Illness." Daniel Chandler and others, "Cost Effectiveness of a Capitated Assertive Community Treatment Program," *Psychiatric Rehabilitation Journal*, Vol. 22, No. 4 (1999), pp. 327-36.

³Robert E. Drake and others, "Rehabilitative Day Treatment vs. Supported Employment: I. Vocational Outcomes," *Community Mental Health Journal*, Vol. 30, No. 5 (1994), pp. 519-32.

225 people at a time in its IPS program and told us that about half of those have jobs at any given time.

Supportive Housing

Supportive housing addresses the needs of people with SMI who are homeless or at risk of becoming homeless. This approach combines housing with access to services and supports, such as case management services, substance abuse treatment, employment assistance, and daily living supports. Supportive housing refers to a range of housing interventions that can be transitional or permanent. Transitional housing is typically group housing, where the person can live for a predetermined period of time, with services and supports provided on-site. Permanent supportive housing, which includes single room occupancy hotels and apartments, has no predetermined time limits and generally includes access to services in the community. There appears to be no single housing model that is most effective for people with SMI. Experts have stated that linking housing and supportive services is crucial for helping people with SMI live independently and that, because of the varying needs of people with SMI who are homeless, a range of housing and service options is necessary.

Selected HUD Programs That Can Assist Homeless People Who Have SMI

Program	Description	Funding
Section 8 Rental Certificate and Voucher Program	Provides rental assistance to very low-income families, elderly persons, and disabled persons for decent, safe, and sanitary housing in the private market.	\$10 billion in fiscal year 1999
Single Room Occupancy Program	Provides rental assistance to homeless individuals to obtain permanent housing in single-room occupancy units.	\$17 million in fiscal year 1999
Shelter Plus Care	Provides rental assistance, together with supportive services funded from other federal, state, local, and private sources, to homeless people with disabilities. Program grants provide rental assistance payments through (1) tenant-based rental assistance, (2) sponsor-based rental assistance, (3) building owner-based rental assistance, or (4) single room occupancy assistance.	\$152 million in fiscal year 1999
Supportive Housing Program	Provides grants to states, local governmental entities, private nonprofit organizations, and community mental health associations to develop supportive housing and supportive services to assist homeless persons in the transition from homelessness and to enable them to live as independently as possible. Program funds may provide (1) transitional housing, (2) permanent housing for homeless persons with disabilities, (3) supportive services for homeless persons not living in supportive housing, (4) housing that is, or is a part of, an innovative development of alternative methods designed to meet the long-term needs of homeless persons, and (5) safe havens. ^a	\$581 million in fiscal year 1999

^aSafe havens are designed to provide safe residences for homeless people with SMI who are living on the street and unwilling or unable to participate in mental health or substance abuse treatment programs or to receive support services. Safe havens are intended to reach homeless people who are suspicious or afraid of more structured supportive housing.

Comments From the Substance Abuse and Mental Health Services Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

DEC 12 2000

TO: Director
Health Care—Public Health Issues
U.S. General Accounting Office

FROM: Acting Administrator

SUBJECT: Comments on Draft GAO Report Titled: *Mental Health: Community-Based Care Increases for People with Serious Mental Illness (GAO-01-224)*

In response to your request of December 1, we have reviewed the draft report titled: *Mental Health: Community-Based Care Increases for People with Serious Mental Illness*. Overall, we believe this report provides a comprehensive history and current information on the nation's response to inpatient and community-based mental health services, inclusive of past and current financial resources, for people with a serious mental illness (SMI).

While we understand why the report could not address all changes in community mental health services for people with SMI, there are two important issues which should not be overlooked. These issues are: (1) the alarming increase in the number of people with SMI who are being treated in the criminal justice system because of inadequate resources for community mental health supports, and (2) the tremendous rise in the consumer movement, which has led many states to support consumer-run services as a vital component of their mental health services and to increasingly solicit consumer input into all aspects of their operations. We believe the report would be more comprehensive if it included some discussion of these very important aspects of community support.

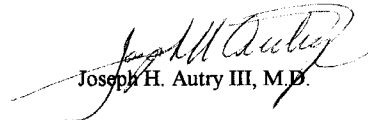
Attached are our technical comments on your draft report.

**Appendix VI
Comments From the Substance Abuse and
Mental Health Services Administration**

Page 2 -Director, Health Care–Public Health Issues, GAO

Thank you for providing us the opportunity to review and comment on this important report. We look forward to receiving your final report and hope it will reflect the concerns we have addressed above.

If you have any questions about these comments, please contact Delores Christie on (301) 443-4543.



Joseph H. Autry III, M.D.

Attachment

Comments From the Health Care Financing Administration



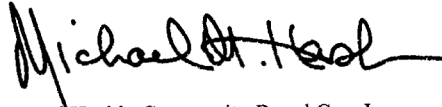
DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: DEC 11 2000

TO: Janet Heinrich
Health Care Public Health Issues
General Accounting Office (GAO)

FROM: Michael M. Hash
Acting Administrator 

SUBJECT: GAO Draft Report: "Mental Health: Community-Based Care Increases for People With Serious Mental Illness" (GAO-01-224)

Thank you for the opportunity to comment on the draft report prepared in response to the request from Senators Roth and Moynihan to review mental health services for persons with serious mental illness (SMI). The Health Care Financing Administration (HFCA) is committed to ensuring that beneficiaries with SMI receive adequate and appropriate community-based mental health services.

As part of your report, the Senators specifically asked you to review how HFCA supports the provision of community-based services for Medicaid-eligible adults with SMI. The information contained in this report will assist us in making sound policy to support the provision of community-based services decisions under our programs for persons with SMI. We appreciate the Senators' interest in this very important subject.

We also appreciate the effort that went into the report and look forward to working with GAO on this and other issues in the future. Our general and technical comments are attached.

Attachment

**Appendix VII
Comments From the Health Care Financing
Administration**

Comments of the Health Care Financing Administration on the
General Accounting Office Draft Report: "Mental Health: Community-Based Care
Increases for People with Serious Mental Illness"

Following is a summary of HCFA's efforts to better serve the needs of persons with SMI under both the Medicaid and Medicare programs.

Medicaid

HCFA strongly supports State efforts to provide community-based mental health services under the Medicaid program. In response to the Supreme Court's Olmstead decision, HCFA has provided guidance to States to assist them in their efforts to ensure that persons with disabilities, including persons with SMI, receive services in the least restrictive environment appropriate for their needs. Four letters have been issued to State Medicaid Directors and Governors as part of an on-going series of guidance materials. We expect to issue additional guidance in the next few months, particularly in the area of how States can more effectively use home and community-based waiver programs to serve persons with mental illness.

As you reference in your report, HCFA issued a letter to State Medicaid Directors summarizing the evidence base for Assertive Community Treatment (ACT) programs for persons with schizophrenia, noting that such programs can be supported under current Medicaid policies. To provide an information base for technical assistance to States about implementation of ACT programs, HCFA and SAMHSA have jointly sponsored a contract to evaluate State experience in supporting evidence-based ACT programs for persons with a serious and persistent mental illness. The evaluation, which has not yet been completed, will examine the factors that contribute to the successful implementation of ACT programs at the State level. It will also focus on how States are using Medicaid and other resources to support these programs; how programs are designed to meet the needs of the particular population to be served; and the outcomes of services from consumer, provider, and systems perspectives.

Further, as part of the implementation of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), HCFA has made available grant monies for States to test demonstration projects which target groups of disabled individuals so that barriers to employment may be removed. Some States are considering applying for demonstration grant money that would target individuals with SMI. Grant monies are also available for States to develop infrastructures to work toward the implementation of the TWWIIA groups. Currently States may also elect to provide Medicaid coverage to three new Optional Eligibility Medicaid groups for individuals with disabilities who work (two under TWWIIA and one under the Balanced Budget Act of 1997). Each of these Optional groups may increase health care coverage to individuals with SMI.

HCFA also has increased its focus on the ongoing monitoring of all Medicaid managed care programs, including managed mental health care programs. The agency has recently revised the initial and renewal 1915(b) managed care waiver application to capture essential information that will help to ensure beneficiary access to quality mental health services. The agency also has

revised the managed care monitoring guide that central and regional offices use when reviewing managed care waiver programs and conducting onsite visits. These review tools include more specific questions regarding special populations, and an entirely new section regarding SMI in the monitoring guide. HCFA regional and central offices are also involved in a cross-cutting workgroup that is examining current processes, creating a monitoring framework, and making recommendations regarding the monitoring processes.

Finally, we also expect that our new managed care regulation, now under development, will improve the responsiveness of managed care organizations to people with mental illnesses.

Medicare

Millions of Americans over age 65 live with mental illness. HCFA has taken steps to help beneficiaries recognize symptoms of mental illness and to obtain professional treatment, especially in the area of clinical depression. For example, we joined with the Administration on Aging and the National Institute of Mental Health in the development and dissemination of a bookmark for older adults entitled, "Before You Say, 'I'm Fine.'" It presents screening questions for older adults to ask themselves, such as if they feel nervous or empty, guilty or worthless, or whether life seems worth living. If their answers indicate that they are depressed, the bookmark suggests talking to a doctor. We started promoting this depression screening information on the Medicare Website at www.medicare.gov in October 1999. HCFA continues to promote and disseminate this important information throughout the country, through regional offices, State health insurance assistance programs, key partners, and the Medicare hotline.

More recently, HCFA distributed via satellite a video news release entitled "Depression: Not A Normal Part of Aging," on December 1 and December 7, 2000. We chose this time to distribute the video news release because for some elderly, the holiday season can be a sad time. The video news release presents a case study of an elderly woman who successfully identified and overcame her clinical depression by seeking professional help. Through the satellite link, the video news release was made available to approximately 900 television stations across the country.

GAO Contact and Staff Acknowledgments

GAO Contact

Helene F. Toiv, (202) 512-7162

Staff Acknowledgments

Other major contributors to this report were Renalyn Cuadro, Nila Garces-Osorio, Brenda R. James, Janina R. Johnson, Carolyn Feis Korman, and Craig Winslow.

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