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II. CONFERENCE REPORT

Financing Policy for Mental Health Services

by Susan Baird Kanaan

A look at the financing and delivery policies surrounding mental health care in the United States underscores the fragmentation found throughout the health care system. Tensions arise between public- and private-sector payers and providers; inpatient versus outpatient settings for care; institution versus community-based services; the medical model versus a comprehensive psychosocial model; the demand for resources from the chronically ill versus people with less serious disabilities; and federal versus state payment systems, to name a few.

In an effort to bring together some of the disparate players in this field to discuss the needs and directions of mental health financing and delivery, Health Affairs convened a one-day roundtable workshop on 15 October 1990, with support from The John D. and Catherine T. MacArthur Foundation. The meeting was convened in Washington, D.C., at the offices of the Mental Health Policy Resource Center. A key goal was to foster dialogue between federal and state policymakers and leading mental health researchers, administrators, providers, and advocates.

Defining The Issues

Steven Sharfstein, formerly director of the Services Division of the National Institute of Mental Health (NIMH) and currently medical director of the Enoch and Sheppard Pratt Hospital in Baltimore, Maryland, set the stage for the day’s discussion with an overview of current mental health services and priority issues. He identified two major and paradoxical problems: unmet need and lack of access to mental health care, on the one hand, and overutilization and excess cost, on the other.

On the first, Sharfstein cited NIMH findings that of the 18.7 percent of the population with a psychiatric disorder, only one in five is receiving treatment. Over 30 percent of the nation’s population has no health insurance, and far more are underinsured. In addition, “in terms of mental health services, there is greater un- and underinsurance than for general health services,” said Sharfstein. “Employees and their insurers do not expect a mental illness or demand the coverage. They prefer dental [coverage] to mental,” he continued. Furthermore, “insurance coverage is considered to be unnecessary by a lot of our payers” because of the existing state hospital system set up to handle the most serious cases, he concluded.

On the second set of problems, overutilization and excess cost, Sharfstein reported that use of for-profit psychiatric facilities is increasing dramatically relative to public facilities, as is the cost of care (Exhibit 1). The major areas of increase in the for-profit sector are substance abuse (up 33 percent between 1986 and 1988) and adolescent mental health treatment (up 65 percent over 1986–1988). This growth has been stimulated in part by aggressive marketing by for-profit hospitals, provoking what Sharfstein called a “managed care counterrevolution” as private payers struggle to contain costs.

Sharfstein asserted that federal and state mandates are needed to enhance services and spread the cost of caring for the seriously mentally ill, to remedy the “economic opportunism of the for-profit sector and the failure of the public sector” to meet their needs. He was the first of many in the day’s discussion to focus attention on those he considers the priority target for services: the seriously or chronically mentally ill. He called for development of a strategy to provide the seriously ill with long-term care in a continuum of services, coordinated by case management. Sharfstein also pointed to the need for a stronger knowledge base to address issues of clinical uncertainty surrounding mental health services and an improved mental health services research data base for sound policy making.
Exhibit 1
Distribution Of Psychiatric Inpatient Care In The United States, 1970,1980, And 1987

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private freestanding for-profit</td>
<td>1%</td>
<td>4%</td>
<td>11%</td>
<td>1 %</td>
</tr>
<tr>
<td>Private freestanding nonprofit</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Acute care general hospital unit</td>
<td>4</td>
<td>15</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>State and county</td>
<td>93</td>
<td>77</td>
<td>65</td>
<td>–28</td>
</tr>
<tr>
<td>Total number of beds</td>
<td>449</td>
<td>203</td>
<td>200</td>
<td>–249</td>
</tr>
</tbody>
</table>


Federal Views

The Health Care Financing Administration (HCFA) oversees payment for mental health services under the Medicare program for the elderly and holds joint responsibility with the states for the Medicaid programs for the poor. HCFA Administrator Gail R. Wilensky told workshop participants: “I think that there have been more changes with regard to the role of the federal government and financing of mental health services than many people understand.” The Omnibus Budget Reconciliation Acts of 1987, 1988, and 1989 “added ambulatory mental health care under the Medicare program, and mandated mental health care in nursing homes under the Medicaid program,” she continued.

Wilensky indicated her strong support for capitated and coordinated systems of financing and delivery for both general and mental health care services. She acknowledged the inequities and perverse incentives in the current system of payment for psychiatric care under Medicare, which were pointed out by a number of mental health researchers at the meeting. (See also “Medicare Payment to Psychiatric Facilities: Unfair and Inefficient?” by Jerry Cromwell and colleagues, on page 124 of this issue of Health Affairs.) Wilensky noted that “in principle” she would favor including Medicare’s payment for psychiatric care under the prospective payment system (PPS), but that wide variations in actual mental health care practice create difficulties in setting a reasonable prospective reimbursement base.

One issue raised in discussions between Wilensky and the mental health leaders was the lack of trust and communication among players in the mental health system, which hinders cooperation and change. Howard Goldman, professor of psychiatry at the University of Maryland and coprincipal investigator at the Johns Hopkins University–University of Maryland Center on Organization and Financing of Care for the Severely Mentally Ill, pointed to this problem: “It seems to me that designing policies and getting them passed on a statutory basis is very exciting. We’ve been more successful in the last few years in that. But implementing change isn’t as sexy... I think that is one place where the Health Care Financing Administration...has made an effort, but has not been able to do things in a timely way.”

In defense of HCFA, Tom Hoyer, director of the HCFA Division of Provider Services Coverage Policy, argued that “it works two ways.... As health care providers go, mental health care providers are about the least attuned as to how to claim payment.” Wilensky also laid some of the blame for implementing legislative changes at the feet of Congress for not clearly spelling out their intent in the statutory language of the new laws: “Congressional intent is just fine and
dandy, but if they screw up their statute, we [HCFA] go according to their statute, and when they get around to changing the statutory language, we’ll get around to changing the regulation with probably a delay of a year and a half.”

The need for greater flexibility in federal payment systems to encourage innovation and cost savings was another topic of discussion between Wilensky and workshop participants. Day treatment and systemwide prospective payment were offered as examples of rational, less expensive alternatives vitiated by current federal policy. Hoyer told participants that he expected newly introduced payment measures, such as capitation schemes, to result in greater flexibility in the system in a year or two.

State Views

Connecticut Mental Health Commissioner Michael Hogan told workshop participants: “There is something going on in many states and in many local public sector mental health operations that have something to teach not just the rest of the public mental health system, but medicine in general.” States such as New Hampshire, Vermont, and Rhode Island and regions of many other states have figured out how to run systems that select patients on the basis of need, emphasize continuity of care, and include clinically managed care as a priority. “It seems to me that what is being learned out there is momentous, and a lot of people inside the Beltway, as well as in the medical community, don’t know about it,” said Hogan.

New York State Mental Health Commissioner Richard Surles described his office’s efforts to create basic structural changes in a state mental health system he described as overbedded and faced with economic crisis and rising need. After researching the underlying statistics of New York’s mental health system, Surles discovered that “the hospital setting has become the crisis center for the psychiatric failures of the system.” In addition, a small percentage of the patients (5 percent) accounted for a disproportionate share of the state’s mental health resources (40 percent).

A roster of these priority high-need clients was selected to receive intensive, case-managed services. Program planners devised flexible service delivery conditions to encourage innovation and economy. For example, case managers have discretionary funds for special needs, and an elaborate system of incentives and regulations was set up within the Medicaid program to encourage shorter lengths-of-stay and increased access and to promote discharge planning and outpatient care. Services were expanded in areas of high need.

In addition to expanding the range of services offered, New York State’s Mental Health Office achieved cost savings for the state. This was accomplished by narrowing the boundaries of the client population and reducing overuse by segments of it. Within thirty-six months, annual days of care were reduced by two million. Admissions by a cohort of high users were reduced by half, and their days of care by 40 percent, in six months.

Surles said one of the major struggles in the public mental health system today is the question of how to “advocate for an expansion, especially a high-cost service, unless you can show that you can reduce” elsewhere by identifying a subset of recipients. One method used by states has been to aggressively wield the authority of the state as regulator and change agent, to exert control over cost and distribution of services. Surles emphasized the importance of using state authority, through financing, regulation, and coordination, as an instrument of public policy.

Establishing Incentives

Goldman, economist Tom McGuire of Boston University, and psychologist Charles Kiesler of Vanderbilt University identified and discussed some of the financial incentives at work in the mental health care system. McGuire called for flexibility in how states can use mental health funds. Goldman noted that while the current Medicaid program contains a structure to fund a broad array of benefits, “there has been no stomach
on the part of many states for paying their half of the bill." Goldman also discussed the distortions in incentives that can arise from a mixed public/private system, as patients are shifted from one payer to another and as private providers have an incentive to "game" the system.

Kiesler discussed the results from his studies of nonfederal general hospitals. He found large increases in Medicaid and self-payment relative to other payment sources, a rapidly accelerating inpatient rate in general hospitals, large increases in affective disorders as a proportion of psychiatric disorders being treated, and increases in treatment by for-profit hospitals for alcohol and drug dependency relative to mental disorders. Kiesler also found that over 60 percent of psychiatric inpatient treatment today is taking place in general hospitals, rather than in psychiatric hospitals.

To bring some specificity to the discussion of incentives, Miles Shore, superintendent of the Massachusetts Mental Health Center, described a program of The Robert Wood Johnson (RWJ) Foundation to stimulate new approaches to delivering and financing mental health care in nine communities. Shore serves as project director for the Nine Cities Program.

Each of the nine cities, selected from fifty-five applicants, received $2.5 million over five years plus low-interest housing loans and HUD Section 8 certificates. The cities are Honolulu; Austin, Texas; Denver, Colorado; Cincinnati, Toledo, and Columbus, Ohio; Charlotte, North Carolina; Philadelphia; and Baltimore.

Shore said the foundation's aim was to establish clinically sound incentives for care of the mentally ill. He outlined the program's seven clinical assumptions. First, each city's plan must take into account the changing nature of mental health needs. Second, plans must recognize a balance between biology and interpersonal and community relations. Third, easy movement within the system is valued. Fourth, plans must emphasize clinical continuity, to minimize change and its negative impacts. Fifth, services are seen as substituting for each other—for example, availability of housing may reduce the need for inpatient services. Sixth, both maximum and minimum needs are defined. Finally, the extreme difficulty of some cases is recognized.

Shore said the incentives espoused in the RWJ program are having the intended effect of stimulating innovation. He cited as examples the high-user methodology developed in Philadelphia and now used successfully in New York State; involvement of empowered community boards in Ohio; and creation in Denver of a fiduciary body to bring together several elements where no single-stream funding had existed. Some sites are exploring use of capitation in financing systems. However, Shore noted: "Capitation is a very simple idea that, when you get into it, is very complicated in terms of the risks to whom and about what."

Future Direction Of Policy Making

As the participants discussed how to convert research and demonstration results into practice, many agreed that the most attractive locus for policy making is at the state rather than the federal level. "I think the states are really the place where it is happening. I don't think the feds are showing any leadership," said HCFA's Hoyer.

Leslie Scallet, executive director of the Washington-based Mental Health Policy Resource Center and cohost of the workshop, commented that simply looking to the states is not enough. "We have to look for ways to integrate knowledge about what the states are doing, and how that can impact the total system," she said.

While no consensus was reached regarding the direction of mental health policy making, the group did recognize several needs within the mental health system. Denis Prager, director of the Health Program at the MacArthur foundation, summarized these needs in his concluding comments. First is to recognize the reality of the demand. "It will be necessary, if we're going to provide services on a rational basis," Prager said, "to identify the subsets of those in need of services, and to design appropriate service systems."

Second is the need to recognize the na-
ture of mental illness as long term and episodic, and that “it is unlikely that the private sector is as suitable as the public sector for providing care in this long-term episodic situation,” said Prager.

Third, there is the need to see mental health and illness on a continuum from no disability to severe disability. Fourth, mental illness is dynamic. “We tend to think of people as being either mentally well or mentally ill, but in fact, they move along the continuum depending on their life situation and the care they’re getting,” Prager said.

Prager also noted the need for creativity in research and policy making and for more and better intersection between the two; the need to improve the base of knowledge about the determinants of mental health and illness; the need to recognize clinical uncertainty in mental health care; and the need to better understand the true effects of both economic and political incentives on the health care system.

The goal of the day’s meeting was summed up in Prager’s final concern: the need to “close the loop of putting practice into knowledge and knowledge into practice.” To achieve this will require breaking down institutional barriers, opening up discussion across disciplines, and working to lessen the fragmentation that pervades the mental health system and isolates it from the broader health care arena.

Participants

Jack Burke, Director, Division of Biometry and Applied Sciences, National Institute of Mental Health; Herman Diesenhaus, Alcohol, Drug Abuse and Mental Health Administration; Laurie Gardueque, The John D. and Catherine T. MacArthur Foundation; Howard Goldman, Mental Health Policy Studies, Department of Psychiatry, University of Maryland School of Medicine; Linda Greenberg, Health Affairs; Trevor Hadley, Department of Psychiatry, University of Pennsylvania; Michael Hogan, Commissioner, Department of Mental Health, State of Connecticut; Tom Hoyer, Director, Division of Provider Services Coverage Policy, Health Care Financing Administration; John K. Iglehart, Editor, Health Affairs; Judy Miller Jones, National Health Policy Forum; Charles Kieser, Chancellor, Vanderbilt University; Chris Koymagi, Director, Federal Relations, National Mental Health Association; Stephen Leff, Senior Vice-President, Human Services Research Institute; Kathleen A. Malloy, Mental Health Policy Resource Center; Kevin J. Marvelle, Mental Health Policy Resource Center; Noel Mazade, Executive Director, National Association of State Mental Health Program Directors Research Institute, Inc.; Thomas G. McGuire, Professor, Boston University; Denis Prager, Director, Health Program, The John D. and Catherine T. MacArthur Foundation; Gail Robinson, Associate Director, Mental Health Policy Resource Center; Leslie Scallet, Executive Director, Mental Health Policy Resource Center; Steven Sharfstein, Executive Vice-President and Medical Director, Enoch and Sheppard Pratt Hospital; Miles Shore, Superintendent, Massachusetts Mental Health Center; Donald M. Steinwachs, Center on the Organization and Financing of Mental Health Services, The John Hopkins University; Richard Stales, Commissioner, State of New York Office of Mental Health; Judith Turner-Crowson, Fellow, The King’s Fund Institute; Jane White, Health Affairs; Gail R. Wilensky, Administrator, Health Care Financing Administration; and Andrea Zuercher, Health Affairs.