Cite this article as:
D L Shern, S A Donahue, C Felton, G R Joseph and N Brier
Partial capitation versus fee-for-service in mental health care
*Health Affairs* 14, no.3 (1995):208-219
doi: 10.1377/hlthaff.14.3.208

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Partial Capitation Versus Fee-For-service In Mental Health Care
by David L. Shern, Sheila A. Donahue, Chip Felton, Genevieve R. Joseph, and Norman Brier

Abstract: Reimbursement strategies represent a key tool in implementing public policy. Often the relationship between changes in reimbursement policy and changes in provider behavior is difficult to predict, particularly in complex service systems. Here we present findings from a multiyear study involving the comparison of alternative Medicaid reimbursement systems for intensive case management services: a fee-for-service arrangement developed specifically for this study, and the partial capitation system in use in New York State. We focus on the impact of these two reimbursement schemes on the number and types of services provided by case managers and on client outcomes.

States have confronted several challenges in organizing and financing services for adults with severe mental illness since deinstitutionalization.¹ Primary among these has been developing program, organizational, and financing schemes that are responsive to the complex needs of adults with serious mental illness within a badly fragmented treatment and support system.² Strategies to integrate services have involved system-level interventions such as the restructuring of urban mental health systems stimulated by The Robert Wood Johnson Foundation, capitated financing schemes, and continuous treatment teams such as those modeled after the work of Leonard Stein and Mary Ann Test.³ Often, however, program and system reforms have not been coordinated with one another or with reimbursement approaches and thus have failed to provide incentives for caregivers to behave in ways that are consistent with the program models.

In this DataWatch we examine the differential effects of fee-for-service and partial capitation approaches for reimbursing intensive case management (ICM) services both on the behavior of case managers and on client outcomes. Our research focuses on New York State’s ICM program, in an attempt to clarify the relationships between reimbursement and outcomes.⁴

David Shern is dean and director of the Florida Mental Health Institute and principal investigator of the study described in this paper. He formerly served as director of the Bureau of Evaluation and Services Research, New York State Office of Mental Health. Sheila Donahue is a research scientist with the bureau and served as the study’s project director. Chip Felton and Genevieve Joseph are research scientists with the bureau. Norman Brier is director of financial planning for the New York State Office of Mental Health.
**Policy context.** Case management services often are reimbursed through a fee-for-service mechanism in which case managers are paid only for face-to-face contacts with clients. As Anthony Lehman notes, this reimbursement model may offer a set of mixed incentives to the case manager. Direct client contact may help a case manager to understand a client’s needs and desires and to develop a trusting relationship. However, this payment method fails to reward the provision of indirect services such as contact with other agencies on the client’s behalf. Moreover, it provides incentives to overserve the client who is compliant, regardless of clinical benefit, and may reinforce a client’s dependence on the formal treatment system. As such, fee-for-service systems may inflate the cost of services to clients and compromise outcomes. To some degree, they also may confuse the treatment and case management roles.

Lehman and others have suggested that capitated financing schemes may address many of the shortcomings inherent in the fee-for-service method. They argue that capitated financing schemes establish single points of accountability for identified clients and that, depending upon their design and implementation, the schemes may provide incentives to efficiently integrate services that meet the complex needs of persons with severe disabilities. Capitated financing fixes maximum liability for payers, thereby providing predictability in budgeting, and may be a useful cost containment strategy, in contrast to open-ended fee-for-service billings. Capitation is one of a group of prospective payment strategies that employs supply-side cost sharing, a control mechanism that is becoming increasingly popular.

The potential pitfalls of capitated schemes also are well known. Capitated schemes can be quite difficult to implement in public systems. When implemented, they may lead to undertreatment. In terms of outpatient services, Kenneth Wells and colleagues report that participants randomly assigned to a fee-for-service plan with no cost sharing incurred 2.8 times the cost of mental health services as did persons assigned to a prepaid health maintenance organization (HMO). Persons in both groups sought services at the same rate, but those in the prepaid plan had only one-third the number of visits that persons in the fee-for-service plan had. No outcome data were included in their study. Information regarding differential outcomes associated with different financing schemes is rare, particularly for persons with serious mental illness.

Many of the desirable features of capitated financing seem to be consistent with the ICM model. Capitated financing could permit creativity and flexibility in meeting the needs of individual clients. Removing the fee-for-service incentive for face-to-face contact likely would facilitate provision of indirect services (such as service brokerage and linkage) that promote reduction in unmet need and improved community integration.
New York’s Intensive Case Management Program

In New York State a reimbursement system was specifically designed to be consistent with the ICM program model. The ICM program seeks to improve quality of life and community integration for persons with severe disabilities resulting from mental illness through advocacy, linkage, and brokerage services, and by easing access to a broad range of treatment and support services.¹⁰ A capitated approach for Medicaid financing of ICM services was developed. This approach is called partially capitated reimbursement because only ICM services are capitated. ICM program clients who participate in Medicaid (about 70 percent of the clients enrolled) receive their primary mental health treatment through the standard Medicaid fee-for-service system or through other state-financed programs.

Since the primary danger of flat-fee financing schemes appears to be undertreatment, the ICM reimbursement system requires a minimum of four face-to-face contacts of any duration per month for payment of the monthly fee. The flat monthly fee of approximately $525 reflects overall program costs prorated to each client. Each ICM provider agency therefore is at risk for financial loss if it cannot maintain minimum contact with a client, if a client enters state hospital or acute inpatient treatment for longer than thirty days (since Medicaid reimbursement stops in either of these two cases), or if the cost of caring for a client exceeds the amount of reimbursement. This reimbursement system seeks to incorporate the desirable features of capitated financing while protecting against its greatest danger, undertreatment. However, given the characteristics of persons typically served by ICM programs, particularly their relative lack of connection to the human services system, it could be argued that providing only minimal incentives for case managers to visit clients directly might impede the development of the relationship between clients and case managers.

We sought to test these hypotheses by designing and implementing an experimental fee-for-service reimbursement system at a large ICM program in Manhattan and comparing its effectiveness with the partially capitated system approach used by a program of similar size in Brooklyn.

Study Methods

**Design.** We used a nonequivalent control group design with repeated measures. Data on case managers’ activities were collected from two sites over a three-month baseline period while each agency was reimbursed by Medicaid through the partial capitation approach. At one experimental site the reimbursement system was then changed to a fee-for-service system, on which it operated for a full calendar year. Data were collected from both
sites during this period on case managers’ activities, client status, and outcomes. The baseline period extended through October, November, and December 1991, and the experimental fee-for-service system operated for all of calendar year 1992. Collection of data over this period permitted a comparison of case managers’ behavior in the two agencies prior to the implementation of the fee-for-service system at one site, and an assessment of the magnitude of the behavior change associated with the fee-for-service system relative to the secular change measured at the comparison site.

The experimental fee-for-service system. The experimental fee-for-service system featured a declining hourly rate (approximately $100 for the first hour) and a maximum daily billable contact time of three hours. It was designed expressly for this study. The hourly rate was based on two factors: (1) data on case managers’ productivity under the partial capitation approach as measured by the number and distribution of hours per week spent in face-to-face client contact by intensive case managers, and (2) the total allowable Medicaid costs for the agency. The important areas of contrast between the existing partial capitation system and the experimental fee-for-service conditions was as follows: (1) Under fee-for-service, no minimum number of contacts was required per month, while four per month were required under partial capitation. (2) Under partial capitation, there was zero marginal revenue gained by the ICM provider agency for contacts in excess of four in a calendar month. (3) The minimum duration of direct contact was not specified under partial capitation; only the total number of contacts that occurred in the month determined whether reimbursement was received. (4) Under fee-for-service, positive marginal revenue was earned by the ICM provider agency as contact duration increased to a ceiling of 151 minutes per day.

Our guiding hypotheses were that the fee-for-service program would favor direct, face-to-face contacts with clients relative to the flat-fee control site, while the control site would preferentially provide indirect services on behalf of clients. To the degree to which this pattern of behavior occurred, we further predicted that clinical outcomes would favor the fee-for-service system, and reductions in unmet need, the partial capitation approach.

Measurement of case managers’ behavior. Case managers’ behavior was captured for fifteen months with an activity log form used by all ICM programs in New York City. On that log, case managers recorded the duration, location, and nature of each contact on a client-specific basis. Activities were reported as either direct or indirect, with the specific type of activity coded as well. The report of a direct activity required that the client be present. Indirect activities were defined as case managers’ efforts performed on behalf of a specific client, but with the client not present.
**Measurement of client status and outcomes.** Client-reported data were collected through interviews using a highly structured research questionnaire, organized into five areas: social/psychological status, unmet needs, quality of life (objective and subjective), mental health service use, and experience with the ICM program (Exhibit 1).

**Sampling frame and response rate.** Every client enrolled with one of the participating agencies was included in the sampling frame. Information on ICM services received was collected for all clients who enrolled in the

### Exhibit 1
Client-Reported Status And Outcome Measures, New York State Intensive Case Management (ICM) Program

<table>
<thead>
<tr>
<th>Domain and measures</th>
<th>Scale</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/psychological status</td>
<td></td>
<td></td>
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<tr>
<td>Self-esteem</td>
<td>Self-Esteem Scale</td>
<td>Rosenthal(^a)</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Hopelessness Scale</td>
<td>Beck(^b)</td>
</tr>
<tr>
<td>Mastery</td>
<td>Mastery Scale</td>
<td>Pearlin and Schooler(^c)</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Colorado Symptom Index</td>
<td>Shem and colleagues(^d)</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>Five multi-item scales assess need for and</td>
<td>Adapted from the</td>
</tr>
<tr>
<td></td>
<td>receipt of self-care, vocational, treatment,</td>
<td>Colorado Treatment</td>
</tr>
<tr>
<td></td>
<td>crisis, and case management services. A</td>
<td>Outcome Study(^d)</td>
</tr>
<tr>
<td></td>
<td>composite measure of unmet need is created by</td>
<td></td>
</tr>
<tr>
<td></td>
<td>summing across the individual scales.</td>
<td></td>
</tr>
<tr>
<td>Life problems</td>
<td>Life Problems Inventory asks respondents to</td>
<td>Felton and colleagues(^e)</td>
</tr>
<tr>
<td></td>
<td>identify the life areas in which they have</td>
<td></td>
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<tr>
<td></td>
<td>major problems (such as finances, housing,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>relationships).</td>
<td></td>
</tr>
<tr>
<td>Quality of life</td>
<td>Respondents are asked about their objective</td>
<td>Adapted from Lehman(^f)</td>
</tr>
<tr>
<td>Objective</td>
<td>status in multiple areas (such as housing,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>work, finances, social supports, leisure</td>
<td></td>
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<td></td>
<td>activities, alcohol/other drug use, involvement</td>
<td></td>
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<tr>
<td></td>
<td>with criminal justice system).</td>
<td></td>
</tr>
<tr>
<td>Subjective</td>
<td>Scales assess overall satisfaction with housing,</td>
<td>Lehman(^f)</td>
</tr>
<tr>
<td></td>
<td>work, finances, education, interpersonal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>relations, family, and health status.</td>
<td></td>
</tr>
<tr>
<td>Mental health service use</td>
<td>The Outpatient Services Scale determines if the</td>
<td>Adapted from the</td>
</tr>
<tr>
<td>Determination of service use</td>
<td>respondent currently has a psychiatrist or a</td>
<td>Colorado Treatment</td>
</tr>
<tr>
<td></td>
<td>therapist or attends a mental health day</td>
<td>Outcome Study(^d)</td>
</tr>
<tr>
<td></td>
<td>program at least once a week.</td>
<td></td>
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<tr>
<td>Satisfaction with service use</td>
<td>The Satisfaction with Outpatient Services Scale</td>
<td>Adapted from the</td>
</tr>
<tr>
<td></td>
<td>by asking how helpful each of the three services</td>
<td>Colorado Treatment</td>
</tr>
<tr>
<td></td>
<td>has been.</td>
<td>Outcome Study(^d)</td>
</tr>
</tbody>
</table>

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**Domain and measures** | **Scale** | **Authors**
--- | --- | ---
Experience with ICM program | Unmet service needs | Created by subtracting the number of services received from the number reported to be needed | Donahue and Feltong

Program principles | ICM Engagement Scale, measures the operationalization of ICM program principles from the client's perspective | Donahue and Feltong

Satisfaction with ICM | Modeled after Larsen's Satisfaction Scale | Larsen

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**Sources:** See below.


program during the fifteen months of the study. In addition, interviewers attempted to contact each of 669 clients for an in-person interview; of these, 443 (66 percent) consented and were interviewed during the fall of 1991. Follow-up interviews were completed one year later with 88 percent of interviewees; the resulting client-reported data set includes information for 388 persons. For the analyses reported here we have included only those clients who were interviewed twice and were continuously enrolled in the study programs during the study period. A total of 278 persons met these criteria—60 percent of the 461 persons enrolled for the entire fifteen months and 72 percent of the 388 persons who were interviewed twice.

**Comparability of the study sites.** A concern that must be addressed when a quasi-experimental design is used is the similarity between the programs and subjects at the two study sites. Although the ICM programs operated in different boroughs of New York City, a number of state and local regulatory mechanisms helped to assure the similarity of the two programs. First, each ICM program did not control those it served. All referrals to an ICM program were submitted to the New York City Human Resources Administration, where they were reviewed and, if approved,
assigned to a provider agency. Second, disenrollment from a program re-
quired each ICM agency to document the appropriateness of the termina-
tion based on specific criteria and to have the termination approved by the
City Department of Mental Health. Third, both ICM programs were gov-
erned by the same set of program principles, including caseload size, twenty-
four-hour availability, and in vivo service delivery. Fourth, all case managers
had to meet the same set of job qualifications and were required to attend a
citywide multisession training course. Fifth, both agencies followed the
same specifications for completion of service plans, progress notes, and
other records. Finally, examination of financial data for fiscal year 1991-
1992 showed that the two programs had similar total costs per full-time-
equivalent employee ($64,786 for the fee-for-service site and $63,843 for
the partial capitation site).

At the start of the study, data from an ICM statewide evaluation were
used to contrast the characteristics of all clients served by the two pro-
gams.11 No significant differences were found between the programs in
terms of client diagnoses, secondary disabilities, symptoms, marital status,
Medicaid eligibility, or living situation. Small but statistically significant
differences were found for race and ethnicity between the programs, which
are consistent with Manhattan/Brooklyn differences. Site differences in
mean age and level of education also were statistically significant but not
substantial.

We next assessed whether the group of continuously enrolled clients who
had consented to be interviewed twice was representative of the full sam-
ple. Within each ICM program, all clients were compared on age, race, sex,
Medicaid eligibility, secondary disabilities including alcohol or other drug
abuse, diagnosis, and type of residence. No significant differences (a = .05)
between continuously enrolled clients and other clients were found. We
then compared the characteristics of continuously enrolled clients who
were interviewed twice with the rest of the continuously enrolled clients
within each program. Again, no significant differences (a = .05) were
found. We therefore were reassured that limiting our analysis to continu-
ously enrolled clients who were interviewed twice did not restrict our
attention to a group with greatly different characteristics than those of
other clients.

Study Results

Impact of reimbursement system on case managers’ behavior. We
assessed changes in case managers’ behavior by comparing the levels of
direct and indirect client contacts at each site over time. Data for the entire
fifteen-month study period were aggregated by program by quarter, yielding
five quarterly averages. The quarterly data then were analyzed for evidence of change over time and differential change by program. For both indirect and direct contacts, the results show changing service patterns over the course of the intervention, and the magnitude of change differed by site. Sustained differences between sites in the volume of indirect and direct contacts delivered also were observed.

Significant linear trends were noted for both indirect and direct contacts. At the partial capitation site the average number of direct contacts per client per quarter decreased over time, with the greatest reductions occurring during the final two quarters of the study. Comparing the fifth quarter to the first, the average number of direct contacts received by a continuously enrolled client decreased by two, from ten to eight. At the fee-for-service site the average number of direct contacts remained nearly constant over the entire fifteen-month period at thirteen per client per quarter.

In contrast to the findings observed for direct contact, the data on indirect contacts show sharp decreases at the fee-for-service site, with the number of indirect contacts declining by 26 percent, from an average of 11.7 in the baseline period to 8.6 in the last quarter. Although some decline was observed at the partial capitation site in the final two quarters, indirect contacts appear relatively stable here in comparison with the trend for the fee-for-service site.

The differences between the two sites in indirect contacts are consistent with the hypothesis that fee-for-service reimbursement would tend to reduce such activity. At first glance, the results for direct contacts appear to contradict what would be predicted for fee-for-service reimbursement, since direct contacts at the fee-for-service site did not increase from the baseline. However, the observed decline in levels at the fee-for-service site was much smaller than what occurred at the partial capitation site. If the partial capitation site reflects the secular trend for all ICM programs, then the observed levels of direct contacts at the fee-for-service site represent an increase relative to the control condition.

**Differential change in client outcomes between study sites.** For both the composite measure of unmet service needs and the Life Problems Inventory, greater improvement was found at the partial capitation site than at the fee-for-service site (Exhibit 2). Outcomes on the social/psychological status measures of hopelessness and mastery favored the partial capitation site, with self-esteem exhibiting a trend toward significance (p = .12). A significant interaction for the ICM Engagement Scale, which measures the conformance of case managers’ behavior to the principles enumerated for the service, was obtained (p < .01), indicating closer congruence with the theoretical program description at the partial capitation site than at the fee-for-service site. A significant interaction regarding met
need for ICM services also favored the partial capitation site. Only one effect favoring the fee-for-service site approached significance: the scale measuring number of leisure activities ($p = .11$).

The subjective quality-of-life composite measure, the mental health service use items, and all but one of the objective quality-of-life measures showed similar rates of change at both sites.

The fee-for-service system was hypothesized to have a relatively greater impact on clinical status, while the partial capitation approach was expected to be more effective in reducing unmet need. Change on the Hopelessness Scale and the unmet need composite measure were used to test these hypotheses. Significant differential change between sites was found for each of these measures. However, the differential change was not in the direction predicted for hopelessness, a clinical status measure. The change over time for clients enrolled in the fee-for-service program was close to zero, while hopelessness decreased for persons served by the partial capitation site by .45 standard deviations, conventionally considered to be a moderately large effect in this type of social science research.

Changes in the unmet need composite measure at the two sites were mirror images of each other. At each site the absolute magnitude of the change was approximately .4 standard deviations; at the partial capitation site, however, unmet need decreased by that amount, while at the fee-for-service site unmet need increased. These results are consistent with the hypothesized effects of the partial capitation approach on obtaining needed treatment and social services.

### Exhibit 2
Client-Reported Status And Outcome Measures Where Differential Change Occurred Between Sites, New York State Intensive Case Management (ICM) Program

<table>
<thead>
<tr>
<th>Domain and measures</th>
<th>Program by time interaction (F)</th>
<th>System favored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social psychological status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mastery</td>
<td>4.92*</td>
<td>PCS</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>5.67**</td>
<td>PCS</td>
</tr>
<tr>
<td>Unmet needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite measure</td>
<td>19.19**</td>
<td>PCS</td>
</tr>
<tr>
<td>Number of problems</td>
<td>5.13**</td>
<td>PCS</td>
</tr>
<tr>
<td>Experience with ICM program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmet need for ICM assistance</td>
<td>13.03**</td>
<td>PCS</td>
</tr>
<tr>
<td>Implementation of ICM program principles</td>
<td>12.57**</td>
<td>PCS</td>
</tr>
</tbody>
</table>

Source: Authors’ calculations based on study data.

Notes: Based on n of 278. PCS is partial capitation system.

* $p < .05$.

** $p < .01$. 

<table>
<thead>
<tr>
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</tr>
<tr>
<td>Implementation of ICM program principles</td>
<td>12.57**</td>
<td>PCS</td>
</tr>
</tbody>
</table>
Discussion And Conclusions

The results of this study suggest that reimbursement systems may be effective mechanisms for the implementation of public policy and should be thoughtfully integrated with program models. In this instance, the public policy rationale for the ICM program involved improving the delivery of services, shifting costs from emergency and inpatient care to community settings, and improving client outcomes. The rationale for the experimental program model involved the hypothesized benefits of reducing system fragmentation and increasing accountability for clients who were particularly challenging. A reimbursement system that provided professional case managers with the flexibility to meet clients’ needs while assuring a minimal level of direct service to each client was developed specifically to support this program model. The overall results of this research suggest that these general hypotheses were correct and that the public policy ends are being achieved.

As might have been expected from the experience of Wells and colleagues, and others, the experimental fee-for-service reimbursement system promoted the provision of face-to-face services. Less well documented is the behavior of providers that is stimulated by capitated financing schemes. In this study the partial capitation approach was associated with a greater reduction in the volume of direct client contacts relative to the baseline period compared with the fee-for-service site, while the volume of indirect services remained constant under the partial capitation condition relative to the baseline period.

Clients served by the partially capitated program experienced generally better outcomes than did those served at the fee-for-service site. As predicted, clients in the partial capitation group showed greater reductions in unmet need than clients in the fee-for-service group did. Unmet need actually increased for the latter. Clients in the partially capitated program reported greater reductions in problems, fewer unmet needs for ICM services, and greater adherence by case managers to the ICM program principles than did clients served under the fee-for-service condition. Contrary to our original predictions, clients in the partial capitation program also seem to have received more clinical benefit from participation in the ICM program than did clients under the fee-for-service condition, particularly in terms of their sense of mastery and hopefulness.

These findings, although inconsistent with our initial hypotheses, may speak to the dependency-creating incentives implicit in a fee-for-service reimbursement system. In this regard, it is interesting that all of the service trend lines, save direct services under the fee-for-service condition, are negative. This indicates that overall services to this continually enrolled
cohort decrease across time, which is generally consistent with their self-reports of improvement in many areas and, perhaps, with their increasing independence from formal support services. No differential changes in aggregate mental health service use were obtained between the groups. Similarly, few differences in subjective or objective quality of life were obtained. Although this was not a focus of the reimbursement study, the consistent differences between the two programs in their aggregate level of services is striking. Consistent with our earlier arguments regarding client dependence, the best outcomes seem to be associated with the program that provides lower levels of both direct and indirect services. These differences cannot be explained by differences in the programs’ clientele and/or in key features of the programs.

These counterintuitive findings, as well as the general need to better understand the relationship between caregiver behavior and client outcomes, inform our current analysis. We are seeking to develop models of the “production function” in these mental health programs and to more sensitively model the complex determinants of client change across time, including both client and program variables.

It is sobering to realize that health and mental health treatment programs are routinely designed with limited or no knowledge of these production functions. In the case of New York’s ICM program, it appears that the reasoning underlying the development of the partial capitation system was correct. However, system features were based on the intuition and professional judgments of policy staff, not on data regarding case managers’ behavior and client outcomes. We hope that as the field of mental health economics matures, policy decisions will be based more frequently upon systematic knowledge of the relations among payment method, providers’ behavior, and client outcomes.

The research described in this DataWatch was supported by Grant no. RO1 MH46365 from the National Institute of Mental Health (NIMH). The authors acknowledge the contributions of the program managers at the study sites—Kathryn Hyer, Thomas Patitucci, Neil Pessan, David Lindy, and Alice Keating—as well as Stuart Scharf, the research field coordinator; and Elizabeth Pease, technical editor, Bureau of Evaluation and Services Research, New York State Office of Mental Health. This DataWatch is based on a presentation made at the Seventh Biennial Research Conference on the Economics of Mental Health, Bethesda, Maryland, 19-20 September 1994.

NOTES


11. A repeated measures analysis of variance model using polynomial contrasts was tested using SPSSX (Statistical Package for the Social Sciences-Version X).

12. Wells et al., “Use of Outpatient Mental Health Services in HMO and Fee-for-Service Plans.”

13. Although not featured in this analysis, several main effects of time indicated general improvement in client status. For both programs, a number of outcome measures showed change in a positive direction. The social/psychological status scales of mastery, hopelessness, and self-esteem showed significant improvement over time. Across the objective quality-of-life measures, the number of leisure activities and adequacy of finances showed gains. Respondents’ subjective quality of life also improved significantly over time, with the subscales comprising this composite indicating increased satisfaction with living situation, finances, leisure activities, family relations, social relations, personal safety, and health status. In the mental health service use area, only satisfaction with outpatient services changed significantly, indicating increased satisfaction. No significant time effects were found for the scales related to clients’ experience with the ICM program, the composite measure of unmet need for services, or the number of problems reported.