Public-Sector Mental Health Care: New Challenges

Decentralization and greater complexity may be barriers to improving quality in today's public mental health systems.

by Michael F. Hogan

Mental health care is unique in that state and local governments finance and manage a distinct health care system for people with these disorders. This public system serves as a safety net, providing for the uninsured and compensating for inadequate benefits in commercial plans. Concerns about inadequate and flawed public systems dominated public debate about mental health care in the 1970s and 1980s. However, in the 1990s issues such as managed care and insurance parity have taken over as dominant concerns.

A review of two past issues of Health Affairs that focused on mental health policy during the 1990s illustrates how concerns have shifted. In the Fall 1992 issue about half of the papers primarily addressed public-sector concerns. Only a single paper primarily addressed managed care. In contrast, the Fall 1995 issue was subtitled “Mental Health in the Age of Managed Care.” Clearly, managed care had become a dominant concern; only one of the major papers in this issue focused primarily on state mental health systems.

Does a reduced level of policy debate about public systems mean that change has slowed? What are the current trends, issues, problems, and possibilities in this sector of health care? In this paper I address these questions, with illustrations from Ohio.

Today's public systems. Behavioral disorders remain essentially the only set of health problems for which state and local governments finance and manage a specialty treatment system. Public funds pay for a large portion of the costs of care for certain other disorders (such as Medicare financing of dialysis), and public services exist for a few rare disorders such as leprosy. However, the public mental health system is the only substantial, disorder-specific treatment system in existence today.

States remain the largest single payers for mental health care, if states’ contributions to Medicaid are considered. National mental health spending in 1996 totaled $66.7 billion. State (and local) governments spent $11.6 billion, not including their share of Medicaid (which ranges from about 30 percent to 50 percent). Medicaid mental health spending was $12.6 billion. In sum, public spending covered 53 percent of all mental health treatment costs. Private insurance payments of $17.9 billion covered only about a quarter of costs.

Although the existence of a two-tier behavioral health system is, according to the Institute of Medicine, “the most unusual aspect of the care and financing system for mental health and substance abuse treatment,” public systems are receiving less policy attention. This is partly because the organizational and financing dynamics of mental health care are different from those of general health care, and this factor is forgotten or ignored in general health care policy discussions. Also,
much of the national debate about health care focuses on federal issues—the future of Medicare, regulation of private financing, and Medicaid—and the public mental health system is mostly a state and local responsibility. Medicare and Medicaid do fund mental health care, but the proportion of these programs devoted to mental health is relatively small and not at the center of funding or policy concerns. Medicaid and Medicare aside, reported 1996 federal mental health spending reached only about $1 billion, or less than 3 percent of all mental health spending. The largest categorical federal mental health effort is the mental health block grant, but its contribution of less than $300 million annually is only about 1 percent of public mental health spending.

A Decade Of Reform

The state leadership role in public mental health care was reinforced around 1980, when President Ronald Reagan’s “new federalism” approach dismantled the Community Mental Health Centers (CMHC) program and President Jimmy Carter’s proposed Mental Health Systems Act in favor of a state-managed block grant. Ironically, effective state reform efforts were strongly shaped by federal leadership at the same time that federal mental health funding and control were being reduced. The Community Support Program (CSP) approach to care and treatment for persons with serious mental illnesses was promoted by the National Institute on Mental Health (NIMH) in the late 1970s and early 1980s. This was the first reform model that viewed serious mental illness as a long-term disability requiring both rehabilitation and treatment, rather than as a problem that could be avoided by providing only short-term acute treatment. Simultaneously, reforms in federal programs, including Social Security and Medicaid, provided resources to help states develop community care systems, and the Robert Wood Johnson Foundation (RWJF) supported efforts to build organized local systems of care. Thus, the public mental health policy environment in the early 1980s was shaped by a coherent vision, increased opportunities for state control, and the availability of funds from non-categorical sources (Medicaid, Social Security, and Housing and Urban Development).

Despite these opportunities, early in this decade it was not apparent that state reform efforts would succeed. The 1990 rating of state mental health programs by the National Alliance for the Mentally Ill (NAMI) and the Public Citizen Health Research Group argued that services for Americans with serious mental illness “are a disaster by any measure used.” Theodore Marmor and Karyn Gill argued that successful mental health care reform was not likely, because “the political system places fundamental constraints on the mobilization of resources to solve the [system’s] profound needs.” At the end of the decade, although some old problems persist and new ones have arisen, state mental health systems have changed and improved dramatically. Three broad trends and issues characterize the reforms: (1) devolution of responsibility to localities, (2) adoption of CSP approaches resulting in postinstitutional community care systems, and (3) use of Medicaid financing to underwrite a substantial portion of community care costs.

Devolution. The term devolution was not used widely until the 1990s to describe the transfer of responsibility for social programs (such as welfare) from the federal government to state and especially local governments. However, devolution is an apt way to characterize a central, if originally unintended, element of public mental health care reform. Organizing mental health care at the community level—although not necessarily via local government—was a central theme of the CMHC and CSP programs. However, moving responsibility to the community level implicitly meant a transfer of responsibility to local government in many states. Thus, state responsibility and resources were transferred to county governments (as in California, Pennsylvania, and New York) or to community boards at the county level (as in Michigan and
Ohio). In about half of the states, with about three-quarters of the U.S. population, state mental health resources and responsibilities are now housed in whole or part in county-based organizations. Even states without a significant county government role (as in New England) have designated local entities such as CMHCs to coordinate local systems of care.

Framing community care as a devolved responsibility illustrates some of the new tensions and dynamics at work in public systems. Service systems linked to local political structures are strongly shaped by local priorities and conditions. Reform initiatives at the state or national level become more distant and diffuse. Describing policy dynamics in the reformed public mental health system, Massachusetts evaluator Fred Altaffer paraphrases former Speaker of the House Tip O'Neill: “All policies are local.”

Postinstitutional community care. In many states mental health care has been transformed from a system dominated by long-term institutional care to one in which hospitalization is a rare event and long-term institutionalization has all but disappeared. In Ohio, for example, in the early 1960s more than 30,000 patients were in state hospitals, and only about 20,000 persons received publicly funded community care. In 1999 only about 1,200 patients were in state hospitals on any given day (more than half with a forensic status), and fewer than 175 civilly committed or voluntary patients had been hospitalized for over a year. In 1997, the last year for which annual data are available in Ohio, about 250,000 persons received publicly funded community care, and there were about 5,000 admissions to state hospitals. Therefore, the odds of being hospitalized for a person receiving community care were about 2 percent, and long-term hospitalization (aside from forensic commitments) had all but disappeared. Many states maintain similar rates of state hospital use. Thus, in a dramatic shift occurring within a generation, admission to state hospitals has become rare, and most stays are brief. Kenneth Minkoff’s 1987 proposition that we were moving into a “postinstitutional” era has proved correct.

Medicaid’s pervasive influence. When Medicaid was enacted, its design was unfriendly to mental health care: It provided no specialty mental health benefits and no coverage for inpatient care in psychiatric facilities for persons ages twenty-two to sixty-four. Based on the U.S. General Accounting Office’s 1977 criticism of federal inaction to support deinstitutionalization, and recommendations of the President’s Commission on Mental Health headed by Rosalynn Carter, optional specialty mental health benefits (for example, case management) were added to Medicaid early in the 1980s.

Since that time, states have relied heavily on these benefits to finance community-support programs. Additionally, since Medicaid pays for (acute) inpatient care in general hospitals but not in state hospitals, states had an incentive to shift short-stay inpatient care to the general hospital sector. These factors combined to make Medicaid a major payer in public systems by the late 1990s. In Ohio, for example, Medicaid payments to community mental health providers in 1982 were about $8 million, or 4 percent of total community mental health revenues. By 1997 Medicaid payments had risen to $196 million, or 27 percent. Counting reimbursement for inpatient and physician services and for medications, Medicaid covered about one-third of all costs of public mental health care in Ohio. A similar robust role for Medicaid exists in most states.

Blending Medicaid and state/local funds. The dynamics of Medicaid’s role in
funding public mental health systems are complex, poorly understood, and frequently problematic. Medicaid often is managed by a separate agency from the state mental health authority, and coordination can be difficult. While Medicaid pays a substantial proportion of community mental health costs, mental health claims are usually only 3–5 percent of total Medicaid costs.

As Exhibit 1 illustrates, the basic logic and “wiring” of Medicaid differ broadly from the design of mental health care supported by state and county general fund appropriations. State funds are usually distributed under grant or contract mechanisms to support an infrastructure of community care. Since funding for community care has always been limited, community mental health personnel have become skilled at balancing needs and resources. This has involved developing alternatives to meet needs in a less costly manner (crisis beds instead of hospitalization, supported housing instead of residential treatment, peer support instead of long-term psychotherapy). In addition, community mental health systems usually manage access to these resources via largely informal clinical decision making by line staff. In general, state and local general funds support loosely coupled and flexibly managed local mental health systems, not the tightly rationalized systems typical under commercial managed care or required under Medicaid waivers.

The differences between Medicaid and other public funds might not be so great, except that resources from both sources are blended within the budgets of local mental health systems and programs. In a typical CMHC or even a specific program such as an assertive community treatment (ACT) team, Medicaid typically will reimburse some services (but not others, such as housing or job supports) to some clients (but not all, because of ineligibility) some but not all of the time (because of periodic changes in eligibility status).

Although Medicaid has provided major financial support for state mental health care reform, the magnitude of its contribution presents new problems. In addition to the complexities described above, budget pressures encourage CMHCs to “maximize” Medicaid revenues by emphasizing delivery of reimbursable services, even if these are not the most clinically appropriate alternative. For example, partial hospitalization is a useful al-

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<th>EXHIBIT 1</th>
<th>Features Of Medicaid Versus State General-Fund Appropriations</th>
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<tr>
<td>Eligibility</td>
<td>Medicaid</td>
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<tr>
<td>Covered services</td>
<td>Based on disability status or poverty</td>
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<td></td>
<td>Limited to specific treatment/rehabilitation services defined in state Medicaid plan</td>
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<tr>
<td>Reimbursement</td>
<td>Fee-for-service payment for units of reimbursable service delivered to eligible persons, unless under managed care waiver</td>
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<td>Rationing</td>
<td>No service limits or controls on service use unless under managed care waiver</td>
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SOURCE: Author’s analysis.
ternative to acute hospitalization but not an effective rehabilitation service. Nevertheless, generous reimbursement for partial hospital service in most Medicaid programs has led to excessive use of such care for long-term rehabilitation. Also, in some states and counties the demand for funds to meet the required state/local match has sometimes threatened funding for other services that may be valuable but not reimbursable by Medicaid (for example, preventive services).

Medicaid and managed care. Fiscal pressures related to Medicaid’s expanded role have led to many state efforts to manage Medicaid mental health services. Most managed care in Medicaid has simply involved enrolling low-income persons in health maintenance organizations (HMOs). However, many managed behavioral health care “carve-out” programs have now been implemented. Although several Medicaid managed mental health projects have been evaluated positively, the list of problematic efforts is certainly longer, and some of these efforts (in Tennessee and Montana, for instance) have affected the credibility and perhaps the quality of the state’s whole mental health program.18

Despite this flawed track record, more use of managed care in Medicaid mental health services is inevitable. As discussed earlier, the administrative requirements of fee-for-service, Medicaid-paid mental health care are complex and problematic in an environment of grant-funded care. Also, unless managed care controls are used, growing Medicaid match requirements will absorb funds formerly devoted to other mental health services. Because of these pressures, efforts to reconcile Medicaid requirements with the structure of local mental health care systems will continue.

Blended solutions that integrate Medicaid with local community mental health systems may work best in public mental health care. Such approaches are being used now in a number of states in which Medicaid and state funds are being managed together at the county level (as in some parts of Pennsylvania and in Michigan), in local mental health authorities (in Maryland), and in CMHCs (in Utah).19 Implemented under Medicaid waivers, they involve empowering the local mental health authority to manage Medicaid as well as state-funded mental health services. The requirements vary, but the states must typically ensure that access is maintained, that there is some statewide comparability of services, and that costs are capped.

These blended approaches improve the fit between Medicaid-paid mental health services and those paid from other sources. They also capitalize on the locally managed systems that have become a central feature of effective public systems. Whether these approaches inhibit the eventual integration of behavioral with physical health services or of public with privately paid mental health care remains to be seen.

Reform in most state systems has produced a locally managed, community-oriented approach. Yet the fundamental division of responsibility for mental health care between private health insurance and the public system remains. The decentralized and devolved public system is much more humane and effective than the old system of state-run hospitals was. But it is also much more complex. This complexity increases the range of investments and commitments to the current reformed system, providing a measure of political support for public mental health services. But decentralization and complexity also make systemic quality improvement and public/private integration much more difficult to achieve. Given these conditions, the next chapter in public mental health care reform is very difficult to predict.
NOTES


12. T. Lutterman, A. Hirad, and B. Poindexter, Funding Sources and Expenditures of State Mental Health Agencies FY 1997 (Alexandria, Va.: National Association of State Mental Health Program Directors Research Institute, 1999).


17. Ohio Department of Mental Health, unpublished data.
