Editorial: Managed Care for the Seriously Mentally Ill

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Many of the most seriously mentally ill now depend on Medicaid to finance their care, and Medicaid patients constitute about a quarter of all patients treated for psychiatric disorders in general hospitals.[1] As was true for many mental patients who were relocated to nursing homes in the 1960s and 1970s, the cost of psychiatric care for patients eligible for Medicaid who are treated in general hospitals is shared by the federal government, but the same patients treated in state mental hospitals are the sole financial responsibility of the states.

States have substantially downsized their mental hospital systems, relying increasingly on general hospitals and community-based mental health care providers to care for the mentally ill. Despite increases in population and possible increases in the prevalence of certain psychiatric conditions, such as affective disorders and substance abuse, the number of psychiatric patients in public hospitals, approximately 101 500 in 1989, is less than one fifth the peak number in the mid-1950s.[2] In 1990 more than 1.5 million patients with mental disorders were discharged from short-stay hospitals.[3] In New York State, which has the largest public mental health system in the country, the number of adult inpatients in state mental health facilities declined by about 45% between 1980 and 1992.[4]

Patterns of care for Medicaid clients with serious mental illness leave much to be desired. Community care is highly fragmented, with poor coordination between hospital and community.[5] Many persons are repeatedly admitted as inpatients during florid episodes of illness, at high cost to the Medicaid program, but are neglected between admissions.

In recent years there has been much interest in developing capitation-type programs to manage the care of persons with serious mental illness so as to balance expenditures more wisely between inpatient and community services, and to focus responsibility for care of specifically identified patients in contrast to responsibility for catchment areas.[6] There is also much current interest in developing "managed care systems" to use Medicaid resources in a more cost-effective way. In its careful monitoring of the provision of services, managed care represents an appropriate way of allocating scarce resources consistent with need and potential benefit. One option is to mainstream the mentally ill into existing health maintenance organizations (HMOs); another is to develop special HMOs for persons with serious and persistent mental illness. There is considerable skepticism about mainstreaming the seriously mentally ill, and circumstantial evidence indicates that the needs of the chronically ill are likely to be neglected in these contexts.[7,8] Unfortunately, we have few data to enable us to assess the value or dangers of adopting this approach.

In this issue, Christianson, Lurie, Finch, Moscovice, and Hartley[9] report on a randomized health services demonstration in which 35% of Medicaid beneficiaries in Hennepin County, Minnesota, were randomly assigned to receive their care from prepaid plans in contrast to fee-for-service Medicaid. This procedure allowed the investigators to track unbiased

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samples of persons with chronic mental illness in these alternative systems. Data were collected at baseline interviews and at follow-up interviews held from 7 to 12 months later. Supplementary data were also collected from records of community-based treatment programs used by participants in the study, allowing examination of charges and reimbursements for services provided to prepaid and fee-for-service patients. These data, although limited, provide the most detailed picture yet of the consequences of mainstreaming the chronic mentally ill into HMOs.

Medicaid beneficiaries with chronic mental illness who were randomly assigned to HMOs were found to use community mental health services in a manner similar to that of fee-for-service Medicaid patients. However, community services were less likely to be reimbursed for these prepaid patients. Christianson and his colleagues believe that understanding patterns of use of community mental health facilities by Medicaid-prepaid patients is important because such patterns of use bear on the financial viability of and public support for such programs. Certainly Christianson et al.'s observation of larger write-offs for the prepaid Medicaid population requires replication in other contexts and with larger samples, but the issue also requires deeper scrutiny. Patterns of use and write-offs may not be the most important determinants of public support for or financial health of community-based mental health programs; many other political and organizational factors play a role.

Christianson and colleagues qualify their findings carefully. The community they worked in has a long tradition of prepaid group practice, and well-established and responsible HMOs. Their data show that in such a setting, a well-designed mainstreaming program can maintain access to specialty community-based services, at least for a short time. It is unclear whether over longer periods of time access would be rationed as costs increased or as community mental health facilities made stronger efforts to capture reimbursement. In this demonstration, participating plans could not require a patient to obtain a physician referral to nonphysician mental health providers; this limitation ensured that patients could continue earlier patterns of service utilization without barriers if they wished. Such a policy, of course, weakens the HMO's financial control, which could be an issue if community mental health programs aggressively pursue private reimbursement.

It is important to be clear on what this study does not tell us. First, at least at a national level, there is much that is defective in traditional Medicaid patterns of care; simply showing that access gets no worse with mainstreaming is hardly a reason for satisfaction. It is reasonable to expect, however, that mainstreaming will improve general health care for patients with chronic mental illness; general health care needs are commonly neglected when these patients are not part of some organized system of services. Direct evidence on this issue is needed. Second, this demonstration does not tell us about the mental health care of patients in HMOs with their own, internally organized mental health programs, or about HMOs operating in communities with an impoverished infrastructure of public specialty mental health services. With respect to the former situation, the RAND Health Insurance Experiment, which focused on psychiatric patients whose illnesses were not chronic, found a lower intensity of mental health care service in prepaid practice than in fee-for-service plans,[10] but could demonstrate no difference in outcomes.[11] Finally, Christianson et al.'s study provides no information on outcomes. Clearly, we need much more research on outcomes in this critical area.

Unfortunately, some of the HMOs in the Minneapolis demonstration experienced adverse selection. For example, when the largest participant—which had enrolled 58% of the blind and disabled Medicaid population, including many of the severely mentally ill—withdrew from the program because of financial losses, public officials discontinued the demonstration pertinent to disabled Medicaid enrollees.[12] Much work remains to be done in dealing with adverse selection, assessing risk, and developing strategies for apportioning risk fairly. Managed care is not viable unless responsible providers are willing to participate in such programs.

Christianson and his colleagues have opened an important area of research. A new generation of studies is needed to better inform us about the administrative arrangements necessary for responsible managed care for the seriously mentally ill; about how the seriously mentally ill use services in alternative delivery systems; and most importantly, about the extent to which various alternatives allow the control of troublesome symptoms, increase the ability to function, and enhance the quality of life for this highly disadvantaged and neglected population. □

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