

- Psychiatry*. 1978;19:83-94.
7. Shadle M, Christianson J. The organization of mental health care delivery in HMOs. *Administration Men Health*. 1988;15:201-225.
  8. Bittker T. Key concepts in prepaid mental health service delivery. *HMO Mental Health Newsletter*. 1987;2:1-5.
  9. Raynes A. Contracts and capitation: the pros and cons of external linkages. Presented at HMO Mental Health: A Course for Administrators and Clinicians, Harvard Medical School, Department of Continuing Education, Boston, Mass, October 26-28, 1988.
  10. Moscovice I, Finch M, Lurie N. Minnesota: plan choice by the mentally ill in medicaid prepaid plans. In: Scheffler R, Rossiter L, eds. *Advances in Health Economics and Health Services Research: Risk-Based Payments Under Public Programs*. Greenwich, Conn: JAI Press; 1989;10:265-280.
  11. Medicaid Demonstration Design and Development Task Force. *A Plan for a Medicaid Demonstration Project in Hennepin County*. A report to the Hennepin County Board of Commissioners, Minneapolis, Minn; 1985.
  12. Christianson J, Lurie N, Finch M, Moscovice I. Mandatory enrollment of medicaid-eligible mentally ill persons on prepaid plans: the Minnesota demonstration project. *Administration and Policy in Mental Health*. 1988;16:51-64.
  13. *The Medicaid Demonstration Project in Hennepin County, Minnesota: Year One*. A report to the Hennepin County Board of Commissioners, Minneapolis, Minn; 1987.

## Commentary: Caring for the Indigent Mentally Ill—New Strategies and Old Problems

Ernesto Ferran, Jr, MD

### ABSTRACT

Christianson and his colleagues examine how Medicaid beneficiaries receive mental health services in HMOs by analyzing two important aspects of service delivery: the use of community-based treatment programs by Medicaid beneficiaries enrolled in health maintenance organizations (HMOs) and the reimbursement levels paid to these programs by HMOs. The hypotheses studied are complex issues that concern mental-health advocates and providers. Traditional community-based mental health services have always struggled to maintain their presence in the health care field, having to contend with changing funding priorities and more serious and multiple problems presented by their patients. For prepaid plans to work effectively for the indigent mentally ill, the complex issues have to be made clear and acknowledged as meaningful variables. (*Am J Public Health*. 1992;82:796-798)

Dr Christianson and his colleagues analyze two important aspects of mental health care delivery for those who have serious mental disorders and are indigent.<sup>1</sup> They want to know whether Medicaid beneficiaries, once enrolled in prepaid medical plans, will utilize mental health services to the same degree as do non-enrolled Medicaid beneficiaries, and whether the plans will pay the mental health providers the amounts requested of them. Advocates for the indigent mentally ill population would define these questions as questions of access to mental health services and protection of funding for providers traditionally vulnerable to new financing schemes. The issues are not only complex, but also mysterious, and they lend themselves to contentiousness and partisanship.

What I want to address are the factors that make these issues complex: the fact that psychiatric standards of care are difficult to quantify; that mental health care providers, in the absence of conclusive outcome studies for traditional services, are promoting new strategies for providing services to the seriously mentally ill; and that agreement on reimbursement for these strategies will continue to be elusive.

By addressing their first question without a directional hypothesis, the authors avoid being drawn into the argument that relates utilization of outpatient mental health care to outcome. It makes sense that they do so: our fascination with health

care expenditures as an object of study or control becomes problematic for disorders of behavior, emotion, or thought, and the relevant standards of care continue to be poorly understood. Consider the near decade-long effort to create adequate diagnosis-related groups for psychiatric disorders. Witness the relatively recent controversies surrounding for-profit psychiatric hospitals, and the accompanying arguments on appropriate inpatient care vs expected or egregious pricing strategies. Have you not wondered, at some point, what it is that the most vulnerable segment of America's homeless really needs—housing, employment, or long-term psychiatric inpatient care? In other words, the quest to quantify robust standards of care for psychiatric disorders continues to generate more controversy than consensus.

The second hypothesis almost speaks for itself: Write-offs will be higher because prepaid plans will not pay the full costs of care. Why wouldn't they? Why even consider that they wouldn't? If outcome data for outpatient mental health services are so scant, and if "managed-care" pricing strategies (e.g., using diagnostic categories to determine allowable units of service) are de-

---

Ernesto Ferran, Jr, MD, is with Gouverneur Hospital, New York, and with New York University Medical Center.

Requests for reprints should be sent to Ernesto Ferran, Jr, MD, Director of Psychiatry, Gouverneur Hospital, 227 Madison Street, New York, NY 10002.

signed to pay for only essential, effective, and efficient services (or so managed care providers would argue), then the obvious conclusion would be that these plans will not want to accept the offerings of community programs without reservation.

Outpatient services for people with serious mental disorders who also happen to be indigent have never been optimal. The struggle to ensure the availability and continued survival of such services has been frustrating, leaving little room for flexibility or innovation within programs. New strategies for this population—case management, home-based crisis intervention, making temporary residences available during crises, to name just a few—are available to only a small portion of the target population. Stable funding over time has never been afforded to programs dedicated to this population, and this is true for reasons other than lack of demonstrated effectiveness. The indigent mentally ill have few allies: they do not constitute a meaningful voting bloc, their disorders are “deviant,” and their visibility is disturbing or even offensive to society at large. In times of budget crises, outpatient services always suffer more than inpatient programs. A population that is chronically disenfranchised has less protection for its needs.

What makes these services so subject to debate? The major reason is that serious mental illness is a catchall term that describes many disorders. Even within diagnostic categories (as defined by the major classification schemes ICD-9 and DSM-III R, but not the overly simplistic diagnosis-related groups) discrete disorders (e.g., schizophrenia) are better understood as syndromes, with varying levels of expression of vulnerabilities, deficits, and so forth. This makes the delivery of individualized treatment quite complex, especially in public programs.

The general Medicaid population has been described as one that uses medical services inappropriately and needlessly often. Except for heavy users (always a small number, albeit very costly), the mentally ill poor can hardly be accused of needless and inappropriate use. In fact, they are likely to shun services, because they are not sure what they're getting, they don't know what works, and they are discouraged by the inconsistent outcomes. These service issues create problems for managed-care plans in contracting for mental health services.

“Managed-care funding” indicates that the provider assumes prospective risk for the cost of services over a specified

period. To manage (i.e., control) these services, the provider must actively steer patients toward effective services provided by efficient practitioners.

Attempts to quantify use and its costs for inpatient psychiatric episodes have focused on many variables, including diagnosis, treatment auspices, age, sex, and mental status. More recent efforts have focused on the distinctions between psychotic and nonpsychotic disorders, between chronic disorders and acute episodes, and between those who do and do not have access to shelter. These variables serve to demonstrate how difficult it is to quantify standards of care for disorders that have as much to do with political, religious, and cultural institutions as they do with medical ones. In addition, we define illness differently over time. Schizophrenia, once considered demonic possession, is now seen as a mental illness that probably has a biological cause; panic disorders, recently episodes surrounded by fear and shame, are now considered biologically influenced, treatable disorders.

The person who experiences a psychotic illness and who has a family, a job, and a home is very different from one who doesn't have these supports. A person's sociability, religious affiliation, and intellectual capacity also should help to determine the type of treatment best suited for that person. Moreover, providers of care for adults with chronic psychiatric disorders cannot possibly command all the skills needed to treat the myriad symptoms of disturbance. Care-givers constantly encounter situations that force them to alter their treatment strategies. In the last decade they have faced homelessness and mental illness, then substance abuse, and now AIDS. Add to these language barriers, cultural differences, and personality disorders, and it becomes clear why it is not easy to link outcome to provider type, when the outcomes rely heavily on what other supports the patient has available.

Advocates and providers of public care defend the public system as the only resource available for the seriously mentally ill, and managed care strategies abound with principles that would ensure their own success. To bring about a truly effective merger between the two systems, however, we need to understand why community-based mental health treatment programs struggle as they do. Such an understanding would allow the responsible public government agencies to facilitate flexibility in initial pricing of

services and mandate use toward more progressive service strategies.

Consider the settings in which public programs are delivered. Community-based programs have recognized that, to be effective, many services must literally be taken to the patient. Drop-in centers, satellite clinics, and outreach programs are often located in storefronts, church basements, and renovated supermarkets. Although services offered in such places need not be second-class, these settings are bound to limit the programs' flexibility and impede ancillary support. In programs that are struggling for space and are overcrowded with patients, providers and administrators cannot readily reclassify therapists as “case managers” or expand services to include outreach, interpreters, support group programming, and so forth. Nor can they extend their hours of operation without the support services—security, liaison with other services, patient registration, even housekeeping—that can be taken for granted in hospital settings.

New (or rediscovered) models of treatment for this population are recognized as effective adjuncts to individual one-to-one therapies. Group treatments that emphasize family support are based on the recognition that offering patients and families information about school, hospital, and vocational systems; education about the patients' disorders; and practical information about medications can contribute to better compliance and less charged family encounters, and therefore to more stable outcomes. Culturally competent treatment is now considered to include more than mere empathy for a different ethnicity, skin color, or language. The phrase connotes proficiency and knowledge of what elements of culture are crucial to diagnostic assessment and treatment strategies.

Yet programs can't offer group treatments if the physical setting can't accommodate large groups and the system doesn't allow reimbursement for family support services; and they can't offer culturally competent care if trained professionals who share the cultural background of the patient population are not available.

Add to all these dimensions the need to link mental health services to programs that address housing, substance abuse, and vocational needs, and it becomes easier to understand why the price of mental health services must include a full range of other interventions. That Medicaid-eligible services currently have pricing schedules does not mean that the effort to in-

clude these interventions has already been made. State agencies that determine fees for medical services often, in allocating limited monies, decide arbitrarily what will and will not be funded. A service that is Medicaid-eligible in one type of setting may not be in another, and there may be no logical reason for the discrepancy.

The payment formulas for managed care may serve to save money for someone, but for whom? The plan, the community mental health program, and state Medicaid programs all stand to be affected by this new and still controversial form of service delivery. If the state limits Medicaid dollars and if the plan limits units of service, and if mergers of managed care and mental health settings do take place, it

stands to reason that the mental health care setting will have to be altered in some way. Mental health programs and their advocates and authorities, when establishing rates for treatment of the seriously mentally ill, need to go beyond the traditional Medicaid-eligible treatments and define for others the importance of "other" treatments—crisis intervention, family support, collateral and home visits, and self-help programs. These treatments form the basis of community-based outpatient care for the seriously mentally ill and make plain the need to establish networks and partnerships of service. Managed-care plans and their administrators must actively consider the argument raised by mental health care providers that

it is important not only to factor in the cost of providing access to housing, rehabilitation, and vocational programs, but also to acknowledge that these services are still relatively new to mental health care plans. There has been a long battle to ensure that mental health services for the seriously mentally ill continue to operate; the battle has now been extended to include services to treat the "new morbidities" faced by this most vulnerable population. □

## Reference

1. Christianson JB, Lurie N, Finch M, Moscovice IS, Hartley D. Use of community-based mental health programs by HMOs: evidence from a Medicaid demonstration. *Am J Public Health.* 1992;82:790-796.

## Erratum

In: Association News: Deceased Members. *Am J Public Health.* 1992;82:753. The following names were omitted from the list of deaths reported to the Association in 1991:

K. N. Rao, MD  
Herbert Rausher, AB, DPM  
Susan Richards, RN  
Hugh B. Robins, MD  
Friedemann O. Rohleder, MD, MPH  
Mary A. Ross, MA  
Eva J. Salber, DPH, MD  
Bernard A. Saltysiak, OD  
Kermit K. Schooler, PhD  
John W. Shackelford, MD, MPH  
Anne E. Shea, MPH  
Charlotte B. Simon, MA  
Henry C. Steed, Jr, MPH  
Oscar Stern, BSC  
Jesse E. Stewart, PhD

Mary M. Sullivan, MA  
Selma G. Tenenbaum, RNC, BSN, MA  
Grey Bennett Thompson, MA, BS, PhD  
Curtis R. Tucker  
Alan E. Treloar, PhD  
John J. Varadi, MPH  
Gary Frank Velat, MD, MPH  
Judith D. Vollers, RN, BS, MS  
Shirley Wattenberg, MA  
Frank C. Watters, BA  
Philip G. Weiler, MD, MPH  
Helen W. Wiesmann, MS  
Edward A. Wolfson, MD, MPH  
Paul R. Wozniak, MA