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Serious Mental Illness and Capitation Financing

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Traditional organization and financing of mental health care has not adequately served the needs of persons with serious mental illness. Capitation financing is being tested in several localities, but little experimental data has been yielded to date, and it is mixed. The results from the Rochester experiment were positive but limited, and some other pilots also reported positive experiences with capitation. Others have ended prematurely or confronted obstacles. Experimental findings are also anticipated from the Philadelphia and California pilots, and others are just beginning. Existing financing mechanisms, cost-shifting efforts, and professional cultures represent powerful obstacles to successfully implementing capitation financing for care of persons with long-term mental illnesses, and potential incentives to underserve enrollees require adequate accountability structures. In spite of obstacles, the goodness of fit between the needs of persons with serious mental illness and capitation flexibility warrant further exploration of this financing modality.

In the early days of the United States, before the states became the entity most responsible for care of persons with serious and persistent mental illness, many persons with schizophrenia and other disabling mental illnesses ended up in prisons or poorhouses. In the mid 1800's, the states assumed principal responsibility for the severely mentally ill, and state hospitals sprang up nationwide. In most states, the resultant pattern was indefinite custodial care or asylum for many of those remanded to this system. Modern neuroleptics emerged in the 1950's, allowing seemingly hopeless persons to leave the hospital and begin new lives, albeit often without the skills or concentration needed to become fully contributing members of society. Government programs such as Social Security disability insurance (SSI and SSDI) and Medicaid were expanded to cover the needs of community tenure for this group. As state finances became tighter and the demands for treatment and accountability became more incessant, states continued downsizing their psychiatric hospitals (Talbott, 1979). In the early 1980's, the Federal government attempted to reduce its growing liability for this group by purging the rolls of the entitlement programs. As more people with serious illness were released to community settings, localities were given little or no additional money to extend their services to an extremely ill, expanding population (Bachrach, 1987b; Bachrach &

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Lamb, 1989). Many seriously mentally ill persons became homeless, especially those with substance abuse or other disabilities. Multiply disabled mentally ill persons experienced the growing unwillingness of burdened service sectors to assume responsibility for persons with other disabilities. As society has become increasingly intolerant of behavioral anomalies and panhandling, large numbers of mentally ill persons have been arrested, often for relatively minor offenses related to their illness or homelessness (e.g. vagrancy, trespassing). Once again, significant numbers of seriously mentally ill persons reside in prisons, jails, and homeless shelters.

This tragedy is testimony to the failure of the mental health system to shift the locus of treatment for seriously mentally ill persons from the state hospital system into community settings. (Bachrach, 1993b; Mechanic 1991), Social systems have not changed sufficiently over history to accommodate the needs of this group. Mental health professional training has been extremely slow to adjust to the growing ranks of seriously mentally ill persons who are now being treated primarily in community programs. As a result, relatively few programs adequately recognize and address the needs of persons who in the past would have been cared for in state hospital settings. Traditional clinical programs rely on patients to actively promote their own care, to reliably show up for appointments, take their prescribed medications, and report potentially important changes in their symptoms. Many persons with serious mental illnesses do not meet these expectations, and slide out of the care system to their detriment. In addition, it is estimated that over 50% aggravate their illness by self-medicating with psychoactive substances (Minkoff, 1993).

Outpatient mental health systems are heavily supported and shaped by insurance reimbursement. Insurance companies strive to reduce risk by avoiding the high costs associated with long term or recurrent illness, partly by not covering long term care needs, and partly by refusing contracts for persons with pre-existing chronic conditions or intensive service utilization history. Commercial insurance almost exclusively reimburse inpatient and clinic services, which generally meets the needs of employed populations but does not adequately address chronic illness. Medicaid, as the safety net for the poor and sick, has extended its coverage to include some of the needs of the chronically ill, such as home health nursing, medications, and transportation services. Most mental health care systems are neither organized nor have incentives to address the needs of persons with serious and persistent mental illness.

CARE NEEDS FOR CHRONIC MENTAL ILLNESS

Fortunately, as persons with schizophrenia approach middle age, almost half of them gain significant recovery from their symptoms, and many are able to become contributing members of society (Harding, 1988). However, history shows us that, left on their own with natural support systems, many persons with schizophrenia and other serious mental illnesses in the community do not make satisfactory adjustments. Eventually they experience some combination of crisis, rehospitalization, arrest, or marginal existence.

The care needs of persons with serious mental illness include important components which span a variety of human services delivery systems. *Outcasts on Main Street*, the Report of the Federal Task Force on Homelessness and the Severely

Mentally Ill (Leshner *et al*, 1992), summarized the essential elements of an effective system of care for persons with severe mental illness. These elements include assertive outreach, integrated case management, safe havens, housing, mental health treatment, substance abuse treatment, health care, income support and benefits, rehabilitation, vocational training and employment assistance, consumer and family involvement, and legal protections. The tendency for the lives of persons with schizophrenia and other serious mental illnesses to deteriorate (e.g., being evicted, losing employment or income, being arrested) promotes a need for caregivers to be involved in active outreach to natural settings.

ORGANIZATION OF CARE

The challenge of establishing appropriate care systems lies partly in the diversity of needs which should be addressed. Currently, the separate organization and funding of systems (i.e., mental health, substance abuse, health, public safety, rehabilitation, social services) which address these needs creates phenomenal obstacles in coordination of care. Obstacles are compounded when the patients are multiply disabled.

Organization and availability of health care and other human services are heavily influenced by methods of funding (Talbott, 1983; Talbott & Sharfstein, 1986). Traditionally organized mental health care has not encouraged positive outcomes for persons with serious and persistent mental illness, and has often resulted in seriously ill persons "failing" to meet the program's expectations.

Other than offering medication, few community programs have decisively established their ability to improve symptoms and functioning with this population, though a modest ability to reduce hospitalization has been demonstrated (Olfson, 1990). Current professional wisdom stresses rehabilitation, development of natural settings and supports, education and early intervention, and relationships which promote continuity and consistency of care (Bachrach, 1987a; Bachrach, 1993a). Case management and PACT programs have enjoyed the widest implementation. Transportability of apparently effective programs is questionable (Bachrach, 1988; Bachrach, 1989), as the culture of programs and the enthusiasm, vision, and dedication of rare individuals cannot be cloned. In many instances, it is the aggravations of financing mechanisms which prevent new model programs from realizing their potential.

Obstacles to organizing effective comprehensive services for this population are daunting. These include: 1) service selection and flexibility are not supported by the financing modalities; 2) persons in need of service are often unable to promote their own interests; 3) service professionals are not trained for this type of work and tend not to choose it; and 4) cost-shifting is the order of the day as no sector wants to assume the burden of cost. It is not an accident that the same pattern of system fragmentation and discontinuity of care can be found everywhere in the continental United States, because the systems organization and financing mechanisms have much in common.

CAPITATION

Rather than seek to place the blame for the failures of our systems to address the needs of persons with serious mental illness, we should continue to seek approaches

which work better. To guide this search, we return to the principles which have evolved over recent years (Bachrach, 1993a; Lehman, 1989; Mechanic, 1991; Talbott, 1983): First, care must be continuous and consistent, supported by long-term caring relationships, clearly defined responsibility for service planning and accountability. Second, funds must be attached to persons rather than programs, flexibility to meet individual needs, rather than programs dictating standards for participation. Third, services must be comprehensive, addressing the needs of the whole person in a coordinated plan for care, client centered, and tailored to the individual's needs.

Attaching funds to persons rather than programs is part of the definition of managed care. In its simplest definition, capitation is the assumption of responsibility for the care of an enrolled individual in exchange for a regular prospective per capita amount of money. Comprehensive capitation involves assumption of responsibility for broad service coverage, including all aspects of living. The remarkable goodness of fit between comprehensive capitation and the needs of persons with serious and persistent mental illness has been noted, though sometimes in conjunction with a litany of fears and obstacles (Babigian & Reed, 1987; Lehman, 1987; Mechanic, 1992; Mechanic & Aiken, 1989; Schinnar *et al.*, 1989; Schlesinger, 1986; Schlesinger, 1989; Schlesinger & Mechanic, 1993).

By removing incentives to rely only on those services which are reimbursed, capitation allows for great flexibility to create or purchase whatever might work to meet the unique needs of individuals. By assigning responsibility and accountability for care to the enrolling provider, discontinuity of care, cost-shifting and other ills are at least in principle diminished. This also allows the bringing together of services from diverse sectors which have been poorly coordinated in the past. At their best, these features would reverse most of the undesirable aspects of the current systems of care for seriously mentally ill persons, and would outweigh potential disadvantages.

Capitation Disadvantages

It is difficult to bring together the necessary funding streams to create a single capitation stream. At a minimum, each governmental entitlement or insurance program would need to develop a broadly applicable methodology which allows for capitation. It should also be recognized that a significant portion of the current cost of care is absorbed by families, social systems, and other informal supports. Many of these costs are presumably borne reluctantly, in the absence of other supports. Assigning responsibility for care raises the risk that the historical estimated costs underestimate the real costs, and that additional cost-shifting efforts will ensue, which attempt to shift costs into the capitation. Also, persons with multiple disabilities should be addressed through joint efforts of related service sectors, which have been abysmally poor bedfellows in the past. Continued failure of these sectors to plan together will promote continued cost-shifting and disjointed care, to the detriment of large and still-growing groups of community persons with serious mental illness and other comorbid disabilities.

The potential for underservice may be too compelling when large sums of money are prospectively attached to persons with poor self-advocacy (Lehman, 1987; Schlesinger & Mechanic, 1993). For this reason, it is imperative that capitation or other managed care programs have an effective mechanism for quality assurance. Maintain-

ing such a mechanism may require more active local governance and oversight than has typically been implemented in localities.

Poorly funded capitation programs may collapse, leading to the conclusion that capitation is an inherently unstable funding mechanism. Persons with serious mental illness are too vulnerable to be shuffled from provider to provider. Providers do not want to enroll very ill persons and be left with the legal or moral imperative to continue their care when the funding stream which supported it has been diminished or abandoned. This was one of the largest fears of the Rochester providers in beginning the capitation pilot (Reed *et al.*, 1992).

Practical difficulties abound, such as establishing capitation groups and rates which are appropriate, whether or how to engage clients who do not wish to participate in care, and how to promote movement up and down an appropriate continuum of care and particularly in and out of the long-term care cohort.

It should be noted that the advantages of capitation are in the area of improvements in care, whereas most of the disadvantages relate to obstacles in implementing or maintaining the capitation system.

Capitation Caveats

Capitation is a financing construct. While it can reverse incentives related to current financing mechanisms, it does not inherently define provider behavior in terms of the organization and delivery of care. In Rochester, relatively traditional programs were created to care for capitation patients, relying on case management, clinical care and medications, continuing treatment programs, commercial housing, and available social programs and supports. Although capitation represented an opportunity to evolve new and creative approaches to care, no provider departed far from traditional models. In program design and values, we depend on the vision and dedication of caregivers to nurture programs which can have an impact, and on the tolerance of funding mechanisms to support them.

Traditional health maintenance organizations (HMOs) or other prospective payment systems are quite different and incompatible with those which need to be operating in managed care for populations with chronic illness. HMOs tend to enroll relatively healthy populations and to specialize in preventive and well-people care. There are strong incentives not to enroll persons who have intensive ongoing needs, and to avoid expensive care, generally through active pursuit of employer contracts which involve large groups of relatively healthy people. Cost control mechanisms are actively employed, including: limiting use of services, co-payments to reduce demand, reduced credential requirements of employees (staff model HMO), risk-sharing with providers, and selective enrollment. Emphasis is on substitution of less expensive, earlier care for more expensive, later care. While persons with serious mental illness can benefit from substitution and early intervention approaches, they probably cannot bear the consequences of underservice as well as relatively healthy populations. The broad range of health and other service needs for persons with chronic illnesses require a different approach to organization and coordination of care than has been characteristic of HMOs, although some HMOs have evolved broader service options than traditionally funded health care delivery organizations. Attempting to combine persons with serious mental illness into the same HMO with general health care creates potentially serious incentive problems and conflicting

requirements for service delivery components and organization. Schlesinger and Mechanic (1993) note important considerations in designing a comprehensive capitation program for persons with chronic illness, including 1) broad coverage (not just health), 2) subsidies targeted to specialized service populations, 3) sophisticated case management (avoiding decentralized group practice delivery models), 4) reinsurance to protect against high cost with provider incentives to control use of expensive services, 5) avoidance of employee sponsorship and experience rating to prevent employment discrimination, and 6) enhanced quality assurance mechanisms. We believe that capitation programs for persons with chronic illness should be organized independently of general managed care programs limited to health, although they could be operated by the same corporate entity.

EARLY CAPITATION EXPERIENCE

Capitation programs have been implemented in a handful of locations, and are being implemented or seriously considered in still others (Babigian & Marshall, 1989; Christianson *et al*, 1989, 1992; Christianson & Linehan, 1989; Hadley & Glover, 1989; Hargreaves, 1992; Harris & Bergman, 1988; Mauch, 1989; Rothbard *et al.*, 1989; Santiago & Berren, 1989). An experimental evaluation, including two years of follow-up, was completed in Rochester, New York (Babigian *et al*, 1991; Cole *et al.*, in press; Reed *et al.*, in press), involving comprehensive capitation with a highly institutionalized group of state hospital patients. The findings of that study indicated generally more positive outcomes for the experimental group, but most group differences fell short of significance. Results from other capitation programs are mixed, although few other experimental studies have been reported to date. As in Rochester, efforts in Rhode Island and Washington D.C. effectively transferred the locus of care from institutions to community settings. Arizona (Santiago & Berren, 1989), California (Hargreaves, 1992), and Philadelphia (Hadley & Glover, 1989; Rothbard *et al.*, 1989) have had capitation programs implemented for several years, and research designs are in place in California and Philadelphia. Some capitation efforts have centered on mainstreaming chronically mentally ill persons through the general health HMO. In Hennepin County, Minnesota (Christianson, 1994; Lurie *et al.*, 1987), 739 Medicaid patients with schizophrenia were randomized to fee-for-service or general capitation, but the capitation collapsed before the end of the first year due to massive financial losses on the part of high risk providers. The comparison produced essentially no differences between fee-for-service and capitation, other than in the reimbursement of providers for services. Utah experimented with use of mental health HMOs, carving out mental health from general health dollars, but results are not yet published (Christianson, 1994).

THE ROCHESTER CAPITATION EXPERIENCE

Program Design

Detailed description of the capitation, the evaluation design and methods, and evaluation outcomes can be found in other sources (Babigian *et al.*, 1991; Cole *et al.*, in press; Reed *et al.*, in press), but a brief summary follows. The Capitation Payments

System (CPS) was designed as a pilot demonstration. Because the financing for the demonstration was ultimately to come from reduction of state hospital census, eligibility was based on state hospital utilization in the prior three years. Patients who had been hospitalized for more than 270 days in three years could be enrolled at the continuous level, which was a true comprehensive capitation condition involving provision of all health care needs. Early in the capitation, the rate set for this group was over $40,000 per year, but was later adjusted to about $25,000 as actual costs were accumulated. Patients who had been hospitalized for 45–270 days in the past three years could be enrolled at the intermittent level, which was a partial capitation condition. At this level, providers were responsible for coordinating all care needs and providing all outpatient mental health (including community support) services and medications. The annual per capita rate for this level fluctuated around $15,000. Additionally, if patients were enrolled in the state hospital outpatient program, a separate capitation amount of $5,000 was available, either as a separate capitation or in conjunction with the intermittent rate. This rate was later adjusted upward, as it was discovered that the outpatient group costs were closer to $10,000 per year. Care responsibility under the capitation for outpatients was the same as for intermittent patients. During the five years of the demonstration, approximately 800 persons were enrolled in the capitation.

Evaluation

Persons who were determined to meet eligibility criteria for capitation were pre-randomized to either the experimental (E) (60%) or the control (C) group (40%). Only those randomized to the experimental condition appeared on rosters for enrollment. Of the pre-randomized patients (E & C), continuous and intermittent patients enrolled in state outpatient programs, those identified for discharge from the state psychiatric center, and those in current treatment in enrolling CMHCs were approached for enrollment in an evaluation study ($N = 422$). The study team obtained measures regarding diagnosis, symptom, functioning, family burden, service utilization, and cost at baseline and one and two year follow-ups. Enrollment in the study was independent of enrollment in the capitation.

To ensure flexibility and choice in the capitation, experimental patients were not automatically enrolled in the capitation. Instead, enrollments were determined by slot availability, clinical assessment and patient choice. As a result, only half of the experimental group was enrolled in the capitation.

Results

A brief review of the significant findings from the evaluation for the continuous (full capitation) group follows.

Hospitalization. The E group had fewer hospital days (182 days/yr vs C group 230 days/yr) in the first year, falling just short of significance in the second year (E 126 days/yr vs C 165 days/yr). Reduced hospitalization also resulted in lower cost for the capitation group. Cost differences in other categories were not significant.

Use of unreimbursable services. The E group required more than twice the level of use of case management and unreimbursable services in both years.

Level of supervision. Fewer persons were maintained in supervised settings for the E group (vs C) both years (59% of E group were in supervised settings vs 74% for the C group in year 2).

Victimization. The E group was more victimized (42% of E vs 22% of C) in the first year, possibly related to less supervised settings.

Time effects. Both E and C groups showed significant improvement on many measures over the two year period, which could be attributed to improvements in community care programs or movement out of institutional settings.

During the five year period of the capitation pilot project, the state hospital census was reduced from over 850 patients to fewer than 400. Area CMHCs developed large comprehensive off-site centers which specialized in treatment of persons with serious and persistent mental illness. In short, the locus of care was effectively transferred to the community for large numbers of state hospital patients. Although resultant pressures have accumulated on acute services since that time, the transition to community care was relatively smooth.

The Rochester capitation ended in early 1993 for a number of reasons (Reed & Babigian, 1994). First, New York State Office of Mental Health was not particularly interested in implementing capitation. Second, the demonstration involved special contract negotiation which was expensive. Lacking existing mechanisms and a commitment to combining funding streams, these negotiations would continue. Third, the managing entity, Integrated Mental Health, Inc., was a not-for-profit membership corporation of providers, which limited its ability to represent community-wide mental health interests and promoted political conflicts. Fourth, the capitation was viewed as expensive by the state Office of Mental Health. Total costs of care were similar between the capitation studies and estimates made by the Office of Mental Health, but capitation picked up a larger share than would normally be borne by mental health dollars, especially residential and living costs (Reed *et al.*, in press). Another concern which may feed the reluctance to implement this model is the potential for abuse as ethically challenged "providers" see large dollars attached to vulnerable persons with poor self-advocacy. The alternative to capitation which has been implemented in New York State is an intensive case management program, which relies on traditional funding mechanisms to pay for non-case management services.

Many Rochester area planners and providers are committed to capitation as uniquely suited to addressing the needs of this population, and continue to search for ways to implement a comprehensive program for SSI, SSD and other seriously mentally ill populations. Current capitation efforts underway in other localities should provide new information regarding improvements in design and implementation of capitation financing which may make it less unstable or susceptible to abuses. Clearly, changes in the ways services are financed require adjustments at all levels of government to facilitate the combining of funding streams into comprehensive capitation rates, with adequate local management to provide oversight. Many of the required changes, such as collaboration by diverse human service system networks, are desirable in any event, but run counter to the organization of our systems. Often, in proposed model programs, especially for groups who are served by multiple service systems (i.e., children, elderly, and multiple-problem families), the essence of a model new intervention is merely the bringing together of responsibility from several disconnected service sectors to coordinate service delivery. Compre-

hensive capitation does this naturally, once the roles and responsibilities of affected service sectors are defined in developing the capitation program.

CONCLUSION

Our endorsement of comprehensive capitation for care of persons with serious and persistent mental illness is based on several observations: First, the majority of expenditures for care in the public mental health system are accrued by a relatively small percentage of persons. Care for this small group can be greatly improved at little or no additional expense by attending to the broader needs of the individuals, substituting less expensive but better tailored care. Second, many persons are poorly served by the current mental health system. Managed care offers better opportunities to actively engage individuals and address unmet needs which currently obviate effective treatment. Although some programs provide generally effective care, there is no other design which offers more flexibility than comprehensive capitation. On the reservation side, there are serious concerns about the ability to establish and maintain the structure and accountability of an effective comprehensive capitation program. On balance, the positive potential of the capitation financing mechanism warrants continued efforts to explore effective ways of implementing it.

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